

# Standard 10. Delivery of care

## 10.1 SUPPORTING RECOVERY

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

### GUIDELINES

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

#### **Recovery-oriented culture and practices (Criterion 10.1.1)**

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

- a mission statement identifying recovery processes and outcomes
- policy statements and guidelines providing recovery-based principles for service delivery
- quality improvement that is developed, implemented and monitored in collaboration with consumers and carers
- staff selection, training and supervision according to recovery values and with consumer and carer involvement
- whole-of-service commitment to responding to cultural differences and Indigenous uniqueness
- stigma and discrimination free practices.

Principles of Recovery Oriented Mental Health Practice include:

- uniqueness of the individual
- real choices
- attitudes and rights
- dignity and respect
- partnership and communication
- evaluating recovery.

(Details of these principles can be found at the back of the National Standards.)

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

Every individual has worth and deserves respect, dignity and effective care. A focus on the consumer's recovery and participation in their own care can facilitate this. Respect and dignity is mandatory regardless of culture, social context, residence or the service setting, particularly in remote Australia.

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

In a recovery model, the aim is to have consumers take responsibility for themselves. This can be achieved by instilling hope, re-establishing a positive identity and self esteem, healing, empowerment, and connection by applying the principles of human rights, providing a positive culture of healing, and culturally informed recovery-oriented services.

Responsibility for self can be achieved by supporting the consumer to:

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

It is important that practitioners working in Aboriginal and Torres Strait Islander settings know how to access appropriate information and identify consumers' strengths and abilities.

The MHS should give consumers and their carers simple and easy to understand information in the appropriate language. This should include information on:

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

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

*10.1.4 The MHS should encourage and support consumer and carer autonomy.*

Autonomy should be understood in a social and cultural context, particularly for Indigenous consumers and carers. Services and practitioners should have access to training resources which explore autonomy in contexts appropriate to Aboriginal and Torres Strait Islander people and suggest ways to support this in local practice.

*10.1.6 The MHS can assist consumers to develop independence and regain self direction, understanding and control of their illness through:*

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

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

Examples of strategies that the MHS can use to promote the rights of individuals with mental illness to social inclusion and citizenship include:

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

- encouraging and supporting consumers to become advocates (further information on advocacy is available in Standards 1 Rights and responsibilities and 3 Consumer and carer participation)
- providing information to consumers that is easy to understand about how they are protected by disability and mental health legislation
- ensuring practitioners know about, and can engage with, relevant work, recreational and family-focused agencies and activities in Aboriginal and Torres Strait Islander settings, including both conventional and traditional activities and practices.

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

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

The responsibility for leading community integration activities should be designated to specific MHS staff.

The MHS should work collaboratively with consumers to develop and review the consumer's goals for re-connecting with the community, consistent with cultural processes and social constraints.

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

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

Location should not compromise efforts and resources to support social inclusion in rural and remote settings.

### **Participation of consumers (Criterion 10.1.8)**

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

In Aboriginal and Torres Strait Islander settings the MHS must ensure individual participation of consumers and carers, and provide support for developing and running consumer and carer representative groups at regional and local levels.

## **Community services and resources (Criterion 10.1.9)**

The MHS should be aware of community services that may support consumers. These could include:

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

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

Carer centered approaches may include:

- involving the carer in treatment and support
- providing culturally informed carer education regarding the relevant mental illness
- training the carer in family communication and problem solving skills
- providing counselling and ongoing support for the carer
- offering support for children of parents with a mental illness
- facilitating contact with relevant support or self-help groups.

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

## SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- an organisational mission statement
- evidence of the organisation's commitment to cultural competence and cultural safety
- information and education being provided to consumers and carers
- links with other service providers
- consumer and carer satisfaction surveys
- treatment, care and recovery plans
- consumer and carer interviews
- evidence of access to consumer-run groups
- evidence of referrals to recovery support programs
- evidence of follow-up
- policies and procedures covering:
  - principles for service delivery
  - cultural safety
  - staff selection
  - training and supervision
  - working with carers
  - education programs
  - referral processes
  - consumer and carer support systems.

## 10.2 ACCESS

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

### GUIDELINES

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

#### Identified needs (Criterion 10.2.1)

The MHS needs to pay particular attention to the diversity of its consumers including Aboriginal and Torres Strait Islander persons, culturally and linguistically diverse (CALD) persons, religious and spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age, legal status and socio-economic status.

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

Access should be regularly monitored to ensure that it is timely, equitable and meets the identified needs of its community. The monitoring process includes seeking feedback from consumers, carers and the community regarding access to the MHS.

Data on waiting times to access the MHS should be analysed and strategies should be developed and implemented to reduce the number of consumers on the waiting list.

The MHS can provide evidence of facilitating access to services through such means as:

- formal links with relevant community groups and other service providers
- use of appropriately trained interpreters or cultural brokers
- staff orientation and ongoing training that includes training about the access process and relevant cultural considerations
- liaison services
- use of technology to improve access (such as Telehealth which provides online medical services).

The MHS should facilitate access to transport where necessary taking into account the capacity of the service and the consumer / carer needs in accordance with relevant legislation and guidelines. The location of services, such as the proximity to transport hubs and / or shopping centres should also be considered.

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

The process of access should be made known to consumers, carers, relevant stakeholders, other agencies and service providers. There should be a documented procedure for disseminating information on the access process to consumers, carers and other service providers.

The MHS should provide information on access to services through prominently displayed posters, brochures and video or multimedia. This information should also be available through the website or via email, fax or post on request. In Indigenous settings this information should be culturally informed and appropriately written for the target population.

### **After-hours care (Criterion 10.2.3)**

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

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

- an information pamphlet with after-hours emergency contact numbers and location of after-hours mental health services in a format that is understandable to consumers and carers
- information on availability of tele-psychiatry or an after-hours telemedicine service provided by a mental health nurse for remote locations
- national or state telephone-based services capable of providing culturally appropriate advice.

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

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

Service settings in Indigenous communities should be designed with an understanding of local cultural expectations.

The MHS should facilitate access to transport where necessary, taking into account the capacity of the service and consumer needs.

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

## SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- consumer survey results
- information sheets, brochures or posters
- clear signage, accessible physical entry points
- consideration of cultural factors in the built, clinical environment
- data on waiting times
- use of technology, such as multimedia information kiosks and telehealth services
- evidence of provision of after-hours emergency contact information for consumers
- Policies and procedures covering:
  - after-hours access
  - transport assistance
  - dissemination of information on access to the service.

## 10.3 ENTRY

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

## GUIDELINES

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

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

The MHS should have a documented entry policy and procedure which includes:

- the system of on call, entry and assessment
- how to ensure the needs of Aboriginal and Torres Strait Islander persons, culturally and linguistically diverse (CALD) persons are met and that religious and spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age and socio-economic status are addressed in the entry process

- the use of interpreters
- assessing the specific needs of the consumer in terms of the type of services required
- the process of making alternative arrangements and a smooth transition of care to a more appropriate MHS if the MHS accessed cannot provide this service.

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

The MHS should have a procedure for disseminating information on the entry process to consumers, carers, and other service providers. This can be done through such activities as mail outs of posters and brochures, providing online information, interagency liaison and regular liaison with referral sources.

Posters and brochures that provide information on the entry process should be prominently displayed in every facility of the MHS and also made available on the MHS website and via email, fax or post on request.

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

Prioritisation of referrals varies, depending on the service and the sector. The MHS can routinely monitor its 'non-accepted' referrals and review procedures where necessary.

The MHS needs to be able to formally identify who is responsible for monitoring and evaluating compliance with entry policies and procedures.

### **Defined pathway for entry into the MHS (Criterion 10.3.4)**

The MHS should have one entry point for each service it delivers.

For mental health services that have multiple sites, the system of on call, entry and assessment needs to be coordinated by the appropriate staff or governing body.

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

The MHS should be able to provide evidence that the individual consumer health record and treatment, care and recovery plan was started when the consumer entered the service. The means of entry to the service should be recorded in the consumer's health record.

The MHS contacts health professionals involved in earlier episodes of care to obtain relevant information as soon as practicable after the consumer enters the MHS. Evidence that the MHS attempted to obtain information on any earlier episodes of care should be documented in the consumer's individual health record.

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

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

For some consumers, voluntary or involuntary status can change within the same admission period to an inpatient facility. The MHS should have protocols available that encourage voluntary status where this does not pose a risk to the consumer, carer, visitors or staff.

The MHS should offer counselling and debriefing for consumers and carers who are admitted as involuntary patients.

Providing a counselling and debriefing service to consumers and carers may not always be appropriate during the admission stage but it is imperative that this occurs during the period of care.

The MHS and relevant evacuation agencies operating in rural and remote settings (such as police, ambulance or the Royal Flying Doctor Service) should ensure they have clear guidelines consistent with the relevant legislation. Whenever involuntary evacuation of a consumer is undertaken carers and other relevant community members should be engaged as early in the process as possible to ensure understanding and cooperation. Feedback to this group should also be guaranteed.

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

On entry to the MHS an interim or permanent person responsible for the coordination of care is appointed to the consumer. The consumer and the carer should be advised of who this person is and any changes should be made known to the consumer and the carer.

The MHS must ensure that in Indigenous settings where there are no resident MH practitioners, there is an identified person (usually within the primary care centre) and a process to ensure that all case management issues and decisions can be directly and appropriately conveyed to consumers and carers.

## **SUGGESTED EVIDENCE**

Evidence that may be provided for this standard includes:

- information on entry criteria
- evidence of dissemination of information
- posters and brochures
- a health record review, including referrals and previous treatment
- evidence of coordination with other sites

- treatment, care and recovery plans
- policies and procedures covering:
  - the referral process
  - triage
  - the entry process, including inclusion and exclusion criteria
  - safe transport
  - evacuation protocols
  - mechanisms for review.

## 10.4 ASSESSMENT AND REVIEW

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

### GUIDELINES

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

Examples of appropriate information include:

- history of previous mental health problems
- medical history
- details of present health
- functional and emotional status, including the consumer's ability to communicate and care for themselves
- cultural and social history and cultural formulation of diagnosis when required
- level of risk the consumer presents to themselves and others
- the consumer's perception of their needs, desired outcomes and their expectations of service delivery
- details of available carer support after the consumer exits the MHS

- consumer's knowledge of how to maintain a healthy lifestyle and reduce the risk of mental health problems
- consumer's economic situation, social circumstances and level of education
- individual needs of the consumer and carers that may affect service delivery
- diagnosis
- education about the disease
- range of treatments available
- information about alcohol, tobacco and other drug (ATOD) services
- crisis intervention plan
- available treatment settings (wherever possible treatment should be administered in a setting of the consumer's choice)
- evaluation of treatment options
- treatment consent forms signed by the consumer and appropriate MHS staff
- details of integration of care with other providers
- service exit plan.

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

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

Owing to the high rates of clients with ATOD concerns, services could benefit from using a self-audit baseline assessment such as COMPASS, to address co-morbid ATOD issues in a more comprehensive, integrated manner. A further self audit could be carried out after 12 months, for example. Services could also benefit from using a validated screening tool related to ATOD use.

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

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

The consumer's preferred setting for assessment could be a home visit rather than in the community mental health centre, emergency department or psychiatric unit. The MHS may use the telephone or video to conduct assessments in situations where face-to-face assessment is not possible due to distance or the consumer's preference.

The MHS should consider using, and documenting, the use of an interpreter, particularly in remote Indigenous settings. Collateral informants should regularly be consulted and their use documented.

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

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

When discharge planning begins early in the admission to inpatient care, the planning is more efficient. Time to communicate and consult with the consumer, the carer and other health care professionals will facilitate continuity of care after the consumer is discharged.

Discharge planning for Indigenous clients must involve inpatient staff, relevant outpatient MHS staff, representatives of the primary care service in the community to which the consumer will return and relevant carers or family.

### **Review (Criteria 10.4.5, 10.4.6)**

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

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

Evidence of an assessment review should be recorded in the consumer's individual health record.

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

### **Follow-up (Criterion 10.4.7)**

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

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

The treatment, care and recovery plan is developed with input from the consumer, carer, the person responsible for the coordination of care and other service providers. It should contain the details of treatment provided and the expected outcomes. It should ensure continuity of care and complement

treatment, care and recovery plans developed by other service providers. The plan should be consistent with the consumer's culture and education. Involvement of carers or cultural brokers should be documented.

Existing carer relationships and the capacity, willingness and needs of the carer should be considered when developing the treatment, care and recovery plan. This ensures that the necessary supports are put in place for the consumer.

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

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

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

## **SUGGESTED EVIDENCE**

Evidence that may be provided for this standard includes:

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

## 10.5 TREATMENT AND SUPPORT

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

### GUIDELINES

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

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

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

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

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

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

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

In rural and remote settings practitioners must ensure processes for frequent monitoring (through primary care or wellbeing services) to identify and respond to Aboriginal and Torres Strait Islander consumer needs.

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

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

Information about the purpose, importance, benefits and risks of proposed treatments needs to be provided to the consumer. This information should be delivered in an appropriate language and media, such as verbal and written information in the relevant language. The service should use family or cultural brokers when necessary.

In private MH services, this information is usually provided by the treating clinician. Where this has occurred, the consumer's health record should show that the treating clinician has provided this information to the consumer.

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

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

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

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

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

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

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

Appropriate ethical authorisations need to be obtained before consumer's can participate in clinical trials and experimental treatments. In the case of Aboriginal and Torres Strait Islander consumers, this should include the NHMRC guidelines for research in Indigenous populations and clearance by state-based Indigenous research ethics committees.

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

Individual consumer needs should be taken into account when determining the least restrictive environment. The environment should enable effective treatment to occur, while ensuring safety and protection of other consumers, staff, visitors and members of the public.

Further information on the least restrictive environment is available from the guidelines of Standards 1 Rights and responsibilities and 6 Consumers.

Because restrictive practices (Mental Health Authority provisions and depot medications) are used more frequently in Indigenous populations, particularly in rural and remote settings, all such decisions should be regularly reviewed and explained to both the consumer and relevant carers.

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

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

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

Strategies to promote adherence to treatment include:

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

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

## **Continuity of care (Criterion 10.5.9)**

The MHS should have in place systems for 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.

The MHS should ensure the involvement of other related service providers when making decisions regarding individual treatment of consumers.

Because of the burden of social adversity and comorbidity in some Aboriginal and Torres Strait Islander communities, diverse agencies and organisations are involved in ongoing care. The MHS should ensure coordination and communication across the services and sectors.

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

Medication forms part of the treatment strategies provided by the MHS and is intended to allow the consumer to function as well as possible while reducing their specific symptoms. Each prescription is documented. Each medication should be reviewed regularly including its appropriateness and any effects due to multiple medications and drug interactions.

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

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

There should be written evidence of appropriate treatment information including:

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

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

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

## **Self-care programs (Criteria 10.5.13, 10.5.14 and 10.5.15)**

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

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

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

A range of programs based on individual needs should be available. It is recognised 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.

In Aboriginal and Torres Strait Islander communities, practitioners should be aware of culturally informed self-care and allied programs (such as men's groups) and be able to help consumer access these resources. Practitioners should also be aware of the resources and services available for the wider community and how to access these programs when appropriate for specific Aboriginal and Torres Strait Islander consumers.

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

- the consumer's condition, including how to care for themselves after they leave the service
- how to follow the service plan and achieve the expected results
- how to use medications, supplies, and equipment in a safe and effective way
- how to develop the skills necessary to meet their own needs and become as independent as possible through self-care programs
- self care resources available from the MHS, other service providers and the internet
- improving and maintaining the consumer's overall health and wellbeing
- accommodation options

- employment options such as apprenticeships and traineeships
- peer-based support programs and services that promote recovery
- appropriate inpatient activity programs.

The MHS must ensure that access to appropriate programs is available and that this is in settings where consumers are not isolated. This is particularly relevant for rural and remote Aboriginal and Torres Strait Islander populations. This may require that carers are present or able to visit, or additional resources may be required for Aboriginal and Torres Strait Islander consumers to maintain community contact.

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

The MHS should explore accommodation options that suit the individual needs of the consumer. Factors to be considered include:

- proximity to primary care providers, family members and carers
- mobility
- visual and hearing impairment
- single sex accommodation
- space for family members where children are concerned.

Where supported accommodation is not provided by the MHS, there should be close collaboration between the MHS and the accommodation provider to facilitate access to other treatment and support programs.

MH services operating in areas with significant Aboriginal and Torres Strait Islander populations should ensure that supported and transitional accommodation options appropriate to Indigenous consumers are available. This includes flexible options in regional centres close to specialist and tertiary services, which are connected with in-community options.

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

Whenever possible the MHS should work with the consumer to find ways to access support programs. These programs should reflect the identified needs of each consumer taking into account their age, stage of development, physical health, and stage in their recovery process. Consumers should be able to choose support programs that are most suitable to them. Practitioners working in rural and remote settings should be aware of the available resources and ways to overcome any problems of location or social disadvantage.

Support programs include:

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

## SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- completed consent forms or copies of consent forms
- evidence treatment, care and recovery plans that diversity has been considered
- medication management and notification of adverse drug reactions
- access to, and availability of, evidence-based guidelines
- evidence that consumers and carers received treatment, care and recovery plans
- details on available support programs
- a review of the consumer's health record
- policies and procedures covering:
  - consent
  - research or clinical trials
  - medication management
  - guardianship
  - discharge planning
  - referral
  - shared care arrangements.

## 10.6 EXIT AND RE-ENTRY

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

### GUIDELINES

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

The consumer's exit from, follow-up and re-entry to the service is the joint responsibility of the private mental health service, the private psychiatrist and the general practitioner.

In rural and remote settings this responsibility demands involvement of the mental health service, the primary care service or Aboriginal and Torres Strait Islander community controlled organisation, and other relevant providers. This may include general practitioners.

### **Access and information on services (Criteria 10.6.1, 10.6.2)**

The consumer should be given formal introductions to various community agencies. Information provided could be in the form of a booklet in a language understood by the consumer and carer, or verbal information relayed with the assistance of interpreters. Any information or introductions should be given before the consumer leaves the service.

Given the limited services available in some rural and remote settings the MHS must keep an updated list of available services and activities and details of how they can help the consumer. This information should be easily accessible and understandable.

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

The exit plan should contain details of:

- the change in the consumer's health status
- the consumer's satisfaction with the service
- perception of quality of life
- a review of the goals in individual treatment, care and recovery plans

- a peer review
- case discussion and methods used to evaluate outcomes (including the consumer's preferred evaluation methods).

Where appropriate these approaches should use culturally adapted processes and resources.

Exit plans for child and adolescent and aged consumers need to consider issues specific to their demographic. For example, aged-care consumers transferring to a nursing home on leaving the MHS and exit plans for child and adolescent consumers are not usually discussed at entry to the MHS.

The MHS should help consumers and their families and carers identify early warning signs of a relapse. The exit plan should include details of symptoms of a pending relapse, sometimes called 'relapse signatures' and a relapse management plan.

Information in the exit plan should include details on:

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

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

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

To assist in the delivery of care detailed in the exit plan in shared care arrangements, information on the consumer should be provided in a timely manner and should include details of:

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

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

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

Due to the relatively high risk of suicide in the first four weeks after discharge and to prevent relapse, the MHS, in conjunction with the treating clinician, is required to follow-up wherever possible within seven days of the consumer being discharged from the service. Consumers flagged for follow-up are identified by a risk assessment performed prior to exiting the service.

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

Despite the greater likelihood of consumer mobility and remote residence, the MHS is responsible for ensuring timely and comprehensive follow up, regardless of location or circumstances, in collaboration with primary care and community controlled organisations.

## **SUGGESTED EVIDENCE**

Evidence that may be provided for this standard includes:

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