

Implementation guidelines  
for **Non-government  
Community Services**

2010

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

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This implementation guide for non-government community organisations accompanies the ten National Standards for Mental Health Services:

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**Standard 2.** Safety

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10.1 Supporting recovery

10.2 Access

10.3 Entry

10.4 Assessment and review

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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
- private office based mental health services.

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 the three implementation guidelines.

An electronic copy of the implementation guideline documents 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>

# What the guide contains

This implementation guide has been developed to help non-government providers of community mental health services across Australia to understand the National Standards for Mental Health Services (National Standards) and to assist them in implementing them.

It has three sections:

**Section 1** is the introduction. It provides an overview to the history of standards for mental health service delivery in Australia, and the development of the revised National Standards.

The section contains the Principles of Recovery oriented mental health practice and the principles that underpin the National Standards.

It briefly examines the application of the National Standards in the non-government community mental health service sector context and explains why the National Standards are important for people with mental illness, their carers and families, the sector and the whole of the service system. It discusses the relationship between the National Standards and service accreditation. It includes discussion of how meeting the National Standards can be more than a compliance obligation, and that they can help in developing a quality assurance framework appropriate to the size, complexity and service types of an organisation.

**Section 2** discusses each standard and its associated criteria from the perspective of the non-government community mental health sector. The National Standards and their associated criteria are designed for the whole of the mental health service system; however, for the non-government community mental health sector, some of the criteria may not apply and others may apply to only some service types.

Section 2 identifies the criteria associated with each standard, and explains whether they are applicable to all or only parts of the sector. It provides guidance about the intent of each standard, suggestions for evidence that might be used to demonstrate compliance and examples of practices and policies that will support compliance.

Most of the National Standards and their associated criteria are linked to others. The final part of Section 2 provides a cross referencing table to assist service providers to identify the links and avoid duplication in the development of evidence and policies and procedures.

**Section 3** addresses the practical issues of implementation—who needs to be involved, what must be done and how it might be done.

It includes some practical suggestions on how to conduct a baseline assessment of current status against the National Standards. Tools are provided to assist service providers to assess their current practices against the National Standards and review progress during implementation. The use of these tools is not obligatory.

Section 3 also discusses how the initial assessment can identify opportunities for service improvement and be the basis for an ongoing commitment to, and development of, a culture of continuous quality in service management and delivery. This can involve boards, staff, consumers, carers, service delivery partners and funding bodies.

Note: These guidelines do not relate to publicly funded specialist community mental health services.

# Section 1.

## Introduction

This section provides an overview of and context for the revised National Standards for Mental Health Services, (National Standards) with a particular focus on their implementation in the non-government community mental health sector. Some of the issues covered in the introduction are addressed in more depth in later sections.

### BACKGROUND TO THE REVISED NATIONAL STANDARDS FOR MENTAL HEALTH SERVICES

The National Standards for Mental Health Services were first introduced in 1996 with the endorsement and support of the Commonwealth, state and territory health ministers. Their development was guided by the principles contained in the national mental health policy of the time and the United Nations' Principles on the Protection of People with Mental Illness. The National Standards were designed primarily for the public specialist health system and were adopted subsequently by all public specialist mental health services and private mental health hospitals across Australia. While some non-government community mental health services adapted elements of the National Standards to their own agency settings with some success, a majority found it difficult to apply many of the National Standards to the community, organisational and service provision context within which they operated.

The context in which mental health services are delivered has changed over the last decade, with both clinical and non-clinical services being more frequently delivered in community rather than hospital settings. There has been a consequent increase in non-government and private sector involvement and in the role of the primary care sector in mental health service delivery. In response to these changes, a review of the National Standards was started in November 2006, in consultation with a wide range of stakeholders including consumers and carers. The revised National Standards are the result.

### THE REVISED NATIONAL STANDARDS FOR MENTAL HEALTH SERVICES

The revised standards have taken into account what worked well with the earlier standards, but better reflect contemporary mental health practices and the current and anticipated environments within which services are delivered. Unlike the earlier National Standards, the revised standards have been designed so that they can be incorporated into the broad spectrum of services within the mental health sector.

The revised National Standards will therefore apply to a wide range of mental health service providers, for example public mental health services, private mental health services, GPs, and non-government providers of community mental health services. They must also be appropriate in a diverse range of communities across Australia. How 'community' is defined varies depending on the purpose, structure and type of service. For example, it could be a geographic catchment area or a target population group.

Given the diversity of service types and of settings in which mental health services are now offered, this shift to a system of standards that apply to the whole service system presented significant challenges as the revised standards were developed.

One of the challenges was that not all of the National Standards are equally relevant to different service types and settings. For example, standards that are critical in an inpatient setting, such as seclusion practices, and trying to achieve a voluntary rather than an involuntary admission to hospital, are not relevant to non-government providers of community mental health services. Some that apply to services which provide accommodation (for example, a hospital or supported community accommodation facility) are not relevant to community-based recovery services.

Some standards need to be interpreted differently for different sectors and settings. For example, the context in which the word 'treatment' is used in the National Standards implies medical treatment, which few non-government community mental health services would provide. A more relevant term for non-government providers would be 'services'. To address the challenges created by the diversity in the service delivery system, and to customise the National Standards for implementation by different parts of the mental health service delivery system, a decision was taken to develop a series of implementation guides to help different sectors and service settings as the new standards are implemented. This document is one of those guides.

## **THE NON-GOVERNMENT COMMUNITY MENTAL HEALTH SECTOR CONTEXT**

There is diversity between different sectors of the mental health service system and diversity within each of those sectors. The range of services delivered by the non-government community mental health sector also varies from state to state.

Services range from intensive personal recovery support to day activity programs and have diverse target groups—for example, a geographic community, people with a particular service need such as accommodation, or people who share a common characteristic such as being carers or being from an Aboriginal and Torres Strait Islander background.

The organisational complexity of the service providers also varies enormously. Some are large national organisations, some are multi service and multi site agencies within states and others are very small organisations with few paid staff and a heavy reliance on the contribution of dedicated volunteers.

Given these wide variations, there will be circumstances in which there will be different expectations of compliance to a particular standard for different types of service provision.

Across all services in Australia the implementation of the National Standards in the non-government community mental health sector will require the involvement and commitment of boards, staff, consumers, carers and funders. Measuring levels of achievement against the National Standards will be an important means of accountability to consumers, carers, community, staff and funders.

## WHY THE NATIONAL STANDARDS ARE IMPORTANT

There are many reasons why the National Standards are important to the mental health service system, including the non-government community mental health sector. These reasons include:

### **1. Assurance to consumers**

The revised standards provide an assurance to people living with a mental illness and to their carers and families that all mental health service providers have similar levels of service safety, quality and accountability. This applies to services in the public, private or community mental health sectors, whether in acute, post acute or community recovery settings. The standards must be met in metropolitan, regional, rural and remote Australia.

The National Standards encompass all of the things an organisation should be doing to provide effective, consumer focussed services. They establish common expectations and support consistency and continuity in care and support services right across the mental health service system. The National Standards assist consumers to understand what they should expect when they access any service in any part of the mental health service system in any state or territory.

### **2. A framework for consumer participation**

The National Standards will provide a consistent and accessible framework through which people living with a mental illness, their carers and families will be able to participate in service planning, implementation, review and evaluation processes.

### **3. Transparency and accountability**

By defining expected levels of service and providing a framework for service monitoring (further discussed in Section 3 of this guide) the National Standards allow service providers to demonstrate that their services are transparent and are meeting their funding accountability requirements.

### **4. Service monitoring and continuous quality improvement**

The National Standards support internal service monitoring and review which can enhance organisational performance. They will assist in the orderly and systemic identification of those areas in which services are performing well and in recognising opportunities for service enhancement. The standards will identify areas that need improvement.

### **5. Promoting respect and trust between different parts of the service system**

The history of the mental health service system in Australia, and in most other first world countries, is one in which the medical model of service delivery has predominated.

Acute medical interventions and a continuing medication regime will continue to be an essential component of the support provided for many people living with a serious mental illness; however, it is now understood that recovery from mental illness often requires a range of skilled interventions and supports which are not in the medical domain.

There have been barriers between the acute public mental health sector and the non-government community mental health sector. These will diminish as the validity and effectiveness of recovery interventions delivered and managed through the community sector are better understood and respected across the whole of the service system. The standards will have all parts of the service system using the same language in the way that they are accountable to consumers and each other. This will be an important context within which respect and trust can be developed over time.

## **6. Providing strategic information at a sector and service system level**

The implementation of common standards across the whole of the mental health service system will provide opportunities for the development of a much better strategic understanding of the Australian mental health service system and its component parts. Many of these opportunities will not be realised in the short term, but implementing the revised standards will pave the way for strategic analysis in the future.

## **THE PLACE OF THE NATIONAL STANDARDS IN THE DELIVERY OF QUALITY SERVICES**

Service delivery in the non-government community mental health sector is influenced by a number of quality, safety and performance requirements other than the National Standards. Some of these are obligatory, some are voluntary. Compliance requirements that contribute to the quality management and service delivery in the non-government community mental health sector include:

- specific state legislation such as the state and territories' Mental Health Act, Occupational Health and Safety Act, Anti-Discrimination Act, Incorporated Associations Act
- the professional regulation requirements which must be met by some practicing mental health professionals
- obligatory external accreditation processes
- service quality conditions set through service purchasing and funding agreements.

Although there are significant variations across the states and territories, all of these compliance requirements contribute to quality management and service delivery and are relevant to the National Standards.

By incorporating the National Standards and these obligatory requirements into a cohesive quality framework, service providers can save themselves work as some requirements overlap or duplicate each other. Incorporating all requirements also gives a systematic, transparent and accountable way for organisations to assure themselves and their consumers about the overall quality of their management and services, and helps them to improve their performance.

Service providers must recognise that the National Standards are only one element of an effective quality assurance system that provides internal and external ways of assessing their service system and of ensuring ongoing improvements in service delivery. Service providers should see the National Standards not just as a compliance requirement but as an integral part of a quality assurance system that is appropriate to the size and service range of each organisation.

## STANDARDS AND ACCREDITATION

The National Standards set out the minimum requirements for all service providers in the mental health service system. As noted above, the National Standards will be most effective if they are seen as an integral part of each service provider's quality assurance system, rather than as a stand-alone obligation.

Accreditation is one means of providing an independent assessment of performance against standards.

A formal accreditation process supports continuous quality improvement in service provision. However, the National Standards do not have to be incorporated into formal accreditation to be meaningful and useful to the non-government community mental health sector.

Accreditation is only one mechanism through which compliance can be monitored, quality improved, and achievements reported. Other ways include the use of reporting frameworks such as key performance indicators, internal monitoring arrangements, internal and external evaluations, and peer review processes. All of these can prove that a service is committed to improving the quality of care, and for all of them the National Standards will be a useful reference point.

Some states already have a strong emphasis on accreditation. In some states, individual agencies have chosen to become accredited with an external accreditation provider. While it is anticipated that the National Standards will be incorporated into relevant accreditation programs, states and territories will make their own decisions on whether accreditation will be mandatory for non-government community mental health service providers.

Service provider organisations will be encouraged to introduce other practices to complement, or in some cases replace, the criteria listed against each standard. What is important is that they demonstrate how they meet the standard.

# Principles of recovery oriented mental health practice

The principles of recovery oriented mental health practice are relevant to all of the 10 national standards and apply to the whole mental health service system, including the non-government community mental health service sector.

*From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding of one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self.*

*It is important to remember that recovery is not synonymous with cure. Recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery – hope, healing, empowerment and connection – and external conditions that facilitate recovery – implementation of human rights, a positive culture of healing, and recovery-oriented services. (Jacobson and Greenley, 2001 p.482)*

The principles of recovery-oriented mental health practice ensure that mental health services are delivered in a way that supports the recovery of mental health consumers.

They are:

## 1. Uniqueness of the individual

Recovery oriented mental health practice:

- recognises that recovery is not necessarily about cure but is about having opportunities for choices and living a meaningful, satisfying and purposeful life, and being a valued member of the community
  - accepts that recovery outcomes are personal and unique for each individual and go beyond an exclusive health focus to include an emphasis on social inclusion and quality of life
- empowers individuals so they recognise that they are at the centre of the care they receive.

## 2. Real choices

Recovery oriented mental health practice:

- supports and empowers individuals to make their own choices about how they want to lead their lives and acknowledges choices need to be meaningful and creatively explored
- supports individuals to build on their strengths and take as much responsibility for their lives as they can
- ensures that there is a balance between duty of care and support for individuals to take positive risks and make the most of new opportunities.

### **3. Attitudes and rights**

Recovery oriented mental health practice:

- involves listening to, learning from and acting upon communications from the individual and their carers about what is important to the individual
- promotes and protects an individual's legal, citizenship and human rights
- supports individuals to maintain and develop social, recreational, occupational and vocational activities which are meaningful to them
- instils hope in an individual about their future and ability to live a meaningful life.

### **4. Dignity and respect**

Recovery oriented mental health practice:

- involves being courteous, respectful and honest in all interactions
- involves sensitivity and respect for each individual, especially for their values, beliefs and culture
- challenges discrimination wherever it exists within our own services or the broader community.

### **5. Partnership and communication**

Recovery oriented mental health practice:

- acknowledges that each individual is an expert on their own life and that recovery involves working in partnership with individuals and their carers to provide support in a way that makes sense to them
- values the importance of sharing relevant information and the need to communicate clearly
- involves working in positive and realistic ways with individuals and their carers to help them realise their own hopes, goals and aspirations.

### **6. Evaluating recovery**

Recovery oriented mental health practice ensures and enables continuous evaluation at several levels:

- Individuals and their carers can track their own progress.
- Services demonstrate that they use the individual's experiences of care to inform quality improvement activities.
- The mental health system reports on key outcomes that indicate recovery. These outcomes include housing, employment, education, social and family relationships, health and well being.

# How the National Standards and their supporting principles apply to the non-government community mental health service sector

This section discusses the principles that underpin the National Standards, and the nine performance indicators that are associated with the delivery of care and services. These principles and performance indicators are the same for all parts of the mental health service system.

## THE NATIONAL STANDARDS FOR MENTAL HEALTH SERVICES

The National Standards focus on recovery and are based on values related to human rights and dignity. They promote the empowerment of consumers of mental health services, their carers and families. They emphasise practices which support continuous improvement in service quality. Although they are presented separately, many of the standards are interrelated. Section 2 of this guide includes a table which identifies those interrelationships so that service providers can avoid duplication by cross referencing their implementation of related standards.

Service providers should find no surprises in the National Standards. The issues that they address should already be the focus of organisations that are committed to providing quality services.

It is important to note that not all criteria associated with each standard apply to the non-government community mental health sector. This is further discussed in Section 2 of this guide.

## COMPLYING WITH THE NATIONAL STANDARDS

All of the National Standards that apply to the non-government community mental health sector are equally important. However, there are differences in compliance expectations.

Standard 6 Consumers brings together criteria that are assessable under other standards. They do not have to be assessed again for Standard 6. Gathering them under Standard 6 ensures that all consumer related criteria are examined together, so that the service provider gets a good composite picture of their performance in relation to consumers.

Most standards can be met at different levels. This is what continuous improvement is about, the capacity to do even better once minimum requirements are met. For example, in Standard 3, Criterion 3.1 a service provider might be able to demonstrate in its year one self assessment that it is has opportunities for consumers and carers to be involved in planning, service delivery, evaluation

and quality programs. That involvement might be once a year and minimal. The service provider could set a goal that by year 3, there will be at least one opportunity every three months for more comprehensive involvement. In the three-year self assessment, this service provider would be meeting Standard 3 Criterion 3.1 more comprehensively than they were in their year one self assessment.

Some standards and the criteria that support them must always be met in full. Standard 2 (Safety) is in this category. All service providers must be able to demonstrate that their services are safe. While continuous improvement should still be a goal, safety requirements must be met. There is no scope for service providers to be at a 'minimal' level of achievement and 'working towards' achieving Standard 2. Similarly if standards have criteria that relate to meeting legislative requirements (for example, Standard 8 Governance, leadership and management, Criteria 8.4 and 8.9) service providers must demonstrate from year one that these criteria are met.

## PRINCIPLES UNDERPINNING THE NATIONAL STANDARDS

The principles behind the National Standards and the nine performance indicators apply equally across all parts of the mental health service system. The principles of recovery oriented mental health practice sit above all of them.

The principles that have been followed in the development of the National Standards are:

- Mental health services should promote an optimal quality of life for people with mental health problems or mental illness.
- Services should be delivered with the aim of sustained recovery.
- Consumers should be involved in all decisions regarding their treatment and care, and as far as possible should have the opportunity to choose their treatment and setting.
- Consumers have the right to have their nominated carers involved in all aspects of their care.
- The role played by carers, as well as their capacity, needs and requirements should be recognised separately from consumers.
- Participation by consumers and carers is integral to the development, planning, delivery and evaluation of mental health services.
- Mental health treatment, care and support should be tailored to meet the specific needs of the individual consumer.
- Mental health treatment and support should impose the least personal restriction on the rights and choices of consumers, while taking into account their living situation, level of support within the community and the needs of their carers.

The National Standards describe care that will be delivered in accordance with each of the nine *Key performance indicators for Australian public mental health services (2005)*:

**Effectiveness:** care, intervention or action achieves desired outcome in an appropriate timeframe.

**Appropriateness:** care, intervention or action provided is applicable to the client's needs and based on established standards.

**Efficiency:** achieving desired results with the most cost effective use of resources.

**Accessibility:** ability of people to obtain health care at the right place and right time irrespective of income, physical location and cultural background.

**Continuity:** ability to provide uninterrupted, coordinated care or service across programs, practitioners, organisations and levels over time.

**Responsiveness:** the service provides respect for all persons and is client orientated. It includes respect for dignity, cultural diversity, confidentiality, participation in choices, promptness, quality of amenities, access to social support networks, and choice of provider.

**Capability:** an individual's or service's capacity to provide a health service based on skills and knowledge.

**Safety:** the avoidance or reduction to acceptable limits of actual or potential harm from health care management or the environment in which health care is delivered.

**Sustainability:** system or organisation's capacity to provide infrastructure such as workforce, facilities, and equipment, and be innovative and respond to emerging needs.

## IMPLEMENTATION

The National Standards have an important place in quality service management and service delivery for mental health service providers.

There will be time costs in implementation, but in the longer term the National Standards should be seen as a core part of operating practice. Most service providers who are committed to quality service delivery would already be working in a way that would meet the standards. The standards will measure and present their practices in a consistent, cohesive and accountable form.

The implementation process will be different for each state and territory and for each individual service provider. For instance service providers in states that already have their own standards or accreditation will start at a different point than those in other states. Other factors that might determine the starting point for individual service providers will include:

- the size and organisational complexity of the service provider
- whether or not the service provider is involved in a voluntary external accreditation program

- whether or not the service provider is working to an internally developed quality assurance framework
- the nature of the service and its consumer group
- the length of time the service has been in operation.

The National Standards establish the minimum national expectations of service providers. The implementation process for each service provider will vary, but all should be able to demonstrate that over time they are enhancing the quality of their services by working according to the principles of recovery oriented mental health practice and the National Standards.

# Section 2.

## Working to the guidelines

### INTRODUCTION

The diversity of the whole mental health service system across which the National Standards must be applied is reflected in the non-government community mental health sector—arguably, because of the nature of the services, even more so. For this reason, while it is anticipated that almost all of what follows will be relevant to the majority of service providers, there will be exceptions. The material is presented as a general guide only.

The National Standards apply to all service providers within the non-government community mental health sector, but not all of the criteria for each standard will be relevant to all organisations. Each organisation will need to review the material presented and make their own judgments about whether specific criteria apply to their service environment. This will depend on their:

- service types
- catchment community
- target groups
- business arrangements
- contractual and funding obligations.

Different service arrangements and laws in each state and territory mean that some criteria will apply in some states and territories but not in others. Each organisation will need to carefully consider each standard and its associated criteria and make decisions about which apply to them.

This section looks at each standard and its associated criteria in detail, with particular reference to the relevance of each criterion to the non-government community mental health service sector. For each standard and its associated criteria, suggestions are made about evidence that service providers might use to demonstrate compliance and about policies and procedures which might assist in demonstrating compliance.

Examples are provided of evidence that service providers might use to demonstrate that they are meeting the criteria associated with each standard.

Some of the criteria for which evidence is suggested might not apply to all service types or service settings within the sector.

The evidence suggested is not definitive. It aims to assist service providers to understand the kinds of information they might be able to use. It is not mandatory to collect or use the evidence suggested. Service providers are encouraged to use whatever evidence is appropriate for their service type and complexity, their catchment community, and their consumers. One piece of evidence might assist the service provider to demonstrate how they are meeting several criteria across a number of standards.

For many of the criteria, evidence will include documentation in the form of policies and procedures. While policies and procedures are important, they will generally not be sufficient on their own to demonstrate that a service provider is meeting the criteria associated with a particular standard. Evidence will need to be provided to demonstrate how the policies and procedures are actually reflected in the way the organisation operates in its physical environment, its day to day work practices and staff behaviour.

# 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 (service provider).

#### **Dignity and respect (Criterion 1.1)**

All consumers have the right to treatment that respects their dignity and privacy.

*Evidence that this criterion is met could include:*

- demonstrating appropriate layout and design of the service provider's facilities, including adequate personal space in communal areas and private interview rooms
- clean and welcoming reception areas and waiting rooms that enable consumers to have personal space
- training of staff in reception areas in how to greet consumers respectfully and make them comfortable while waiting to be seen
- where consumers are placed in an environment not optimal for privacy due to overriding considerations such as safety and risks, showing that they are treated respectfully and that privacy is established as soon as practicable
- showing that consumer expectations and goals for their recovery are fundamental drivers for the services they receive
- ensuring that private rooms with adequate sound proofing are available for assessments and consultations.

## Legislation (Criterion 1.2)

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

➤ <http://www.privacy.gov.au/business/health>

Information provided on this website 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

The website <http://www.privacy.gov.au/> provides links to:

- privacy legislation in all states / territories
- International Human Rights instruments.

*Evidence that this criterion is met could include:*

- documentation of how the organisation identifies and applies relevant legislation
- information provided to staff at orientation
- supervision documentation
- organisational policies and procedures that incorporate and demonstrate how compliance with legislation and guidelines is monitored.

## Informed consent (Criterion 1.3)

Informed consent means that a person:

- is provided with appropriate and adequate information
- is capable of understanding the nature of the information and the consequences of a decision made in relation to this information
- can freely make decisions without unfair pressure or influence from others.

An individual cannot give valid consent if they lack the capacity to make an informed decision.

However, a person with a mental illness might experience changes in both their mental state and their needs, and their capacity to provide informed consent may fluctuate.

In obtaining informed consent, the service provider should consider the following:

- information might need to be provided in different ways depending on the consumer's needs and mental state at the time
- what the consent applies to should also be made very clear— what information will be shared, with whom and how
- the need to avoid assumptions that consent provides a blanket approval for sharing information
- consumers have the right to change or retract their consent.

Consideration should also be given to the consumer having the opportunity to nominate someone they trust to make decisions on their behalf if they are unable to give informed consent.

*Evidence that this criterion is met could include:*

- demonstrating that information about informed consent is provided in different ways depending on the consumer's needs and mental state at the time
- documentation to demonstrate that consumers are informed about what information will be shared, with whom and how and that they have the right to change or retract their consent
- evidence that consumers are informed about and provided with opportunities to make advance directives in relation to the services they receive
- evidence that the service provider's intake or initial assessment process includes procedures to identify consumers who are subject to relevant orders or arrangements such as community treatment orders or adult guardianship arrangements.

## **Rights and responsibilities information (Criteria 1.4, 1.5, 1.6) (partially applicable 1.7)**

The *Mental health: statement of rights and responsibilities* (1991) is available at:

➤ <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-publicat.htm>

and links to human rights standards that Australia has agreed to uphold are available at:

➤ [http://www.hreoc.gov.au/human\\_rights/index.html](http://www.hreoc.gov.au/human_rights/index.html)

*Evidence that these criteria are met could include:*

- a commitment to upholding consumers' rights being explicit in the organisation's statement of values or service principles
- having posters on display, statements on web sites, policies and procedures in place in relation to:
  - consumer rights
  - upholding and respecting consumer rights, and responding to concerns
  - consumer complaints
  - staff and volunteer codes of conduct
  - duty of care
  - privacy and confidentiality
- demonstrating that information about their rights is given to consumers when they come into the service, and that it is provided in a format appropriate to their age, communication needs and their cultural background. This may include the translation of documents into other languages
- providing all consumers who enter the service with a copy of the *National Standards for Mental Health Services*
- ensuring that a simple, accessible process is in place to receive and address consumer complaints, including support for the consumer to access an advocate to support them during a complaint resolution
- providing information about consumer rights to their families or legal guardians as appropriate
- providing information about human rights for people with mental illness in the orientation program for new staff and volunteers
- providing information to consumers about mental health advocacy organisations, mental health legal centres, peer support workers, and consumer or carer consultants.

### **Privacy and confidentiality (Criteria 1.8, 1.9)**

Respect for privacy must be demonstrated while ensuring that risks are properly addressed and managed and that the service is safe for the consumer, other consumers, staff, visitors and members of the public.

Confidentiality of personal information should be in accordance with Commonwealth, state and territory legislation.

Meeting confidentiality requirements includes ensuring that consumers understand both the commitment to maintain confidentiality and the limitations of that commitment. Limitations include conflicts between a duty of care to the consumer and the duty to maintain privacy and respect confidentiality. For example, if there are concerns that a consumer might hurt themselves, or pose a threat to another individual or group, or that someone else poses a threat to a consumer, confidentiality might need to be broken to ensure the safety of those concerned.

Confidentiality might also need to be broken for the organisation to comply with its obligations at law.

The need for confidentiality does not bar carers from discussions about treatment, care and recovery plans, unless the consumer has refused or withdrawn consent, in which case general discussions may take place.

While the consumer has a right to have others involved in their care, it is important they also have a right to refuse it when the service provider nominates others to be involved, providing refusal does not impose a risk to anyone.

*Evidence that these criteria are met could include:*

- service provider facilities having private interview rooms
- residents having space for personal possessions including a lockable wardrobe or drawers (accommodation services)
- consumers being given information on entry into the service (in formats that are appropriate, for example to their age, communication and cultural needs) about confidentiality and its limits
- confidentiality and its limits being covered during orientation for new staff, volunteers, contractors and students
- expectations of organisational behaviour being made clear—for example workplace signs reminding staff that consumer files must not be left on desks, that computer screens must be turned off when not in use and not be visible to the public
- material such as posters and brochures on privacy and confidentiality—for example Privacy Commission fact sheets—being displayed.

## **Involvement in care (Criteria 1.10, 1.11, 1.12)**

Mental health service consumers being involved in their care is fundamental to the recovery approach.

*Evidence that these criteria are met could include:*

- consumers being given information about their rights and their own role in recovery goal setting, individual service planning and review
- documenting the consumer's active participation in developing their recovery goals and individual support plans
- review arrangements demonstrating how the consumer was actively involved in the process
- consumer feedback arrangements.

Further information can be found in Standard 6 Promotion and prevention.

### **Access to records (Criteria 1.13, 1.14)**

Consumers having access to personal records is a strong demonstration they are actively involved in their own recovery. Where necessary, they should have the right to amend incorrect personal information, or to add an alternative view.

Consumers having access to their own records should be in accordance with Commonwealth, state and territory legislation. Any legislative exclusion should be appropriately applied. Access can be restricted in some circumstances. Restrictions should only apply after very careful consideration. Denied access should be explained to the consumer in a format appropriate to their personal circumstances.

*Evidence that these criteria are met could include:*

- documenting that consumers have been given information about their right to access their personal records
- documenting when consumers have requested access and the outcomes.

### **Advocacy (Criterion 1.15)**

Independent advocacy enables consumers to exercise their rights and remain in control of their situation. It empowers them.

Advocacy ranges from the formal such as the state and territory-based Public Advocate or Public Guardian, to the informal, where an advocate is a trusted friend or family member nominated by the consumer.

Non-government services have the option of formal advocacy, employing peer support workers, or having volunteers whose role includes consumer advocacy.

Community legal services, including specialist mental health legal services also have an important advocacy role.

*Evidence that this criterion is met could include:*

- displaying posters that advertise the role of the Public Advocate or Public Guardian
- displaying posters and information on how to access advocacy services
- complaints management information brochures containing information about rights to engage an advocate, and how to do so
- employing a peer support worker or having trained peer support volunteers
- collaborating in initiatives with advocacy organisations
- documenting in their personal records any support that consumers have been given to access advocacy and support services.

### **Consumer feedback (Criterion 1.16)**

A core requirement in working within a recovery framework is consumer feedback about their individual services and the service provider organisation more broadly.

*Evidence that this criterion is met could include:*

- documenting consumer involvement in initial assessments and individual service review processes
- annual formal consumer feedback surveys with findings being used to support continuous service improvement
- regular consumer feedback meetings conducted by the service provider
- documenting consumer contributions to service provider strategic plans and service evaluations
- posters and brochures displaying service provider compliment, complaint and grievance procedures
- displaying and giving consumers information about external organisations they can access, such as advocacy service providers.

Policies and procedures that demonstrate compliance with Standard 1 Rights and responsibilities will include those that address:

- consumer rights and responsibilities
- management of personal consumer information including arrangements that support consumer access to all personal information held by service providers within legislative requirements
- consumer advocacy
- management of an informed consent process

- privacy and confidentiality
- complaints and grievances
- use of interpreters including Auslan interpreters
- cultural assessment
- compliance with legislation.

It is important to remember that policies and procedures alone are not sufficient to demonstrate that a service provider is meeting a standard's requirements. It is necessary to demonstrate how the policies and procedures have been implemented and guide organisational practices and behaviours.

# 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 the service provider takes all necessary steps to ensure 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)**

Service providers must ensure the safety and wellbeing of consumers, carers, staff and others.

Cultural beliefs are an important aspect of consumer understanding and responses to health care. They should be taken into consideration when reviewing safety issues. Culturally inappropriate care may result in misunderstandings that put the consumer at risk of events which may adversely affect their mental health and recovery.

Services should be aware of the National Safety Priorities in Mental Health. They should ensure that applicable legislation addressing safety and their own policies and procedures are available and complied with.

*Evidence that this criterion is met could include:*

- documenting risk management assessments, management plans and review arrangements
- safety signage being visible at risk locations
- documenting the training of staff in strategies to identify, prevent or de-escalate agitation, aggression and interpersonal violence
- documenting that staff have a current basic first aid certificate
- documenting that new staff received safety awareness information during orientation
- evidence of regular safety practice exercises involving staff, volunteers and consumers; (for example using fire extinguishers, evacuations)

- a safety suggestion scheme, encouraging staff, volunteers, students and consumers to articulate their ideas or concerns, and giving positive feedback to those that do
- experts addressing staff meetings on the consequences of incorrect workplace practices in areas such as manual handling or body stressing, stress and fatigue, slips, trips and falls.

National safety priorities (Criterion 2.2 is not applicable to the sector, Criteria 2.3, 2.4, 2.5 are partially applicable).

Where applicable, Criteria 2.3, 2.4, 2.5 and 2.6 should be implemented in line with the *National Safety Priorities in Mental Health: a national plan for reducing harm* (2005)—and in line with an analysis of risks specific to the individual service provider.

### **Legislation, regulations and guidelines (Criteria 2.6, 2.7)**

Applicable safety legislation, regulations and guidelines include, but are not limited to:

- the Australian Health Ministers' *Mental health: statement of rights and responsibilities* (1991)
- state and territory occupational health and safety legislation
- state and territory mental health legislation and related Acts.

Information on infection control should be available to staff, consumers and visitors. Appropriate infection control and work place hygiene standards should be in place.

### **Staff safety (Criteria 2.8, 2.9, 2.10)**

Service providers should employ an appropriate number of staff to ensure their safety and the safety of consumers, carers and others.

The risk assessment of staff working conditions should include, but is not limited to:

- staff working alone and their access to others at all times
- personal security on-site as well as 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 applicable legislation.

*Evidence that these criteria are met could include:*

- documenting risk management assessments, management plans and review arrangements
- safety signage being visible at risk locations
- visual evidence of a safe environment
- staff access to mobile phones, pagers, personal security alarms to expedite communication during critical incidents
- records of staff training in occupational health and safety
- an occupational health and safety manual
- documenting staff meetings to demonstrate that safety issues are regularly considered and responded to
- documenting critical incident debriefings that assist staff after being exposure to traumatic incidents.

## **Assessment (Criterion 2.11)**

Regular environmental assessments should be carried out and action taken to mitigate the risk of harm, including sexual abuse, self harm and other interpersonal violence.

Risk assessment of consumers should be conducted on entry and regularly thereafter, to ensure any change to their health status is identified. Timely assessment should be undertaken to minimise the risk of harm to themselves and others. Risk assessment should also be conducted on discharge or exit. In some cases on discharge or exit, risk assessment should be conducted on the carer, such as when the carer is a child or aged person.

*Evidence that this criterion is met could include:*

- documenting organisational risk management assessments, management plans and review arrangements
- documenting analysis of critical events and post-event remedial action
- documenting board leadership in the development of organisational risk management plans and review arrangements that are being met
- risk assessments and regular reviews being documented in consumers' files
- evidence of risk assessments being given to a service to whom care is being transferred
- where appropriate, documenting risk assessments in relation to a carer.

## Review and analysis of risks (Criteria 2.12, 2.13)

There should be evidence of regular organisational reviews of safety, which lead to recommendations that are implemented and regularly reviewed as part of a continuous risk management process. Boards should oversight risk management.

*Evidence that these criteria are met could include:*

- documenting organisational risk management assessments, management plans and review arrangements
- documenting the regular review of risk management plans by boards.

Policies and procedures that demonstrate compliance with Standard 2 will include but not necessarily be limited to those that address:

- organisational risk identification, management and review
- risk assessments for consumers
- safe transportation of consumers
- workplace health and safety
- arrangements for safe home visits
- medication and adverse medication event management (as appropriate to the type of service being provided)
- infection control, workplace hygiene and safe food handling (as appropriate to the type of service being provided)
- managing verbal and physical violence
- reporting and management of adverse incidents
- arrangements for critical incident debriefing for staff, consumers, carers and other visitors when they have been exposed to a traumatic incident within the service.

It is important to remember that policies and procedures alone are not sufficient to demonstrate that a service provider is meeting the requirements of a standard. It is also necessary to demonstrate how the policies and procedures have been implemented and guide organisational practices and behaviours.

# 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 service providers engage in ongoing consultation with consumers, carers and others in its community regarding the planning, delivery, development, monitoring and evaluation of services. The service provider should ensure that support and training is given where appropriate.

#### **Participation (Criteria 3.1, 3.2)**

Fundamental to the Principles of Recovery Oriented Mental Health Practice is the active participation of the consumer and, with their consent, their carers. This involves all aspects of the service provided and, more broadly, the way the organisation operates. Active participation empowers consumers and gives them control in their situation.

Service providers must understand that the way:

- staff relate to and speak about consumers and carers
- consumers and carers relate to staff
- programs are structured and delivered
- the organisation embraces (or doesn't embrace) consumer driven initiatives
- are all part of the organisational culture that send messages to consumers and carers about how they are viewed.

Consumer and carer participation can occur across many levels, including:

- treatment and care
- employment as consultants and advocates
- service delivery and evaluation

- policy development and individual and service planning
- education and training
- staff recruitment.

Methods need to be used that are appropriate to the service being provided and appropriate to the needs and circumstances of consumers and carers. The goal is to engage and support them in all areas of service planning, delivery, evaluation and quality assurance activities.

*Evidence that these criteria are met could include:*

- giving consumers information about their rights and their role in recovery goal setting, individual service planning and review
- documenting active participation by consumers in the development of their recovery goals and individual support plans
- individual service review arrangements that demonstrate how consumers were actively involved in the process
- annual formal consumer feedback surveys with findings being used to support continuous service improvement
- regular consumer feedback meetings conducted by the service provider
- documenting consumer contributions to strategic plans and service evaluations
- consumer and carer positions on boards being mandated in the organisation's constitution
- consumer and carer representation on, for example, service planning, delivery, evaluation activities, quality assurance committees
- demonstrating how consumer and carer feedback contributes to continuous service improvement.

### **Support and training (Criterion 3.3)**

Where consumers, carers or others are involved, the service provider should ensure that there is access to training and support where required.

*Evidence that this criterion is met could include:*

- documenting the training and support provided.

## Advocacy (Criteria 3.4, 3.5)

Consumers and carers should be given information about the role of advocates and advocacy organisations, and how to access advocacy services.

This could include a list of state and territory organisations such as:

- The Mental Health Carers ARAFMI Australia, ↗ <http://www.arafmiaustralia.asn.au/>
- the Mental Illness Fellowship of Australia, ↗ <http://www.mifa.org.au/>
- Children of Parents with a Mental Illness (COPMI), ↗ <http://www.copmi.net.au/>
- the Commonwealth Carer Resource Centre on 1800 242 636 (free call)
- other state and territory based organisations.

Where a service provider employs consumers and carers as advocates their role must be clear, meaning the extent to which they are accountable to management and the extent to which they are accountable to consumers who use the service. Arrangements should also be in place to assist them when conflicts arise.

*Evidence that these criteria are met could include:*

- posters on display that advertise the role of the state and territory Public Advocate or Public Guardian, and other mental health advocacy services
- complaints management information brochures containing information about rights to engage an advocate, and how to do so
- employing a peer support worker or having trained peer support volunteers
- documenting the training given to peer support workers, volunteers and consumer and carer advocates
- documenting in individual records the support consumers and carers were given to access advocacy and support services.

## Employment of consumers and carers (Criterion 3.6)

Consumers and carers can be employed to fill any 'mainstream' position for which they are qualified. They can also be employed in specialist roles such as consultants and liaison, and to conduct research.

Consumer or carer staff members should be well informed about what processes are in place to protect, advise and support them. Mentoring and supervision should be provided, as should training and support where required.

*Evidence that this criterion is met could include:*

- consumers and carers being employed in 'mainstream' positions
- peer support workers being employed or having trained peer support volunteers
- guidelines for the roles and responsibilities of peer support workers (paid and volunteer)
- documenting arrangements that support them
- documenting training given to peer support workers and consumer and carer advocates.

### **Documentation of participation (Criterion 3.7)**

*Evidence that this criterion is met could include:*

Policies and procedures should include documentation of consumer and carer participation including:

- the process for choosing consumers, carers and other representatives and the length of time for which the selections will be made
- arrangements for payment (either direct or in kind) and reimbursement for expenses, in accordance with the consumer's preference
- arrangements for training and skills development
- identification of equipment, space and budget requirements
- arrangements for consultation with the consumer and carer constituency
- documenting activities, numbers, hours, payments (direct or in kind) and reimbursements involving consumers and carers
- documenting training and support arrangements for consumers and carers in peer support, advocacy and other representative roles, and feedback from consumers and carers on the effectiveness of these arrangements
- training and information given to staff so they understand the importance of consumer and carer participation and how to get the most from it
- feedback from consumer and carer representatives that they feel valued and are satisfied with training and support arrangements.

Policies and procedures to demonstrate compliance with Standard 3 will include but not necessarily be limited to those that address:

- consumer and carer participation in personal service planning and review
- consumer and carer participation in organisational planning, program design and review and evaluation arrangements, including training and support, mentoring and supervision for peer
- support workers, volunteers, carers and consumers in specialist roles
- consumer and carer representation on committees.

It is important to remember that policies and procedures alone are not sufficient to demonstrate that a service provider is meeting a standard's requirements. It is also necessary to demonstrate how the policies and procedures have been implemented and guide organisational practices and behaviours.

# 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 (service provider) provide services that are appropriate and safe for the diverse population in their defined community.

Making services as accessible as possible is good for everyone, not just people from diverse groups with special access needs.

Board and staff understanding of the barriers to the delivery of services to a diverse community are important factors in creating accessible services. These barriers can be attitudinal, physical, and procedural.

Organisations that understand this will be able to recognise and respond to the barriers and to understand the multiple levels of diversity within their community. These organisations will develop cultural competence. They will also develop the processes and practices that encourage inclusiveness and establish the progression of learning about diversity and differences and how they affect the way services are accessed, delivered, received and promoted.

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

### Identification (Criterion 4.1)

The organisation should identify the groups that could be assisted by its services, then take steps to understand and respond to any access barriers and communicate this to staff.

*Evidence that this criterion is met could include:*

- analysing census data against the service's demographic profile
- reporting on meetings with groups in the catchment community to identify their service and support needs
- documenting the collaboration between individuals and organisations with specialist expertise, such as in transcultural mental health and gay and lesbian advocates, to gain knowledge about the diversity in the catchment community and to better understand service and support needs.

## **Response to needs (Criterion 4.2)**

Responses should address attitudinal, physical, and procedural barriers.

*Evidence that this criterion is met could include:*

- respect for and responsiveness to diversity in service delivery principles and values statements
- documenting that staff have been trained in cross cultural awareness
- documenting that staff have been trained in disability awareness
- documenting the use of interpreters with consumers and carers who are not proficient in English or who are deaf
- board membership and staffing reflecting community diversity
- specialist positions in the organisation, for example culturally and linguistically diverse and Aboriginal and Torres Strait Islander liaison staff
- information in the main community catchment languages dealing with issues such as rights and responsibilities or the programs offered by the service provider
- intake procedures taking into consideration cultural and linguistic needs
- the use of evidence based culturally appropriate clinical instruments (if relevant to the types of services provided)
- building alterations and modifications to reduce physical access barriers
- complaint resolution procedures that take into consideration diversity factors
- policies and procedures that recognise diversity and are non discriminatory
- the consumer base being broadly representative of the range of diversity in the catchment community.

### **Planning (Criterion 4.3)**

Service providers should use methods appropriate to their service to engage the main cultural and social diversity groups within its community in all service planning, delivery, evaluation and quality assurance activities.

*Evidence that this criterion is met could include:*

- documenting consultation with community catchment groups in the development of strategic plans
- the outcomes and strategies formulated in strategic plans reflect the diversity of the catchment community and their service needs.

### **Other service providers (Criterion 4.4)**

Service providers should collaborate with or work through specialist providers, rather than in addition to, when trying to disseminate information directly to a group. Staff should know how to access specialist services such as interpreters (including Auslan interpreters), and ethnic and Aboriginal and Torres Strait Islander community and health workers.

Evidence that this criterion is met could include:

- MOUs or other collaborative arrangements with specialist service providers
- documenting when interpreters and bilingual counsellors are used
- documenting in consumers' individual records when liaison staff and other related service providers are used
- involving specialist service providers in staff training.

### **Staff (Criteria 4.5, 4.6)**

Service providers should have access to current information on social and historical factors applicable to current circumstances, such as issues surrounding victims of trauma, refugees and how identified groups react to choices.

*Evidence that these criteria are met could include:*

- documenting the training provided to staff on what information is available about the diversity in the catchment community and how to use this information to deliver appropriate services
- staff and volunteer orientation programs that include information on the diversity in the catchment community
- Documenting that staff have been trained in cross cultural awareness.

Policies and procedures to demonstrate compliance with Standard 4 will include but not necessarily be limited to those that address:

- service access—physical, social and cultural and information
- how organisations identify and respond to the social, cultural, religious and spiritual customs and values of the diverse groups in their catchment community
- commitment to staff training and development to ensure appropriate diversity responsiveness
- how staff collect, disseminate and use information on applicable social and historical factors of identified diversity groups
- the processes used to ensure that identified diversity groups are represented in board membership, in staffing and on organisational committees
- how and when liaison staff—such as ethnic health workers, interpreters and other related service providers with diversity and expertise programs—are engaged
- how to work with interpreters, including Auslan interpreters.

It is important to remember that policies and procedures alone are not sufficient to demonstrate that a service provider is meeting a standard's requirements. It is also necessary to demonstrate how the policies and procedures have been implemented and guide organisational practices and behaviours.

# 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

The intent of this Standard is to ensure that service providers develop appropriate and effective activities for promotion of mental health and prevention of mental health problems and / or mental illness. For the majority of non government community mental health services promotion and prevention activities will not be a core funded role, but a secondary activity to support primary activities.

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

#### **Development of activities (Criterion 5.1) (partially applicable to the sector)**

Development of promotion and prevention activities will be influenced by the size and scope of services provided and the sector in which the service provider operates. Some will be specifically funded to undertake promotion and prevention activities. Most will undertake promotional activities to support core service delivery activities, for example through involvement in Mental Health Week, Schizophrenia Awareness Week or Carers Week, rather than as a stand alone core function.

*Evidence that this criterion is met could include:*

- promotion and prevention activities appropriate to target groups, funding and core services.

#### **Appropriate activities (Criterion 5.2) (partially applicable to the sector)**

As for Criterion 5.1, activities will be influenced by the size, scope of services provided and the sector in which the service provider operates.

*Evidence that this criterion is met could include:*

- conducting promotion and prevention activities appropriate to the target group and core services
- participating in awareness raising and community education activities as part of Mental Health Week, Schizophrenia Awareness Week and Carers Week.

### **Collaborative partnerships (Criterion 5.3)**

Service providers which do not have promotion and prevention activities as part of their core funding roles should consider local opportunities to work in collaboration with other mental health and related services areas, including carer support service providers. Collaborative partnerships help to distribute responsibility and share resources to address different components of the promotion and prevention effort.

Partnerships can also be developed with mainstream organisations, around the needs of particular groups of consumers—for example sporting or recreational clubs, universities or TAFE colleges, or community arts centres—to promote community re-entry and healthy lifestyles for consumers as part of their recovery.

Service providers could also link to the acute or post acute public or private mental health service that is meeting the consumer's medical and medication needs. They could also link to programs aimed at preventing the development of co-morbid illness and maintaining good health in consumers, carers and staff.

*Evidence that this criterion is met could include:*

- collaborating with others to conduct promotion and prevention activities appropriate to shared target groups and core services
- partnerships with mainstream community services to promote the social inclusion and healthy lifestyle of people recovering from mental illness
- collaborative partnerships with related community service sectors such as drug and alcohol services, Indigenous and multicultural services, youth services and housing, to raise awareness and educate the community as part of Mental Health Week, Schizophrenia Awareness Week, Carers Week and other relevant local, state, territory and national events
- collaborative partnerships with public and private acute and post acute mental health services
- service provider representation on inter-sectoral reference groups, external committees and boards involved in promotion and prevention activities
- providing fact sheets that promote a healthy lifestyle, either online or print based, for consumers and carers and other service providers, on topics such as exercise and mental health or mental health and heart disease.

## **Coordination of partnerships (Criterion 5.4)**

Service providers should have mechanisms to demonstrate coordination of partnerships for promotion and prevention activities.

*Evidence that this criterion is met could include:*

- documented roles and responsibilities of organisations and individuals involved in the partnerships and collaborations
- minutes of meetings
- plans that identify goals, objectives, actions and evaluation strategies.

## **Workforce (Criterion 5.6) (partially applicable to the sector)**

Workforce development on mental health promotion and prevention will be a primary focus for services funded for this role but a secondary focus for most non-government providers of community mental health services for which promotion and prevention activities are an adjunct to their core programs.

*Evidence that this criterion is met could include:*

- documenting promotion and prevention training for staff
- staff participation in networking forums and planning workshops
- board, staff, consumer and carer attendance and presentations at conferences that have prevention and promotion as a theme.

Policies and procedures to demonstrate compliance with Standard 5 will include but not necessarily be limited to those that address:

- conditions for promotional and prevention partnerships with applicable sectors or settings
- commitment to engaging with mainstream community organisations such as sporting and recreational clubs, educational facilities, community employers and arts organisations as part of promoting recovery and community re-entry.

It is important to remember that policies and procedures alone are not sufficient to demonstrate that a service provider is meeting the standard's requirements. It is also necessary to demonstrate how the policies and procedures have been implemented and guide organisational practices and behaviours.

# 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.**

### GUIDELINES

The consumer standard is not assessable, as it contains criteria that are all 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 have the right to be treated with the respect and dignity equal to any human, at all times. Wherever possible, consumers should be able to access a staff member of their own gender if required.

Under some circumstances, consumers may be subject to the provisions of mental health and related legislation, or have a legal guardian lawfully authorised to make a decision on their behalf, which compels the consumer to receive treatment. Services provided must be consistent with the applicable legislation.

#### **Consumers rights and responsibilities (Criteria 6.3, 6.4)**

The consumer statement of Rights and Responsibilities, provided on admission to the service provider and at regular intervals thereafter, should include:

- consumers' safety and wellbeing being upheld by the service provider
- consumers' rights to privacy and confidentiality (within articulated safety and legal constraints) being upheld
- consumers having the right to seek other opinions regarding the care, assessment, and services provided to them
- the relationships between consumers, carers, family and friends being respected and honoured and, with the consumer's consent, used to support recovery

- consumers work in partnership with service providers toward recovery goals
- the language, cultural, and gender needs of consumers are reflected in recovery goals as determined by the consumer
- consumers' complaints and grievances are addressed without compromising service provision to them
- consumers have the responsibility for maintaining their own health and welfare, and for setting their recovery goals, nominating those, if any, from whom they want support
- consumers treating staff with dignity and respect.

Education about rights and responsibilities should be an ongoing process that might take different forms as a recovery journey progresses. The service provider can help the consumer to understand information through making sure there are opportunities for the consumer to ask questions, using interpreters and peer support workers and consumer advocates.

Arrangements should be in place to offer support to consumers, their families, staff and visitors immediately following a critical incident.

### **Relationships (Criterion 6.5) (partially applicable to the sector)**

Least restrictive alternative is an important concept to understand. Generally, services in a community setting would be regarded as being less restrictive than, for example those provided to a consumer as a voluntary in-patient in a hospital. They would be much less restrictive than those provided to a consumer as an involuntary patient in hospital.

The more restrictive the environment, the more it is likely to remove some rights and decision making capacity from the consumer.

Existing carer relationships and the capacity, willingness and needs of carers are key considerations when determining the most appropriate treatment, services 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 and support to occur and services to be provided that are consistent with recovery goals, while ensuring safety and protection of other consumers, staff, visitors and members of the public.

### **Identification of clinician (Criterion 6.6)**

The staff member involved in initial contact could be called a case manager, care coordinator or key worker. They coordinate the assessment, treatment and support.

This criterion might or might not be relevant to a non-government provider of community mental health services according to the client group and the nature of services provided. For consumers who are receiving services through a public or private hospital clinical team, the care coordinator role is likely to be filled by the member of that treating team who has key worker responsibilities.

### **Partnerships (Criterion 6.7)**

Each consumer participates fully in the development of their individual treatment, care and recovery plan and in the evaluation of outcomes to ensure that goals are achieved. A copy of the plan is given to the consumer wherever possible. In the non-government sector, 'treatment' might not be an appropriate title for the plan. 'Care and recovery' might be more accurate. In this sector it should always be possible to give the consumer a copy.

### **Informed consent (Criterion 6.8)**

Consent to care is obtained by:

- providing information about the choice of services, supports and (when relevant) the treatment available
- ensuring that this information is understood
- supporting consumers to make informed choices.

The importance of understanding what is required for informed consent is a relevant consideration.

### **Care plans (Criterion 6.9)**

Each consumer should have an individual comprehensive treatment, care and recovery plan which is based on the consumer's assessment and which has been developed in partnership with the consumer and their nominated carers.

If a multi-agency multidisciplinary team is providing different elements of care and support, information about care and support will be a shared responsibility. Alternatively if it is a sole provider, then they have sole responsibility to ensure the consumer has current and accurate information about the services provided.

In the context of non-government community based services, 'services provided' might be a more accurate descriptor than 'treatment and care'.

### **Access to information (Criterion 6.10) (partially applicable to the sector)**

A small number of non-government community mental health service providers might have a primary responsibility for clinical care, but generally treatment options would be the responsibility of a private or public mental health service acute or post acute clinical care team, or a GP.

Service providers should ensure that consumers are given information about other support services appropriate to their recovery goals, not only the service they are accessing through the service provider.

Consumers should have access to information about their mental illness, the principles of recovery-oriented mental health practice, treatment options, risks and benefits, effects and side-effects, ongoing care and rehabilitation arrangements. This information should be discussed with consumers by an appropriate member of the care team, with the discussion being 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 only include carers and family members, but also staff and service providers where this does not impose a risk to the consumer, carer or service provider staff.

### **Exit plans (Criterion 6.12)**

Appropriate arrangements should be made for an exiting consumer. They should always include an exit risk assessment.

Consumers and carers should be helped to identify early warning signs of relapse. Exit plans should include symptoms of pending relapse and an accompanying relapse management plan.

As appropriate to the type of services provided and the conditions under which they are provided, exit plans should include some or more of the following:

- 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 nominated service provider and arrangements for ongoing follow-up
- community resources likely to be required
- other people likely to be involved
- other details identified by consumer and 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 service provider
- service provider point of contact in relation to the most recent episode of treatment and support.

## **Continuity of care (Criterion 6.13)**

Follow-up arrangements should be planned and in place before exit. They should be documented in the individual health record.

The consumer is given formal introductions to various community agencies where 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 given information about how to access their own health records. This should include information on who can access records on their behalf.

Consumer information sheets on privacy legislation are available from

➤ <http://www.privacy.gov.au/> and

➤ <http://www.privacy.gov.au/business/health>

## **Contact (Criterion 6.16)**

This criterion is most relevant to providers who are involved in supported community accommodation. More broadly, support for re-establishing and maintaining significant social relationships is a responsibility of all service providers and is fundamental to a recovery approach.

In relation to accommodation, what is important for recovery are flexible visiting times, quiet space for meeting with visitors and access to a means of contacting family and friends.

## **Service planning (Criteria 6.17, 6.18)**

Service providers should use methods appropriate to their individual service to engage consumers and carers in all areas of service planning, delivery, evaluation and quality assurance activities.

Staff induction processes should include training in how to gain consumer participation and awareness in how important it is.

# 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

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.

#### **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. Service providers should have policies to address these possibilities. Child and Adolescent Mental Health Services (CAMHS) sometimes work more closely with carers than other services and might deal exclusively with the parent or carer, depending on the consumer's age.

Issues of custodial and non custodial parents and legal guardianship should be considered and addressed, as well as whether the carer is a consumer within another service provider. Policies and service delivery protocols should address these situations.

It is important for service providers to understand that there is a range of ideas in the community about what a carer is. Not all carers will identify, or describe themselves, as carers, or want to be referred to as carers.

*Evidence that this criterion is met could include:*

- service provider referral forms should include a request for information about carers and their involvement
- service provider intake or initial assessment processes should have procedures to identify carers and their involvement

- service provider intake or initial assessment processes should have procedures to identify consumers who are under Adult Guardianship arrangements
- documenting individual service reviews that include consideration of carers and their role.

## **Partnerships (Criteria 7.2, 7.3)**

Partnerships and communication are a principle of recovery-oriented mental health practice. Unless consumers make an informed consent not to involve carers, services should be delivered in partnership with consumers and carers.

Carers should be engaged as soon as possible when consumers enter the service. Service providers should continue to seek information from carers that contribute to the services provided and achievement of recovery goals. Carers should be involved in individual service reviews and in exit planning.

Where carers are not identified at the referral or initial assessment stages, service providers should continue to attempt to identify whether there is carer support.

A Carers' Rights and Responsibilities Statement should be provided to and discussed with carers as soon as possible.

The statement should be guided by the requirements of state or Territory Carers' Acts and charters where they are in place, but should generally include:

- confirmation of respect for the valued role of carers
- confirmation that carer wellbeing is important to the service provider and consumer recovery
- confirmation of respect for carers rights, choices and opportunities to enjoy optimum health, social, spiritual and economic well being and to participate in family, social and community life, employment and education
- recognition of the challenges carers face in balancing their caring role with other roles and their own needs, and support for them to achieve that balance
- information about recovery-oriented mental health practice
- what information will be provided about the mental health condition, and the services being provided to the consumer
- information about confidentiality obligations, the limits to confidentiality commitments and how service providers engage with carers when consumers do not want personal information shared
- support for carers to contribute information and views that might help service providers to support consumers and contribute to recovery goals
- confirmation that the relationship between carers and consumers is respected and honoured

- a commitment to working in partnership with consumers, carers and other service providers
- confirmation that the language and cultural needs of carers will be respected.

Consumer consent will always be one determining factor in how a service provider manages carer participation. Other ways that carers are involved, and the extent to which it is appropriate to involve them, will vary across different service types and in relation to different consumer, family and carer situations. Social and cultural factors should also be taken into account.

Practical strategies to support partnerships with carers at the individual level will vary according to whether or not there is consumer consent, and to the needs and wishes of the consumer and carer. Opportunities for carers to ask questions about their rights and responsibilities and to be given information should be provided throughout all phases of care.

It is important to understand that partnerships around the services provided to individual consumers are only one way that partnerships can be established with carers. With the right skills, training and support, carers can also be involved at the organisational level and systemic levels.

For example at the organisational level, a carer could represent carers on the board, contribute to program reviews and evaluations and the development of the strategic plan, participate as a member on staff selection panels, or be involved in staff training.

At the systemic level a carer could represent the service provider on mental health region's Carer Advisory Group, participate in a staff training program for a public mental health service or be part of a carer advocacy organisation. At this level, consumer consent for carer involvement is not needed unless the role has a direct connection to the consumer in which case their consent may be required.

*Evidence that these criteria are met could include:*

- a Carers' Rights and Responsibilities statement
- the carer being given information about the organisation and the services being provided to the consumer and about mental illness and recovery-oriented service delivery
- documenting that the carer is included in individual service planning and reviews and other discussions about treatment and support, including discharge planning or the cessation of a service
- a carer's plan being in place as part of the consumer's individual service plan
- training for staff on strategies for communicating with carers who are developing effective partnerships with carers and families
- documenting the involvement of carers at the organisational level
- documenting support for carers to contribute at the systemic level.

## Provision of information (Criterion 7.4)

Written material on carer rights and responsibilities and on the National Standards for Mental Health Services should be prominently displayed in service providers' public areas and be available on websites where there is one. They should also be provided to carers personally on request or when they are involved in initial intake and assessment processes. For states and territories that have a Carers' Act or a Carers' Charter, information about them should also be provided.

The information should be available in formats and languages appropriate to the diversity of the catchment community.

*Evidence that this criterion is met could include:*

- documentation to confirm that carers have been provided with a service provider Carers' Rights and Responsibilities Statement, a copy of the *National Standards for Mental Health Services* (2010) and, as applicable, the relevant state or territory Carers' Act or Carers' Charter
- documentation to confirm that carers have been provided with information about service provider complaints management processes
- documentation to support that carers have been advised about mental health carer advocacy and support groups and organisations.

## Diversity of carers (Criterion 7.5)

Carers of Aboriginal and Torres Strait Islander persons, culturally and linguistically diverse (CALD) persons and persons with disabilities should be specifically identified and supported by service providers within and outside their communities.

*Evidence that this criterion is met could include:*

- documenting that census data has been analysed
- respect for and responsiveness to diversity in service provider service delivery principles and values statements
- documenting that staff have been trained in cross cultural awareness
- documenting the use of interpreters with consumers and carers who are not proficient in English or who are deaf
- board membership and staffing diversity that reflects the catchment community
- specialist positions, for example culturally and linguistically diverse and Aboriginal and Torres Strait Islander liaison staff

- making available to carers, information in the main community catchment languages dealing with issues such as rights and responsibilities or the programs offered by the service provider
- intake procedures taking into consideration cultural and linguistic needs
- building alterations and modifications to reduce physical access barriers.

## **Age of carers (Criterion 7.6)**

Service providers should consider the needs of carers who are children or aged persons and provide information on how they can access support.

*Evidence that this criterion is met could include:*

Documentation to confirm that information is provided to young and aged carers about organisations that can assist them, including but not limited to:

Mental Health Carers ARAFMI Australia, ↗ <http://www.arafmiaustralia.asn.au/>,

Mental Illness Fellowship of Australia, ↗ <http://www.mifa.org.au/>

Children of Parents with a Mental Illness (COPMI), ↗ <http://www.copmi.net.au/>

The Australian Government site on mental health, ↗ [www.mentalhealth.gov.au](http://www.mentalhealth.gov.au)

Department of Health and Ageing, ↗ <http://www.health.gov.au>

Commonwealth Respite and Care Link Program, freecall 1800 052222 or

↗ <http://www9.health.gov.au/ccsd/>

## **Confidentiality (Criterion 7.7)**

Service provider staff require a sound understanding of the confidentiality principles of the Mental Health Act and Commonwealth, state and territory legislation, which define what information can be conveyed to families and other carers and under what circumstances.

How to engage with carers when a consumer makes an informed decision that they do not want the carer involved in their recovery journey, or to be provided with personal information, is discussed below in relation to criteria 7.8 and 7.9.

*Evidence that this criterion is met could include:*

- documenting that information about confidentiality requirements has been provided to staff and volunteers in orientation programs
- documenting how carers are engaged and supported when consumers make informed decisions that carers are not to be provided with personal information or to be partners in their recovery journey.

## Consultation (Criteria 7.8, 7.9, 7.10)

Carers need access to information on consumer mental health status and how service provider programs complement any medical and other treatments and contribute to recovery.

Any discussions with carers about the personal aspects of consumer care should be in accordance with Commonwealth, state or territory privacy legislation. The service provider's primary duty of care is to the consumer. Any consequences to the consumer should be considered when they do not give consent to disclose information to the carer.

Decisions barring carers from involvement changes the way service providers engage with carers but does not mean there should be no contact with carers. Carers in this situation will often have very high needs for support. Safety issues for consumers and carers will need to be evaluated to determine how the organisation proceeds.

Ways that service providers can provide opportunities for carers to participate in these circumstances, without breaching consumer confidentiality decisions, can include ensuring that carers:

- have access to information about their consumer's mental health in general terms, and reassurance about the supports that monitor the consumer's well being
- still have the opportunity to present their issues, to have them listened to and taken into account in the assessment, planning and delivery of services to the consumer
- have opportunities to be involved in the organisation at the service level, even though their involvement in decision making about the consumer is limited
- have service provider support to help them access carer support and advocacy services.

*Evidence that these criteria are met could include:*

- documenting what information is provided to carers that does not require consumer consent
- documenting what information is provided to carers with consumer consent
- documenting what information about confidentiality requirements is provided to staff and volunteers in orientation programs
- documenting how carers are engaged and supported when consumers make informed decisions that carers are not to be provided with personal information or to be partners in their recovery journey.

## **Exit information (Criteria 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.

Services that could provide this support are listed under Criterion 7.6. Those listed are organisations with a national presence but advice should also be provided about other state and territory based services that can provide ongoing support to carers once the consumer exits the service.

*Evidence that these criteria are met could include:*

- giving carers information brochures detailing available sources of ongoing support
- displaying posters and brochures in service provider public areas, providing information on respite services, carer respite centres, carer resource centres and carer counselling programs
- providing information on service provider websites.

## **Training (Criteria 7.15, 7.16, 7.17) (partially applicable to the sector)**

Staff should be trained to consider and understand the ongoing needs of carers when a consumer is exiting a service and to be aware of the services to which they can refer carers for ongoing support.

*Evidence that these criteria are met could include:*

- documenting the training of staff in the ability to assess carer capacity to provide care for the consumer after discharge
- the use of carer assessment tools to assess carer capacity to provide care to the consumer
- giving carers information about available sources of ongoing support when a consumer exits the service.

Policies and procedures to demonstrate compliance with Standard 7 will include, but not necessarily be limited to, those that address:

- carer rights and responsibilities and how they are conveyed to staff, volunteers, consumers and carers
- carer identification
- what information is provided to carers and how that information is provided

- how carers are involved, the structures and activities that are in place to facilitate their involvement at the individual, organisational and systemic levels
- engagement with local and regional carer support services, including specialist groups such as those for children of parents with a mental illness or culturally specific carer support groups, and how those links are established and maintained
- confidentiality provisions, and the management of situations in which the wishes and needs of a consumer conflict with the wishes and needs of their carer
- arrangements for the resolution of carer complaints and disputes.

It is important to remember that policies and procedures alone are not sufficient to demonstrate that a service provider is meeting a standard's requirements. It is also necessary to demonstrate how the policies and procedures have been implemented and guide organisational practices and behaviours.

# 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 in place to facilitate effective governance of the service.

Governance obligations are different for the non government community mental health service sector. However, even within the sector, not all organisations are legally structured the same way. Many will be associations incorporated under the applicable state and territory Associations Incorporation legislation. Others might be companies or companies limited by guarantee.

Legal structure is a key determinant of what is required in terms of an organisation's governance and accountability responsibilities. It is the responsibility of each organisation to understand its legal structure and obligations. This section provides general information only.

The ACT Council of Social Services (<http://www.actcoss.org.au>) has identified five duties of board or management committee members. They are as follows

**1. Fiduciary duty**—the duty to act in the best interest of the organisation.

Within fiduciary duty is the expectation that board or management committee members will act with a duty of care, loyalty and obedience to purpose, in keeping with the philosophy and objectives of the organisation. Staff and perhaps volunteers run the daily affairs of the organisation, but the board or management committee is ultimately responsible for maintaining financial and legal responsibilities.

**2. Duty to act honestly**—to apply reasonable skills, act in good faith and in the best interests of the organisation.

**3. Duty of care and diligence**—the duty to abide by the constitution of the organisation and to know and comply with all legal requirements.

This includes taking all reasonable steps to minimise risk for the organisation. It also includes working on a positive public perception of the organisation. It also means the board making sure it has enough information to make decisions.

**4. Duty of confidentiality**—the duty to keep confidential all organisational and board or management committee information.

This includes not expressing dissent about a decision with which an individual member disagrees; the board or management committee should speak as one voice. If a member cannot live with a decision that has been debated and voted on, they need to leave the board. Once a decision is made it is a decision of the board and management committee as an entity.

**5. Duty to declare any conflict of interest**—the duty of each member to inform the board or management committee of any personal interest in any matter before it, and to absent themselves from issues where there is the possibility of a perceived or real personal or financial interest.

## **Integration and coordination (Criterion 8.1)**

As appropriate for the size of the organisation providing the services and where the mental health service sits in its total suite of services, there should be evidence of the links between the service and the wider organisation in the organisation's strategic and operational plans.

The board or management committee is the final point of accountability across all of the organisation's settings and programs.

The board or management committee delegates authority to senior executives and managers and defines their responsibility for the operation of clinical and non clinical services to achieve goals and ensure service integration, coordination and effective outcomes for its consumers.

*Evidence that this criterion is met could include:*

- the content of the organisation's strategic and operational plans
- documenting the roles and responsibilities of the board, its office bearers and CEO for corporate and (as appropriate to the nature of the services provided) clinical governance.
- documenting delegations.

## **Promotion and prevention (Criterion 8.2) (partially applicable to the sector)**

Service providers should develop plans that identify the person or position responsible for developing promotion and prevention strategies at the organisation and individual staff levels.

This criterion will only be relevant to service providers with funding expressly to undertake promotion and prevention activities.

*Evidence that this criterion is met could include:*

- a promotion and prevention plan.

## **Development and review of strategic plan (Criterion 8.3)**

Service provider strategic plans need to be consistent with legislative requirements, and national, state and territory level mental health policies and related documents.

Strategic plans should include the following components:

- the organisation's purpose, principles and values
- the key outcomes to be achieved across the years covered by the plan
- the key strategies through which the outcomes will be achieved
- the information that will be used to monitor progress and report on outcomes.

Its development should be informed by an analysis of the needs of consumers and the catchment community, ongoing service delivery obligations as determined in funding agreements, the contributions of staff, consumers, carers and other stakeholders identified by the organisation.

*Evidence that this criterion is met could include:*

- documenting the contribution of staff, consumers, carers, and representatives of key groups within the catchment community, to the development and review of the strategic plan
- the strategic plan document
- documenting that the plan is regularly reviewed and adjustments made when necessary (for example in board or management committee minutes, reports of planning meetings)
- according to the size and structure of the service, an operational plan for the mental health service which is linked to the strategic plan.

## **Compliance with legislation and related Acts (Criterion 8.4)**

Commonwealth, state and territory legislation and Acts and service funding agreements guide the development of policies and procedures.

There should be a system to disseminate information when changes are made to mental health legislation. The system to ensure compliance with legislation should include, but not be limited to, identifying and disseminating new or amended standards, codes of practice, guidelines and legislation.

*Evidence that this criterion is met could include:*

- a compliance framework for monitoring and evaluating compliance with the organisation's policies and procedures
- qualification free audits.

## **Resources (Criterion 8.5)**

Service providers have sound financial management practices and demonstrate a clear budget allocation for the delivery of services.

*Evidence that this criterion is met could include:*

- qualification free audits
- services delivered within budget allocation
- a planning and monitoring cycle that demonstrates that expenditure is always within available funds, and that the organisation is always aware of its overall financial position
- a record keeping system for financial transactions that meets accounting standards, and provides accurate and useful financial reports
- a control and risk management system that ensures procedures protect the organisation against fraud or insolvency.

## **Recruitment, selection and staff development (Criteria 8.6, 8.7)**

Staff recruitment practices should conform to applicable equal opportunity legislation.

Job descriptions should accurately reflect the skills, qualifications, experience and personal attributes required to perform duties effectively. The organisation must have an ongoing commitment to the supervision and ongoing training and development of all staff.

*Evidence that these criteria are met could include:*

- job description documentation
- recruitment documentation
- working with children and other police clearances
- the staff orientation program
- documenting that staff supervision is undertaken and poor performance is adequately managed
- documenting that staff performance reviews are completed every year
- the staff training and development calendar
- the staff code of conduct.

### **Critical incidents (Criterion 8.8)**

The service provider should have a formal process to review critical incidents. The process should support both staff and others within the service provider 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.

*Evidence that this criterion is met could include:*

- a critical incident reporting and response system.

### **Information management (Criterion 8.9)**

Information management includes consumer records in both individual and aggregated formats that can be understood by those involved in the delivery of services. The National Privacy Principles are the base line standards some private sector organisations need to comply with under the Privacy Act 1988 in relation to personal information they hold. This includes non-government community mental health service providers. Copies are available from:

➤ <http://www.privacy.gov.au/materials/types/infosheets>.

*Evidence that this criterion is met could include:*

- information audits that confirm compliance with legislative requirements
- a control and risk management system that documents the information security measures that ensure physical (hard copy) information security, computer and network information security, other communications security and personnel security.

## Risk management (Criterion 8.10)

Risk management is a key responsibility of the board or management committee, but one in which the CEO and staff must also be involved. It is a process which involves:

- identifying the risks
- assessing and evaluating the risks (for example by considering the likelihood of an identified risk event occurring and its consequences)
- deciding on the response to the risk, how it will be treated (accepted, avoided, reduced or transferred) and the action to be taken
- monitoring and reviewing the effectiveness of the response or treatment.

At all stages, good organisational communication at all levels is an essential success factor.

Information gathered through feedback, complaints, incidents and adverse reporting should be part of corporate governance and, as applicable to the types of services provided, clinical governance including risk management processes.

Service providers must have documented systems that are evaluated to ensure effective corporate and, as applicable to the types of services provided, clinical risk management practices are in place.

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

*Evidence that this criterion is met could include:*

- risk management being documented as a standing item on board and management committees, and actions taken after risks have been considered
- the board and management committee code of conduct
- documenting what training is provided to board and management committee members and staff in corporate and, as applicable to the types of services provided, clinical risk management practice
- the corporate and, as applicable to the types of services provided, clinical risk management plans
- risk assessment reviews and actions taken following reviews.

## Formal quality improvement program (Criterion 8.11)

Service providers should analyse data and information to promote effective services for consumers and carers, to assist with the evaluation of service delivery and to develop staff training programs. Data management systems can be used to provide evidence of quality improvement activities as a result of data evaluation.

Quality improvement programs should include capacity to use consumer and carer feedback, complaints, adverse events and critical incidents to improve service quality. Programs should include service level evaluation and evaluation of individual outcomes, including the extent to which the service has contributed towards the consumer achieving recovery goals. Staff, consumers, carers, key groups within its community and other service providers, should be involved in service evaluation.

*Evidence that this criterion is met could include:*

- the quality improvement framework.

Policies and procedures to demonstrate compliance with Standard 8 Governance, leadership and management will include, but not necessarily be limited to, those that address:

- organisational governance including the roles and responsibilities of the board, office bearers and the Chief Executive Officer
- the development and review of the strategic plan and associated operational plans as appropriate for the size and service complexity of the organisation
- financial management and organisational accountability and reporting
- information management
- service quality and continuous quality improvement
- corporate and, as applicable to the types of services provided, clinical risk management.

It is important to remember that policies and procedures alone are not sufficient to demonstrate that a service provider is meeting a standard's requirements. It is also necessary to demonstrate how the policies and procedures have been implemented and guide organisational practices and behaviours.

# 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.

This standard focuses on when a public or private service is the primary provider of treatment.

In this case, staff from non-government services will generally be team participants rather than care coordinators. If on any occasion they do take on the role of care coordinator—such as when an interagency interdisciplinary team is involved in treatment and recovery support—criteria 9.1, 9.2, 9.3 and 9.4 apply.

Other reasons they may take on the role of care coordinator are, for example in the interests of the long term stability of the consumer, or in response to service options in particular geographic areas. In these cases criteria 9.1, 9.2, 9.3 and 9.4 also apply.

In this context, Standard 9 Integration gives guidance on what non-government providers should expect when consumers are referred from a public or private service that is the primary provider.

### **Continuity and coordination of care (Criterion 9.1) (partially applicable to the sector)**

The coordinator of care's role is to make sure everyone involved in a treatment—in and outside the organisation—works together. This involves matching consumers with the most appropriate providers across the continuum of care, ensuring seamless and timely transition to other levels of service, and minimising duplication in assessment, planning and delivery.

The coordinator is selected as soon as possible after a consumer enters the service, and the consumer and, where appropriate, carers are informed that this person is responsible for:

- coordinating assessment
- coordinating treatment and support
- facilitating a smooth transition of care to other services as required
- planning collaboratively with the consumer and carers
- communicating with the consumer and, where appropriate, carers regarding all aspects of care
- coordinating the interdisciplinary care team.

### **Support for interdisciplinary care teams (Criterion 9.2) (partially applicable to the sector)**

The mental health service should schedule regular interdisciplinary care team meetings to ensure there is a shared focus.

There should be regular auditing of treatment, care and recovery plans during each episode of care to document what has been done.

Team members contribute their particular expertise. The team should share information and work together. Team leadership should be task-dependent with tasks defined by the individual consumer's situation. The coordinator should be a member of the team and coordinate functions so the team achieves the best possible outcome for the consumer.

### **Collaborative planning (Criterion 9.3) (partially applicable to the sector)**

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

Service providers can provide treatment and support at several sites such as inpatient, community based rehabilitation, recovery centre and home.

For organisations with many sites, the process of engagement with the service and transfer between services should be standardised. Consumers need to be informed where services will be provided.

To promote integration and continuity of care between programs and sites there should be regular team leader meetings and service-wide meetings that include inpatient and community staff as appropriate to the consumer's circumstances.

Contacts with internal and external services and providers should be documented—this includes referrals, policies and procedures.

Service providers should ensure that staff are familiar with the policy and procedures relating to contact with internal and external services and providers.

Service providers should have an up-to-date resource folder in hard and soft copy to inform staff, consumers and carers about the range of other health and related services.

There should be regular meetings with other service providers to maintain links and partnerships—or establish them—that facilitate continuity of care for the consumer.

### **Links with primary health care providers (Criterion 9.4) (partially applicable to the sector)**

Shared care arrangements between general practitioners (GPs), private psychiatrists, non-government organisations and other applicable agencies should be used to facilitate consumer recovery.

Examples of shared care arrangement models include but are not limited to:

- GPs and other mental health care providers, such as the Better Access Program, which aims 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 is being transferred to the primary care provider, such as the GP, the service provider should provide feedback to help the GP manage the consumer. This feedback should contain:

- notification of discharge from hospital and what has happened to the consumer
- any change in legal status of the consumer, for example community treatment orders (CTO) or community care orders (CCO), changes in treatment, medication, physical health, pathology results
- treatment recommendations for the GP
- contact person and process for re-entry to the service provider if the consumer relapses.

### **Interagency and inter-sectoral links (Criterion 9.5)**

Service providers should work in collaboration with other related service providers, including welfare services, primary care practitioners, disability support services, emergency departments and aged care providers in ways that support consumers to achieve their recovery goals.

For some service providers, according to the service types provided and the extent to which relationships are systemic rather than around individual consumers, links and partnerships with other services such as Alcohol and Other Drug Services (AODS), youth support services and community housing services might be supported by formalised service agreements or MOUs.

*Evidence that this criterion is met could include:*

- referral processes into the service and from the service
- documenting team meetings
- individual support plans that include engagement with other services to support the consumer to achieve their recovery goals
- MOUs with other service providers
- links and partnerships with other service providers.

Policies and procedures to demonstrate compliance with Standard 9 Integration will include, but not necessarily be limited to, those that address:

- referral processes into the service and transfer to other service providers
- staff involvement in multidisciplinary interagency teams
- collaborative partnerships and conditions for MOUs
- the service provider's resource directory.

It is important to remember that policies and procedures alone are not sufficient to demonstrate that a service provider is meeting a standard's requirements. It is also necessary to demonstrate how the policies and procedures have been implemented and guide organisational practices and behaviours.

# Standard 10. Delivery of care

## 10.1 SUPPORTING RECOVERY

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**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 service providers facilitate the recovery journey for consumers by assisting consumers to achieve wellness and their recovery goals, 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. The Principles of Recovery Oriented Mental Health Practice, as set out earlier in these guidelines, should drive all service provider programs, policies and procedures.

*Evidence that this criterion is met could include:*

- an organisational purpose statement that includes reference to recovery processes and outcomes
- organisational values and principles that make explicit the commitment to supporting recovery
- programs, policies and procedures for service delivery that are based on recovery principles
- quality improvement that is developed, implemented and monitored collaboratively with consumers and carers
- the Principles of Recovery Oriented Mental Health Practice guide staff selection, training and supervision.

## **Dignity and respect (Criterion 10.1.2)**

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

*Evidence that this criterion is met could include:*

- the consumer's own expectations and goals for their recovery are fundamental drivers for the services they receive
- clean and welcoming reception areas and waiting rooms
- reception area staff trained in how to greet consumers respectfully and make them comfortable while waiting to be seen
- private rooms with adequate sound proofing available for assessments and consultations.

## **Recognition and support (Criterion 10.1.3)**

Acknowledging the uniqueness of the individual is a principle of recovery-oriented mental health practice. It empowers consumers as they know they are the centre of the care and support services they receive.

A key part of the recovery approach is to help consumers assume responsibility for themselves. This is achieved by instilling hope, re-establishing a positive identity and self esteem, healing and empowerment. They also feel connected, through the implementation of human rights principles, a positive culture of healing, and recovery-oriented services.

*Evidence that this criterion is met could include:*

- documenting that the consumer has been supported to develop their own recovery goals and that services have been tailored to help them achieve those goals
- with the consumer's consent, engaging with other service providers, carers, family and friends, to make plans for reaching these goals
- feedback from consumers that they feel empowered to take on decision-making tasks
- providing information and education to consumers and carers—in formats appropriate to their needs—about the consumer's condition, how they can take responsibility for their own well being, and how to improve and maintain their overall health and well being
- documenting that the consumer has been given access to information on peer-based support programs and services that promote recovery.

## **Self (Criteria 10.1.4, 10.1.6)**

Service providers can help consumers to develop independence and regain self-direction, understanding and control of their illness.

*Evidence that these criteria are met could include:*

- documenting the use of advance care directives and individual service recovery plans
- demonstrating how consumers are supported to develop connections with communities
- relationships and partnerships with community organisations beyond the mental health service system
- educating staff about special interest groups and community activities for consumers.

## **Social inclusion and citizenship (Criterion 10.1.5)**

Social inclusion and the ability to contribute to the life of their community is important in the recovery journey of many consumers. Service providers can have a systemic advocacy role as well as an advocacy and support role to individuals who want to engage or re engage with their community.

*Evidence that this criterion is met could include:*

- documenting that consumers are participating in all aspects of service planning, development and implementation (more information on consumer participation is available from Standard 3)
- documenting links with mainstream community organisations (such as sporting, recreational and social clubs, community arts centres) facilities (gyms, swimming pools, recreation centres) and educational and vocational services (schools TAFEs and universities, employers and employment support providers) to support recovery
- documenting that the service provider has actively encouraged and supported consumers to become advocates (more information on advocacy is available from Standards 1 and 3)
- 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)**

Reconnection with the community should be viewed as fundamental to recovery and a primary goal of service providers. Service providers should support and encourage consumers to develop and re-establish appropriate connections with family, friends and community support networks.

Service providers should always consider opportunities for the consumer to engage, as a step in their recovery, not only with other mental health or specialist services, but with mainstream community organisations such as sporting and recreational clubs, schools, TAFE colleges and universities and community arts centres.

Service providers should work collaboratively with consumers to develop and review goals for re-connecting with the community. The service provider culture should value and foster the use of peer-support and consumer self-help.

*Evidence that this criterion is met could include:*

- documenting engagement with families, carers and friends
- documenting collaborative relationships with specialist and mainstream community organisations for the benefit of individual consumers
- consumers accessing mainstream services as part of their recovery
- educating staff and consumer and carer advocates about the range of support networks available in the community, such as local community 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)**

Service providers should have knowledge of the roles and services of a wide range of community services that consumers could utilise to achieve recovery goals.

*Evidence that this criterion is met could include:*

- Service providers having a regularly updated resource directory which staff are trained to use.

### **Carer centred approaches (Criterion 10.1.10)**

This criterion links to Standard 7 Carers. With the consumer's informed consent, and with consideration of cultural and other social factors, relationships should be encouraged with family, carers, sexual partner, friends, peers, cultural groups and the community because they are important supports to recovery.

*Evidence that this criterion is met could include:*

- with the consumer's informed consent, their active involvement in the services they receive
- educating carers about the relevant mental health condition
- training for consumers, carers and families in communication and problem solving skills
- providing carer counselling and ongoing support or referral to a carer support service
- providing services and support to children of parents with a mental illness
- a documented process through which carers are involved when a consumer withholds or withdraws consent to their involvement
- referrals to applicable support and self help groups.

Policies and procedures to demonstrate compliance with Standard 7 Carers will include, but not necessarily be limited to, those that address:

- carer rights and responsibilities and how they are conveyed to staff, volunteers, consumers and carers
- what information is provided to carers and how it is provided
- how carers are involved, and the structures and activities that facilitate their involvement at the individual, organisational and systemic levels
- links with local and regional carer support services, including specialist groups such as those for children of parents with a mental illness or culturally specific carer support groups, and how those links are established and maintained
- confidentiality provisions, and the management of situations in which the wishes and needs of a consumer conflict with the wishes and needs of their carer
- arrangements for the resolution of carer complaints and disputes.

## 10.2 ACCESS

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**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.

#### **Identified needs (Criterion 10.2.1)**

Service providers should pay particular attention to the diversity of its individuals: Aboriginal and Torres Strait Islander persons, culturally and linguistically diverse (CALD) persons, religious and spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age and socio-economic status.

More information on culture and diversity is available in the guidelines of Standard 4.

Access should be regularly monitored to ensure that it is timely, equitable and meets the identified needs of the catchment community.

*Evidence that this criterion is met could include:*

- analysis of census data against the service's demographic profile
- community needs analyses
- feedback from consumers, carers and the community regarding access to the service provider
- documented formal links with applicable community groups and other service providers
- use of appropriately trained interpreters, including Auslan interpreters
- staff orientation and ongoing training that includes training about the access process.

#### **Provision of information on access (Criterion 10.2.2)**

The process of access should be made known to consumers, carers, applicable stakeholders, other agencies and service providers.

*Evidence that this criterion is met could include:*

- a documented procedure for disseminating the information to consumers, carers and other service providers
- displaying posters and brochures in public areas, making them available through a website and through other means as appropriate to the needs of the catchment community.

### **After hours care (Criterion 10.2.3) (partially applicable to the sector)**

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

*Evidence that this criterion is met could include:*

- a consumer information pamphlet that includes after hours emergency contact numbers and the location of after hours mental health services in a format that is understandable to consumers and carers
- the service provider's after hours telephone message saying how to access emergency after hours care and support
- for services in remote areas, information on availability of tele-psychiatry, for example an after hours telemedicine service provided by mental health nurse.

### **Physical access (Criterion 10.2.4)**

For service providers that operate from premises built before the current building access standards were in place, providing physical access can be a challenge, for example in terms of costs to address barriers and lease constraints. In these circumstances service providers need to think laterally about how to reduce the physical barriers. This could include meeting with consumers and carers who have significant mobility constraints in another location, or referring them to other support services that have the necessary physical access arrangements.

All service providers should have clear signage, and take whatever action possible to reduce access barriers. It is important to realise that not all barriers are structural. An access audit is likely to identify barriers that could be reduced at little or no cost, such as furniture, pot plants, pamphlet carousels and mats that could be moved, and doors and gates with complex latches that could be changed (unless they are required for safety reasons).

Information on physical access is available at the Australian Human Rights Commission website:

➤ [http://www.hreoc.gov.au/disability\\_rights/index.html](http://www.hreoc.gov.au/disability_rights/index.html)

*Evidence that this criterion is met could include:*

- results of physical access audits
- Clear signage, visual inspection of physical entry points
- disability awareness training for staff
- pamphlets and brochures that include information about physical access to the service.

## 10.3 ENTRY

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**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 (service provider) are made known to the community it serves and that entry processes are efficient.

#### **Documented entry policy and process (Criterion 10.3.1)**

Entry criteria should not directly or indirectly favour or discriminate against consumers from any groups that are a subset of the target population.

Service providers should have a documented entry policy and initial assessment process that includes:

- referral requirements
- eligibility, initial assessment and, as applicable to the service type, funding for the service provided and priority of access considerations
- ensuring the following are addressed in the entry process: the needs of Aboriginal and Torres Strait Islander persons, culturally and linguistically diverse (CALD) persons, religious and spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age and socio-economic status
- documenting advice about choices and supported referral to other services if the service provider cannot provide appropriate services documenting analysis of 'non-accepted' referrals for satisfaction with outcome.

*Evidence that this criterion is met could include:*

- service provider service eligibility, assessment and priority of access policies and procedures
- feedback from consumers and carers who have made approaches about entry to the service
- analysing census data and the service's demographic profile.

### **Provision of information on the entry process (Criterion 10.3.2)**

Service providers should have a procedure for disseminating information on the entry process to consumers, carers, and other service providers.

*Evidence that this criterion is met could include:*

- information brochures that include service provider service eligibility, assessment and priority of access policies and procedures
- feedback from consumers and carers who have made approaches about entry to the service
- providing information to referring agencies.

### **Prioritisation of referrals (Criterion 10.3.3)**

The need to prioritise referrals will depend on the service type, service demand and funding. Some services might be able to accommodate all consumers who meet the service eligibility criterion and for whom the service is appropriate. Where prioritising access to the service is necessary, service providers should ensure that the criteria do not directly or indirectly favour or discriminate against consumers from any groups that are a subset of the service's target population.

Where consumers are assessed as having low priority, they should be given information about other appropriate services they might be able to access more quickly.

*Evidence that this criterion is met could include:*

- brochures that include information on how eligible consumers are prioritised for access to the service
- analysing referrals which are given low priority for satisfaction with outcome, and documenting the findings
- advice to the consumer and, as appropriate, to carers, on choices and supported referral to other services if the service provider cannot provide appropriate services.

### **Defined pathway for entry into the service provider (Criterion 10.3.4) (partially applicable to the sector)**

Service providers should have one entry point for the system of referral, entry and assessment for each service it delivers.

*Evidence that this criterion is met could include:*

- brochures with information about entry points including any toll free numbers
- information about the entry pathway provided to referring agencies.

### **Minimise delay and duplication (Criterion 10.3.5)**

An individualised consumer health record (if appropriate to the type of services being delivered) and individual recovery plan should be developed when a consumer enters the service. This should include the means of entry to the service.

To reduce duplication, and with the consumer's informed consent, contact should be made with health and other service providers involved in earlier stages or episodes of care to obtain applicable information as soon as practicable after the consumer enters the service.

If the consumer withholds consent an appropriate clinical and organisational assessment should be made to determine the risks to the consumer, staff and other consumers of providing the service without the necessary background information.

*Evidence that this criterion is met could include:*

- the consumer's health record (if applicable to the type of service provided)
- the consumer's individual recovery plan
- documenting contact with and information provided by health and other service providers during the initial assessment period.

### **Involuntary admission (Criteria 10.3.6, 10.3.7)**

These criteria are not applicable to the non-government community mental health service sector.

### **Care management on entry (Criterion 10.3.8)**

According to the service type, size of the organisation, and staffing arrangements in the service, service providers should appoint a care coordinator to coordinate services and liaise with others who are also providing services to the consumer. Consumer and carers should be advised who this person is and of any subsequent changes.

*Evidence that this criterion is met could include:*

- providing information to the consumer and carers on entry
- information on consumer files about referrals, treatment and service provision history
- documenting service links and coordination and communication with others who are providing or have provided services to the consumer
- individual recovery plans.

## **10.4 ASSESSMENT AND REVIEW**

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

### **GUIDELINES**

The intent of this Standard is to ensure that the service providers collect, review and record information that is appropriate to the service type and consumer's individual needs and recovery goals. Assessment and review practices should reflect good practice in recovery oriented mental health and be conducted in collaboration with the consumer, and with the consumer's informed consent, their carer/s. Review practices should have progress towards achievement of the consumer's recovery goals as a primary focus.

Examples of appropriate information could include but are not limited to:

- the consumer's service choices and recovery goals and how the consumer sees the services provided as contributing to the achievement of those goals
- the consumer's diagnosis and history of previous mental health issues
- details of present health and medical history
- functional and emotional status, including the consumer's ability to communicate and care for themselves
- level of risk the consumer presents to themselves and others
- carer support arrangements

- the 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 circumstances of the needs of the consumer and carers that may affect service delivery
- consent forms signed by the consumer and appropriate service provider staff
- details of the integration of the service with other providers and arrangements for collaboration
- the least restrictive environment within which services can be provided to the consumer
- service exit plan.

*Evidence that this criterion is met could include:*

- assessing and reviewing policies and procedures that have recovery as their primary focus
- documentation on individual consumer files.

### **Assessment tools and methods (Criterion 10.4.1)**

Evidence based assessment tools and methods should be used as appropriate to the types of services provided. They could include individual service provider functional assessments, family input, suicide and other risk assessment, problem oriented assessment, formulation and mental status examination.

Evidence that this criterion is met could include:

- assessing and reviewing policies and procedures that have recovery as their primary focus
- the assessment methods and tools in use
- documentation on individual consumer files.

### **Conduct of assessments (Criteria 10.4.2, 10.4.3)**

Assessments conducted during first contact are recorded in the consumer's individual health record. This should include information about:

- service choices offered
- recovery goals
- the consumer's informed consent about what information will be shared by the service provider, and with whom and how it will be shared
- the consumer's informed consent for information to be obtained from others
- who was involved in the assessment, including the consumer, the referrer, other service providers and carer.

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

Wherever possible, and taking into account the service provider's staffing levels and risk assessment, the assessment should take place in the setting preferred by the consumer. Telephone and video technologies can be used when face-to-face assessment is not possible due to distance or the consumer's preference.

*Evidence that these criteria are met could include:*

- assessing and reviewing policies and procedures that have recovery as their primary focus
- the assessment methods and tools in use and the extent to which they support good practice in recovery
- documentation on individual consumer files.

### **Planning discharge (Criterion 10.4.4)**

This criterion is not relevant to non-government community mental health service providers. Criterion 10.6 refers to service exit and re-entry.

### **Review (Criteria 10.4.5, 10.4.6) (partially applicable to the sector)**

Assessments should be regularly reviewed and updated. Reviews should be conducted in ways that are consistent with recovery-oriented mental practice. The particular requirements of a review depend on many factors such as the type or complexity of services provided, the consumer's recovery goals and collaborative arrangements that support the achievement of recovery goals.

Reviews should include re-assessment of identified risk and the least restrictive environment in which services can be provided. They should also include the extent to which mainstream community services can be utilised to support the consumer's continued progress.

*Evidence that these criteria are met could include:*

- regular assessment reviews conducted at planned intervals, or at other times when there are significant changes in the consumer's circumstances or to the services provided—these should be documented in the consumer's individual health record
- assessment reviews demonstrating progress towards recovery goals.

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

## **Follow-up (Criterion 10.4.7 partially applicable to the sector)**

When a consumer declines the offer of service and the offer of assessment, the referring service should be advised. Support and referral should be offered to carers where applicable.

*Evidence that this criterion is met could include:*

- documenting on referral forms that a referrer has been advised when a consumer declines an offered service.

## **Interdisciplinary care plan (Criterion 10.4.8)**

The care and recovery plan is developed with input from the consumer and, with the consumer's consent, carers and coordinator. It should contain details of the treatment and services provided.

It should also contain information on how the services being provided contribute to recovery goals, provide continuity of care and complement other treatment, and care and recovery plans developed by other service providers.

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.

*Evidence that this criterion is met could include:*

- the assessment methods and tools in use and the extent to which they support good practice in recovery
- documentation on individual consumer files
- documenting that the consumer and, as appropriate, carers have received a copy of the current care and recovery plan and have been supported to ensure they understand the contents and that it addresses their needs and the consumer's recovery goals
- consumer and carer feedback.

## 10.5 TREATMENT AND SUPPORT

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**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 eligible consumers in the defined catchment community has access to high quality, evidence based treatment, care and support services that are based on the Principles of Recovery Oriented Mental Health Practice.

#### **Best available evidence (Criterion 10.5.1)**

Service providers should deliver services consistent with current evidence-based research, guidelines and legislation.

*Evidence that this criterion is met could include:*

- the evidence base on which programs and services are designed
- documenting staff participation in continuing professional development to assist service providers to remain knowledgeable and skilled
- outcomes of service reviews and evaluations that influence future practices.

#### **Treatment and services (Criterion 10.5.2)**

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

Services should be appropriate to the consumer's age, stage of development, physical health, recovery goals and the stage in their recovery process.

More information on culture and diversity is available in the guidelines for Standard 4.

*Evidence that this criterion is met could include:*

- services with design features that specifically respond to the needs of the major diverse groups in the catchment community
- staffing arrangements that reflects the diversity in the catchment community
- documenting that staff have been trained in cross cultural awareness
- documenting that staff have been trained in disability awareness
- documenting the use of interpreters with consumers and carers who are not proficient in English or who are deaf
- having specialist positions in the organisation, for example culturally and linguistically diverse and Aboriginal and Torres Strait Islander liaison staff
- having consumer information available in the main cultural group languages
- using evidence based culturally appropriate clinical instruments (if relevant to the types of services provided)
- building alterations and modifications to reduce physical access barriers.

### **Information on therapies (Criterion 10.5.3)**

This criterion is relevant only to those non-government community mental health services that provide clinical and therapeutic services.

Consumers should be given information about the purpose, importance, benefits and risks of proposed treatments. The media and language should be appropriate to the consumers' needs.

Service providers should give this information in conjunction with the treating clinician or therapist, who might have discussed therapies with the consumer before their admission to the service. Informed consent must be obtained before treatment begins.

Consumers should be encouraged to ask questions about the therapies offered throughout the treatment process.

*Evidence that this criterion is met could include:*

- documenting that informed consent requirements have been met:
  - before any treatment or intervention commences
  - when services are changed
  - when services are added
  - when the consumer makes an informed decision about changing treatment

- documenting that consumers have been given information via means that are appropriate for their age, cultural and social circumstances about:
  - treatment options, the recommended treatment and why it is recommended
  - steps in the treatment process.

### **Clinical trials and experimental treatments (Criterion 10.5.4)**

This criterion is relevant only to those non-government community mental health services that provide clinical services.

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

*Evidence that this criterion is met could include:*

- documenting authorisations
- documenting what information is given to consumers about the purpose, importance, benefits and risks of the clinical trials and experimental treatment in an appropriate language and media for their needs.

### **Least restrictive environment (Criterion 10.5.5)**

The concept of least restrictive environment is fundamental to community re-entry and social inclusion for people with disabilities, including those experiencing a mental illness. It is a key element in working in a recovery based service delivery model.

Least restrictive environment means a consumer should have the opportunity and, as necessary, active support and encouragement, to participate in mainstream community services and activities to the greatest extent possible as they work towards their recovery goals.

Individual consumer needs should be taken into account when determining the least restrictive environment in which the service can be provided. This should include the extent to which recovery goals can be achieved through helping the consumer to access mainstream community services such as sporting and recreational clubs, transport, education facilities and community arts centres, rather than relying only on specialist mental health services and programs.

It is essential to consider the safety of consumers, carers, other consumers, service provider staff and members of the public when determining the least restrictive environment.

The least restrictive environment can change as the consumer moves through the recovery journey, and should be the subject of consideration in service planning and assessment reviews.

More information is available from the guidelines of Standards 1 Rights and responsibilities and 6 Consumers.

*Evidence that this criterion is met could include:*

- partnerships with mainstream organisations, around an individual consumer or group of consumers, for example with a sporting or recreational club, a university or TAFE college, or a community arts centre, to promote community re-entry and healthy lifestyles for consumers as part of their recovery
- providing information to staff, and consumer and carer advocates about the range of support networks available in the community such as local community and volunteer groups, faith communities and educational institutions
- individual consumer recovery plans that include the utilisation of mainstream organisations
- documenting on consumer files that they are accessing mainstream services as part of their recovery.

### **Medication management (Criterion 10.5.6)**

This criterion is relevant to non-government community based mental health services that provide clinical treatment services or other services in which the consumer requires medication during their hours of attendance.

Service providers should have a documented and regularly monitored procedure for the safe storage, transport and administration of medications. There should be a system in place for the use of personal medications during transit situations, such as during transfer from one service to another.

Evidence that this criterion is met could include:

- a medications policy and procedures
- visual sighting of safe locked storage location
- documenting the administration of medication.

### **Adherence to evidence based treatment (Criteria 10.5.7, 10.5.8)**

These criteria are relevant only to non-government community based mental health services that provide clinical treatment services. Non-government organisations should adhere to evidence based approaches to care and support across all areas of service delivery including provision of clinical treatment services where relevant.

*Evidence that these criteria are met could include:*

- documenting the shared care arrangements between the service provider and the primary health care provider
- documenting that the consumer's psychiatric states is monitored through collaboration with the consumer, carers and the primary health care provider
- giving consumers and, with their informed consent, carers with information and education about the consumer's illness and options for treatment, and the effects of the illness, including on interpersonal relationships, work and physical health
- giving consumers and carers information and education about how to identify stressors and early warning signs that could initiate relapse.

(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)**

To promote continuity of care, collaborative and coordinated case management with other service providers such as alcohol and other drug services, aged care, disability services, supported accommodation services and court liaison services should be in place where appropriate.

*Evidence that this criterion is met could include:*

- documenting that arrangements are collaborative and coordinated
- documenting on consumer files the involvement of other service providers in decisions regarding care and recovery plans.

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

This criterion is relevant only to non-government community based mental health services that provide clinical treatment services.

Medication is part of the treatment strategies of service providers and is directed toward maximising the functioning of the consumer while reducing their specific symptoms. Each prescription must be documented. There should be regular medication reviews that include consideration of the continuing 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.

*Evidence that this criterion is met could include:*

- medication charts
- documenting medication reviews.

## **Evaluation of treatment and support (Criterion 10.5.11)**

For most non-government services that provide clinical treatment services, it is the support aspect of this criterion that is relevant. The treatment aspect is relevant only to those service providers who provide clinical and treatment services.

Consumers and carers should be engaged in all levels of evaluation.

*Evidence that this criterion is met could include:*

For support services:

- consumer and carer feedback
- service evaluation reports
- documenting how evaluations have contributed to service improvement.

For treatment:

- documenting information that includes:
  - the illness or disorder
  - the range of treatments available
  - potential benefits and possible adverse effects
  - how long before treatment will begin to have an effect
  - costs and choices with regard to the use of therapy, medication and other technologies
  - options for treatment setting—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
  - the consent process.

## **Range of agencies and programs (Criterion 10.5.12)**

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

*Evidence that this criterion is met could include:*

- documented roles and responsibilities of organisations and individuals involved in joint programs
- documenting on the consumer's files that they participated in a joint program.

## **Self care programs (Criteria 10.5.13, 10.5.14)**

Self-care, independence, health and wellbeing are success factors for recovery and should be part of the education program provided by the service provider.

Peer workers and consumer educators are important contributors to the education program. Positive relationships with family, carers, sexual partner, friends, peers, cultural groups and the community are also important and should be encouraged.

When applicable, the service provider provides a range of support options and referral to other services such as those with programs for consumers to live independently in their own accommodation, shared accommodation, supervised or supported residences and public refuges.

These services need to be appropriate to the age of the consumer, for example necessary skills required by CAMHS consumers may include 'risk safe behaviours'.

According to individual needs and recovery goals, and recognising that some people require ongoing care and support while others require a single episode of care and support, the service provider should offer a choice of referral to other services that will maximise independence and involvement with the community.

With consideration to the consumer's mental and physical health status, cultural background, and family, social and economic circumstances, service providers should provide the consumer and carers with simple and easy to understand information on self care matters that could include:

- the consumer's condition, including how to care for themselves after they exit the service
- how to follow their recovery plan and achieve their outcomes
- 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 service provider, other service providers and the internet
- the importance of physical activity and how to improve and maintain overall health and well-being
- accommodation options
- education options and employment options such as apprenticeships and traineeships
- peer based support programs and services that promote recovery
- providing access to appropriate inpatient activity programs.

*Evidence that these criteria are met could include:*

- brochures (from the service provider and other sources) that address self care issues
- information provided to consumers and carers at assessments and reviews.

### **Accommodation options (Criterion 10.5.16)**

Specific housing and accommodation options should be explored that suit the health, cultural, family, social and economic circumstances of the consumer.

Where supported accommodation is not provided by the service provider, there should be close collaboration between the service and accommodation providers to facilitate access to the range of services that will best support the consumer to achieve their recovery goals.

*Evidence that this criterion is met could include:*

- documenting links and collaboration between accommodation and other community support providers
- consumer feedback on their satisfaction with their accommodation.

### **Support systems (Criterion 10.5.17)**

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

Support programs can be specialist mental health programs or mainstream services and could include but are not limited to:

- residential and supported housing
- community sporting and recreational clubs and community arts organisations
- education programs and vocational support systems
- employment programs
- mentoring and peer support programs
- family support programs and family interventions.

*Evidence that this criterion is met could include:*

- documenting links and collaboration between the service provider and other community support providers
- documenting on individual consumer files that they have been able to choose support programs that contribute to their recovery goals.

## 10.6 EXIT AND RE-ENTRY

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

### GUIDELINES

The intent of this criterion is to ensure that service providers assist consumers when they exit the service and provide them with sufficient information on how to re-enter the service if / and / or when required.

#### **Access and information on services (Criteria 10.6.1)**

As appropriate to their circumstances, the consumer is given information about, referral or supported introduction to, community agencies which can offer support after they have exited the service.

*Evidence that this criterion is met could include:*

- brochures about community services
- documenting on individual consumer files that they were provided with information as part of the exit process, and that referrals and supported introductions were made where required.

### **Development of exit plans (Criteria 10.6.3, 10.6.4)**

Exit plans should contain the following: measurement of change in health status, satisfaction with service, perception of quality of life, review of goals, peer review, case discussion and methods used to evaluate outcomes, including the consumer's preferred evaluation methods.

Exit plans for child, adolescent and aged consumers need to be developed with consideration for issues specific to their demographic.

For example aged care consumers transferring to a nursing home and exit plans for child and adolescent consumers are not usually discussed at entry to the service provider.

Consumers, their families and carers should be helped to identify early warning signs of a relapse. Exit plans should include information about symptoms of pending relapse, sometimes called 'relapse signatures' and an accompanying relapse management plan, which includes information about accessible crisis services.

Depending on the type of service the consumer has received, the intensity and duration of service and whether the service provider was the primary case manager or a supporting service provider, the exit plan could include the following:

- information for the preferred health care provider, for example the GP 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 involved in post exit support and, as necessary, referral and facilitated introduction arrangements
- other people to be involved and their roles
- other details identified by the consumer and carers
- preferred method of evaluating recovery outcomes for the consumer
- details of follow-up arrangements with the consumer
- plans for identifying early warning signs of relapse

- information on how to re-enter the service
- a clear point of contact in the service provider regarding the most recent episode of support
- shared care arrangements with GPs, private psychiatrists and non-government organisations if applicable.

*Evidence that these criteria are met could include:*

- exit plans
- documenting exit interviews
- providing information brochures to carers detailing available sources of ongoing support for them when a consumer exits the service
- displaying posters and brochures in the organisation's public areas
- providing information on respite services, carer respite centres, carer resource centres and carer counselling programs
- providing information on the service provider's website when there is one.

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

Arrangements for re-entry will depend on the type of service that has been provided. On exiting the service the consumer and their carers should be advised of the processes to follow should re-entry be required.

*Evidence that these criteria are met could include:*

- exit interview documentation that re-entry information was provided to the consumer and their carers.

### **Follow-up of consumers (Criterion 10.6.8)**

This criterion is not applicable to the non-government community mental health sector.

For the purposes of this criterion, 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.

Due to the relatively high risk of suicide in the first four weeks after discharge and to prevent relapse, the service provider, in conjunction with the treating clinician, is required to follow-up wherever possible within seven days of discharge. Consumers flagged for follow-up are identified by a risk assessment performed before they exit.

There is a clear and documented follow-up process which identifies the responsible agency and crisis service for the period following exit.

Policies and procedures to demonstrate compliance with Standard 10 Delivery of care will include those that address:

- consumer rights and responsibilities
- privacy and confidentiality
- compliance with legislation
- management of personal information
- management of an informed consent process
- management of situations in which the wishes and needs of a consumer conflict with the wishes and needs of their carer
- clinical risk assessments for consumers
- recovery-oriented mental health practice
- service access—physical, social, cultural and information
- service eligibility and priorities for access
- referral and service entry arrangements
- initial assessments
- recovery planning
- reviews recovery plans
- exit planning
- referral processes from the service to other services
- consumer and carer participation in individual service planning and review
- consumer and carer participation in organisational planning, program design and review and evaluation
- consumer and carer representation on the organisation's committees
- diversity responsiveness
- use of interpreters, working with interpreters including Auslan interpreters
- cultural assessments

- carer rights and responsibilities
- identification of carers
- information provision to carers
- how carers are involved at the individual, organisational and systemic levels
- staff involvement in multidisciplinary interagency teams
- engagement with mainstream community organisations such as sporting and recreational clubs, educational facilities, community employers and arts organisations as part of promoting recovery and community re-entry
- engagement with local and regional carer support services, including specialist groups such as those for children of parents with a mental illness or culturally specific carer support groups, and how those links are established and maintained
- safe transportation of consumers
- occupational health and safety
- safe home visits
- medication and adverse medication event management (as appropriate to the type of service being provided)
- managing verbal and physical violence
- critical incident reporting and management
- critical incident debriefing to assist staff, consumers, carers and other visitors when they have been exposed to a traumatic incident within the service
- service and program review and evaluation
- service quality and continuous quality improvement.

It is important to remember that policies and procedures alone are not sufficient to demonstrate that a service provider is meeting a standard's requirements. It is also necessary to demonstrate how the policies and procedures have been implemented and guide organisational practices and behaviours.

# CROSS REFERENCING OF THE 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.

<b>Criteria</b>	<b>Cross referenced with:</b>
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

# Section 3:

## Implementation tools

### INTRODUCTION

As noted in earlier sections, implementation requirements vary depending on state and territory arrangements, current organisational experience in working within a quality and continuous improvement service system, and other factors.

This section addresses some of the practical issues for service providers to consider as the implementation process begins: who needs to be involved, what will need to be done and how it might be done.

It includes some practical suggestions and tools to help organisations conduct a baseline assessment of current performance against each of the National Standards. It is not mandatory to use the tools.

This section also discusses how base line assessment can identify opportunities for service improvement, and be the basis for ongoing commitment to, and development of, a culture of continuous quality in service management and delivery, involving boards, staff, consumers, carers and funding bodies.

### **What does quality mean for your organisation—how do you already demonstrate management and service quality?**

Section 2 noted that service delivery in the non-government community mental health sector (as in other parts of the mental health service system) is influenced by a number of different quality, safety and performance requirements.

The National Standards are an important component of this environment, but not the only one. Embracing a continuous quality improvement culture involves more than complying with the National Standards, and will not necessarily require the same actions from all organisations.

Practices which indicate that the service has a commitment to continuous improvement could include but are not limited to:

- regular meetings to review, for example, complaints, processes that have gone wrong and communication breakdowns—resulting in changed processes to address the issue
- operating programs that have a strong evidence base to support their efficacy
- regular reviews of organisational risks and the strategies in place to mitigate them
- regular (perhaps twice per year) forums with consumers and carers to discuss issues such as service provision and what is working well or less well for them

- inviting experts to visit the agency or to attend staff meetings to talk on issues of interest or concern
- processes for staff to provide suggestions for service improvement, and for rewarding good ideas
- staff performance appraisal systems and acting on what they identify as needing to be addressed, such as staff training and development needs and succession planning
- regular reviews and evaluations of services or elements of services and acting upon the findings
- adopting and working within a documented quality framework or having external accreditation arrangements in place.

The size, type of service, service mix complexity, service locations, funding and financial arrangements and board and staffing structure and expertise, are all factors that will influence the organisation's approach to service quality and continuous quality improvement.

The following are questions which, at the start of the National Standards implementation process, will help organisations to take a considered approach to what implementation will mean for them.

The questions will help to place the Principles of Recovery Oriented Mental Health Practice and the National Standards for Mental Health Services in the broader context of a quality system and a continuous quality improvement culture.

Answering the questions will also help you to identify what you already have in place and what you already do that will demonstrate compliance with the National Standards.

Key questions to ask include:

- What will our organisation look like, what will be the signs that it has a commitment to recovery practice and continuous quality improvement?
- What are the core quality principles we want to embrace, and what for us will be the key processes of quality improvement?
- What can we do ourselves with our existing resources and expertise, and who might be able to help us?
- What resources, systems, structures do we already have in place that help us to demonstrate our compliance with the National Standards and our commitment to continuous quality improvement?
- What other resources and tools would be useful and how do we access them?
- How do the Principles of Recovery Oriented Mental Health Practice and the National Standards for Mental Health Services fit into this; how do they relate to and support what we want to do?

With a strong commitment from the board and staff, it is possible for even very small organisations to make significant achievements towards continuous quality improvement, and to integrate the Recovery Principles and the National Standards into their daily operations to contribute to that outcome.

Once implemented, the National Standards should not be an add-on or an additional work load on already hard working boards, managers and staff. They should simply be a part of how the organisation goes about the business of quality management and service delivery.

## **Policies and procedures**

Clearly written and comprehensive policies and procedures are an important part of a well managed organisation that delivers quality services.

Some service providers will find as they implement the National Standards that there are areas in which they need to review policies and procedures or develop new ones. Sometimes organisations get so involved in making sure that they have the 'right' policies and procedures in place that the Policy and Procedures Manual becomes an end in itself, instead of the means to quality management and quality service delivery.

The purpose of having policies and procedures is to guide organisational practices and behaviours, not to meet a compliance requirement. Organisations can have excellent policies and procedures and still be poorly managed or providing services of less than optimal quality.

When reviewing existing policies and procedures or developing new ones as part of implementing the National Standards, do not lose sight of:

- WHY you have the particular policy and procedure
- WHO has to act in ways that are set out in the policy and procedure
- WHAT the organisation needs to do to help those people to do what is required of them, for example through information, supervision and training.

The best policies and procedures are generally those in which the people who have to carry them out understand why they are necessary and have a say in their development.

## **Before you begin your baseline assessments for each standard**

Before starting your assessment of where your service stands in relation to each standard and its criteria consider this: who in your network could you collaborate with in implementation, and who might be able to help you.

For example, it could be another non-government mental health service provider or a public mental health service with which you have a collaborative relationship.

Two collaborative strategies worth considering are:

- implementation partnerships, in which two or more organisations work on the implementation of a particular standard at the same time
- mentoring partnerships, in which a larger, more established organisation mentors and supports a smaller, newer organisation during implementation.

If you identify a need to purchase training, perhaps other services also have a similar need. Consider sharing the costs and resources.

Plan to implement incrementally. Organisations are strongly encouraged to work on one standard at a time.

Initially, especially for smaller organisations, the task might seem daunting. It is important to remember that:

- Your service probably already has a number of things in place that you have simply not thought of as evidence or indicators in relation to the National Standards—things that are part of your existing quality arrangements, or just part of the way you do business.
- Now is the time to go through your agency and service documentation in a planned way to see what might relate to one or more of the National Standards. This includes your strategic and operational plans, policies and procedures, consumer and carer information sheets, fact sheets, training records and memoranda of understanding.
- Peer non-government community mental health service providers might have information and resources that will help you, and you might have something that might help them in return—for example, relating to the standard under consideration or another standard.
- There are a lot of resources (including templates and model policies and procedures) developed not only for non-government community mental health services but also for other service sectors such as Alcohol and Other Drug services, Disability Services and Home and Community Care Services. Much of the material developed in other sectors is very relevant to the National Standards. You might be able to access these through your local networks, but the internet is also a rich source.

## **Who should conduct the baseline assessments?**

Who should conduct the baseline assessment for each standard will vary according to the standard, but it will always be easier and produce a more comprehensive picture if more than one person is involved. For example, board members and senior managers should be involved in assessing Standard 8. Governance, leadership and management.

Consumers should be involved in assessing Standards 3 and 6, and carers Standard 7, but they could also make a useful contribution to others. Occupational health and safety representatives should be involved in Standard 2. Regardless of who is involved, a relevant senior person in the organisation should have a leadership role in relation to each assessment.

## **Identify your existing evidence**

Responding to the questions about what quality means for your organisation and how you already demonstrate service quality and management will help to establish your organisation's baseline status as you begin the implementation process.

A current state assessment template is provided at the end of this section to help you to decide where you currently are in relation to each standard before you begin work on it. You are not obliged to use this template if your organisation has other tools or resources that will work better for you.

Remember, not all criteria for each standard are relevant to the non-government community mental health sector, and you don't necessarily have to meet all of the applicable criteria to demonstrate that you are meeting a particular standard.

Try to collect all the evidence you have in relation to the standard and its criteria, remembering to consider what is already contained in your existing policies and procedures, fact sheets, training records, et cetera. Remember also that one piece of evidence might be relevant to multiple standards and multiple criteria.

## **Review your current state and additional evidence requirements**

When you have completed the current state assessment for a standard, step back and look at what it tells you:

- What are you already doing well? As part of your commitment to continuous quality improvement, what are your opportunities for further service improvement?
- Are you able to take action for further improvement now, or should you wait until other areas are at a level with which you are satisfied?
- In what areas do you have evidence of progress, but still need to do further work?
- What will it take, what evidence will be required to demonstrate that you have reached the level you think you need to reach for baseline compliance in these areas?
- Who needs to do the work and who will monitor progress?
- Are there any significant gaps—where you have no evidence—and are some of these gaps more critical than others?
- What do you need to do, what evidence must be collected to address the gaps?
- Are there other organisations that might have some of what you need, that you can approach for assistance? Now is the time to use your networks.

## **Complete the action sheet**

Use the action worksheet to set out what you need to do—based on the assessment you have made—and who needs to do it. Set realistic deadlines.

## **Implement the actions and monitor progress**

Begin work on the identified areas. Use the review form to review the progress you have made and the evidence you now have in place for this standard. Remember that the best approach is one of continuous quality improvement. You don't have to do everything up front. You might identify opportunities for service improvement that you will not act upon until the following year.

## **Sign off and move to the next standard**

When you are satisfied that you have done all that you planned to do at the implementation stage for this standard, move on to the next one.

# Current State Assessment Form

## Standard 1: Rights and Responsibilities

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

Indicator	Relevance to Service		Current Performance in Relation to this Indicator		
	Yes	No	We are satisfied that we meet this Criterion (Evidence)	We partially meet this Criterion (Evidence)	Criterion not yet met
1.1 The MHS upholds the right of the consumer to be treated with respect and dignity at all times					
1.2 All care is delivered in accordance with applicable Commonwealth/State/Territory mental health legislation and applicable acts					
1.3 All care delivered is subject to the informed consent of the voluntary consumer and wherever possible, of the involuntary consumer in accordance with Commonwealth/State/Territory jurisdictional and legislative requirements					

Indicator	Relevance to Service		Current Performance in Relation to this Indicator		
	Yes	No	We are satisfied that we meet this Criterion (Evidence)	We partially meet this Criterion (Evidence)	Criterion not yet met
1.4 The MHS provides consumers and their carers with a written statement together with a verbal explanation of their rights and responsibilities, in a way that is understandable to them as soon as possible after entering the MHS and at regular intervals throughout their care					
1.5 Staff and volunteers are provided with a written statement of the rights and responsibilities of consumers and carers, together with a written code of conduct as part of their induction to the MHS					
1.6 The MHS communicates with consumers, carers and other service providers and applies the rights and responsibilities of involuntary patients as per applicable Commonwealth/ State/Territory mental health legislation and other requirements					

Indicator	Relevance to Service		Current Performance in Relation to this Indicator		
	Yes	No	We are satisfied that we meet this Criterion (Evidence)	We partially meet this Criterion (Evidence)	Criterion not yet met
1.7 The MHS upholds the right of the consumer to have their needs understood in a way that is meaningful to them, and appropriate services are engaged when required to support this					
1.8 The MHS upholds the right of the consumer to have their privacy and confidentiality recognized and maintained, to the extent that it does not impose serious risk to the consumer or others					
1.9 The MHS upholds the right of the consumer to be treated in the least restrictive environment, to the extent that it does not impose serious risk to the consumer or others					

Indicator	Relevance to Service		Current Performance in Relation to this Indicator		
	Yes	No	We are satisfied that we meet this Criterion (Evidence)	We partially meet this Criterion (Evidence)	Criterion not yet met
1.10 The MHS upholds the right of the consumer to be involved in all aspects of their treatment, care and recovery planning					
1.11 The MHS upholds the right of the consumer to nominate if they wish to have (or note to have) others involved in their care to the extent that it does not impose serious risk to the consumer or others					
1.12 The MHS upholds the right of carers to be involved in the management of the consumer's care, with the consumer's informed consent					

Indicator	Relevance to Service		Current Performance in Relation to this Indicator		
	Yes	No	We are satisfied that we meet this Criterion (Evidence)	We partially meet this Criterion (Evidence)	Criterion not yet met
1.13 The MHS upholds the rights of consumers to have access to their own health records in accordance with applicable Commonwealth/ State/ Territory legislation					
1.14 The MHS enacts policies and procedures to ensure that personal and health related information is handled in accordance with Commonwealth/ State/Territory privacy legislation when personal information is communicated to health professionals outside the MHS, carers, or other applicable agencies					

Indicator	Relevance to Service		Current Performance in Relation to this Indicator		
	Yes	No	We are satisfied that we meet this Criterion (Evidence)	We partially meet this Criterion (Evidence)	Criterion not yet met
1.15 The MHS upholds the right of the consumer to access advocacy and support services					
1.6 The MHS upholds the right of the consumer to express compliments and grievances regarding their care and to have them addressed by the MHS					
1.17 The MHS upholds the right of the consumer, wherever possible, to access a staff member of their own gender					

# Action Form

## Standard 1: Rights and Responsibilities

The Rights and Responsibilities of people affected by mental health problems and/or mental illness are upheld by the MHS and are documented, prominently displayed, applied and promoted throughout all phases of care

Indicator	Action Required	By Whom?	By When?
1.1 The MHS upholds the right of the consumer to be treated with respect and dignity at all times			
1.2 All care is delivered in accordance with applicable Commonwealth/State/Territory mental health legislation and applicable acts			
1.3 All care delivered is subject to the informed consent of the voluntary consumer and wherever possible, of the involuntary consumer in accordance with Commonwealth/State/Territory jurisdictional and legislative requirements			

Indicator	Action Required	By Whom?	By When?
1.4 The MHS provides consumers and their carers with a written statement together with a verbal explanation of their rights and responsibilities, in a way that is understandable to them as soon as possible after entering the MHS and at regular intervals throughout their care			
1.5 Staff and volunteers are provided with a written statement of the rights and responsibilities of consumers and carers, together with a written code of conduct as part of their induction to the MHS			
1.6 The MHS communicates with consumers, carers and other service providers and applies the rights and responsibilities of involuntary patients as per applicable Commonwealth/State/Territory mental health legislation and other requirements			
1.7 The MHS upholds the right of the consumer to have their needs understood in a way that is meaningful to them, and appropriate services are engaged when required to support this			

Indicator	Action Required	By Whom?	By When?
1.8 The MHS upholds the right of the consumer to have their privacy and confidentiality recognized and maintained, to the extent that it does not impose serious risk to the consumer or others			
1.9 The MHS upholds the right of the consumer to be treated in the least restrictive environment, to the extent that it does not impose serious risk to the consumer or others			
1.10 The MHS upholds the right of the consumer to be involved in all aspects of their treatment, care and recovery planning			
1.11 The MHS upholds the right of the consumer to nominate if they wish to have (or note to have) others involved in their care to the extent that it does not impose serious risk to the consumer or others			
1.12 The MHS upholds the right of carers to be involved in the management of the consumer's care, with the consumer's informed consent			

Indicator	Action Required	By Whom?	By When?
1.13 The MHS upholds the rights of consumers to have access to their own health records in accordance with applicable Commonwealth/State/Territory legislation			
1.14 The MHS enacts policies and procedures to ensure that personal and health related information is handled in accordance with Commonwealth/State/Territory privacy legislation when personal information is communicated to health professionals outside the MHS, carers, or other applicable agencies			
1.15 The MHS upholds the right of the consumer to access advocacy and support services			
1.6 The MHS upholds the right of the consumer to express compliments and grievances regarding their care and to have them addressed by the MHS			
1.17 The MHS upholds the right of the consumer, wherever possible, to access a staff member of their own gender			

# Review Form

## Standard 1: Rights and Responsibilities

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

Indicator	Progress Made and Date	Action Still to be Completed by When
1.1 The MHS upholds the right of the consumer to be treated with respect and dignity at all times		
1.2 All care is delivered in accordance with applicable Commonwealth/State/Territory mental health legislation and applicable acts		
1.3 All care delivered is subject to the informed consent of the voluntary consumer and wherever possible, of the involuntary consumer in accordance with Commonwealth/State/Territory jurisdictional and legislative requirements		

Indicator	Progress Made and Date	Action Still to be Completed by When
<p>1.4 The MHS provides consumers and their carers with a written statement together with a verbal explanation of their rights and responsibilities, in a way that is understandable to them as soon as possible after entering the MHS and at regular intervals throughout their care</p>		
<p>1.5 Staff and volunteers are provided with a written statement of the rights and responsibilities of consumers and carers, together with a written code of conduct as part of their induction to the MHS</p>		
<p>1.6 The MHS communicates with consumers, carers and other service providers and applies the rights and responsibilities of involuntary patients as per applicable Commonwealth/State/Territory mental health legislation and other requirements</p>		
<p>1.7 The MHS upholds the right of the consumer to have their needs understood in a way that is meaningful to them, and appropriate services are engaged when required to support this</p>		

Indicator	Progress Made and Date	Action Still to be Completed by When
1.8 The MHS upholds the right of the consumer to have their privacy and confidentiality recognized and maintained, to the extent that it does not impose serious risk to the consumer or others		
1.9 The MHS upholds the right of the consumer to be treated in the least restrictive environment, to the extent that it does not impose serious risk to the consumer or others		
1.10 The MHS upholds the right of the consumer to be involved in all aspects of their treatment, care and recovery planning		
1.11 The MHS upholds the right of the consumer to nominate if they wish to have (or note to have) others involved in their care to the extent that it does not impose serious risk to the consumer or others		
1.12 The MHS upholds the right of carers to be involved in the management of the consumer's care, with the consumer's informed consent		

Indicator	Progress Made and Date	Action Still to be Completed by When
1.13 The MHS upholds the rights of consumers to have access to their own health records in accordance with applicable Commonwealth/ State/ Territory legislation		
1.14 The MHS enacts policies and procedures to ensure that personal and health related information is handled in accordance with Commonwealth/ State/Territory privacy legislation when personal information is communicated to health professionals outside the MHS, carers, or other applicable agencies		
1.15 The MHS upholds the right of the consumer to access advocacy and support services		
1.16 The MHS upholds the right of the consumer to express compliments and grievances regarding their care and to have them addressed by the MHS		
1.17 The MHS upholds the right of the consumer, wherever possible, to access a staff member of their own gender		





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All information in this publication is correct as of October 2010