National Standards for Mental Health Services

endorsed by the AHMAC National Mental Health Working Group December 1996

national mental health strategy

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- The Mental Health Branch of the Commonwealth Department of Health & Family Services.
- State and Territory Mental Health Branches.

Foreword

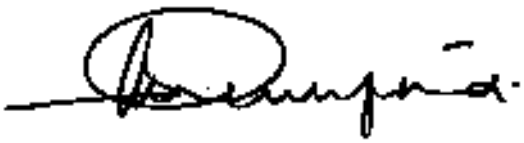
It is widely recognised that service standards and quality assurance programs within health services are an essential part of achieving high standard health care. This applies equally to mental health services. Implementation of national mental health service standards represents an important opportunity to improve the quality of mental health care in Australia.

I therefore commend to you the following *National Standards for Mental Health Services*, endorsed by the Australian Health Ministers' Advisory Council's National Mental Health Working Group on 3 December 1996. In providing its endorsement, the Working Group reaffirmed its commitment to national service standards and quality service provision. The Working Group's endorsement also signifies an important milestone in the achievement of the 1992 agreement by Australian Health Ministers to the development of national standards for mental health services under the National Mental Health Strategy.

The standards can be used as a blueprint for the development of new services or as a guide to service enhancement and continuous quality improvement. They can be used as a tool to inform consumers and carers about what to expect from a mental health service and as a check list for service quality. They can also assist consumers and carers to participate in a service's planning, development and evaluation processes.

On behalf of the National Mental Health Working Group, I would like to extend our appreciation to all those involved in the development of these national standards.

The Working Group has agreed that state and territory mental health services will use the standards as much as possible over the next twelve months and will be interested in any feedback about the standards based on experience with them during that time. If you wish to provide such feedback, please contact the Director of Mental Health in your state or territory or the Mental Health Branch of the Department of Health and Family Services, by telephone (02) 6289 7823, or by writing to MDP 37, GPO Box 9848, Canberra, ACT 2601.



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Chair
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January 1997

National Standards for Mental Health Services

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National Standards for Mental Health Services

In this document MHS is used to abbreviate mental health service

Section 1 - Introduction

Overview

The project to develop the national standards for mental health services was funded by the Commonwealth Department of Health and Family Services (CDHFS) through the Australian Health Ministers Advisory Council's (AHMAC) National Mental Health Policy Working Group (NMHPWG) as part of the National Mental Health Strategy.

The National Mental Health Policy has set the directions for development and reform in mental health care in Australia since 1992. The policy states that the 'direction set down in the national policy will result in significant improvement in the treatment, care and quality of life for all Australians who suffer from mental health problems and mental disorders.' The National Mental Health Policy lays the foundation for these standards.

The development of national outcome standards for mental health services, quality assurance programs for mental health services and support of an independent system of assessing whether services are meeting standards has been endorsed and supported by Commonwealth, State and Territory Health Ministers in the National Mental Health Plan (1992) and the National Mental Health Policy (1992).

This project was conducted between October 1995 and October 1996. The project brief was to develop a set of mental health service standards which could be applied to all mental health services across Australia. A second task was to provide recommendations on how to implement and monitor these standards.

This project was jointly undertaken by three organisations with experience in developing and assessing health care standards. They are The Australian Council on Healthcare Standards (ACHS), the Community Health Accreditation and Standards Program (CHASP) and the Area Integrated Mental Health Service Standards (AIMHS).

The standards are outcome oriented with an emphasis on the end result for consumers and carers. The standards are also intended to reflect a strong values base, related to human rights, dignity and empowerment. The development of these standards has been guided by the principles contained in the National Mental Health Policy and the United Nations *Principles on the Protection of People with Mental Illness.* Additional and complementary principles have been developed to further guide the development of the standards. These are presented as follows:

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1 National Mental Health Policy (April 1992), Australian Government Publishing Service, Canberra, p. Foreword.

Guiding Principles for the Standards

- the promotion of optimal quality of life for people with mental disorders and/or mental health problems;
- a focus on consumers and the achievement of positive outcomes for them;
- an approach to consumers and carers that recognises their unique physical, emotional, social, cultural and spiritual dimensions;
- the recognition of the human rights of people with mental disorders as proclaimed by the United Nations *Principles on the Protection of People with Mental Illness* and the Australian Health Ministers *Mental Health Statement of Rights and Responsibilities;*
- equitable access to appropriate mental health services when and where they are needed;
- community participation in mental health service development;
- informed decision making by individuals about their treatment;
- continuity of care through the development of intersectoral links between mental health services and other organisations;
- a mental health system which emphasises comprehensive, coordinated and individualised care;
- accountability to consumers, carers, staff, funders and the community;
- adequate resourcing of the mental health system;
- equally valuing the various models and components of mental health care.

Format of the Standards

There are three sections in the standards. Standards 1 to 7 are related to universal issues which address issues of human rights, dignity, uniqueness and community acceptance.

Standards 8 to 10 address issues related to mental health service organisational structure and links between parts of the mental health sector.

Standard 11 has six parts (each part has a standard) which describe the process of delivering care on a continuum commencing with access to the MHS and concluding with exit from the MHS.

Standard 11.4 has five parts (each part has a standard) which broadly describe the types of treatment and support available.

The standards are cross referenced and indexed. The standards should be used as a whole rather than in part although some standards and criteria will be more relevant to certain mental health services.

The Consultation Process

The standards are the result of extensive consultation and collaboration with many individuals and organisations within the mental health sector.

A number of approaches were undertaken in order to ensure the broadest possible public comment on draft 1 and draft 2. These included public consultation meetings, drafts for public comment, consumer-run consultations, toll-free telephone, field trialing of the standards with mental health services and constituency representation on the National Reference Committee.

Applicability of the Standards

The standards are intended to be applicable to mental health services throughout Australia. The consultation and field trialing has indicated that the standards are relevant to all types of mental health services.

Some services may have difficulty relating to all of the standards and, in some cases, there will be overlap with other sets of standards such as the Disability Services Standards. It may be useful in these cases for the mental health service to adapt the notes and examples to increase local relevance and usefulness.

The standards are not prescriptive. Understanding the intent of each standard and criteria will assist in applying it in a practical manner to a particular service.

Uses for the Standards

The uses for these standards can be summarised as follows:

National Accreditation Program

The standards should complement the existing standards for health care in a system of independent and external review such as is used by The Australian Council on Healthcare Standards and the Community Health Accreditation and Standards Program.

It is important that any accreditation of mental health services complements existing standards and monitoring systems such as the Disability Services Standards and Nursing Homes Standards.

Monitoring by the States

Each State or Territory Government should incorporate the standards into service / funding agreements and regularly monitor achievement of the standards. An example of this is the Minimum Service Standards in Queensland.

Mental Health Service Development

The standards should also be used as a blueprint for the development of a mental health service and would be particularly useful in new or changing services.

Mental Health Service Quality Improvement

A mental health service should use the standards as a guide to good service delivery and quality improvement. The sample worksheet which follows is an example of how a mental health service could self monitor' their performance using the standards and a simple rating scale. The Area Integrated Mental Health Service Standards (AIMHS) are an example of how this has can be done successfully.

Consumer and Carer

The standards inform consumers and carers about what to expect from a mental health service. Therefore consumers and carers could use the standards to feed-back into a service's planning, development and evaluation processes. The Area Integrated Mental Health Service Standards (AIMHS) are an example of how this has can be done successfully.

Sample Worksheet and Scoring for the Standards

Mental health services, consumers and carers may choose to develop a tool for rating attainment of the standards locally. The following scale is recommended as a guide only. A full size worksheet is located at the end of this document.

A rating scale and worksheet should indicate the extent to which a standard is attained as well as provide an opportunity to identify what should improve in order for the standard to be better attained.

It is not recommended to have a 'fully attained' score because this implies that no further improvement is possible. The rating 'not applicable' should be used sparingly, as often criteria are applicable, but difficult to attain for specific reasons, which may include geographical remoteness or lack of financial support. These standards are designed to complement a quality improvement process which continually strives for further improvement.

The following simple rating scale is suggested for use with the worksheet contained at the end of this document.

RATING CODE	RATING	EXPLANATION OF RATING
A	Attained	MHS has attained the criteria (thus meeting the standard) but is investigating opportunities to exceed the requirements
AP	Attained Partially	MHS has attained most, but not all, of the criteria.
AI	Attainment Initiated	MHS has attained some of the criteria and commenced activities which are intended to ensure the attainment of all criteria.
UA	Unattained	The criteria were not attained (thus standard not met).
NA	Not Applicable	The criteria are not relevant to the MHS.

Adapted from the Area Integrated Mental Health Services Standards (1991; 1995)

Section 2 - National Standards for Mental Health Services

Standard 1 - Rights

The rights of people affected by mental disorders and/or mental health problems are upheld by the MHS.

Criteria

1.1 Staff of the MHS comply with relevant legislation, regulations and instruments protecting the rights of people affected by mental disorders and/or mental health problems.

Notes and Examples: Includes The UN Principles on the Protection of People with a Mental Illness and Improvement in Mental Health Care, The Australian Health Ministers Mental Health Statement on Rights and Responsibilities', *mental health legislation, EEO legislation, Anti-discrimination legislation, OH&S legislation, professional and departmental codes of conduct and Registration acts, Disability Services Acts.*

1.2 Consumers and their carers are provided with a written and verbal statement of their rights and responsibilities as soon as possible after entering the MHS.

Notes and Examples: This should occur at first face to face contact with the MHS or as soon as the consumer's mental state allows for the comprehension of the information. Children have their rights explained to them as well as to the child's parent or legal guardian.

1.3 The written and verbal statement of rights and responsibilities is provided in a way that is understandable to the consumer and their carers.

Notes and Examples: Written material is provided in a variety of languages and a variety of media, accredited interpreters and advocates are used.

1.4 The statement of rights includes the principles contained in the Australian Health Ministers *Mental Health Statement of Rights and Responsibilities* (1991) and the United Nations *General Assembly Resolution on the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1992).*

1.5 The right of the consumer not to have others involved in their care is recognised and upheld to the extent that it does not impose imminent serious risk to the consumer or other person(s).

1.6 Independent advocacy services and support persons are actively promoted by the MHS and consumers are made aware of their right to have an independent advocate or support person with them at any time during their involvement with the MHS.

Notes and Examples: Posters and brochures which promote independent advocacy and support services are prominent displayed in every facility of the MHS; staff facilitate the use of independent advocates and support persons for consumers.

1.7 The MHS upholds the right of the consumer and their carers to have access to accredited interpreters.

Notes and Examples: Information on interpreters is prominently displayed, staff facilitate the use of interpreters for consumers and carers.

1.8 The MHS provides consumers and their carers with information about available mental health services, mental disorders, mental health problems and available treatments and support services.

Notes and Examples: Information leaflets available in a variety of languages in a variety of media, information nights, support to local consumer and carer groups, community forums.

1.9 The MHS recognises the rights of people with mental disorders and/or mental health problems in their service goals and staff job descriptions.

1.10 The MHS has an easily accessed, responsive and fair complaints procedure for consumers and carers and the MHS informs consumers and carers about this procedure.

Notes and Examples: Posters and brochures which provide information on the complaints procedure are prominently displayed in every facility of the MHS.

1.11 Documented policies and procedures exist and are used to achieve the above criteria.

1.12 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Notes and Examples: The MHS continually monitors and reviews the number of consumers who are not informed of their rights.

Cross References: Cultural Awareness (7), Delivery of Care (11), Privacy & Confidentiality (5), Safety (2), Service Development (9) and Treatment & Support (11.4)

Standard 2 - Safety

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

Criteria

2.1 The MHS and its staff comply with relevant legislation, regulations and other instruments.

Notes and Examples: Includes The UN Principles on the Protection of People with a Mental Illness and Improvement in Mental Health Care, *The Australian Health Ministers* Mental Health Statement on Rights and Responsibilities, *occupational, health & safety legislation, anti-discrimination legislation and mental health legislation.*

2.2 Treatment and support offered by the MHS ensure that the consumer is protected from abuse and exploitation.

Notes and Examples: Safety is considered in terms of physical, social, psychological and cultural dimensions. Consumers are protected from financial, sexual and physical abuse.

2.3 Policies, procedures and resources are available to promote the safety of consumers, carers, staff and the community.

Notes and Examples: Mobile phone, security measures, pagers, personal alarms, debriefing process, staffing levels, complaints procedure, independent monitoring, occupational health & safety (OH&S) policy, critical incident reports, policy on the transport of consumers from one location to another in a safe and dignified way.

2.4 Staff are regularly trained to understand and appropriately and safely respond to aggressive and other difficult behaviours.

Notes and Examples: Consumers are involved in this training, recognised safety training courses are used.

2.5 A staff member working alone / solo has the opportunity to access another staff member at all times in their work settings.

Notes and Examples: Staffing levels of two or more per shift per MHS, access in remote areas to other staff via telephone, access to non-mental health staff in remote areas.

2.6 A consumer has the opportunity to access a staff member of their own gender.

2.7 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Notes and Examples: The MHS continually monitors and reviews critical incidents related to consumer and staff safety.

Cross References: Rights (1), Privacy & Confidentiality (5), Cultural Awareness (7) and Treatment & Support (11.4)

Standard 3 - Consumer and Carer Participation

Consumers and carers are involved in the planning, implementation and evaluation of the MHS.

Criteria

3.1 The MHS has policies and procedures related to consumer and carer participation which are used to maximise their roles and involvement in the MHS.

Notes and Examples: The policy acknowledges that consumers and carers should be involved at every level of the MHS, the different expertise and interests that each group may have, identifies the requirements of each group in terms of information, equipment, space and budget, and whether consumers and carers want collective or separate representation.

3.2 The MHS undertakes and supports a range of activities which maximise both consumer and carer participation in the service.

Notes and Examples: Establishment of advisory committees, consumer carer networks, consumer/carer evaluations of the MHS, establishing and maintaining contact with consumer/ carer groups, public meetings, consumer/carer participation on staff recruitment processes, consumer/carer participation in peer and staff education & training, provision of space and equipment for consumers and carers to use.

3.3 The MHS assists with training and support for consumers, carers and staff which maximise consumer and carer participation in the service.

Notes and Examples: Training in peer support, consulting, staff selection, computer skills and financial management.

3.4 A process and methods exist for consumers and carers to be reimbursed for expenses and/or paid for their time and expertise where appropriate.

Notes and Examples: Advice is sought from State/Territory Consumer Advisory Group (CAG) to determine rates of payment, a budget (which may be separate for each group) is managed by the consumer and carer representatives.

3.5 The MHS has a written statement of roles and responsibilities (code of conduct) for consumers and carers participating in the service which is developed and reviewed with consumers and carers.

Notes and Examples: Advice sought from State/Territory CAG, covers areas such as confidentiality, accountability, responsibilities, rights and conflict of interest.

3.6 Consumer and carers are supported to independently and individually determine who will represent the views of each group to the MHS.

Notes and Examples: MHS supports a confidential mail-out to current clients which enables elections for representative positions.

3.7 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Notes and Examples: The MHS continually monitors and reviews consumer and carer satisfaction with opportunities to participate in the MHS.

Cross References: Integration (8), Service Development (9), and Inpatient Care (11.4.E)

Standard 4 - Promoting Community Acceptance

The MHS promotes community acceptance and the reduction of stigma for people affected by mental disorders and/or mental health problems.

Criteria

4.1 The MHS works collaboratively with the defined community to initiate and participate in a range of activities designed to promote acceptance of people with mental disorders and/or mental health problems by reducing stigma in the community.

Notes and Examples: Consumers and carers have the opportunity to be involved in all aspects of this activity such as promotion of positive images of people with mental disorders (Mental Health Week), school education programs, public information nights and joint communal activities in their locality. A community development model might be used or joint programs developed with other agencies. Consumers and carers have the opportunity to be involved in the education of the community and other serviceproviders.

4.2 The MHS provides understandable information to mainstream workers and the defined community about mental disorders and mental health problems.

Notes and Examples: Consumers have the opportunity to be involved in the education of the community and other service providers such as staff from the Commonwealth Employment Service (CES), Department of Housing staff, police, emergency department staff, local community groups, court support programs, child protection staff, General Practitioners, public information nights, talks to other agencies, specific information for people of non-English speaking background.

4.3 Documented policies and procedures exist and are used to achieve the above criteria.

4.4 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Notes and Examples: The MHS continually monitors and reviews the number, type and outcomes of activities.

Cross References: Prevention & Mental Health Promotion (6), Integration (8), Access (11.1), Planning for Exit (11.5), and Exit & Re-entry (11.6)

Standard 5 - Privacy and Confidentiality

The MHS ensures the privacy and confidentiality of consumers and carers.

Criteria

5.1 Staff of the MHS comply with relevant legislation, regulations and instruments in relation to the privacy and confidentiality of consumers and carers.

Notes and Examples: Includes The UN Principles on the Protection of People with a Mental Illness and Improvement in Mental Health Care, The Australian Health Ministers Mental Health Statement on Rights and Responsibilities, *Freedom of Information Act, privacy legislation, departmental guidelines, professional codes of conduct, Registration Acts, and Australian Standards for Medical Records.*

5.2 The MHS has documented policies and procedures which ensure the protection of confidentiality and privacy for consumers and carers and these are available to consumers and carers in an understandable language and format.

Notes and Examples: MHS policies available on request, information about privacy and confidentiality is available in a variety of languages and variety of media, use of accredited interpreters. Research, information systems, case registers are subject to full ethical review and clearance.

5.3 The MHS encourages, and provides opportunities for, the consumer to involve others in their care.

Notes and Examples: Family, carer(s), friends, significant others, home visits are available, adequate private space for visitors is provided and visiting times are convenient, play space for children, involvement of General Practitioners, private psychiatrist and/or other person nominated by the consumer.

5.4 Consumers give informed consent before their personal information is communicated to health professionals outside the MHS, to carers or other agencies or people.

5.5 Consumers have the opportunity to communicate with others in privacy unless contraindicated on safety or clinical grounds.

Notes and Examples: A visitors' room, single room accommodation, private waiting space and private counselling rooms.

5.6 The location used for the delivery of mental health care provides an opportunity for sight and sound privacy.

Notes and Examples: Consumers in counselling rooms cannot be seen or heard from outside, no personal information elicited in waiting rooms.

5.7 Consumers have adequate personal space in regard to indoor and outdoor physical care environments.

Notes and Examples: Private waiting areas, reception, room size, numbers in rooms, outdoor space in inpatient units, compliance with Building Code of Australia and other guidelines for health care facilities.

5.8 Consumers are supported in exercising control over their personal space and personal effects in residential and inpatient settings.

Notes and Examples: Opportunity to select decoration, arranging of furniture, who comes and goes, daily routine, personal and lockable cupboards, own or shared room in residential facilities (including inpatient units) as desired by the consumer and consistent with best clinical outcome and safety.

5.9 Confidential processes exist by which consumers and carers can regularly feedback their perception of the care environment to the MHS.

Notes and Examples: Includes options for anonymity such as a suggestion box, satisfaction surveys and independent reviews.

5.10 Consumers have appropriate space and privacy in order to practice their cultural, religious and spiritual beliefs.

5.11 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Notes and Examples: The MHS continually monitors and reviews policies and procedures relating to privacy and confidentiality.

Cross References: Rights (1), Supported Accommodation (11.4.B), and Inpatient Care (11.4.E)

Standard 6 - Prevention and Mental Health Promotion

The MHS works with the defined community in prevention, early detection, early intervention and mental health promotion.

Criteria

6.1 The MHS has policy, resources and plans that support mental health promotion, prevention of mental disorders and mental health problems, early detection and intervention.

Promotion of Mental Health

6.2 The MHS works collaboratively with health promotion units and other organisations to conduct and manage activities which promote mental health and prevent the onset of mental disorders and/or mental health problems across the lifespan.

Notes and Examples: Collaboration with other organisations to investigate issues related to urban planning, education and housing.

6.3 The MHS provides information to mainstream workers and the defined community about mental disorders and mental health problems as well as information about factors that prevent mental disorders and/or mental heath problems.

Notes and Examples: Promotional packages of information for employment service staff, Department of Housing staff, police, emergency department staff, local community groups, court support staff, General Practitioners.

Prevention of Mental Disorders and Psychiatric Disability

6.4 The MHS has the capacity to identify and appropriately respond to the most vulnerable consumers and carers in the defined community.

Notes and Examples: Services for the children of parents with a mental disorder, services for victims of abuse, assertive follow-up, intensive case management, mobile outreach services, elder abuse and liaison with school counsellors.

6.5 The MHS has the capacity to identify and respond to people with mental disorders and/or mental health problems as early as possible.

Notes and Examples: Specific program for early psychosis intervention, minimal waiting times for assessment, school screening, links with child health services, liaison with court support services and General Practitioners.

6.6 Treatment and support offered by the MHS occur in a community setting in preference to an institutional setting unless there is a justifiable reason consistent with the best outcome for the consumer.

6.7 Each consumer receives assistance to develop a plan which identifies early warning signs of relapse and appropriate action.

Notes and Examples: Relapse management plan; carers are involved with the consumer's free and informed consent.

6.8 The MHS ensures that the consumer has access to rehabilitation programs which aim to minimise psychiatric disability and prevent relapse.

Notes and Examples: Living skills program, case management, family approaches, respite and social drop-in.

6.9 Wherever possible and appropriate, vocational and social needs are met through the use of mainstream agencies with support from the MHS.

Notes and Examples: TAFE, sports clubs and events, Commonwealth Rehabilitation Service. Where such services cannot be accessed, the MHS provides alternatives for the consumer.

6.10 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Notes and Examples: The MHS continually monitors and reviews the health promotion activities undertaken, or participated in, by the MHS.

Cross References: Promoting Community Acceptance (4), Access (11.1), and Integration (8)

Standard 7 - Cultural Awareness

The MHS delivers non-discriminatory treatment and support which are sensitive to the social and cultural values of the consumer and the consumer's family and community.

Criteria

7.1 Staff of the MHS have knowledge of the social and cultural groups represented in the defined community and an understanding of those social and historical factors relevant to their current circumstances.

Notes and Examples: Use of census data, meetings with cultural groups, open publicforums, dialogue with community leaders, collaboration with individuals and organisations with expertise in transcultural mental health, use of accredited interpreters and bilingual counsellors, staff knowledge of relevant policy documents, understandingof Aboriginal and Torres Strait Islander history.

7.2 The MHS considers the needs and unique factors of social and cultural groups represented in the defined community and involves these groups in the planning and implementation of services.

Notes and Examples: The MHS provides culturally specific services (Aboriginal and Torres Strait Islander mental health staff), appropriate community controlled models for Aboriginal and Torres Strait Islander mental health care, gender related issues such as incest, domestic violence, access for people with disabilities, culturally based understanding of mental illness and appropriate interventions. The MHS investigates under-utilisation of mental health services, contemporary healing methods, role of family and community, communication issues for non-English speaking people, visually impaired people, people with dual disability, deaf people and illiterate people. The MHS promotes specific cross-cultural staff training, and involvement of representatives of relevant cultural groups in the development of the MHS.

7.3 The MHS delivers treatment and support in a manner which is sensitive to the social and cultural beliefs, values and cultural practices of the consumer and their carers.

Notes and Examples: Considers the role of family and community, use of interpreters & advocates, need for consumer to stay with family and community during care, religious practices.

7.4 The MHS employs staff or develops links with other service providers/organisations with relevant experience in the provision of treatment and support to the specific social and cultural groups represented in the defined community.

Notes and Examples: Aboriginal and Torres Strait Islander mental health worker, ethnic health worker, bilingual counsellor, links with specific services such as the Transcultural Mental Health Centre and Aboriginal and Torres Strait Islander mental health unit.

7.5 The MHS monitors and addresses issues associated with social and cultural prejudice in regard to its own staff.

Notes and Examples: Cross cultural training of staff, rotation across settings and programs, education involving consumers and carers from a range of different social and cultural groups.

7.6 Documented policies and procedures exist and are used to achieve the above criteria.

7.7 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Notes and Examples: The MHS continually monitors and reviews representation of social and cultural groups amongst caseloads within the MHS.

Cross References: Rights (1), Integration (8), Access (11.1), Entry (11.2), Assessment & Review (11.3), and Treatment & Support (11.4)

Standard 8 - Integration
Standard 8.1 - Service Integration

The MHS is integrated and coordinated to provide a balanced mix of services which ensure continuity of care for the consumer.

Criteria

8.1.1 There is an integrated MHS available to serve each defined community.

Notes and Examples: All of the separate programs such as inpatient care, crisis intervention, case management & rehabilitation, disability support, health promotion, developmental programs are functions of one mental health service. Separately funded programs work collaboratively to achieve a single integrated mental health care system for the defined community.

8.1.2 The consumer's transition between components of the MHS is facilitated by a designated staff member and a single individual care plan known to all involved.

Notes and Examples: Case manager maintains contact with consumer between inpatient and community setting and between acute and rehabilitation programs.

8.1.3 There are regular meetings between staff of each of the MHS programs and sites in order to promote integration and continuity.

Notes and Examples: Team leaders meetings, service wide meeting which includes inpatient and community staff.

8.1.4 Opportunity exists for the rotation of staff between settings and programs within the MHS, and which maintains continuity of care for the consumer.

8.1.5 The MHS has documented policies and procedures which are used to promote continuity of care across programs, sites, other services and lifespan.

Notes and Examples: How a consumer might receive treatment from the one mental health service at several sites such as inpatient, living skills centre and home, how staff of different disciplines or programs might work together, arrangements for shared care with General Practitioners, private psychiatrists, non-government organisations and other relevant agencies. Links between child, adolescent, adult and elderly programs, service providers and settings.

8.1.6 The MHS has specified procedures to facilitate and review internal and external referral processes within the programs of the MHS.

Notes and Examples: Documented policy and procedures, regular meetings with other service providers.

8.1.7 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Notes and Examples: The MHS continually monitors and reviews the individual care plan.

Cross References: Cultural Awareness (7), Service Development (9), and Planning for Exit (11.5)

Standard 8.2 - Integration within the Health System

The MHS develops and maintains links with other health service providers at local, state and national levels to ensure specialised coordinated care and promote community integration for people with mental disorders and/or mental health problems.

Criteria

8.2.1 The MHS is part of the general health care system and promotes comprehensive health care for consumers, including access to specialist medical resources.

Notes and Examples: The MHS works collaboratively with General Practitioners, welfare services, disability support services, school counsellors and aged care assessment teams.

8.2.2 Mental health staff know about the range of other health resources available to the consumer and can provide information on how to access other relevant services.

Notes and Examples: Up-to-date resource folder, education by other health service providers including General Practitioners, private psychiatrists and other private therapists.

8.2.3 The MHS supports the staff, consumers and carers in their involvement with other health service providers.

Notes and Examples: Support might be in the form of referral, sharing of resources and/or sharing of expertise between the MHS and the Emergency Department.

8.2.4 The MHS has formal processes to promote inter-agency collaboration.

Notes and Examples: Documented policies & procedures exist; links with other mental health services and other health service providers are developed, such as private psychiatrists, General Practitioners, non-government organisations and other agencies.

8.2.5 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Notes and Examples: The MHS continually monitors and reviews complaints regarding access to the MHS.

Standard 8.3 - Integration with Other Sectors

The MHS develops and maintains links with other sectors at local, state and national levels to ensure specialised coordinated care and promote community integration for people with mental disorders and/or mental health problems.

Criteria

8.3.1 Mental health staff know about the range of other agencies available to the consumer and carers.

Notes and Examples: Resource folder and education by other agencies.

8.3.2 The MHS supports its staff, consumers and carers in their involvement with other agencies wherever possible and appropriate.

Notes and Examples: Support might be in the form of referral, sharing of resources, sharing of expertise to agencies like Department of Housing, Disability Services, CES, Police Services, schools, Commonwealth Rehabilitation Services and Court Liaison Services.

8.3.3 The MHS has formal processes to develop intersectoral links and collaboration.

Notes and Examples: Documented policies and procedures, minuted meetings.

8.3.4 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Notes and Examples: The MHS continually monitors and reviews the level and type of intersectoral activities participated in by the MHS.

Cross References: Service Development (9), Access (11.1), Entry (11.2), Inpatient Care (11.4.E), and Planning for Exit (11.5)

Standard 9 - Service Development

The MHS is managed effectively and efficiently to facilitate the delivery of coordinated and integrated services.

Criteria

Organisational Structure

9.1 The MHS is managed by an appropriately qualified and experienced person with authority over, and accountability for, mental health service resources and planning.

9.2 There is single point accountability for the MHS across all settings, programs and age groups.

Notes and Examples: Single point accountability for clinical and administrative management of the MHS, single director of MHS or executive team.

9.3 The MHS has an organisational structure which identifies it as a discrete entity within the larger organisation.

Notes and Examples: A mental health service within a general hospital, a private psychiatric hospital within a company structure.

9.4 The organisational structure of the MHS ensures continuity of care for consumers across all settings, programs and age groups.

9.5 The organisational structure of the MHS reflects a multidisciplinary approach to planning, implementing and evaluating care.

Notes and Examples: Directors, program managers & team leader positions are open to staff of all disciplines, multidisciplinary teams, sessional staff are used and links with other service providers are developed.

9.6 A system exists which ensures that staff are aware of their roles and responsibilities within the MHS.

Notes and Examples: Collaboratively written and annually reviewed job descriptions, orientation program, staff performance appraisal and organisational chart.

Planning

9.7 The MHS produces and regularly reviews a strategic plan which is made available to the defined community.

Notes and Examples: Available on request, covers all aspects of the MHS, kept in locallibrary.

9.8 The strategic plan is developed and reviewed through a process of consultation with staff, consumers, carers, other appropriate service providers and the defined community.

9.9 The strategic plan includes:

- consumer and community needs analysis
- quality improvement plan
- service evaluation plan including the measurement of health outcomes for individual consumers
- plan for maximising consumer and carer participation in the MHS
- plan for improving the skills of staff, and
- relevant financial information.

9.10 The strategic plan is consistent with national mental health policies and legislative requirements.

9.11 The MHS has operational plans based on the strategic plan, which establish time frames, responsibilities of organisations and/or individuals and targets for implementation.

Notes and Examples: Policies are derived from the strategic and operational plans, and are developed and reviewed with staff, consumers and carers. Policies identify person responsible for implementation and date of most recent and next review. Policies are reviewed annually.

Funding

9.12 The MHS manages a dedicated budget using nationally accepted accounting practices.

9.13 The MHS allocates a portion of its budget for the provision of staff development and, in the public sector, for the promotion of consumer and family / carer participation in the MHS.

Resource allocation

9.14 Resources are allocated according to the documented priorities of the MHS and reflect national mental health policies.

9.15 Resources are allocated in a manner which follow the consumer' and allows the MHS to respond promptly to the changing needs of the defined community.

Notes and Examples: Redeployment of staff across programs according to demand, resources 'follow' the consumer as part of any transition from inpatient care to community care.

9.16 Where the MHS has redeployed staff according to demand, it ensures that staff are a dequately trained for new and/or changing roles and ensures that continuity of care for consumers is maintained.

Staff training and development

9.17 The MHS regularly identifies training and development needs of its staff.

Notes and Examples: Through performance appraisal, surveys, supervision and with reference to industry-validated core competencies for mental health staff.

9.18 The MHS ensures that staff participate in education and professional development programs.

Notes and Examples: Where needed, specific professional groups are trained and supported in the delivery of services, consumers and carers are involved in the planning and delivery of the education program, covers critical incident stress debriefing and the National Standards for Mental Health Services.

9.19 New staff are provided with an orientation program to the MHS.

Notes and Examples: This may be specific as well as general orientation and should include familiarity with the National Standards for Mental Health Services.

9.20 The MHS ensures that staff have access to formal and informal supervision.

Notes and Examples: Multidisciplinary, discipline specific, group or individual supervision, case reviews and peer review.

9.21 The MHS has a system for supporting staff during and after critical incidents.

Notes and Examples: Critical incident stress debriefing protocol available 24 hours perday and peer review of such incidents.

Information systems

9.22 The MHS collects and aggregates data which promote effective care for consumers and their family/carer, assist with the management and evaluation of the MHS, and promote staff training and research.

9.23 Data are collected in a manner which ensures reliability, validity and timeliness of reporting.

9.24 Data collected are analysed and used to promote continuous quality improvement within the MHS.

9.25 Information is made available to funders, staff and the defined community in an understandable format within the bounds of confidentiality requirements.

9.26 Data collection is consistent with statutory requirements and State/Territory/ National requirements for mental health services.

9.27 Data collected are stored and reported in a manner which ensures confidentiality and complies with relevant legislation.

Service evaluation, outcome measurement, research and quality improvement

9.28 There is documented accountability and responsibility for the evaluation of the MHS.

Notes and Examples: The director of the MHS or delegate, best practice coordinator, research officer, research/evaluation committee.

9.29 The MHS has a service evaluation strategy which promotes participation by staff, consumers, carers, other service providers and the defined community.

9.30 The MHS routinely monitors health outcomes for individual consumers using a combination of accepted quantitative and qualitative methods.

Notes and Examples: Consumer/carer satisfaction surveys, story telling, quality of life measures, measures of change in individual health status, measures of change in individual functioning, and consultation with consumers on the relevance and parameters of various outcome measures.

9.31 The MHS conducts or participates in appropriate research activities.

Notes and Examples: Original research, replication studies, participating in larger research projects and appropriate medication trials.

9.32 Research proposals are reviewed by an ethics committee constituted and functioning in accordance with the National Health and Research Medical Council Statement on Human Experimentation and Explanatory Notes.

Notes and Examples: There is a mechanism for involving consumers and carers in the ethical review of research proposals.

9.33 The MHS is able to demonstrate a process of continuous quality improvement.

Notes and Examples: Quality plan, quality activities coordinator, quality on the agenda of all meetings, quality skills training, method for reporting results, feedback to staff, consumer & family/carer involvement, regular review of service activity, quality of links with other service providers, monitoring of relevant clinical indicators, staff satisfaction and turnover levels.

9.34 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Notes and Examples: The MHS continually monitors and reviews its quality improvement plan and processes.

Cross References: Rights (1), Consumer & Carer Participation (3), Privacy & Confidentiality (5), Access (11.1), Assessment & Review (11.3), Integration (8) and Planning for Exit (11.5)

Standard 10 - Documentation

Clinical activities and service development activities are documented to assist in the delivery of care and in the management of services.

Criteria

10.1 The MHS complies with relevant legislation and regulations protecting consumer confidentiality and ensures that documentation processes are such that confidentiality is protected.

Notes and Examples: Includes matters such as access and confidentiality in relation to records in the Freedom of Information Act and the Australian Standards for Medical Records.

10.2 Treatment and support provided by the MHS are recorded in an individual clinical record which is accessible throughout the components of the MHS.

Notes and Examples: A paper or computer record unique to each consumer, the consumer's current status under any relevant legislation is clearly identifiable within the record. Consumers are provided with opportunities to access their clinical records.

10.3 Documentation in the individual clinical record is dated, signed (with designation), shows the time of each intervention and is legible.

10.4 A system exists by which the MHS uses the individual clinical record to promote continuity of care across settings, programs and time.

Notes and Examples: A single clinical record exists for each consumer, networked computerised records and safe transport of the individual clinical record.

10.5 Documentation is a comprehensive, factual and sequential record of the consumer's condition and the treatment and support offered.

Notes and Examples: Files are audited regularly.

10.6 Each consumer has an individual care plan within their individual clinical record which documents the consumer's relevant history, assessment, investigations, diagnosis, treatment and support services required, other service providers, progress, follow-up details and outcomes.

10.7 The MHS ensures that only authorised persons have access to information about the consumer.

Notes and Examples: Boards (such as a whiteboard in a ward setting or in a crisis team office) used to record consumer information are only visible to authorised persons, consumer's files are stored according to Australian Standards for medical records, passwords for computer files.

10.8 Documented policies and procedures exist and are used to achieve the above criteria.

10.9 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Notes and Examples: The MHS continually monitors and reviews the standard of clinical records through regular file audits.

Cross References: Privacy & Confidentiality (5), Entry (11.2), and Assessment & Review (11.3)

Standard 11 - Delivery of Care

Principles guiding the delivery of care

The care, treatment and support delivered by the mental health service is guided by:

Choice:

Access to a range of specialised mental health treatment and support options and information to assist in the selection of the most appropriate option(s) in the setting most empowering for the consumer.

Social, cultural and developmental context:

Specialised mental health treatment and support which respect and utilise for optimal benefit, the consumer's social and cultural values, beliefs, practices and stage of development.

Continuous and coordinated care:

Specialised mental health treatment and support are provided in a continuous and coordinated manner by a range of service providers in and between a range of settings.

Comprehensive care:

Access to specialised mental health treatment and support services is available throughout the consumer's lifespan and is able to meet their specific needs during the onset, acute, rehabilitation, consolidation and recovery phases of their mental disorder and/or mental health. Each component of the mental health service, such as the psychiatric unit and the community mental health team, is equally valued by theorganisation.

Individual care:

Specialised mental health treatment and support are tailor-made for each individual.

Least restriction:

Specialised mental health treatment and support which impose the least personal restriction of rights and choice in balance with the need for treatment.

Standard 11.1 - Access

The MHS is accessible to the defined community.

Criteria

11.1.1 The MHS ensures equality in the delivery of treatment and support regardless of consumer's age, gender, culture, sexual orientation, socio-economic status, religious beliefs, previous psychiatric diagnosis, past forensic status and physical or other disability.

11.1.2 The community to be served is defined, its needs regularly identified and services are planned and delivered to meet those needs.

Notes and Examples: Community advisory committees, public forums, needs analysis, data collection and analysis, community controlled analysis of need.

11.1.3 Mental health services are provided in a convenient and local manner and linked to the consumer's nominated primary care provider.

Notes and Examples: Psychiatric assessment, acute care, day programs, home visiting are all provided locally. Extended office hours, flexible visiting times are available. Collaboration with General Practitioners, Private Psychiatrists, Disability Support staff. Opportunity exists for non-local services to be made available to the consumer in special circumstances.

11.1.4 The MHS is available on a 24 hour basis, 7 days per week.

Notes and Examples: Crisis Teams, extended hours teams, remote on call, monitored answering machine, toll free number, cooperative arrangements with other appropriately skilled service providers and community agencies including General Practitioners, private psychiatrists, general hospitals. It is understood that not all components of a MHS will operate on this basis but that the crisis intervention component will be available which will facilitate prompt referral to other programs and providers.

11.1.5 The MHS ensures effective equitable access to services for each person in the defined community.

Notes and Examples: Attention is paid to the needs of people of Aboriginal, Torres Strait Islander and non-English speaking backgrounds as well as ethnicity, gender, sexual orientation, culture, socio-economic status, age, disability and previous psychiatric diagnosis. This might be facilitated by forming links with relevant community groups and service providers, use of appropriately trained interpreters and bilingual counsellors, community development, subsidisation of treatment, recruitment and ongoing training of staff.

11.1.6 The MHS informs the defined community of its availability, range of services and the method for establishing contact.

Notes and Examples: Information is available in a variety of languages and a variety of media, wide distribution of information within the community(s) served.

11.1.7 The MHS, wherever possible, is located to promote ease of physical access with special attention being given to those people with physical disabilities and/or reliance on public transport.

Notes and Examples: Close proximity to public transport, clear signage, level access, assistance with transport where necessary, friendly and spacious waiting areas which accommodate children.

11.1.8 Documented policies and procedures exist and are used to achieve the above criteria.

11.1.9 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Notes and Examples: The MHS continually monitors and reviews waiting times for initial assessment.

Cross References: Rights (1), Prevention & Mental Health Promotion (6), Integration (8), and Service Development (9)

Standard 11.2 - Entry

The process of entry to the MHS meets the needs of the defined community and facilitates timely and ongoing assessment.

Criteria

11.2.1 The process of entry to the MHS is made known to the defined community.

Notes and Examples: Use of media, promotional flyers, interagency liaison, information in a variety of languages in a variety of formats, regular liaison with referral sources. The process of entry is made known to General Practitioners, private psychiatrists, school counsellors and youth services.

11.2.2 The MHS has documented policies and procedures describing its entry process, inclusion and exclusion criteria and means of promoting and facilitating access to appropriate ongoing care for people not accepted by the service.

Notes and Examples: Should be consistent with national mental health policy, promote continuity of care, identify accountability of MHS staff, collaboration with other service providers such as General Practitioners, private psychiatrists and mental health services in other areas.

11.2.3 The MHS can be entered at multiple sites which are coordinated through a single entry process.

Notes and Examples: One system of On Call, intake, assessment and triage which can be accessed by the community in many locations such as emergency department, general practice, private psychiatric practice, community health centre, psychiatric unit, police service, schools and early childhood centres.

11.2.4 The entry process to the MHS can be undertaken in a variety of ways which are sensitive to the needs of the consumer, their carers and the defined community.

Notes and Examples: Non-traumatic, non-damaging and non-discriminatory for the consumer. Entry could be via telephone, unscheduled attendance at agreed location, home visit, appointment, mail, video technology, use of interpreters, cultural and language sensitivity, mental health expertise available through emergency departments and provided by consultation liaison psychiatrist, attendance by community mental health service and attendance by inpatient psychiatric unit staff.

11.2.5 The entry process to the MHS is specialised and complementary to any existing generic health or welfare intake systems.

Notes and Examples: Discrete On Call, intake, admission process that is linked to other processes such as generalist community health intake, emergency department triage, calls to police and ambulance.

11.2.6 An appropriately qualified and experienced mental health professional is available at all times to assist consumers to enter into mental health care.

Notes and Examples: Mental health staff in specialist mental health service, support and training to generalist health staff, emergency department staff, police by the MHS, mental health staff on generalist community health team, consultation-liaison psychiatry, phone availability and appropriately trained generic health worker with specialist mental health support in remote settings.

11.2.7 The process of entry to the MHS minimises the need for duplication in assessment, care planning and care delivery.

Notes and Examples: Interim or permanent case manager or key worker appointed during entry, multidisciplinary individualised client record and multidisciplinary individual care plan started during entry.

11.2.8 The MHS ensures that a consumer and their carers are able to, from the time of their first contact with the MHS, identify and contact a single mental health professional responsible for coordinating their care.

Notes and Examples: Case manager, care coordinator, key worker or delegate in the original person's absence. The staff member who is involved in the consumer's initial contact with the service coordinates assessment, treatment and support and/or facilitates a smooth transition of care to a more appropriate colleague.

11.2.9 The MHS has a system for prioritising referrals according to risk, urgency, distress, dysfunction and disability.

Notes and Examples: Suicide Risk assessment protocol, crisis intervention service, emergency psychiatric triage scale, consistent with national mental health policies.

11.2.10 The MHS has a system that enables separate assessment of more than one consumer at a time.

Notes and Examples: 1st On Call/2nd On Call, back-up intake worker, more than one interview space, staff linked to one another by pagers and more than one direct telephone line to the service.

11.2.11 The MHS has a policy which acknowledges that assessment and the entry process to the service are linked.

Notes and Examples: Includes requirements for staff accountability, documentation when "on call" or providing intake and the ongoing nature of assessment and review.

11.2.12 The MHS has a system which ensures that the initial assessment of an urgent referral is commenced within one hour of initial contact and the initial assessment of a non-urgent referral is commenced within 24 hours of initial contact.

Notes and Examples: Professional assessment of urgency, the assessment process may be commenced with initial history taking, risk assessment, needs assessment over the telephone by an appropriately qualified mental health professional.

11.2.13 Documented policies and procedures exist and are used to achieve the above criteria.

11.2.14 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Notes and Examples: The MHS continually monitors and reviews the level and frequency of duplicate assessments.

Cross References: *Rights (1), Safety (2), Privacy & Confidentiality (5), Cultural Awareness (7), Integration(8), Documentation (10), Access (11.1), Assessment & Review (11.3), Planning for Exit (11.5) and Exit & Re-entry (11.6)*

Standard 11.3 - Assessment and Review

Consumers and their carers receive a comprehensive, timely and accurate assessment and a regular review of progress.

ASSESSMENT

Criteria

11.3.1 Assessments are conducted by appropriately qualified and experienced mental health professionals.

Notes and Examples: Staff of all health disciplines are, with appropriate training, involved in conducting assessments.

11.3.2 Wherever possible, the assessment is conducted in a setting chosen by the consumer. The choice of setting is negotiated by the consumer and the MHS and considers the safety of those people involved.

Notes and Examples: The MHS provides a home visit rather than expecting the consumer to attend the community mental health centre, emergency department or psychiatric unit. Carers are involved with the informed consent of the consumer.

11.3.3 The MHS has a procedure for appropriately following up people who decline to participate in an assessment.

Notes and Examples: Non-intrusive future contact, feedback and planning with referring agent, support to carers.

11.3.4 The MHS has a system for commencing and recording assessment during the consumer's first contact with the service.

Notes and Examples: Intake procedure, on call arrangements, appointments procedure and reception procedure.

11.3.5 The assessment process is comprehensive and, with the consumer's informed consent, includes the consumer's carers (including children), other service providers and other people nominated by the consumer.

Notes and Examples: Multidisciplinary assessment which includes physical, social and psychological strengths, risks, family & functional components, relevant history (including previous treatments such as medication), diagnosis and short-term individual care plan and is recorded in a standardised format for the MHS.

Information is gathered from a number of sources including, with the consumer's informed consent, the General Practitioner, private psychiatrist, school counsellors, family and other people nominated by the consumer.

11.3.6 The assessment is conducted using accepted methods and tools.

Notes and Examples: May include diagnostic classification systems, functional assessments, psychometric testing, collaborative interview, family interview, suicide and other risk assessment, problem oriented assessment, formal clinical interview, mental status examination, standardised documentation format and includes physical assessment.

11.3.7 The MHS has documented protocols and procedures describing the assessment process.

Notes and Examples: Includes the unique requirements of people of a non-English speaking background, Aboriginal & Torres Strait Islander people, deaf people, people with disabilities and children.

11.3.8 The assessment is recorded in an individualised clinical record in a timely and accurate manner.

11.3.9 There is opportunity for the assessment to be conducted in the preferred language of the consumer and their carers.

Notes and Examples: Use of accredited interpreters, bilingual counsellors, transcultural mental health services.

11.3.10 Staff are aware of, and sensitive to, cultural and language issues which may affect the assessment.

Notes and Examples: Staff specialised in transcultural mental health either conduct the assessment or guide the work of other clinicians. This is particularly important for the assessment of a person with an Aboriginal or Torres Strait Islander background.

11.3.11 Diagnosis is made using internationally accepted medical standards by an appropriately qualified and experienced mental health professional.

11.3.12 Where a diagnosis is made, the consumer and carers (with the consumer's informed consent) are provided with information on the diagnosis, options for treatment and possible prognoses.

11.3.13 Wherever possible, the MHS conducts face-to-face assessments but may use telephone and video technologies where this is not possible due to distance or the consumer's preference.

Review

11.3.14 The MHS ensures that the assessment is continually reviewed throughout the consumer's contact with the service.

11.3.15 Staff of the MHS involved in providing assessment undergo specific training in assessment and receive supervision from a more experienced colleague.

Notes and Examples: Assessment methods, working with interpreters, individual & group supervision.

11.3.16 New assessments are subjected to a clinical review process by the MHS.

Notes and Examples: Peer review, case presentation, ward rounds, intake meeting, allocation meeting, clinical supervision and shift handover.

11.3.17 All active consumers, whether voluntary or involuntary, are reviewed at least every three months. The review should be multidisciplinary, conducted with peers and more experienced colleagues and recorded in the individual clinical record.

11.3.18 A review of the consumer is additionally conducted when:

- the consumer declines treatment and support
- the consumer requests a review
- the consumer is injures themself or another person
- the consumer receives involuntary treatment
- there has been no contact between the consumer and the MHS for three months
- the consumer is going to exit the MHS
- monitoring of consumer outcomes (satisfaction with service, measure of quality of life, measure of functioning) indicates a sustained decline.

11.3.19 The MHS has a system for the routine monitoring of staff case loads in terms of number and mix of cases, frequency of contact and outcomes of care.

11.3.20 Documented policies and procedures exist and are used to achieve the above criteria.

11.3.21 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Notes and Examples: The MHS continually monitors and reviews the proportion of caseloads not reviewed within three months.

Cross References: Rights (1), Safety (2), Privacy & Confidentiality (5), Integration (8), Service Development (9), Documentation (10), Entry (11.2) and Planning for Exit (11.5).

Standard 11.4 - Treatment and Support

The defined community has access to a range of high quality mental health treatmentand support services.

Criteria

11.4.1 Treatment and support provided by the MHS reflect best available evidence and emphasise positive outcomes for consumers.

11.4.2 Treatment and support provided by the MHS, including any participation of the consumer in clinical trials and experimental treatments, are subject to the informed consent of the consumer.

Notes and Examples: Under some circumstances, the consumers may be subject to the provisions of Mental Health Legislation, or have a legal guardian lawfully authorised to make a decision on their behalf, which compels the consumer to receive treatment. Under all circumstances, the MHS must make every attempt to obtain informed consent prior to the administration of any treatment.

11.4.3 The MHS ensures access to a comprehensive range of treatment and support services which are, wherever possible, specialised in regard to a person's age and stage of development.

Notes and Examples: Child, adolescent and elderly mental health programs, expert staff in the area of child, adolescent and elderly mental health, effective links with other specialist service providers.

11.4.4 The MHS ensures access to a comprehensive range of treatment and support services which are specialised in regard to a consumer's stage in the recovery process.

Notes and Examples: Programs and staff that focus on onset and acute needs, help consolidate gains in the acute phase, promote rehabilitation and ensure follow-up, and promote and support recovery.

11.4.5 The MHS provides access to a comprehensive range of treatment and support services which cater for the needs of people compelled to receive treatment involuntarily, whether in an inpatient or community setting.

11.4.6 The MHS ensures access to a comprehensive range of treatment and support services which address physical, social, cultural, emotional, spiritual, gender and lifestyle aspects of the consumer.

11.4.7 The MHS ensures access to a comprehensive range of treatment and support services which are, wherever possible, specialised in regard to dual diagnosis, other disability and consumers who are subject to the criminal justice system.

Notes and Examples: Dual case management with alcohol and other drug services, collaborative treatment with other service providers such as aged care, psychiatric disability support, disability services and court liaison services.

11.4.8 The MHS ensures access to a comprehensive range of treatment and support services which are, wherever possible, specialised in addressing the particular needs of people of ethnic backgrounds.

11.4.9 There is a current individual care plan for each consumer, which is constructed and regularly reviewed with the consumer and, with the consumer's informed consent, their carers and is available to them.

Notes and Examples: Copy given to consumer wherever possible, participation by other persons nominated by the consumer such as advocate, General Practitioner, private psychiatrist or other service provider.

11.4.10 The MHS provides the least restrictive and least intrusive treatment and support possible in the environment and manner most helpful to, and most respectful to, the consumer.

Notes and Examples: This may, at times, be compromised by the consumer's preference or status under mental health legislation.

11.4.11 The treatment and support provided by the MHS is developed collaboratively with the consumer and other persons nominated by the consumer.

Notes and Examples: Consumer participates fully in the development of the individual care plan and in the evaluation of outcome.

11.4.12 Documented policies and procedures exist and are used to achieve the above criteria.

11.4.13 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Notes and Examples: The MHS continually monitors and reviews the standard of individual care plans.

Cross References: Rights (1), and Assessment & Review (11.3)

Standard 11.4.A- Community Living

The MHS provides consumers with access to a range of treatment and support programs which maximise the consumer's quality of community living.

Criteria

Self Care

11.4.A.1 The setting for the learning or the re-learning of self care activities is the most familiar and/or the most appropriate for the generalisation of skills acquired.

Notes and Examples: In the consumer's own home, the consumer's local shops, transport.

11.4.A.2 Self care programs or interventions provide sufficient scope and balance so that consumers develop or redevelop the necessary competence to meet their own everyday community living needs.

Leisure, Recreation, Education, Training, Work and Employment

11.4.A.3 The MHS ensures that settings for day programs provide adequate indoor and outdoor space for consumers.

11.4.A.4 The MHS ensures that the consumer has access to an appropriate range of agencies, programs and/or interventions to meet their needs for leisure, recreation, education, training, work, accommodation and employment.

11.4.A.5 The MHS supports the consumer's access to education, leisure and recreation activities in the community.

11.4.A.6 The MHS provides access to, and/or support for consumers in employment and work.

Notes and Examples: Might be full time or part time, paid or voluntary, supported employment or open market employment; liaison with Commonwealth Rehabilitation Service and other relevant psychiatric and disability support services.

11.4.A.7 The MHS supports the consumer's access to vocational training opportunities in appropriate community settings and facilities.

Notes and Examples: Apprenticeships, traineeships

11.4.A.8 The MHS promotes access to vocational support systems which ensure the consumer's right to fair pay and conditions, award (or above) payment for work and opportunities for union membership.

11.4.A.9 The MHS supports the consumer's desire to participate in Further or Continuing Education.

Notes and Examples: TAFE courses, university studies and links with other relevant psychiatric disability support services.

11.4.A.10 The MHS provides or ensures that consumers have access to drop-in facilities for leisure and recreation as well as opportunities to participate in leisure and recreation activities individually and/or in groups.

Family, Relationships, Social and Cultural System

11.4.A.11 The consumer has the opportunity to strengthen their valued relationships through the treatment and support effected by the MHS.

Notes and Examples: Relationships with family, carer, sexual partner, friends, peers, cultural group and community.

11.4.A.12 The MHS ensures that the consumer and their family have access to a range of family-centred approaches to treatment and support.

Notes and Examples: Family involvement in hospital care, family education regarding the relevant mental disorder(s), training in family communication and problem solving skills, family counselling and ongoing support, support for children of parents with a mental disorder, contact with relevant support / self help groups.

11.4.A.13 The MHS provides a range of treatments and support which maximise opportunities for the consumer to live independently in their own accommodation.

11.4.A.14 Documented policies and procedures exist and are used to achieve the above criteria.

11.4.A.15 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Notes and Examples: The MHS continually monitors and reviews satisfaction amongst consumers in regard to their quality of community living.

Cross References: Promoting Community Acceptance (4), Cultural Awareness (7), and Treatment & Support (11.4)

Standard 11.4.B - Supported Accommodation

Supported accommodation* is provided and/or supported in a manner which promotes choice, safety and maximum possible quality of life for the consumer.

** Psychiatric inpatient accommodation is addressed under Inpatient Care (Standard 11.4.E)*

Supported accommodation provided by the MHS

Criteria

11.4.B.1 The MHS has guidelines for the provision of accommodation which are adhered to.

Notes and Examples: National Working Party on Housing for People with a Disability emphasises four principles - equal rights and responsibilities, service which meets individual needs, independent living and inclusion in community life and choice, Disability Services Standards, State/Territory Departmental Guidelines. Compliance with Residential Tenancies Acts.

11.4.B.2 Consumers and carers have the opportunity to be involved in the management and evaluation of the facility.

Notes and Examples: Residents' committee, Board of Management, participation in evaluation of accommodation programs.

11.4.B.3 The accommodation program is fully integrated into other treatment and support programs.

Notes and Examples: Crisis intervention, case management, rehabilitation/living skills, shared care with General Practitioners and Private Psychiatrists, and schooling are all available. Where supported accommodation is not provided by the MHS then there is close collaboration between the MHS and the accommodation provider to ensure access to other treatment and support programs.

11.4.B.4 Accommodation is clean, safe and reflects as much as possible the preferences of the consumers living there.

Notes and Examples: Decor, house rules, cleaning routines, cooking and shopping routines, single sex accommodation if required, secure, adequate personal space in regard to indoor and outdoor physical environments.

11.4.B.5 Access to the accommodation is non-discriminatory and determined on priority of need alone.

Notes and Examples: Consistent with documented MHS priorities, catchment area limitations, consistent with national mental health policies.

11.4.B.6 A range of treatment and support services is delivered to the consumers living in the accommodation according to individual need.

Notes and Examples: Crisis intervention, living skills training, medication supervision, assistance with activities of daily living, home visits when required, 24 hour access to the MHS.

11.4.B.7 Consumers living in the accommodation are offered maximum opportunity to participate in decision making with regard to the degree of supervision in the facility, decor, visitors, potential residents and house rules.

11.4.B.8 There is a range of accommodation options available and consumers have the opportunity to choose and move between options if needed.

Notes and Examples: Single and multiple occupancy, single sex accommodation, single and shared sleeping areas, space for family members where children are concerned, a range of accommodation types including long and short-stay settings, transitional, respite.

11.4.B.9 Where desired, consumers are accommodated in the proximity of their social and cultural supports.

Notes and Examples: Near family, friends, carers, familiar neighbourhood and community.

11.4.B.10 The accommodation maximises opportunities for the consumer to participate in the local community.

Notes and Examples: Close to public transport, recreation facilities, shopping facilities, use of mainstream agencies, General Practitioners.

11.4.B.11 The accommodation maximises opportunities for the consumer to exercise control over their personal space.

Notes and Examples: Lockable bedrooms, lockable cupboards and choice of visitors.

11.4.B.12 Wherever possible and appropriate, the cultural, language, gender and preferred lifestyle requirements of the consumer are met.

Notes and Examples: Ability to communicate with other consumers living there, ability to communicate with staff, ability to participate in their normal lifestyle, religious and cultural activities.

11.4.B.13 Consumers with physical disabilities have their needs met.

Notes and Examples: Issues of access for mobility-impaired people, safety issues for visually and hearing impaired, special communication requirements of deaf people such as TTY telephone and flashing doorbell.

Accommodation provided by agencies other than the MHS

11.4.B.14 The MHS supports consumers in their own accommodation and supports accommodation providers in order to promote the criteria above.

Notes and Examples: Support to consumers to live independently in their own accommodation, support to consumers in boarding houses and public refuges.

11.4.B.15 The MHS provides treatment and support to consumers regardless of their type of accommodation.

11.4.B.16 The MHS does not refer a consumer to accommodation where he / she is likely to be exploited and/or abused.

Notes and Examples: The MHS physically investigates local accommodation options, stays involved with consumers after they are accommodated, forms links with accommodation providers, advocates for improvement where required, reports alleged exploitation.

11.4.B.17 Documented policies exist and are used to achieve the above criteria.

11.4.B.18 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Notes and Examples: The MHS continually monitors and reviews complaints about accommodation services.

Cross References: Rights (1), Safety (2), Integration (8), Community Living (11.4.A), and Inpatient Care (11.4.E)

Standard 11.4.C - Medication and Other Medical Technologies

Medication and other medical technologies are provided in a manner which promotes choice, safety and maximum possible quality of life for the consumer.

Criteria

11.4.C.1 Medication and other technologies used are evidence-based and reflect internationally accepted medical standards.

11.4.C.2 Medication and other technologies are prescribed, stored, transported, administered and reviewed by authorised persons in a manner consistent with legislation, regulations and professional guidelines.

Notes and Examples: RANZCP Guidelines covering medication, electro-convulsive therapy and seclusion, ANZCMHN Practice Standards, Registration Acts, Poisons Act, National Health Act, mental health legislation, departmental guidelines for administration of medication, and other regulatory bodies.

11.4.C.3 The MHS obtains the informed consent of the consumer prior to the administration of medication or use of other medical technologies such as Electro Convulsive Therapy.

Notes and Examples: Consistent with Mental Health Acts, Guardianship Acts.

11.4.C.4 The consumer and their carers are provided with understandable written and verbal information on the potential benefits, adverse effects, costs and choices with regard to the use of medication and other technologies.

Notes and Examples: Use of interpreters, information in a variety of languages and variety of media, a system of checking to see that the information is understood, information on other available and appropriate methods of treatment.

11.4.C.5 Wherever possible and appropriate, the MHS provides the option of medication being prescribed and administered in a setting of the consumer's choice.

Notes and Examples: Home visits by prescribing doctor, supervision of medication in the home by MHS, flexible office hours.

11.4.C.6 The MHS ensures that a system exists which monitors to prevent - and promptly provides the consumer with appropriate treatment for any adverse effects of medication.

Notes and Examples: Contingency plan for the treatment of such adverse effects in the consumer's individual care plan, 24 hour access to an appropriately trained professional, a responsive outreach service, education of the consumer and carers of how to deal with the adverse effects, MHS support to emergency departments, MHS support to General Practitioners, private psychiatrists and other service providers.

11.4.C.7 Where the consumer's medication is administered by the MHS, it is administered in a manner which protects the consumer's dignity and privacy.

Notes and Examples: Medication is taken to each consumer in an inpatient unit rather than having to queue at the clinic and their preference for privacy is known.

11.4.C.8 "Medication when required" (PRN) is only used as a part of a documented continuum of strategies for safely alleviating the consumer's distress and/or risk.

Notes and Examples: Documented in the individual care plan describing other strategies to be used prior to or in conjunction with P.R.N. medication.

11.4.C.9 The use of medication and other technologies is monitored and reported utilising nationally accepted clinical indicators and other benchmarks.

Notes and Examples: ACHS clinical indicators for psychiatry, RANZCP guidelines, manufacturer's recommended maximum daily doses.

11.4.C.10 The MHS ensures access for the consumer to the safest, most effective and most appropriate medication and/or other technology.

Notes and Examples: Maintenance of technology to recommended levels of safety, subsidising costs of medication, prescription of generic brands of medication to reduce cost, access to diagnostic equipment on area / state level etc.

11.4.C.11 The MHS promotes continuity of care by ensuring that, wherever possible, the views of the consumer and, with the consumer's informed consent, their carers and other relevant service providers are considered and documented prior to administration of new medication and/or other technologies.

Notes and Examples: Involvement of General Practitioner, private psychiatrist, case manager, advocate in decision making.

11.4.C.12 The consumer's right to seek an opinion and/or treatment from another qualified person is acknowledged and facilitated and the MHS promotes continuity of care by working effectively with other service providers.

Notes and Examples: Shared care with General Practitioners and private psychiatrists, other opinions from within the MHS.

11.4.C.13 Where appropriate, the MHS actively promotes adherence to medication through negotiation and the provision of understandable information to the consumer and, with the consumer's informed consent, their carers.

11.4.C.14 Wherever possible, the MHS does not withdraw support or deny access to other treatment and support programs on the basis of a consumer's decision not to take medication.

11.4.C.15 Documented policies and procedures exist and are used to achieve the above criteria.

11.4.C.16 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Notes and Examples: *The MHS continually monitors and reviews occasions of adverse reactions to medication requiring urgent attention.*

Cross References: Rights (1), Safety (2), Cultural Awareness (7), Integration (8), Treatment & Support (11.4), and Planning for Exit (11.5)

Standard 11.4.D - Therapies

The consumer and the consumer's family/carer have access to a range of safe and effective therapies.

Criteria

11.4.D.1 Therapies offered or recommended by the MHS reflect best available evidence and are conducted by appropriately qualified and experienced mental health professionals.

11.4.D.2 The MHS provides access to a range of accepted therapies according to the needs of the consumer and their carers.

Notes and Examples: The MHS should provide the therapies or refer to another service provider; group and individual methods, psycho-therapeutic, psycho-educational, family centred, rehabilitative and supportive therapies might be provided.

11.4.D.3 The extent to which therapies are directly provided by the MHS is determined according to the assessed need of the defined community and the documented priorities of the MHS.

Notes and Examples: Priority towards people with greatest distress, dysfunction and disability, documented in policies and procedures and strategic plan. The priorities of the MHS should reflect national mental health policies.

11.4.D.4 The consumer is supported to make an informed choice on the most acceptable form of therapy from the range available.

Notes and Examples: Information provided in a variety of languages and a variety of media.

11.4.D.5 The consumer is informed by the MHS of the potential benefits, potential adverse effects, financial costs and any other foreseeable inconvenience associated with the provision of a particular therapy.

Notes and Examples: Use of interpreters to facilitate understanding and informed decision making.

11.4.D.6 The MHS promotes continuity of care for consumers referred outside the MHS for a particular therapy.

Notes and Examples: Liaison with the service provider, shared care arrangement, follow-up contact to consumer and, with the consumer's informed consent, the consumer's carers.

11.4.D.7 Therapies provided by the MHS are provided in an environment which is safe, private, comfortable and affords minimal disruption.

11.4.D.8 Documented policies and procedures exist and are used to achieve the above criteria.

11.4.D.9 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Notes and Examples: The MHS continually monitors and reviews consumer and carer unmet demand for specific therapies.

Cross References: Privacy & Confidentiality (5), Cultural Awareness (7), Integration (8), Service Development (9), Documentation (10), Treatment & Support (11.4), and Exit & Re-Entry (11.6)

Standard 11.4.E - Inpatient Care

The MHS ensures access to high quality, safe and comfortable inpatient care for consumers.

Criteria

11.4.E.1 The MHS offers less restrictive alternatives to inpatient treatment and support provided that it adds value to the consumer's life and with consideration being given to the consumer's preference, demands on carers, availability of support and safety of those involved.

Notes and Examples: Community based acute care programs, respite, separate settings for consumers with acute and sub-acute disorders.

11.4.E.2 Where admission to an inpatient psychiatric facility is required, the MHS makes every attempt to promote voluntary admission for the consumer.

11.4.E.3 The MHS ensures that a consumer who requires involuntary admission is conveyed to hospital in the safest and most respectful manner possible.

Notes and Examples: Conveyed by carer, conveyed by case manager or delegate, conveyed by ambulance and/or police with case manager or delegate present, minimal sedation and restraint.

11.4.E.4 The MHS ensures that the admission assessment includes the views of other current service providers and the consumer's carers.

Notes and Examples: Joint assessment with case manager, contact initiated to General Practitioner, carer, private psychiatrist, regular visits to inpatient unit by case manager.

11.4.E.5 The MHS ensures that there is continuity of care between inpatient and community settings.

Notes and Examples: Case manager or delegate is involved in admission, treatment and discharge planning, case manager or delegate visits the consumer regularly whilst in hospital, single point of clinical and administrative accountability between settings, utilisation of staff across settings, single clinical record, involvement of carer in admission and discharge planning and involvement of other service provider in admission, treatment and discharge planning.

11.4.E.6 As soon as possible after admission, the MHS ensures that consumers receive an orientation to the ward environment, are informed of their rights in a way that is understood by the consumer and are able to access appropriate advocates.

Notes and Examples: Consumer advocates, consumer consultants, clergy, legal representation, tour of the ward and introductions, introduction to key worker/case manager, treating doctor, information available in variety of languages and variety of formats.

11.4.E.7 The MHS assists in minimising the impact of admission on the consumer's family and significant others.

Notes and Examples: Care of dependent children, support for extended family, mother and baby units or other provision for parenting, arrangements for care of pets.

11.4.E.8 The MHS ensures that the consumer's visitors are encouraged.

Notes and Examples: Private, safe and comfortable meeting space, access to means of contacting visitors, flexible visiting times, accommodation for visitors travelling long distances and play space for children.

11.4.E.9 The MHS ensures that there is a range of age appropriate day and evening activities available to consumers within the inpatient facility.

11.4.E.10 The MHS provides opportunities for choice for consumers in regard to activities and environment during inpatient care.

Notes and Examples: Choice about waking and retiring times, diet, day and evening activities, access to smoking or non-smoking outdoor areas, clothing and self care regimes.

11.4.E.11 The MHS seeks regular feedback from consumers on the activities and environment associated with inpatient care.

11.4.E.12 The MHS, where appropriate, enables consumers to participate in their usual religious and/or cultural practices during inpatient care.

Notes and Examples: Prayer rituals, dietary requirements, visitors, gender issues, contemporary healing methods.

11.4.E.13 Consumers and their carers have the opportunity to communicate in their preferred language.

Notes and Examples: Use of interpreters, bilingual counsellors, visual and hearing impaired people using appropriate communication aids.

11.4.E.14 The MHS provides a physical environment for inpatient care that ensures protection from harm, adequate indoor and outdoor space, privacy, and choice.

Notes and Examples: Indoor and outdoor environments, separate space for consumers with acute and sub-acute disorders, lockable cupboard for personal possessions, segregation/ specialised units on the basis of gender and/or age, monitored seclusion, flexible access to personal space such as bedroom, complies with building codes and guidelines.

11.4.E.15 Documented policies and procedures exist and are used to achieve the above criteria.

11.4.E.16 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement performance as part of a quality improvement process.

Notes and Examples: The MHS continually monitors and reviews episodes of acute inpatient care.

Cross References: Rights (1), Safety (2), Privacy & Confidentiality (5), Integration (8), Documentation (10), Assessment & Review (11.3), Treatment & Support (11.4) and Planning for Exit (11.5).

Standard 11.5 - Planning for Exit

Consumers are assisted to plan for their exit from the MHS to ensure that ongoing follow-up is available if required.

Criteria

11.5.1 Each consumer's documented individual care plan includes an exit plan which is begun during entry to the MHS to ensure ongoing continuity of care once the consumer has exited from the MHS.

Notes and Examples: Details that should be included in the exit plan: preferred ongoing health care provider (ie: General Practitioner, Private Psychiatrist), community resources likely to be required, other people likely to be involved, other details as identified by the consumer and/or carer and consumer's preferred method of evaluating outcome of care for the consumer. The exit plan is commenced during entry to the MHS and developed during assessment, delivery of care and review of care throughout the consumer's contact with the MHS.

11.5.2 The exit plan is reviewed in collaboration with the consumer and, with the consumer's informed consent, their carers at each contact and as part of each review of the individual care plan.

11.5.3 The exit plan is made available to consumers and, with the consumer's informed consent, their carers and other nominated service providers.

11.5.4 The consumer and their carers are provided with understandable information on the range of relevant services and supports available in the community.

Notes and Examples: Information provided might be in the form of a booklet available in a language understood by the consumer and family / carer, verbal information relayed with the assistance of appropriately trained interpreters and formal introductions to various community agencies.

11.5.5 A process exists for the earliest appropriate involvement of the consumer's nominated service provider.

Notes and Examples: Shared care arrangements with General Practitioners private psychiatrists and non-government organisations.

11.5.6 The MHS ensures that consumers referred to other service providers have established contact and that the arrangements made for ongoing follow-up are satisfactory to the consumer, their carers and other service provider prior to exiting the MHS.

Notes and Examples: Contact between MHS, consumer, carers and other nominated service providers; case manager accompanies consumer to first meeting with other service provider and satisfaction surveys.

11.5.7 All services provided by the MHS are planned and delivered on the basis of the briefest appropriate duration of contact consistent with best outcomes for the consumer.

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

11.5.8 Documented policies and procedures exist and are used to achieve the above criteria.

11.5.9 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Notes and Examples: The MHS continually monitors and reviews exit plans contained in the individual care plan.

Cross References: Integration (8), Inpatient Care (11.4.E), and Promoting Community Acceptance (4)

Standard 11.6 - Exit and Re-entry

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

Criteria

11.6.1 Staff review the outcomes of treatment and support as well as ongoing follow-up arrangements for each consumer prior to their exit from the MHS.

Notes and Examples: Measurement of change in health status, satisfaction with service, perception of quality of life, review of goals in individual care plan, peer review, case discussion and methods used to evaluate outcomes include the consumer's preferredmethods as identified in the Exit Plan.

11.6.2 The MHS ensures that the consumer, their carers and other service providers and agencies involved in follow-up are aware of how to gain entry to the MHS at a later date.

11.6.3 The MHS ensures that the consumer, their carers and other agencies involved in follow-up, can identify an individual in the MHS, by name or title, who has knowledge of the most recent episode of treatment and/or support.

Notes and Examples: Most recent case manager, key worker, primary care provider, intake officer, team leader.

11.6.4 The MHS attempts to re-engage with consumers who do not keep the planned follow-up arrangements.

11.6.5 The MHS assists consumers, carers and other agencies involved in follow-up to identify the early warning signs which indicate the MHS should be contacted.

Notes and Examples: Symptoms of pending relapse (sometimes called "relapse signatures") and an accompanying relapse management plan.

11.6.6 The MHS ensures that the individual clinical record for the consumer is available for use in any potential future contact with the MHS.

11.6.7 Documented policies and procedures exist and are used to achieve the above criteria.

11.6.8 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Notes and Examples: The MHS continually monitors and reviews the frequency and reasons for unexpected re-entry into the MHS within six months of exit.

Cross References: Integration (8), Access (11.1), Entry (11.2) and Planning for Exit (11.5).

Section 3 - Glossary of Terms

advocates	People who have been given the power by consumers to speak on their behalf, who represent the concerns and interests of the consumer as directed by the consumer. Although governments and others may give power to advocates, such advocacy is token unless it is directly accountable to the consumer. *Mental Health Statement of Rights and Responsibilities, Australian Government Publishing Service, 1991*
appropriately qualified and experienced mental health professional	An individual with recognised qualifications and experience which enable them to provide appropriate treatment and support to the consumer and their carers. The degree of formal training and expertise required will be determined by factors such as the degree of specialisation required/ available (eg: staff specialising in child and adolescent mental health), the needs of the defined community (eg: Aboriginal and Torres Strait Islander mental health staff, ethnic health workers) and the type of services being delivered (acute care, residential support, drop-in, rehabilitation). (For example: might be a recognised health professional with qualifications in psychiatry, medicine, psychology, occupational therapy, social work, mental health nursing, teaching or a person with limited formal qualifications but with relevant experience such as a consumer, carer, tradesperson).
assessment	The systematic and ongoing evaluation of information about a consumer in order to ascertain his / her diagnosis, needs and desired outcomes of care. Assessment forms the basis for the development and review of an individualised care plan in collaboration with the consumer, their family, carers and significant others.
care	All services and interventions provided to a person with a mental disorder and/or mental health problem by health and other sectors, community organisation, family and carers.
care environment	The environment in which the MHS delivers treatment and support. It could be a living skills centre, a psychiatric inpatient unit, community centre, school or hostel.

carer	A person whose life is affected by virtue of his or her close relationship with a consumer, or who has a chosen and contracted caring role with a consumer. *Mental Health Statement of Rights and Responsibilities, Australian Government Publishing Service, 1991* Carer, in this document, may also refer to the consumer's identified family, including children and parents, as well as other legal guardians and people significant to the consumer It is also acknowledged that for some people their carer may be their community.
case manager	An identified and accessible staff member of the mental health service who is responsible for coordinating the treatment and support provided to an individual consumer and their carers. (For example: might also be called a case coordinator, key worker, case worker).
clinical indicator	A measure of the clinical management and outcome of care; a method of monitoring care and services, which attempts to flag' problem areas, evaluate trends and so direct attention to issues requiring further review. *The EQuIP Guide, The Australian Council on Healthcare Standards (ACHS), 1996*
community living	The ability of the consumer to live independently in the community with the best possible quality of life.
consumer	A person making use of, or being significantly affected by a mental health service. *Mental Health Statement of Rights and Responsibilities, Australian Government Publishing Service, 1991*
continuity of care	The provision of barrier-free access to the necessary range of health care services, across hospital, community and other support services, over any given period of time with the level of support and care varying according to individual needs.
defined community	The community to which the mental health service provides treatment and support. (For example: it might be a catchment area population, privately insured population, state wide population, specific cultural group within the population)
disability	A disability is any restriction or lack of ability to perform an activity within the expected range for a human being. *Mental Health Statement of Rights and Responsibilities, Australian Government Publishing Service, 1991*
disability support service	A range of service responses which enable the individual to live as independently as possible and be included in the ordinary life of their community.

entry process	The process provided by the mental health service which assists the consumer and their carers to make contact with the mental health service and receive appropriate assistance.
exit	When the consumer no longer requires treatment, support or any other service from the mental health service, and there has been alast review of the case with peers and the case is closed. Exit is prepared for in a collaborative manner with the consumer. This may be referred to as discharge in some services.
family	The family of the consumer.
individual care plan	A documented set of goals collaboratively developed by the consumer and the MHS (usually the case manager). The individual care plan sets the direction for treatment and support, identifies necessary resources and specifies outcomes for the consumer. It is recorded in the consumer's individual clinical record.
informed consent	Informed consent is consent obtained freely, without coercion, threats or improper inducements, after questions asked by the consumer have been answered, after appropriate disclosure to the patient, adequate and understandable information in a form and language demonstrably understood by the patient. Such answers and disclosures must be sufficient to enable the consumer to make a fully informed decision based on all relevant factors including the nature of treatment involved, the range of other options and the possible outcomes and implications for the consumer and others. *Adapted from the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, June 1992 with the assistance of the Mental Health Legal Centre (Vic).*
initial contact	The first time the consumer makes contact with the mental health service during any episode of care.
integrated mental health service	A mental health service which brings together a number of components into a unified system which ensures continuity of care for consumers. These components include: ■ a unified management system between inpatient and community services, ■ a case management system, ■ a single point (or process) of entry into the service, ■ multidisciplinary teams, ■ active involvement of consumers and carers, ■ specialist crisis intervention, assessment, acute care, ongoing care and rehabilitation care across the consumer's lifespan.

links	The formal and informal aspects of the relationship between the mental health service and another service provider, agency or sector.
medication and other medical technologies	The range of evidence based therapeutic and diagnostic approaches which use medication and other technology as their basis. (For example: might include ECT, seclusion)
mental disorder	A mental disorder may be defined as a significant impairment of an individual's cognitive, affective and/or relational abilities which may require intervention and may be a recognised, medically diagnosable illness or disorder. *Mental Health Statement of Rights and Responsibilities, Australian Government Publishing Service, 1991*
mental health	Mental health is the capacity of individuals within the groups and environment to interact with one another in ways that promote subjective well being, optimal development and use of mental abilities (cognitive, affective and relational) and achievement of individual and collective goals consistent with justice. *Mental Health Statement of Rights and Responsibilities, Australian Government Publishing Service, 1991*
mental health problem	A mental health problem is a disruption in the interactions between the individual, the group and the environment producing a diminished state of mental health. *Mental Health Statement of Rights and Responsibilities, Australian Government Publishing Service, 1991*
mental health service	An organisation that provides, as its core business, primary, secondary and, in some cases, tertiary treatments and support to people with mental disorders and/or mental health problems. A mental health service should be specialised and complimentary to other health services.
operational plan	A plan on a short term basis that provides details of how the strategic plan will be accomplished.
other service provider	Another organisation or individual practitioner who provides a direct health or welfare service to the consumer.
people of non-English speaking background	A person, or the offspring of a person born in a country where English is not the first language.
program	A part or function of the mental health service such as the rehabilitation team, health promotion unit, the crisis team, the living skills centre or inpatient psychiatric unit. (For example: some mental health services have only one team which performs all these functions)

psychiatric inpatient unit	A ward/unit/facility in a general hospital, private psychiatric hospital, stand alone psychiatric hospital or some other location used primarily for the treatment of mental disorders and / other mental health problems. (For example: might also be called a special care suite or ward in a house)
quality improvement process	A process which measures performance, identifies opportunities for improvement in the delivery of care and services, and includes action and follow-up.
service evaluation	A systematic evaluation of the performance of the mental health service, in full or in part, using relevant and accepted methods. (For example, could be a description of service activity, consumer satisfaction with the service, monitoring of individual health outcomes for consumers)
significant others	Those people that the consumer identifies as being significant in their life.(For example: might be a friend, family, clergy, employer)
strategic plan	A plan that is organisation-wide, establishes an organisation's overall objectives; and seeks to position the organisation in terms of its environment.
support	Direct services and interventions provided to a person with a mental disorder and/or mental health problem and associated disability aimed at reducing handicap and promoting community tenure (eg: assistance with cooking and cleaning). Support services do not necessarily have a treatment or rehabilitation focus.
therapies	The range of therapeutic approaches which reflect best available evidence and are used in mental health care (excluding medication and other medical technologies). (For example: could include psycho-therapeutic, psycho-educational, rehabilitative, collaborative approaches using individual and/or group methods)
treatment	Specific physical, psychological and social interventions provided by health professionals aimed at the reduction of impairment and disability and/or the maintenance of current level of functioning.
triage	A system for determining the relative priority of new referrals. (For example: might also be called intake, or on call or engagement)

Section 4 - Index

Section 5 - References

The full Literature Review for the Project can be found in Volume 3 - The Supplementary Report.

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Section 6 - Worksheets

The sample worksheet that follows is an example of a simple self-evaluation tool that mental health services could use in conjunction with these standards and the rating scale described in Section 1 of this volume.

Criteria Name and Number (List the name and number of the criteria as it is found in the standards - eg: Rights 1.2) Tick the appropriate rating	**RATING ***					**How could the MHS improve?** (Identify what the MHS needs to do in order to attain the criteria at the next review and how progress will be fed back to those concerned)	**Who is the person responsible?** (Identify the person(s) responsible for ensuring attainment of the criteria at the next review and reporting progress)	**When will the next review of this criterion occur?** (State a date by which improvement with the criteria could be expected and progress reported)
	A	AP	AI	UA	NA			

* A - Attained; AP - Attained Partially; AI - Attainment Initiated; UA - Unattained; NA - Not Applicable.
For further explanation, please refer to Section 1 - Introduction

Notes

Notes

Notes

Criteria Name and Number (List the name and number of the criteria as it is found in the standards - eg: Rights 1.2) Tick the appropriate rating	**RATING** *					**How could the MHS improve?** (Identify what the MHS needs to do in order to attain the criteria at the next review and how progress will be fed back to those concerned)	**Who is the person responsible?** (Identify the person(s) responsible for ensuring attainment of the criteria at the next review and reporting progress)	**When will the next review of this criterion occur?** (State a date by which improvement with the criteria could be expected and progress reported)
	A	AP	AI	UA	NA			

* A - Attained; AP - Attained Partially; AI - Attainment Initiated; UA - Unattained; NA - Not Applicable.

For further explanation, please refer to Section 1 - Introduction

National Standards for Mental Health Services