

Standard 10. Delivery of care

10.1 SUPPORTING RECOVERY

The MHS incorporates recovery principles into service delivery, culture and practice providing consumers with access and referral to a range of programs that will support sustainable recovery.

GUIDELINES

The intent of this Standard is to ensure that mental health services (MHS) facilitate the recovery journey for consumers by assisting consumers to achieve wellness, rather than just treating the illness.

Recovery oriented culture and practices (Criterion 10.1.1)

In recovery-oriented services recovery values are reflected in the organisation, administration and staffing. Examples include:

- a mission statement identifying recovery processes and outcomes
- policy statements and guidelines providing recovery-based principles for service delivery
- quality improvement that is developed, implemented and monitored collaboratively with consumers and carers
- staff selection, training and supervision according to recovery values and with consumer and carer involvement across all phases of care.

Principles of recovery oriented practice include:

- uniqueness of the Individual
- real choices
- attitudes and rights
- dignity and respect

- partnership and communication
- evaluating recovery.

Dignity and respect (Criterion 10.1.2)

Every individual has worth and is deserving of respect, dignity and effective care. A focus on the consumer's recovery and participation in their own care can facilitate this.

Recognition and support (Criterion 10.1.3)

In a recovery model the aim is to have consumers assume responsibility for themselves. This can be achieved by instilling hope, re-establishing a positive identity and self esteem, healing, empowerment, and connection through the implementation of the principles of human rights, providing a positive culture of healing, and recovery-oriented services. Responsibility for self can be achieved by supporting the consumer to:

- develop their own goals
- work with other health care providers, carers, family and friends, to make plans for reaching these goals
- take on decision-making tasks
- engage in self care.

The MHS should provide consumers and their carers simple and easy to understand information and education on:

- the consumer's condition including how to care for themselves after they exit the service
- how to follow the treatment, care and recovery plan and achieve the expected results
- improving and maintaining the consumer's overall health and wellbeing
- peer based support programs and services that promote recovery
- appropriate inpatient activity programs.

Self (Criteria 10.1.4, 10.1.6)

MHS can help their consumers develop independence and regain self-direction, understanding and control of their illness through:

- advance care directives and treatment, care and recovery plans
- helping consumers develop connections with communities
- establishing relationships with community organisations beyond the mental health service system
- establishing policy and procedures that allow consumers opportunity for choice and control
- educating staff about special interest groups and community activities for consumers.

Social inclusion and citizenship (Criterion 10.1.5)

Examples of strategies that MHS can employ to advocate for the rights of individuals with mental illness to social inclusion and citizenship include but are not limited to:

- asking consumers about what worked and what didn't work for them in their own recovery, including how the treatment, care and recovery plans supported or hindered their progress
- encouraging and supporting consumers to participate in all aspects of service planning, development and implementation (further information on consumer participation is available from Standard 3 Consumer and carer participation)
- encouraging and supporting consumers to become advocates (further information on advocacy is available from Standards 1 Rights and responsibilities and 3 Consumer and carer participation)

providing information to consumers in an understandable format about how they are protected by disability and mental health legislation.

Positive connections—social, family and friends (Criterion 10.1.7)

Re-connection to the community should be viewed as a primary goal of the MHS and reflected in the MHS mission statement. The MHS should support and encourage consumers to develop and/or re-establish appropriate connections with family, friends and community support networks.

The MHS should work collaboratively with consumers to develop and review the consumer's goals for re-connecting with the community.

The culture of the MHS should value and foster the use of peer-support and consumer self-help.

Education should be provided to staff and consumer/carer advocates about the range of support networks that are available in the community such as local civic and volunteer groups, faith communities and educational institutions.

Participation of consumers (Criterion 10.1.8)

This criterion is covered by the guidelines in Standard 3 Consumer and carer participation.

Community services and resources (Criterion 10.1.9)

Examples of community services that mental health services should have knowledge of and support consumers to use include:

- drug and alcohol services
- youth services
- housing

- employment
- Centrelink
- aged care services
- health promotion/public health
- local government
- churches and religious groups
- educational institutions
- Aboriginal and Torres Strait Islander groups
- multicultural groups
- early childhood services
- volunteer groups.

Carer centered approaches (Criteria 10.1.10)

Carer centered approaches may include:

- involvement in treatment and support
- carer education regarding the relevant mental illness
- training in family communication and problem solving skills
- carer counselling and ongoing support
- support for children of parents with a mental illness
- contact with relevant support/self help groups.

Relationships with family, carers, sexual partner, friends, peers, cultural groups and the community are encouraged.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- organisational mission statement
- information and education provided to consumers and carers
- links with other service providers
- consumer and carer satisfaction surveys
- treatment, care and recovery plans
- consumer and carer interviews

- evidence of access to consumer run groups
- evidence of referrals to recovery support programs
- evidence of follow-up
- policies and procedures:
 - principles for service delivery
 - staff selection
 - training and supervision
 - working with carers
 - education program
 - referral process
 - consumer and carer support systems.

10.2 ACCESS

The MHS is accessible to the individual and meets the needs of its community in a timely manner.

GUIDELINES

The intent of this Standard is to ensure that access to mental health services is reasonable and equitable.

After hours care (Criterion 10.2.3)

Information should be available about how consumers can access after hours care.

Evidence of efforts to provide after hours emergency contact information for consumers includes:

- information pamphlet with after hours emergency contact numbers and location of after hours mental health services in a format that is understandable to consumers and carers.

Physical access (Criterion 10.2.4)

The MHS should have clear signage, disabled access and sufficient waiting areas.

The MHS transport assistance policy and procedure should outline options for accessing assistance based on individual consumer needs and risks.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- consumer survey results
- information sheets/brochures/posters
- clear signage, visual inspection of physical entry points
- data on waiting times
- use of technology such as telehealth
- evidence of provision of after hours emergency contact information for consumers
- policies and procedures:
 - after hours access
 - transport assistance
 - dissemination of information on access to the service.

10.3 ENTRY

The entry process to the MHS meets the needs of its community and facilitates timeliness of entry and ongoing assessment.

GUIDELINES

The intent of this Standard is to ensure that entry processes to the mental health service (MHS) are made known to the community it serves and that entry processes are efficient.

Whenever possible the MHS should access the consumer's previous health record to eliminate duplication.

Documented entry policy and process (Criterion 10.3.1)

The MHS should have a documented entry policy and procedure which includes but is not limited to:

- the system of on call, entry and assessment

- ensuring the needs of Aboriginal and Torres Strait Islander persons, culturally and linguistically diverse (CALD) persons, religious/spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age and socio-economic status are addressed in the entry process
- the use of interpreters
- assessing the specific needs of the consumer in terms of the type of services they need.

If the MHS cannot provide appropriate services to the consumer, alternative arrangements are made to facilitate a smooth transition of care to a more appropriate MHS.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- treatment, care and recovery plans
- policies and procedures:
 - referral process
 - triage
 - entry process including inclusion and exclusion criteria
 - safe transport.

10.4 ASSESSMENT AND REVIEW

Consumers receive a comprehensive, timely and accurate assessment and a regular review of progress is provided to the consumer and their carer(s).

GUIDELINES

The intent of this Standard is to ensure that the mental health service (MHS) provides evidence that appropriate information is collected, reviewed and recorded in the individual consumer's health record as part of the assessment, review, treatment and recovery process.

Examples of appropriate information include:

- history of previous mental health problems
- medical history

- details of present health
- functional and emotional status including the consumer's ability to communicate and care for themselves
- cultural and social history and cultural formulation of diagnosis when required
- level of risk the consumer presents to themselves and others
- the consumer's perception of their needs, desired outcomes and their expectations of service delivery
- carers' support available after the consumer exits the MHS
- consumer's knowledge of how to maintain a healthy lifestyle and reduce the risk of mental health problems
- consumer's economic situation, social circumstances and level of education
- individual needs of the consumer and carers that may affect service delivery
- diagnosis
- education about the disease
- range of treatments available
- information about alcohol, tobacco and other drug services
- crisis intervention plan
- options for treatment setting (whenever possible treatment should be administered in a setting of the consumer's choice)
- evaluation of treatment options
- treatment consent forms signed by the consumer and appropriate MHS staff
- details of integration of care with other providers
- service exit plan.

Assessment tools and methods (Criterion 10.4.1)

Assessment tools and methods appropriate to the individual MHS include diagnosis, functional assessment, family input, suicide and other risk assessment, problem oriented assessment, formulation and mental status examination. The MHS should be able to provide evidence of the use of culturally appropriate assessment tools and methods used.

Because there are many clients with alcohol, tobacco and other drug (ATOD) problems, services could benefit from the administration of a self-audit baseline assessment, such as COMPASS, to address co-morbid ATOD issues in a more comprehensive, integrated way. A further self audit could be carried out after, for example, 12 months. Services could also benefit from a validated screening tool related to ATOD use.

Conduct of assessments (Criteria 10.4.2, 10.4.3)

Evidence that assessments are conducted during the consumer's first contact with the MHS is recorded in the consumer's individual health record. There should be evidence of who was involved, including other service providers and/or the carer.

Information on informed consent is available in the guidelines for Standard 1 Rights and responsibilities.

Planning discharge (Criterion 10.4.4)

When discharge planning begins early, the planning is more efficient. Sufficient time to communicate and consult with relevant stakeholders, such as the consumer, carer and other health care professionals will facilitate continuity of care following discharge.

Review (Criteria 10.4.5, 10.4.6)

Assessment is reviewed regularly. A complete assessment depends on many factors such as type or complexity of services provided so information should be continually updated as necessary.

Crisis intervention should be included in treatment, care and recovery plans both for this episode and for future presentations.

Evidence of assessment review is recorded in the consumer's individual health record.

Information on risk assessment is provided in the guidelines for Standard 2 Safety.

Follow-up (Criterion 10.4.7)

Risk assessment is conducted and documented for people who decline to participate in an assessment and an appropriate form of contact is planned with the referring agent. Support is offered to carers when relevant.

Interdisciplinary care plan (Criterion 10.4.8)

The treatment, care and recovery plan is developed with input from the consumer, carers, the person responsible for the coordination of care and other service providers. It should contain the details of treatment provided and expected outcomes to meet the consumer's individual needs, provide continuity of care and complement treatment, care and recovery plans developed by other service providers.

Existing carers' relationships and the capacity, willingness and needs of the carers should be considered when developing the treatment, care and recovery plan so that the necessary supports are for the consumer are established.

The MHS should be able to provide evidence that the consumer and their carers have received a copy of the current treatment, care and recovery plan and that steps have been taken to ensure that the content of the treatment, care and recovery plan is understood by the consumer and their carers.

The age of consumers and carers will affect the degree to which they are involved in the development of their care and recovery plans. Care and recovery plans should be age appropriate especially where there are young carers. Child and adolescent consumers who experience problems within their family may have a legal guardian or others involved in their care and support who may need to be involved in the care plan.

The consumer participates fully in the development of the individual treatment, care and recovery plan and in the evaluation of outcomes.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- assessment methods and tools
- health record review of treatment, care and recovery plans
- consumer survey results
- policies and procedures:
 - follow-up procedures
 - assessments including risk assessments
 - development of treatment, care and recovery plans.

10.5 TREATMENT AND SUPPORT

The MHS provides access to a range of evidence based treatments and facilitates access to rehabilitation and support programs which address the specific needs of consumers and promotes their recovery.

GUIDELINES

The intent of this Standard is to ensure that the defined community has access to high quality treatment and support.

The person responsible for the coordination of the consumers care is involved in the admission, treatment and discharge planning.

Best available evidence (Criterion 10.5.1)

In conjunction with the treating clinician the MHS delivers treatment consistent with current evidence based guidelines and legislation. The MHS can facilitate access to continuing professional development to help service providers remain knowledgeable and skilled, as well as provide access to resources and current clinical practice guidelines.

Treatment and services (Criteria 10.5.2)

Treatment options need to address Aboriginal and Torres Strait Islander persons, culturally and linguistically diverse (CALD) persons, religious/spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age profile and socio-economic status.

Treatment and support systems should be applicable to the consumers' age, stage of development, physical health, and stage in their recovery process.

Further information on culture and diversity is available in the guidelines for Standard 4 Diversity responsiveness.

Information on therapies (Criterion 10.5.3)

Information about the purpose, importance, benefits and risks of proposed treatments need to be provided to the consumer. This information should be delivered in an appropriate language and media for the consumers needs, such as verbal and written information in the relevant language. The MHS should provide this information in conjunction with the treating clinician, as the treating clinician may have discussed therapies with the consumer before they were admitted to the service, and should be documented.

Opportunities should be provided for consumers to ask questions about the therapies offered throughout the treatment process.

Informed consent must be obtained before treatment. The MHS must have a consent form or access to a copy of a consent form that has information about:

- the type of treatment
- steps in the treatment process.

The MHS should obtain consent or sight evidence that consent has been obtained:

- before any treatment or intervention begins
- when services are changed
- when services are added
- when the consumer makes an informed decision about changing their treatment.

This should be documented in the consumer's health record.

Clinical trials and experimental treatments (Criterion 10.5.4)

Appropriate ethical authorisations need to be obtained before consumers can participate in clinical trials and experimental treatments.

Medication management (Criterion 10.5.6)

MHS should have a procedure for pharmaceutical review of prescribing, storage, transport and administration of medications. There should be a system for the use of personal medications during transit, such as on admission to hospital and transfer from one service to another.

Adherence to evidence based treatment (Criteria 10.5.7, 10.5.8)

Strategies to promote adherence to treatment include:

- establishing and maintaining shared care arrangements between the MHS and the primary health care provider
- monitoring the consumer's psychiatric states through collaboration with the consumer, carers and the primary health care provider
- providing ongoing education to the consumer and their carers with the consumer's informed consent about the consumer's illness and options for treatment
- establishing an overall treatment plan in collaboration with the consumer, their carers and their primary health care provider
- enhancing adherence to the treatment plan—this requires the acceptance of psychosocial intervention, vocational goals and addressing relationship issues
- an atmosphere of tolerance in which the consumer feels free to discuss treatment markedly improves adherence
- increasing the understanding of the effects of the illness
- helping consumers cope with their interpersonal relationships, work and other physical health needs
- identifying stressors and early warning signs that could initiate relapse—early warning signs are often nonspecific and may just present as a change in mood, anxiety or social withdrawal.

The strategies detailed above are adapted from *MJA Practice Essentials: Managing schizophrenia in the community* (Harry H Hustig and Peter D Norrie, 1998).

Continuity of care (Criterion 10.5.9)

Dual case management with alcohol and other drug services and collaborative treatment with other service providers such as aged care, psychiatric disability support, disability services and court liaison services should be developed whenever needed.

The MHS ensures the involvement of other related service providers when making decisions about individual treatment of consumers.

Use of medication and / or other therapies (Criterion 10.5.10)

The use of medication forms part of the treatment strategies provided by the MHS and is directed toward maximising the functioning of the consumer while reducing their specific symptoms. Each prescription is documented. Regular review includes the appropriateness of each medication as well as the use of multiple medications and drug interactions.

Any other therapies that may be used are reviewed regularly to ensure their appropriateness to the consumers' age, stage of development, physical health, and stage in their recovery process.

Evaluation of treatment (Criterion 10.5.11)

There is written evidence of appropriate treatment information including:

- information about the illness or disorder
- range of treatments available
- potential benefits and possible adverse effects
- how long before treatment will begin to have an effect
- costs and choices on the use of therapy, medication and other technologies
- wherever possible treatment should be administered in a setting of the consumer's choice
- likely consequences in the event of refusal of treatment
- evaluation of treatment and support outcomes
- consent process.

Range of agencies and programs (Criterion 10.5.12)

Consumers should have the opportunity to be involved in the joint programs developed with other agencies. Community based agencies and programs may include education providers, community recreation programs, paid or voluntary work, and help from other employment and consumer-run support services.

Self care programs (Criteria 10.5.13, 10.5.14 and 10.5.15)

Self care, independence, health and wellbeing are part of the education program provided by the MHS. Peer workers and consumer educators are important contributors to the education program.

Relationships with family, carers, sexual partner, friends, peers, cultural groups and the community are encouraged.

When applicable the MHS provides a range of treatment and support or referral to the appropriate services and programs for consumers to live independently in their own accommodation, shared accommodation, supervised or supported residences and public refuges. These services need to be relevant to the age of the consumer. For example necessary skills required by CAMHS consumers may include 'risk safe behaviours'.

A range of programs based on individual need is available with recognition that some people will need continuing care while others will need a brief episode of care. All programs should attempt to maximise a person's independence and involvement with their community.

The MHS should provide consumers and their carers simple and easy to understand information and education on:

- the consumer's condition including how to care for themselves after they exit the service
- how to follow the treatment plan and achieve the expected results
- how to use medications, supplies and equipment in a safe and effective way
- developing the skills necessary to meet their own needs and become as independent as possible through self care programs
- self care resources available from the MHS, other service providers and the internet
- improving and maintaining the consumer's overall health and wellbeing
- accommodation options
- access to information on employment options such as apprenticeships and traineeships
- access to information on peer-based support programs and services that promote recovery
- provision of access to appropriate inpatient activity programs.

Support systems (Criterion 10.5.17)

Whenever possible and appropriate, ways to access support programs are developed collaboratively with the consumer and reflect the identified needs of each consumer, taking into account their age, stage of development, physical health and stage in their recovery process. Consumers should be able to choose support programs that are most suitable to them.

Support programs include:

- residential/supported housing
- vocational support systems
- education programs
- employment programs
- family programs and family interventions.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- completed consent forms or copies of consent forms
- evidence of diversity responsiveness in treatment, care and recovery plans
- access to and availability of evidence based guidelines
- medication management and notification of adverse drug reactions
- evidence that consumers and carers received treatment, care and recovery plans
- availability of support programs
- range of support programs
- consumer health record review
- policies and procedures:
 - consent
 - research/clinical trials
 - medication management
 - guardianship
 - discharge planning
 - referral
 - shared care arrangements.

10.6 EXIT AND RE-ENTRY

The MHS assists consumers to exit the service and ensures re-entry according to the consumer's needs.

GUIDELINES

The intent of this standard is to ensure that mental health services (MHS) have policy and procedures on how to assist consumers when they exit the service and that consumers are provided with sufficient information on how to re-enter the service if / and / or when required.

Access and information on services (Criteria 10.6.1, 10.6.2)

The consumer is given formal introductions to various community agencies. Information provided might be in the form of a booklet available in a language understood by the consumer and carers or verbal information relayed with the assistance of appropriately trained interpreters. Any information or introductions are given before the consumer exits the service.

Development of exit plans (Criteria 10.6.3, 10.6.4)

The exit plan should identify:

- measurement of change in health status
- satisfaction with service
- perception of quality of life
- review of goals in individual treatment
- care and recovery plan
- peer review
- case discussion
- methods used to evaluate outcomes, including the consumer's preferred evaluation.

Development of exit plans for child and adolescent and aged consumers needs to take into consideration issues specific to their demographic. For example, aged care consumers transferring to a nursing home upon exit from the MHS and exit plans for child and adolescent consumers are not usually discussed at entry to the MHS.

Consumers and their families/carers should be helped to identify early warning signs of a relapse. Symptoms of pending relapse, sometimes called 'relapse signatures', and an accompanying relapse management plan, which includes the accessible crisis services, should be included in the exit plan.

Information in the exit plan should include:

- the preferred health care provider for example the general practitioner or private psychiatrist
- the earliest possible involvement of the consumer's nominated service provider and arrangements for ongoing follow-up
- community resources likely to be needed
- other people likely to be involved
- other details identified by the consumer and/or carers
- preferred method of evaluating outcomes for the consumer
- details of follow-up arrangements with the consumer
- plans for identification of early warning signs of relapse
- information on how to re-enter the MHS
- a clear point of contact in the MHS regarding the most recent episode of treatment and/or support
- shared care arrangements with GPs, private psychiatrists and non-government organisations if applicable.

Re-entering the service (Criteria 10.6.5, 10.6.6, 10.6.7)

At the time of discharge any continuing arrangements for treatment and support should be reviewed by the MHS.

To help in the delivery of care in accordance with the discharge/exit plan in shared care arrangements, for example with a GP, information on the consumer should be provided promptly and include:

- treatment, medication, physical health and any pathology results
- requirements/recommendations for the GP in future treatment of the consumer
- process of returning care to the MHS provider in the case of relapse
- contact information of the person responsible.

Follow-up of consumers (Criterion 10.6.8)

For the purposes of criterion 10.6.8 discharge is defined as discharge from an inpatient unit or discharge from an episode of care. The criterion does not apply to final discharge of the consumer from the mental health service.

Consumers flagged for follow-up are identified by a risk assessment performed before exiting the service.

There is a clear and documented follow-up process, which identifies the responsible agency, carer and crisis service for the period following the consumer's exit from the service.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- exit plans showing evidence of relapse management
- shared care arrangements
- evidence of risk assessments and follow-up
- dissemination of information to primary health care providers
- policies and procedures:
 - development of exit plans
 - access
 - exit and re-entry
 - follow-up procedures.