

Implementation guidelines
for Private Office Based
Mental Health Practices

2010

Implementation guidelines for Private Office Based Mental Health Practices

ISBN: 978-1-74241-300-6

Online ISBN: 978-1-74241-301-3

Publications Approval Number: 6639

Copyright Statements:

Paper-based publications

(c) Commonwealth of Australia 2010

This work is copyright. Apart from any use as permitted under the Copyright Act 1968, no part may be reproduced by any process without prior written permission from the Commonwealth. Requests and inquiries concerning reproduction and rights should be addressed to the Commonwealth Copyright Administration, Attorney-General's Department, Robert Garran Offices, National Circuit, Barton ACT 2600 or posted at <http://www.ag.gov.au/cca>

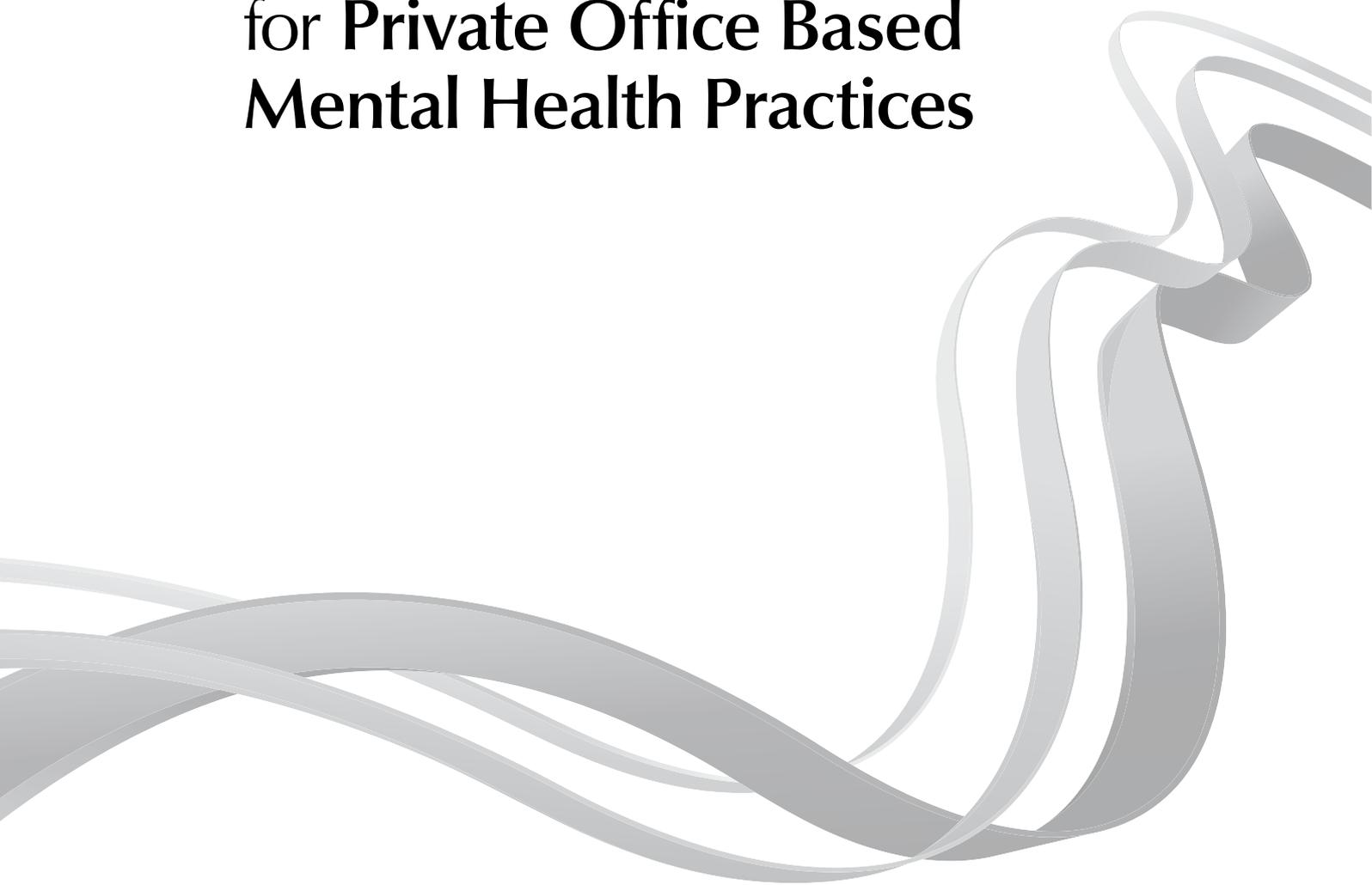
Internet sites

(c) Commonwealth of Australia 2010

This work is copyright. You may download, display, print and reproduce this material in unaltered form only (retaining this notice) for your personal, non-commercial use or use within your organisation. Apart from any use as permitted under the Copyright Act 1968, all other rights are reserved. Requests and inquiries concerning reproduction and rights should be addressed to Commonwealth Copyright Administration, Attorney-General's Department, Robert Garran Offices, National Circuit, Barton ACT 2600 or posted at <http://www.ag.gov.au/cca>

The revision of the National Standards for Mental Health services and the development of the corresponding Implementation Guidelines were funded by the Australian Government.

Implementation guidelines
for **Private Office Based
Mental Health Practices**



2010

Contents

This implementation guide for private office based mental health practices accompanies the ten National Standards for Mental Health Services.

Standard 1. Rights and responsibilities

Standard 2. Safety

Standard 3. Consumer and carer participation

Standard 4. Diversity responsiveness

Standard 5. Promotion and prevention

Standard 6. Consumers

Standard 7. Carers

Standard 8. Governance, leadership and management

Standard 9. Integration

Standard 10. Delivery of care

10.1 Supporting recovery

10.2 Access

10.3 Entry

10.4 Assessment and review

10.5 Treatment and support

10.6 Exit and re-entry

The guide provides more detail about the implementation of the National Standards and how they apply to your service. It is one of three guideline documents developed by and for different sector groups. The other two are for:

- public mental health services and private hospitals
- community (non-government) organisations.

The guidelines were developed with input and recommendations from:

- the alcohol, tobacco and other drugs (ATOD) sector
- Aboriginal and Torres Strait Islander people
- culturally and linguistically diverse (CALD) community sector
- mental health consumers and carers.

The recommendations from these groups have been incorporated into each of the three implementation guidelines.

An electronic copy of the implementation guidelines, as well as the National Standards for Mental Health Services, can be downloaded from the Mental Health Standing Committee website:

➤ <http://www.health.gov.au/mhsc>

GUIDELINES AND SUGGESTED EVIDENCE FOR PRIVATE OFFICE BASED MENTAL HEALTH PRACTICE

The National Standards for Mental Health Services (the National Standards) and the supporting guidelines aim to continually improve the quality of mental health care for all Australians. They are underpinned by a recognised need to respond to the growing cultural and social diversity in the Australian community including the needs of Aboriginal and Torres Strait Islander people. This diversity is reflected in mental health consumers and carers, as well as among professionals working in mental health services.

The National Standards and guidelines recognise that every interaction between consumers, carers, communities and service providers in the mental health care environment is influenced by a complex matrix of beliefs, values and attitudes towards health, illness and recovery.

Many of the criteria of the National Standards have similar themes or key issues. These are detailed in the cross-referencing table found at the back of this document.

Standard 1.

Rights and responsibilities

The rights and responsibilities of people affected by mental health problems and / or mental illness are upheld by the mental health service (MHS) and are documented, prominently displayed, applied and promoted throughout all phases of care.

GUIDELINES

The intent of this Standard is to ensure that consumers, carers, and any other people affected by mental health problems are provided with information that will assist them to understand and exercise their rights and responsibilities while accessing mental health services (MHS).

Dignity and respect (Criterion 1.1)

All consumers have the right to treatment that respects their dignity and privacy. When consumers are placed in an environment where privacy is compromised because of essential treatment, then the MHS should have processes to ensure that they are treated respectfully and that full privacy is established as soon as practicable. Private waiting space and private rooms for assessments and consultations should be available.

Legislation (Criterion 1.2)

The MHS should have access to legislation, acts and guidelines related to their service. There are many sources for this information. Current information on relevant legislation, acts and guidelines, such as an extract from the Privacy Act or fact sheets are available from:

➤ <http://www.privacy.gov.au>

Information provided includes:

- national privacy legislation
- consumer information “My Health My Privacy My Choice”
- information sheet on the Privacy Act
- guidelines on health privacy
- guidelines on research privacy.

Links to privacy legislation in all states and territories and international human rights instruments can also be found at [➤ http://www.privacy.gov.au](http://www.privacy.gov.au) .

There should be evidence of a process to incorporate and monitor compliance with legislation and guidelines where applicable.

Informed consent (Criterion 1.3)

Informed consent should always be obtained before any treatment and documented in the person’s health record.

Consumers may sometimes be subject to the provisions of mental health legislation, or have a legal guardian lawfully authorised to make, on their behalf, a decision that compels the consumer to receive treatment. Services provided must be consistent with the relevant Commonwealth and state and territory mental health legislation and related Acts.

Rights and responsibilities information (Criteria 1.4, 1.5, 1.6, 1.7)

Rights and responsibilities information should be provided in an age and culturally appropriate way, in languages relevant and appropriate to the defined community. The office based practitioner is responsible for ensuring that the patient and, if relevant, his or her carers understand their respective roles and responsibilities. This should be documented in the clinical record.

Written current information on rights and responsibilities available to consumers, carers and staff should include but not be limited to:

- a copy of the National Standards for Mental Health Services
- a copy of the *Mental health: statement of rights and responsibilities* (1991) available at [➤ www.health.gov.au](http://www.health.gov.au)

- complaints procedures including phone number and address of independent bodies
- the responsibility of consumers and carers to treat staff and volunteers of the MHS with respect
- how staff of the MHS uphold the right of consumers and carers to be treated with respect
- the responsibility of the consumer to disclose relevant information about themselves that may affect treatment.

The MHS can help a consumer understand and to be understood by offering the:

- use of interpreters
- opportunity to ask questions
- use of consumer advocates
- involvement of important family members or supporters in joint discussion of rights and responsibilities.

Evidence should be included in the health record that rights and responsibilities were discussed verbally with the consumer and carers when appropriate.

Privacy and confidentiality (Criteria 1.8, 1.9)

The consumer's right to privacy and personal space should be considered in the layout and design of private consulting and therapy rooms. The environment should enable effective treatment to occur, while ensuring safety and protection of other consumers, staff, visitors and members of the public.

Confidentiality of personal information should accord with Commonwealth and state and territory legislation and staff should be made aware of relevant policies and procedures.

Examples of consumer rights to privacy and confidentiality being respected include:

- provision of private waiting space
- private rooms for assessments and consultations
- lockable cupboards for personal possessions
- staff discretion when discussing consumers
- use of accredited interpreters
- anonymity in providing feedback and suggestions to the MHS.

Involvement in care (Criteria 1.10, 1.11, 1.12)

The MHS should offer the opportunity to all those who are affected by mental illness to learn about mental illness, through facilitating access to relevant information and support.

The consumer should be involved in their treatment, care and recovery planning and the provision of information about their illness will assist this.

While the need for confidentiality to be respected is recognised, this does not preclude the involvement of carers in discussions on the consumer's treatment, care and recovery plan. However, if the consumer has refused or withdrawn consent, general discussions may take place.

The consumer has a right to have others involved in their care, but it is important to recognise that they have the right of refusal if the MHS nominates to have other staff or service providers involved, providing this refusal does not impose a risk to the consumer or other staff or service providers.

Access to records (Criteria 1.13, 1.14)

Access by consumers to their own records should accord with Commonwealth and state or territory legislation. Legislative exclusions to the right of access should be appropriately applied.

Policy and procedures about use, disclosure and handling of personal and health related information should address any issues that may be relevant to each mental health service.

Advocacy (Criterion 1.15)

Posters and brochures providing information on how to access advocacy services should be prominent in the MHS.

Evidence of access to advocacy and support services should be documented in the individual consumer health record.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- rights and responsibilities brochure/leaflet
- Privacy Commission fact sheets
- staff training module on rights and responsibilities, privacy and confidentiality
- examples of ongoing support for staff
- posters/brochures on privacy
- translated consumer provided documents
- the availability of copies of the National Standards for Mental Health Services
- health records review
- visual evidence of private consulting rooms etc
- quantitative and qualitative methods to obtain consumer and carer satisfaction
 - patient surveys
 - focus groups
 - informant interviews
- policies and procedures:
 - management of health information
 - use of interpreters
 - consumer advocacy
 - voluntary and involuntary consumers
 - consent process
 - privacy and confidentiality
 - complaints and grievances
 - cultural assessment
 - compliance with legislation.

Standard 2.

Safety

The activities and environment of the MHS are safe for consumers, carers, families, visitors, staff and its community.

GUIDELINES

The intent of this Standard is to ensure that mental health services (MHS) provide a safe environment for consumers, carers, visitors and staff. This can be achieved by identification, analysis, treatment or correction, monitoring and review of risks to safety.

Promoting safety (Criterion 2.1)

The MHS must ensure the safety and wellbeing of its consumers, carers, staff and others.

Cultural beliefs form an important aspect of consumers' understanding and response to health care. Protection of consumers' cultural needs should be considered when reviewing safety issues. Care should be delivered with consumers' culture and diversity taken into account. Otherwise culturally inappropriate care may result in misunderstandings, placing the consumers at risk of events that may adversely affect their mental health and recovery. Further requirements of culture and diversity are addressed in Standard 4 Diversity responsiveness.

Culturally safe environments are those in which a consumer feels safe and that their mental health and overall health needs are understood. When a consumer's culture is viewed as an essential component of their care they feel empowered to make decisions on their care and recovery.

Legislation, regulations and guidelines (Criteria 2.6, 2.7)

Examples of relevant safety legislation, regulations and guidelines include:

- the Australian Health Ministers' *Mental health: statement of rights and responsibilities (1991)*
- national and state and territory working groups guidelines on quality and safety
- state and territory occupational health and safety legislation

- state and territory mental health legislation and related Acts
- *National safety priorities in mental health: a national plan for reducing harm (2005)*
- Royal Australian and New Zealand College of Psychiatrists Code of Ethics 2004.

Information on infection control should be available to staff, consumers and visitors and infection control standards should be adhered to in the MHS.

The MHS must have policy and procedures to ensure the safety of all people within the service setting, particularly those who are vulnerable.

The MHS must be conducted in an appropriately designed facility ensuring the physical environment is appropriate to deliver and facilitate safe and effective care.

The policies and procedures to address safety issues for consumers, carers and staff in office based practice include:

- identifying the appropriate delivery of care for the consumer
- identifying the carers
- managing medication and adverse medication events
- managing clinical handover and transfer of care
- minimising the risk of self harm and suicide
- identifying and managing risks
- security measures
- controlling infection.

The MHS should have procedures to help staff, consumers, their carers and other visitors when they have been exposed to a traumatic incident within the service.

Staff safety (Criteria 2.8, 2.9, 2.10)

The MHS should employ sufficient staff to ensure their safety and the safety of consumers, carers and others. If staff are required to work alone the MHS should have written protocols that address any issues identified in a risk assessment.

The risk assessment of staff working conditions could include:

- staff working alone and access to others at all times
- personal security on and off site
- violence and aggression

- lifting and manual handling
- hazardous substances
- security of medications and other stores
- evacuation in the event of a fire or other danger
- adverse event or incident management.

Staff should be trained in workplace health and safety in accordance with relevant legislation. There should also be evidence of staff participation in comprehensive, updated and revised training in the use of strategies to identify, prevent or de-escalate agitation, aggression and interpersonal violence.

The MHS should have a formal critical incident and emergency response plan to ensure the safety and security of staff and others within the MHS when such incidents occur.

Assessment (Criterion 2.11)

Regular assessments of the environment of the MHS should be carried out and action taken to mitigate the risk of harm.

Review and analysis of risks (Criteria 2.12, 2.13)

Office based practitioners should regularly review environmental risk and its mitigation.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- policies and procedures:
 - workplace health and safety
 - risk management
 - aggression and violence
 - infection control
 - staffing and resource management
 - staff safety.

Standard 3.

Consumer and carer participation

Consumers and carers are actively involved in the development, planning, delivery and evaluation of services.

GUIDELINES

The intent of this Standard is to ensure that where appropriate and relevant in private office based mental health practices (MHS) there is an ongoing consultation with consumers, carers and others in its community regarding the planning, delivery, development, monitoring and evaluation of services.

Participation (Criteria 3.1, 3.2)

The MHS should use methods that suit an individual practice when engaging with and supporting consumers and carers in all areas of service planning, delivery, evaluation and quality assurance activities.

The consumer and carer participation needs to reflect the cultural and social diversity within which the MHS operates.

Examples of appropriate methods include:

- consumer and carer representation on service planning, delivery, evaluation and quality assurance committees
- use of consumer and carer feedback
- the terms of reference for the consumer and carer groups, and service planning, delivery, evaluation and quality assurance committees reflect the need for formal links and integration between them.

Support and training (Criterion 3.3)

Consumers and carers who are involved with the MHS must have access to training and support.

Advocacy (Criteria 3.4, 3.5)

Information on how to access advocacy services should be provided for example in the rights and responsibilities document and may include:

- a list of organisations such as Mental Health Carers ARAFMI Australia
- (information available at: ↗ <http://www.arafmiaustralia.asn.au>) and Children of Parents with a Mental Illness (COPMI) (information available at: ↗ <http://www.copmi.net.au>)
- other identified organisations in the state or territory, such as the Commonwealth Carer Resource Centre on 1800 242 636 (free call).

It is essential that consumer and carer advocates are provided with culturally appropriate information and support.

The MHS must explore alternative ways to ensure culturally appropriate advocacy. For example, it may be preferable to conduct periodic workshop sessions with a group of consumers or carers from different ethnic groups or from a particular remote community so a more representative and accurate 'voice' is heard.

Employment of consumers and carers (Criterion 3.6)

Consumers and carers can be employed in an MHS in these ways:

- as consumer/carer consultants on projects
- as peer workers
- in consumer/carer liaison with agencies
- in research.

Employed consumers and carers should be well informed about what processes are in place to protect, advise and support them. When consumers and carers are employed, the MHS should ensure they are mentored and supervised and have access to any training and support they may need.

Documentation of participation (Criterion 3.7)

Documentation of consumer and carer participation in the MHS should contain policies and procedures on:

- the process for choosing consumers, carers and other representatives
- payment (either direct or 'in kind') and reimbursement for expenses, in accordance with the preference of the consumer or carer
- how to identify the equipment, space and budget needed
- determining whether consumers or carers want collective or separate representation
- consultation with representatives from the MHS community as required.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- evidence of service participation activities such as planning decisions, meeting minutes, payment and expense reimbursement
- evidence on demographics of consumers and carer participation, which must include age, gender and ethnicity
- policies and procedures:
 - consumer and carer participation including training and support
 - advocacy including training and support, mentoring and supervision
 - representation on committees
 - terms of reference for consumer and carer committees
 - position descriptions for consumer and carer consultants.

Standard 4.

Diversity responsiveness

The MHS delivers services that take into account the cultural and social diversity of its consumers and meets their needs and those of their carers and community throughout all phases of care.

GUIDELINES.

The intent of this Standard is to ensure that mental health services (MHS) are culturally responsive and appropriate for the culturally and linguistically diverse population in their defined community.

MHS that recognise and respond to the multiple levels of diversity within their community will develop cultural competence.

Cultural competence refers to the processes and practices that facilitate inclusiveness and address the inequities in health care for people from CALD backgrounds. It means learning about diversity and how it affects the way services are accessed, delivered, received and promoted. This learning process should be incorporated into all aspects of policy making, administration, practice and service delivery. It should systematically involve CALD consumers, carers, key stakeholders and communities in the planning, delivery and evaluation of services.

Aboriginal and Torres Strait Islander cultural competency refers to the ability to understand and value the perspectives of Aboriginal and Torres Strait Islander people and provides the basis upon which all Australians may engage positively in a spirit of mutual respect and reconciliation. MHS should recognise the right to self determination and form meaningful partnerships based on cultural respect and culturally responsive and safe practice.

MHS should be aware of the definition:

Aboriginal health is not just the physical well being of an individual but is the social, emotional and cultural well being of the whole community in which each individual is able to achieve their full potential thereby bringing about the total well being of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life. (National Aboriginal Community Controlled Health Organisation (NACCHO, 1996)

Further information on cultural safety is available in the guidelines for Standard 2 Safety.

Identification (Criterion 4.1)

The MHS should identify the diverse groups within its catchment area and patterns of use and under-use of the MHS. This information should be used to plan and develop culturally competent services and strategies to improve access to the service.

The MHS should provide evidence that it uses methods such as:

- analysis of census data and relevant research on CALD mental health issues
- collaborations with CALD groups and relevant community organisations
- open public forums in partnership with relevant CALD stakeholders
- collaboration with expert individuals, networks and organisations such as the Transcultural Mental Health and Refugee Centres to gain knowledge on the diversity in the local community
- collaboration with community health and welfare organisations and services to develop local protocols for Aboriginal and Torres Strait Islander people
- developing relationships with local Aboriginal and Torres Strait Islander elders and peak groups.

Response to needs (Criterion 4.2)

The MHS should have documented evidence to show:

- consultations and partnership with local CALD services
- the provision of training to all staff, including management, on the diversity of needs within its catchment and on culturally competent service delivery
- how consultation and representation of CALD groups are sought within the service's relevant committees and working groups
- how consultation and representation of Aboriginal and Torres Strait Islander communities are sought within the service's relevant committees and working groups
- how complaints, dispute and grievance resolution procedures address diversity factors
- how the service engages with CALD community organisations and experts in transcultural mental health
- how and when the MHS engages interpreters.

Policies, procedures and work practices that recognise and are responsive to the needs of the MHS community include:

- the social and cultural customs and values of Aboriginal and Torres Strait Islander people identified within its community
- the social and cultural customs and values of people from CALD backgrounds identified within its community

- issues of gender and sexual orientation
- issues of age and differences in socio-economic status
- physical or intellectual disabilities
- religious customs and spiritual values of people identified within its community.

The MHS should have documented evidence on how staff access and distribute multilingual resources to consumers, carers and others on rights and responsibilities and relevant mental health topics.

The MHS should have documented evidence to demonstrate assessment and treatment processes inclusive of the consumer's and carer's cultural and linguistic needs.

MHS should ensure that all data for Aboriginal and Torres Strait Islander people is community informed. Available socioeconomic and cultural data must be in a useable form. All data should be available to staff and the community through orientation programs, cultural awareness training and ongoing updates.

Planning (Criterion 4.3)

The MHS must use methods that are always appropriate and engage the CALD groups and the Aboriginal and Torres Strait Islander community in all areas of service planning, delivery, evaluation and quality assurance activities. This should be demonstrated within its strategic and business plans.

All policy and development proposals need to consider how they affect Aboriginal and Torres Strait Islander people and CALD communities.

Other service providers (Criterion 4.4)

The MHS needs to demonstrate that it has policies and procedures that allow access to professional services (such as interpreters, Aboriginal and Torres Strait Islander health workers, cultural consultants and transcultural mental health services and networks) and how this information has been communicated to staff, consumers and carers.

The MHS needs to demonstrate how and when it will engage interpreters or bilingual workers to facilitate culturally appropriate assessment, diagnosis and treatment. The use of interpreters or bilingual workers needs to be coordinated in consultation with the consumer and carer to ensure culturally sensitive and safe practice.

Evidence of the use of liaison staff or other related service providers should be documented in the consumer's health record.

In keeping with the principle of self determination for Aboriginal and Torres Strait Islander people, MHS should develop appropriate partnerships with other service providers, organisations and programs with experience of diversity.

Staff (Criteria 4.5, 4.6)

The MHS needs to demonstrate that staff are skilled in accessing information about socio-cultural, linguistic and historical factors relevant to the mental health of people from CALD backgrounds, especially those who have had traumatic or refugee experiences.

The MHS needs to demonstrate that staff are able to access cultural competency training in mental health and provide documentation showing the percentage of staff who annually attend this training.

The MHS, when it is appropriate, should integrate the use of available culturally and linguistically diverse and Aboriginal and Torres Strait Islander liaison staff into service delivery.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- analysis of census data
- cultural appropriateness of services and clinical instruments
- evidence of use of interpreters
- translated documents
- evidence of percentage of staff who have completed cultural competency training in mental health
- analysis of the cultural and linguistic backgrounds of consumers and carers of the MHS
- evidence of seeking cultural input from cultural informants, bilingual workers or relevant others
- evidence of partnerships with Aboriginal and Torres Strait Islander communities
- evidence of use of related service providers
- policies and procedures:
 - working with Aboriginal and Torres Strait Islander consumers and carers
 - working with CALD consumers and carers
 - use of interpreters
 - special needs groups
 - staff training
 - disputes and grievances
 - dissemination of cultural information
 - representation on committees
 - evidence of implementation and regular review of policies and procedures.

Standard 5.

Promotion and prevention

The MHS works in partnership with its community to promote mental health and address prevention of mental health problems and / or mental illness.

GUIDELINES

For office based practices this standard has limited applicability because of the nature of the service provided. However all attempts are made to ensure that the mental health services develop appropriate and effective activities to promote mental health and prevent mental health problems and/or mental illness.

This Standard should be read in conjunction with Standard 8 Governance, leadership and management.

Development of activities (Criterion 5.1)

Development of promotion and prevention activities will be influenced by the size, scope of services provided and the sector the MHS operates in, for example, public, private, or the non-government organisation sector.

The MHS should link their promotion and prevention strategies to the early intervention of mental health problems and/or mental illness in accordance with the key directions of the *National mental health promotion, prevention and early intervention action plan (2000)*.

Strategies need to be developed that capture the needs of our culturally and socially diverse population. Mental health promotion and prevention initiatives from conception through to implementation and evaluation need to be designed for culturally and socially diverse population groups

Strategies for Aboriginal and Torres Strait Islander populations should also be informed by the *National Framework for Aboriginal and Torres Strait Islander Health (2003 – 2013)* and based on established partnerships with Aboriginal and Torres Strait Islander stakeholders.

Appropriate activities (Criterion 5.2)

To address this standard the MHS should consider establishing and maintaining partnerships with carers, consumers and relevant stakeholders to share and combine resources.

Collaborative partnerships (Criterion 5.3)

Collaborative partnerships should be considered with other appropriate internal and external stakeholders to clarify roles and coordinate efforts. Through partnerships responsibility is distributed and resources for addressing different components of the promotion and prevention effort shared.

Examples of sectors and settings include:

- drug and alcohol services
- youth sector
- housing
- employment
- Centrelink
- aged care services
- health promotion/public health
- local government
- community services
- churches and religious groups
- schools
- tertiary education sector
- Aboriginal and Torres Strait Islander groups
- divisions of general practice
- multicultural groups
- early childhood services
- maternal and baby health services
- media/celebrity
- local councils.

The MHS should have links to programs aimed at preventing the development of co-morbid illness and maintaining good health in consumers, carers and staff.

Strategies to promote awareness of the relationship between mental and physical health include:

- depression and anxiety awareness programs
- early psychosis awareness programs
- parent and family education programs

- stress management programs
- mental health in the workplace
- mental health education in schools
- smoking cessation programs
- alcohol, tobacco and other drug services and/or programs
- leisure skills programs
- programs that promote social inclusion and healthy lifestyles, such as links with sporting and recreation clubs
- provision of fact sheets, either online or print based, to consumers, carers and other service providers, for example, on exercise and mental health, mental health and heart disease, or sleep and mental health
- joint community education programs such as with MHS and general practitioners
- local action groups.

Workforce (Criterion 5.6)

Workforce development on mental health promotion and prevention will be relevant in larger office based practices. These include:

- training programs
- networking forums and planning workshops
- attendance and presentations at conferences
- mentoring and supervision
- access to online clearing houses, journals, practical resources and training programmes
- access to key experts for advice.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- partnerships with relevant sectors or settings
- promotional packages
- identification of position responsible for promotion and prevention
- workforce development
- evidence of promotion and prevention strategies and plans
- policies and procedures:
 - promotion and prevention
 - workforce training programs
 - mentoring and supervision.

Standard 6.

Consumers

Consumers have the right to comprehensive and integrated mental health care that meets their individual needs and achieves the best possible outcome in terms of their recovery.

(Note: The consumer standard is not assessable, as it contains criteria that are all assessable within the other standards.)

GUIDELINES

The consumer Standard is not assessable, as it contains criteria that are assessable within the other standards. The intent of gathering these criteria under one standard is to ensure that all of these elements are examined together.

Treatment of consumers (Criteria 6.1, 6.2)

Consumers of mental health services (MHS) have the right to be treated with the respect and dignity equal to any human at all times.

Consumers rights and responsibilities (Criteria 6.3, 6.4)

The consumer statement of rights and responsibilities provided on admission to the MHS and at regular intervals thereafter should include:

- consumers safety and wellbeing are upheld by the MHS
- consumers' rights to privacy and confidentiality are upheld
- consumers have the right to seek other opinions for care, assessment and treatment
- the relationships between consumers, carers, family and friends are respected and honoured
- consumers work in partnership with service providers
- language and cultural needs of consumers are addressed
- consumers complaints and grievances are addressed without compromising service provision to them
- consumers have the responsibility for maintaining their own health and welfare
- consumers respecting the rights of others
- consumers respecting the staff and treating them with dignity and respect
- consumers involvement in their treatment, care and recovery plan.

Education about rights and responsibilities should occur at admission and continue until the consumer's mental state allows comprehension of the information. Discussion about the rights and responsibilities, choice of treatment and the treatment, care and recovery plan should be clearly documented in the health record.

The MHS can help a consumer understand the information provided on their care by offering:

- interpreters
- cultural guides
- an opportunity to ask questions
- consumer advocates
- family and community involvement when appropriate.

The MHS should have a policy and procedures for offering appropriate support to consumers, their families, carers, staff and visitors immediately after a critical incident.

Relationships (Criterion 6.5)

Existing carers' relationships and the capacity, willingness and needs of the carers are key considerations when determining the most appropriate treatment and support for consumers. Individual consumer needs should be taken into account to determine what would be the least restrictive environment. The environment should enable effective treatment to occur, while ensuring safety and protection of other consumers, staff, visitors and members of the public.

Identification of clinician (Criterion 6.6)

The clinician responsible for the consumer's initial contact with the service coordinates assessment, treatment and support and/or facilitates a smooth transition of care to the appropriate service or clinician. This position could be called a case manager, care coordinator or key worker.

Partnerships (Criterion 6.7)

Each consumer participates fully in the development of the individual treatment, care and recovery plan and in the evaluation of outcomes to ensure that goals are achieved. A copy of the treatment, care and recovery plan is given to the consumer and carer wherever possible. For Aboriginal and Torres Strait Islander persons involvement of community and family may be essential in the development of such plans.

Informed consent (Criterion 6.8)

Consent to care is obtained by providing information about the choices of services and treatment available by ensuring this information is understood and by supporting consumers to make informed choices.

Care plans (Criterion 6.9)

Each consumer should have an individual comprehensive treatment, care and recovery plan developed in partnership with the consumer and their carers.

Access to information (Criterion 6.10)

Consumers should have access to information on the mental illness, treatment options, risks and benefits, effects and side effects, ongoing care and rehabilitation arrangements. This information should be discussed with consumers and carers with evidence of the discussion recorded in the health record.

Right to involve (Criterion 6.11)

Consumers have the right to nominate who is involved in their treatment, care and recovery planning. This does not just include carers and family members.

Exit plans (Criterion 6.12)

The consumers' exit plan should include:

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

Consumers and their carers should be helped to identify early warning signs of relapse. Symptoms of pending relapse and an accompanying relapse management plan should be included in the exit plan.

Continuity of care (Criterion 6.13)

Arrangements for follow-up should be planned and in place before consumers leave the service and these arrangements documented in the individual health record.

The consumer is given formal introductions to various community agencies when necessary. Community based agencies and programs may include education providers, community recreation programs, paid or voluntary work, supported or other employment and consumer run support services.

Consumer records (Criteria 6.14, 6.15)

Consumers are provided with information about how to access their own health records. This should include information on who can access records on the consumers' behalf in accordance with relevant legislation. Consumer information sheets on privacy legislation are available from

➤ <http://www.privacy.gov.au>

Standard 7.

Carers

The MHS recognises, respects, values and supports the importance of carers to the wellbeing, treatment, and recovery of people with a mental illness.

GUIDELINES

Where there is relevant legislation services should ensure compliance. e.g. *Carer Recognition Act*.

The intent of this Standard is to ensure that carers are informed and involved in the treatment, care and recovery planning of the consumer when the carer has an ongoing role to support the consumer.

In the context of this standard 'carer' refers to family members or friends of people with a mental illness whose life is affected by the mental illness and includes the partner, parent, friend or child of the consumer [see criterion 7.1].

Identification of carers (Criterion 7.1)

Carers can be parents, partners, brothers, sisters, friends or children of any age. A carer can also be a state or territory guardianship board or tribunal appointed guardian or administrator and MHS should have policies to address these possibilities. Issues of custodial/non custodial parents and legal guardianship should be considered and addressed, as well as whether the carer is a consumer within another MHS. Policies and service delivery protocols should address these situations.

Among Aboriginal and Torres Strait Islander people, carers can include individual members of a family who may not necessarily be blood relatives and skin groups and can embrace entire communities. A different definition of 'carer' applies. Identification of carers can therefore be difficult and flexibility in recording carer information has to be applied.

Partnerships (Criteria 7.2, 7.3)

Care should be delivered in partnership with consumers, carers and other relevant clinicians.

When there is a carer (nominated by the consumer or otherwise identified), they should be engaged as soon as possible in the episode of care with clear and open communication and the sharing of information. The MHS should routinely seek information from carers that contribute to care. When the carer has not been identified at admission, the MHS should continue to attempt to identify the carer.

Consideration of the role of the extended family and of the greater community must also be taken into account when working with Aboriginal and Torres Strait Islander and CALD communities. Culture and the social behaviours influence Aboriginal and Torres Strait Islander people's decisions about when and why they seek services. This includes acceptance or rejection of treatment and the likelihood of adherence to treatment and follow-up, the likely success of prevention and health promotion strategies, the consumer's assessment of the quality of care and their views about the health service and its staff. Help from Aboriginal health workers and cultural 'guides' is vital in establishing meaningful contact with families from rural and remote communities.

Provision of information (Criterion 7.4)

Written material on rights and responsibilities should be provided in a variety of languages and a variety of media. This material should be prominently displayed in every facility of the MHS and also made available on the MHS website and via email, fax or post upon request.

Consideration must also be given to alternative means of engaging with the general population in remote communities on mental health. Information technology could be used to facilitate involvement, for example, in the form of 'talking' posters. Books in the local language and display of mental health information in Indigenous organisations and facilities could all help.

Information should include:

- where to access a copy of the *National Standards for Mental Health Services* (2010) for example by provision of a web address*
- organisation brochure on rights and responsibilities, which can be a photocopy of the organisations statements
- where to access the *Mental health: statement of rights and responsibilities* (1991)*
- where to access human rights instruments/statements.*

*Information on where to access these documents is available in the guidelines for Standard 1 Rights and responsibilities.

Opportunities for carers to ask questions and to be given information are provided throughout all phases of the consumer's care.

Contact and discussion with carers should be clearly documented in the health record.

Confidentiality (Criterion 7.7)

Staff of the MHS should understand the confidentiality principles of the Mental Health Act and Commonwealth, state or territory legislation, which defines what information can be conveyed to families and other carers and under what circumstances. Documented policies and procedures should address these issues.

MHS staff need to be aware of the different attitude to information sharing in remote Indigenous communities where communal sharing of responsibilities and of information relating to individuals is the norm.

Posters in language providing the essential elements of consumer and carer legal rights ought to be placed in all MHS services, office based services, hospitals and primary health care services.

Consultation (Criteria 7.8, 7.9, 7.10)

Carers need access to information on the mental illness of the consumer, treatment options, ongoing care and rehabilitation arrangements. Any discussions with the carer about the personal aspects of the consumer's care should accord with Commonwealth and state and territory privacy legislation. The MHS primary duty of care is to the consumer and any consequences to the consumer should be considered when the consumer's consent is not provided to disclose information to the carer. The MHS should have documented policies and procedures to address these issues and staff need to have access to and training on these.

There should be evidence in the consumer's health record that information on the consumer's condition has been sought from the identified or nominated carers. Liaison with carers throughout a consumer's episode of care should be documented in the health record.

Exit information (Criteria 7.11, 7.12, 7.13)

Carers should have access to information on respite services, counselling, crisis support, education and training to maximise their wellbeing and ability to care and advocate for the consumer.

Information is available on services and support for carers including children and adolescents at:

- The Australian Government site on mental health: ↗ www.mentalhealth.gov.au
- Department of Health and Ageing website: ↗ www.health.gov.au

Posters and brochures providing information on respite services, carer respite centres, carer resource centres and carer counselling programs are prominently displayed in every facility of the MHS and made available on the MHS website and via email, fax or post upon request.

Policies and procedures should guide the MHS on how to work in partnership with carers and need to address the importance of the carer's role to the consumer, the health care provider, the MHS and in the community.

Participation (Criterion 7.14)

The organisation and delivery of MHS must occur within a framework that sensitively unites Aboriginal and Torres Strait Islander people's cultural rights, views and values and the science of human services. Knowledge of what Aboriginal and Torres Strait Islander people value and how MHS staff and carers can work with these values to achieve better services for clients will be helped by having Aboriginal and Torres Strait Islander carers participate.

Examples of how to ensure Aboriginal and Torres Strait Islander people(s) involvement as carers include providing financial and other practical assistance to:

- attend meetings
- attend interview panels
- review draft policies
- provide input at orientation programs
- participate in service planning days
- participate in de-identified reviews of complaints.

It may be necessary to liaise with communities to include Aboriginal and Torres Strait Islander carers who live in rural and remote Australia.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- rights and responsibilities information
- health record/treatment, care and recovery plan reviews
- posters and brochures
- staff training records
- policies and procedures:
 - working with carers
 - identification of carers
 - privacy and confidentiality
 - training programs
 - advocacy, including training and support, mentoring and supervision.

Standard 8.

Governance, leadership and management

The MHS is governed, led and managed effectively and efficiently to facilitate the delivery of quality and coordinated services.

GUIDELINES

The intent of this Standard is to ensure that structures are put in place to facilitate effective governance of the mental health services (MHS).

Integration and coordination (Criterion 8.1)

The MHS should address both corporate and clinical governance responsibilities.

The MHS strategic plan needs to accord with legislative requirements and national and state/territory level mental health policies and related documents.

The MHS should ensure that staff have access to formal supervision. Depending on the setting, supervision of staff can be multidisciplinary, discipline specific, under an individual or group, or by peer or case review.

Critical incidents (Criterion 8.8)

The MHS should have a formal process to review critical incidents. The process should support both staff and others within the MHS affected by the critical incident. The outcomes of the review of incidents should be used to inform ongoing prevention plans.

Further information on critical incidents is available in the guidelines for Standard 2 Safety.

Data management systems provide evidence of:

- compliance with legislative requirements
- achievement of reporting requirements.

Risk management (Criterion 8.10)

Information gathered through feedback, complaints, incidents and adverse reporting should be part of clinical and corporate governance, including risk management processes.

The MHS must have documented systems that are evaluated to ensure corporate and clinical risks are:

- identified
- analysed
- evaluated
- treated
- continuously monitored and reviewed
- communicated.

Further information on risk management is available from the guidelines for Standards 2 Safety and 4 Diversity responsiveness.

Formal quality improvement program (Criterion 8.11)

The MHS analyses data to promote effective care for consumers and their carers.

The MHS has documented systems that are evaluated to ensure complaints, adverse events, critical incidents and near misses reporting are used for quality improvement activities. Information gathered through feedback, complaints, incidents and adverse events reporting should be part of clinical governance, including risk management processes.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes policies and procedures covering:

- a framework for the development of policies
- schedules for policy review
- evaluation of compliance to policies and procedures
- regular review and update of policies
- human resources.

Standard 9.

Integration

The MHS collaborates with and develops partnerships within its own organisation and externally with other service providers to facilitate coordinated and integrated services for consumers and carers.

GUIDELINES

The intent of this Standard is to ensure that mental health services are integrated and provide continuity of care for consumers and carers at several levels, from the individual consumer level, to the person coordinating the care, the team and organisational levels, through to that involving other service providers.

Continuity and coordination of care (Criterion 9.1)

The person responsible for coordination of care coordinates services by helping consumers, carers and the service providers to work together by facilitating links with others in and outside the organisation.

Collaborative planning (Criterion 9.3)

The MHS should provide information and inform staff, consumers and carers about the range of health care and related services that are available.

Contacts with internal and external services and providers should be documented.

Links with primary health care providers (Criterion 9.4)

Shared care arrangements between GPs, private psychiatrists, non-government organisations and other relevant agencies should be used to facilitate consumer recovery when appropriate.

Examples of models of shared care arrangements include:

- General practitioners (GP) and other mental health care providers, such as the Better Access Initiative, and the Access to Allied Health Professionals (ATAPS) program which aim to increase community access to mental health professionals.
- Community mental health case manager, the mental health intake and assessment team and the acute mental health unit.

When clinical supervision for the patient is being transferred to another provider information should be given to help the new practitioner to manage the consumer.

Interagency and intersectoral links (Criterion 9.5)

The MHS works in collaboration with other related service providers, such as welfare services, primary care practitioners, disability support services, emergency departments, aged care providers and transcultural and multicultural mental health agencies.

Linkages and partnerships with external services, such as alcohol, tobacco and other drug services, should be supported by formalised service agreements or there should be clear procedures on how to establish and maintain memoranda of understanding (MOUs).

The MHS needs to develop links between child and adolescent, adult and older person programs and other service providers, to ensure a smooth transition to age appropriate services as required.

Examples of linkage and partnership agreements include:

- drug and alcohol services
- youth sector
- housing
- employment
- Centrelink
- aged care services
- health promotion/public health services
- local government
- community services
- churches and religious groups
- schools
- tertiary education sector
- Aboriginal and Torres Strait Islander groups
- divisions of general practice
- multicultural groups
- early childhood services
- maternal and baby health services.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- audit of treatment, care and recovery plans
- discharge summaries supplied to other health care providers
- evidence of shared care arrangements
- links and partnerships with other service providers, such as alcohol, drug and tobacco services
- policies and procedures:
 - contact with internal and external services
 - process of transfer between services
 - orientation program
 - supervision and training programs.

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.

CROSS REFERENCING OF NATIONAL STANDARDS FOR MENTAL HEALTH SERVICES

Standard 1. Rights and responsibilities

The rights and responsibilities of people affected by mental health problems and/or mental illness are upheld by the mental health service and are documented, prominently displayed, applied and promoted throughout all phases of care.

Criteria	Cross referenced with:
1.1	6.1 and 10.1.2
1.2	7.9 and 8.4
1.3	6.8 and 10.4.3
1.4	4.1, 6.3, 7.4, 7.5 and 7.6
1.7	4.1
1.8	7.7
1.9	6.5 and 10.5.5
1.10	6.7, 10.4.7, 10.4.8 and 10.5.11
1.11	1.12, 6.11, 7.3, 10.4.3, 10.4.8 and 10.6.4
1.12	1.11, 6.11, 7.1, 7.2, 10.4.3, 10.4.8 and 10.6.4
1.13	6.14
1.14	6.15 and 7.7
1.15	3.4

Standard 2. Safety

The activities and environment of the mental health service are safe for consumers, carers, families, visitors, staff and its community.

Criteria	Cross referenced with:
2.1	4.1 and 6.2
2.4	10.5.6
2.5	10.3.7
2.8	8.6
2.11	8.10 and 10.4.5

Standard 3. Consumer and carer participation

Consumers and carers are actively involved in the development, planning, delivery and evaluation of services.

Criteria	Cross referenced with:
3.1	6.17, 7.14 and 10.1.8
3.3	6.18 and 7.15
3.4	1.15
3.5	6.18 and 7.15

Standard 4. Diversity responsiveness

The mental health service delivers services that take into account the cultural and social diversity of its consumers and meets their needs and those of their carers and community throughout all phases of care.

Criteria	Cross referenced with:
4.1	1.4, 7.5 and 7.6
4.3	5.2 and 8.3
4.4	5.1 and 8.3
4.5	5.6 and 8.7

Standard 5. Promotion and prevention

The mental health service works in partnership with its community to promote mental health and address prevention of mental health problems and/or mental illness.

Criteria	Cross referenced with:
5.1	4.4 and 8.2
5.2	4.3 and 8.3
5.3	3.1, 6.17 and 7.14
5.6	8.7

Standard 6. Consumers

Consumers have the right to comprehensive and integrated mental health care that meets their individual needs and achieves the best possible outcome in terms of their recovery.

Criteria	Cross referenced with:
6.1	1.1 and 10.1.2
6.2	2.1
6.3	1.4
6.4	1.4
6.5	1.9 and 10.5.5
6.6	9.1 and 10.3.8
6.7	1.10 and 10.5.11
6.8	1.3 and 10.4.3
6.9	10.4.8
6.10	10.5.2
6.11	1.12, 10.4.3 and 10.4.8
6.12	10.6.4
6.13	10.6.5
6.14	1.13
6.15	1.14
6.16	1.9, 7.7 and 10.5.3
6.17	3.1, 5.3 and 7.14
6.18	3.3, 3.5 and 7.17

Standard 7. Carers

The mental health service recognises, respects, values and supports the importance of carers to the wellbeing, treatment, and recovery of people with a mental illness.

Criteria	Cross referenced with:
7.1	1.12
7.2	1.12, 10.4.3 and 10.4.8
7.3	1.11
7.4	1.4
7.5	4.1
7.6	4.1
7.7	1.8, 8.4 and 1.14
7.9	1.2 and 10.5.3
7.10	10.5.8 and 10.5.11
7.12	10.4.4 and 10.6.4
7.13	10.6.2
7.14	3.1, 6.17 and 10.1.8
7.15	3.3 and 3.5

Standard 8. Governance, leadership and management

The mental health service is governed, led and managed effectively and efficiently to facilitate the delivery of quality and coordinated services.

Criteria	Cross referenced with:
8.2	4.4, 5.1 and 5.5
8.3	4.3 and 5.2
8.6	2.8
8.7	4.5 and 5.6
8.9	1.14, 6.5 and 7.7
8.10	2.11 and 10.4.5

Standard 9. Integration

The mental health service collaborates with and develops partnerships within its own organisation and externally with other service providers to facilitate coordinated and integrated services for consumers and carers.

Criteria	Cross referenced with:
9.1	6.6 and 10.3.8
9.4	10.5.9 and 10.6.5
9.5	10.1.9

Standard 10. Delivery of Care

10.1 SUPPORTING RECOVERY

The mental health service 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.

Criteria	Cross referenced with:
10.1.2	1.1 and 6.1
10.1.4	10.5.13
10.1.6	10.5.11
10.1.7	10.5.12
10.1.8	3.1 and 7.14
10.1.9	9.5, 10.5.16 and 10.5.17

10.2 ACCESS

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

Criteria	Cross referenced with:
10.2.2	10.3.2
10.2.4	10.3.4

10.3 ENTRY

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

Criteria	Cross referenced with:
10.3.2	10.2.2
10.3.3	9.4 and 10.5.9
10.3.4	10.2.4
10.3.7	2.5
10.3.8	9.1

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).

Criteria	Cross referenced with:
10.4.1	10.5.1
10.4.3	1.3, 1.11, 1.12, 6.8, 6.11, 7.2, 10.4.8, 10.5.3 and 10.6.4
10.4.4	10.6.3
10.4.5	2.11
10.4.8	1.3, 1.11, 1.12, 6.9, 6.11, 7.2, 10.4.8 and 10.6.4

10.5 TREATMENT AND SUPPORT

The mental health service 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.

Criteria	Cross referenced with:
10.5.1	10.4.1
10.5.2	6.10
10.5.3	7.9 and 10.4.3
10.5.4	1.3
10.5.5	1.9 and 6.5
10.5.6	2.4
10.5.8	7.10
10.5.9	9.4 and 10.3.3
10.5.11	1.10, 6.7, 7.10, 10.1.6 and 10.4.8
10.5.12	10.1.7
10.5.13	10.1.4
10.5.15	9.5 and 10.1.9
10.5.16	10.1.9
10.5.17	10.1.9

10.6 EXIT AND RE-ENTRY

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

Criteria	Cross referenced with:
10.6.2	7.13
10.6.3	10.4.4
10.6.4	1.11, 1.12, 6.12, 7.12 and 10.4.8
10.6.5	6.13 and 9.4



www.health.gov.au

All information in this publication is correct as of October 2010