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H

From: Anne Brennan
To: Geppert, Leanne
Date: 11/27/2013 7:25 pm
Subject: Re: BAC Acute Admission

Sure. i will advise Laura

A/Clinical Director
Barrett Adolescent Centre
The Park-Centre for Mental Health
Ph 07 32718752

>>> Leanne Geppert 11/27/2013 7:24 pm >>>

Thanks Anne

Got your other message too - I think they should

Are you happy with this? L

Dr Leanne Geppert

-----Original Message-----

From: Anne Brennan

Cc: Elisabeth Hoehn <

Cc: Leanne Geppert <

To: Terry Stedman <

Sent: 27/11/2013 17:48:52

Subject: BAC Admission

Hi Terry

Anne

A/Clinical Director
Barrett Adolescent Centre
The Park-Centre for Mental Health
Ph

West Moreton Hospital and Health Service Barrett Adolescent Centre Clinical Oversight Meeting

File / Meeting Note

Date/Location:	4pm, 12 December 2013. Meeting with teleconference option.
Attendees:	<p>CHQ*: Assoc Prof Stephen Stathis (Clinical Director), Judi Krause (Executive Director, CYMHS), Dr Elisabeth Hoehn (Clinical Director)</p> <p>West Moreton: Sharon Kelly (ED, MHSS), Dr Anne Brennan (A/Clinical Director BAC), Dr Terry Stedman (Clinical Director, MHSS), Michelle Giles (Director Community MH and Allied Health), Dr Leanne Geppert (A/Director of Strategy)</p> <p>MHAODB: Dr Bill Kingswell (ED MHAODB)</p> <p>* Dr Peter Steer (CE, CHQ) joined first 15 mins of meeting</p>

Discussion:	<ol style="list-style-type: none"> 1. [REDACTED] 2. [REDACTED] 3. [REDACTED] 4. [REDACTED] 5. BAC operational funding to transfer to CHQ upon closure of BAC. All decisions re use of BAC operational funding will be jointly considered from this point forward between WM and CHQ. 6. Identification of potential risk to providing ongoing safe care by familiar staff at BAC over next 6 weeks: <ol style="list-style-type: none"> a. Investigation completed and next HR steps commenced, resulting in increased staff stress and likely increase in leave/resignations b. Some staff indicating alternative job offers and indicating resignations. 7. BAC school finished today.
Action Taken / Decisions:	<ol style="list-style-type: none"> 8. [REDACTED] 9. [REDACTED]

West Moberg Hospital and Health Service

Barrett Adolescent Centre Clinical Oversight Meeting

	<p>10. BAC Holiday Program to continue, even if no inpatients able to attend.</p> <p>11. BAC remains open until 26/1/13. If all inpatients are discharged from BAC in alignment with their individual transition plans before 26/1/13, the Centre will continue to function as a day centre to support the delivery of the Holiday Program until the closure date.</p>
Outcome:	<p>Anne Brennan</p> <p>12. [REDACTED]</p> <p>Leanne Geppert</p> <p>13. File note of this meeting.</p> <p>14. Draft joint WM and CHQ brief to respective CE's for approval to transfer \$ to respective HHSs to provide [REDACTED] care for [REDACTED]. [REDACTED] Copy to MHAODB.</p> <p>15. Draft DG to DG brief re [REDACTED]</p>

West Moreton Hospital and Health Service Barrett Adolescent Centre Consumer Meeting

File / Meeting Note	
Date / Location:	8:45am 18 December 2013. Meeting with teleconference option.
Attendees:	CHQ*: Dr Peter Steer (CE), Assoc Prof Stephen Stathis (Clinical Director), Ingrid Adamson (Project Manager SWAETR) West Moreton: Linda Hardy (A/CE), Dr Leanne Geppert (A/ED, MHSS), Dr Anne Brennan (A/Clinical Director BAC)

Discussion:

1. Current BAC inpatients – [REDACTED] This meeting called to discuss individual clinical transition plan [REDACTED] and the associated strategic actions to ensure plan is feasible.
2. [REDACTED]
3. [REDACTED]
4. Peter Steer concurred on these decisions.
If through the transition processes of other inpatients [REDACTED]
5. [REDACTED] All clinicians agreed to this plan, which was supported by executive staff in meeting.
6. [REDACTED]
7. Minister's Office (senior advisor) needs to be updated and briefed on discussions.
8. Urgent correspondence received from (Ms A Earls) through MD09 that needs to be addressed regarding young people being transitioned earlier than expected from BAC. Unanimous recommendation not to meet with Ms Earls – address via standard written correspondence pathway.
9. Key issues – a closure date was set as 2/2/14, however, clinical needs of inpatients will be the primary drivers associated with transition plans of individuals and it may be that there are no inpatients at a time prior to 2/2/14. The holiday program will be delivered as planned. There is no gap to service provision – the individual consumers are having their care needs met.

Action List:

10. Clinical decision made to [REDACTED]
11. [REDACTED]
12. [REDACTED]
13. Linda Hardy and Leanne Geppert to provide briefing to Lesley Dwyer.
14. Linda Hardy and Leanne Geppert to seek options for joint CHQ and WM briefing of the Minister's Adviser as a matter of urgency and communicate options. Briefing to be provided on the rationale behind decisions regarding consumers at BAC.
15. West Moreton and CHQ to formulate a response to urgent correspondence (Ms A Earls). Leanne Geppert to forward correspondence to Peter Steer.

J

West Moreton Hospital and Health Board

EXECUTIVE COMMITTEE MEETING AGENDA PAPER

Committee:	Executive Committee		
Meeting Date:	16 August 2013	Agenda Item Number:	2.1
Agenda Subject:	Barratt Adolescent Centre		
Action required:	<input type="checkbox"/> For Recommendation	<input type="checkbox"/> For Discussion	<input checked="" type="checkbox"/> For Noting
Author: Sharon Kelly	Position: ED Mental Health and Specialised Services		Date: 8/8/2013
<input checked="" type="checkbox"/> Recommendation/s are consistent with Strategic Plan <input checked="" type="checkbox"/> Funding impacts are included within approved budget <input checked="" type="checkbox"/> Risks are identified and mitigation/management strategies included <input checked="" type="checkbox"/> Implications for patient and/or staff care and well-being have been identified			

Proposal

That the West Moreton Hospital and Health Board Executive Committee:

Note current actions in relation to the implementation of the Barrett Adolescent Strategy

Background

1. Investigations into contemporary model of care for Adolescents requiring extended treatment and rehabilitation mental health care were commenced in November 2012 utilising a range of strategies
2. The Board supported in principle the recommendations of the Expert Clinical Reference Group at its May 2013 meeting with some further high level communication and risk mitigation strategies prior to progressing to announcement and implementation.
3. Progress presented to The Board July meeting and community announcement occurred by The Minister for Health, Mr Lawrence Springborg on Tuesday 6 August.

Key Issues or Risks

4. Communication Strategy
 - a. In depth communication plan developed for announcement with endorsement by strategic partners and the Minister's Office.
 - b. All steps in plan adhered to and undertaken within 3 days of announcement
 - c. Key notes :-
 - i. Staff were advised prior to announcement by ED MH&SS and Chief Executive WMHHS. Included in the meeting was the Department of Education Director and HR staff.
 - ii. All current consumers and their carers were individually spoken to prior to announcement publically with positive responses.
 - iii. Key themes were the positive response to the state-wide governance changes to Children Health Queensland; the commitment to ensure current and future consumers will be supported into contemporary models.
 - iv. Media has been underwhelming in negativity and all concerns raised by individuals are being attended to as a priority.
5. Patient discharge strategy:
 - a. All current consumers have an up to date discharge plan.
 - b. A number of consumers were identified for discharge over the next four months.
 - c. The treating team have already commenced discussions with each of the family carer's to identify what resources or care may be required by the consumer post December 2013.
 - d. Consumers on the wait list have been identified and correspondence provided outlining the process to occur.
 - e. Receiving HHS services are engaged in each of these consumers as well to identify what care or alternate services may be required post closure of the BAC facility.
 - f. Current negotiations are occurring with the Clinical Director regarding the appropriateness or requirement for short term admissions for some on the wait list.

Children's Health Queensland Hospital and Health Service

State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy

A/Chair:	A/Director of Strategy, Mental Health & Specialised Services WM HHS (LG)
Secretariat:	SW AETR Project Manager (IA)
Attendees	SW AETR Project Officer (LJ) A/Executive Director Office of Strategy Management, CHQ (DM) Director of Psychology, CHQ HHS (JS) [REDACTED] A/Divisional Director CYMHS CHQ HHS (PL) Operational Manager Alcohol, other Drugs & Campus, Mater (AT) [REDACTED] Nurse Unit Manager, Mental Health, Metro South HHS (JB) A/Clinical Director CYMHS (EH)
Conf Call	A/Director Planning & Partnership Unit MHAODB (MK)
Apologies	Divisional Director CYMHS CHQ HHS (JK) Clinical Director CYMHS CHQ HHS (SS) Clinical Services Program Manager, Metro South Addiction and Mental Health Service (RH) Queensland Alliance (RN)
Observers/ Guests:	Nil

Page 1 of 6

Item No	Topic	Action	Committee member	Due date
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	<p><i>Working Group 2 – BAC Transition</i></p> <ul style="list-style-type: none"> • Anne Brennan is going to chair this group • Currently there has been no decision made regarding transition of consumers. Any decision regarding the reduction in bed numbers and taking no further admissions will impact on the work this WG undertakes. No decision had been made at the time of this meeting. • The BAC Team have started the process of looking at consumer care plans for the future based on individual clinical care needs. • LG has suggested that this WG adopt an approach similar to that of a Complex Needs Panel (involving DETE, Housing, Communities and CYMHS clinical staff) specific to the individual. • Committee agreed to change the name of the WG to BAC Transition Panel • Terms of Reference – [REDACTED] raised an issue with confidentiality of consumer identity (specifically in Status Reports, Plans and Risk Management). LG confirmed that any reporting will not identify individuals – this is not about clinical risk to the consumer but rather risks of the initiative, e.g. reduction in bed numbers will create pressure on other service options, etc. • LG proposed to change the Panel membership to include BAC staff in the first instance and to involve other HHS representatives where they are involved in the treatment of a specific individual. The Committee supported this change. • LG also advised that she spoke to Darren Nellie (from the Wait List Team) and he has agreed to participate on the Panel, as required. 			
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Children's Health Queensland Hospital and Health Service

Item No	Topic	Action	Committee member	Due date
	<p>[REDACTED]</p> <p>Recommendation:</p> <ul style="list-style-type: none"> • [REDACTED] • WG2 renamed to BAC Consumer Transition Panel • WG2 membership altered to include BAC Staff only – HHS representatives will be involved on an 'as needs' basis. <p>[REDACTED]</p>	[REDACTED]		
	[REDACTED]	[REDACTED]		
	[REDACTED]	[REDACTED]		
	[REDACTED]	[REDACTED]		
4.	Matters for Decision			
	[REDACTED]	[REDACTED]		
	[REDACTED]	[REDACTED]		
	[REDACTED]	[REDACTED]		

Children's Health Queensland Hospital and Health Service

Item No	Topic	Action	Committee member	Due date
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
5.	Matters for Discussion			
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
6.	Standard Agenda Items			
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Children's Health Queensland Hospital and Health Service

[illegible]

Children's Health Queensland Hospital and Health Service

Item No	Topic	Action	Committee member	Due date
1	[REDACTED]	[REDACTED]		
2	[REDACTED]	[REDACTED]		
3	[REDACTED]	[REDACTED]		
4	[REDACTED]	[REDACTED]		
5	[REDACTED]	[REDACTED]		
6	[REDACTED]	[REDACTED]		
7	Matters for Noting	[REDACTED]		
8	For Information	[REDACTED]		

Next meeting Wednesday 9th October 2013, 9am – 10.30am, CYMHS Spring Hill.

ENDORSED BY:

Signature:

Date: /09/13

Name:

Position:

L



CO0914_23

Ms Kristi Geddes
Minter Ellison
PO Box 7844
WATERFRONT PLACE QLD 4001

Dear Ms Geddes

I refer to your letter to Dr John Allen, Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch dated 15 August 2014, in relation to Health Service Investigation – Barrett Adolescent Psychiatric Centre.

I have requested [REDACTED]

[REDACTED] These consumers had different transition plans that were based on their individual needs. It is also noted that a further consumer had [REDACTED]. The details of these consumers and a short summary is provided in attachment one.

[REDACTED] office will be providing all relevant information and records to your office and I request that acknowledgement of receipt is completed.

Should you require any further information in relation to this matter, I have arranged for [REDACTED] on telephone [REDACTED] to be available to assist you.

Yours sincerely

[REDACTED]

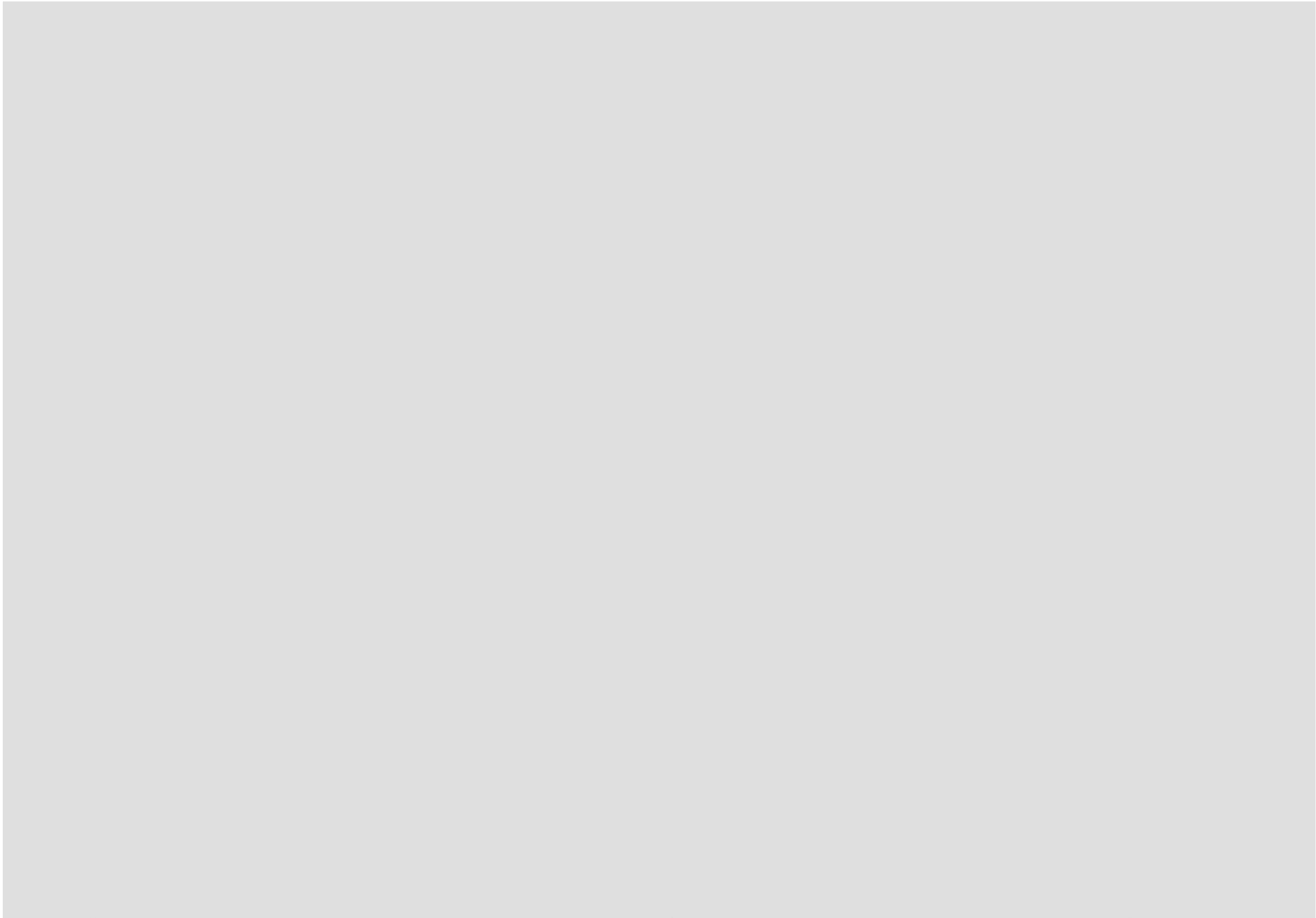
[REDACTED]

Office

Postal

Phone

	Date of Birth	Admission Date	HHS or Town of Residence (Last Recorded)	Information from
--	---------------	----------------	--	------------------



CY – Child and Youth
CL – Consultation Liaison
BAC – Barrett Adolescent Centre
ACU – Academic Clinical Unit
NGO – Non-Government Organisation
GP – General Practitioner

CCIMHA – Consumer Integrated Mental Health Application

Metro South HHS
03/09/2014

CONFIDENTIAL

M



Australian Government

NATIONAL
**mental
health**
strategy

National Standards for Mental Health Services

2010

National Standards for Mental Health Services 2010

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Australian Government

National Standards for Mental Health Services

2010

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Implementation guides

To accompany the National Standards for Mental Health Services there are three Implementation Guideline documents that provide more detail to inform the implementation of the Standards.

The implementation guides provide clear directions for mental health services on how the criteria of the Standards apply to different services.

The three guideline documents are aimed at the following service sector groups:

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

The guideline documents were developed with significant input and recommendations from the following areas:

- Alcohol, Tobacco and Other Drugs (ATOD)
- Aboriginal and Torres Strait Islanders
- Culturally And Linguistically Diverse (CALD)

The recommendations from these groups have been incorporated in an integrated fashion within each of the three implementation guideline documents.

An electronic copy of the implementation guideline documents can be found on the Mental Health Standing Committee website. These are available for downloading from this website at:

• <http://www.health.gov.au/mhsc>

Foreword

The National Standards for Mental Health Services (the Standards) were first introduced in 1996 to assist in the development and implementation of appropriate practices and guide continuous quality improvement in mental health services, which at that time were predominantly provided through State and Territory funded specialist clinical mental health services. They were welcomed by the service sector and were very influential in how services responded to the needs and expectations of consumers and carers.

Much has changed since then, with increased service provision in the community—both clinical and non-clinical, expansion of the non-government and private sectors, and greater focus on the role of the primary care sector in mental health. New services have been developed and funded through all levels of government.

In response to these changes, a review of the Standards was commenced in November 2006, in consultation with the sector, and with consumers and carers. The review consisted of a number of different phases and avenues of consultation. Significant effort was made to ensure the consultation was as inclusive as possible although it is acknowledged that some stakeholders would have preferred an even more extensive consultation process. The inclusion of a recovery standard is a new and welcomed addition. This standard in particular may further evolve as experience is gained in its implementation and measurement.

These National Standards for Mental Health Services focus on:

- how services are delivered
- whether they comply with policy directions
- whether they meet expected standards of communication and consent
- whether they have procedures and practices in place to monitor and govern particular areas—especially those which may be associated with risk to the consumer, or which involve coercive interventions.

All of the Standards, except the consumer standard, are designed to be assessed. In contrast, the consumer standard is designed to inform consumers about their rights and responsibilities and the key elements underpinning the provision of quality service that consumers can expect to receive from mental health service providers throughout the continuum of care. The consumer standard is therefore not intended to be assessed, as it contains criteria that are all assessable within the other standards.

The Standards have been developed to be applied across the broad range of mental health services. This includes bed based and community mental health services, those in the clinical and non-government sectors, those in the private sector and also those in primary care and general practice. They are not intended to apply to services where mental health is not the main focus of care, such as generic community services which support people with a range of disabilities, or generic aged care services. Other practice frameworks are more appropriately applied in those settings. However, when assessing the performance of a mental health service against the Standards, it will be necessary to do this within the context of the individual mental health service i.e. the expectations will vary depending on the service type and setting.

Consideration of the Standards should also be incorporated into the delivery of services such as indigenous health services, alcohol tobacco and other drug services (ATODS) and aged care services, where they are responsible for the delivery of mental health care within the service. The Standards apply to ATOD services that are part of a mental health service. For stand-alone ATOD services, mental health services should be able to demonstrate that they are developing or have collaborative / partnership arrangements in place to ensure integration and coordination of care for consumers.

Expectation that the Standards will be incorporated across the broad range of mental health services marks a significant shift, and one that will need to be developed over time. It is anticipated that the Standards will be a 'living document' that will further evolve as services across the spectrum progressively strive to meet relevant and expected standards of care.

Across the health and community sectors, service delivery is influenced by a number of different quality, safety and performance frameworks. The Standards represent only one component of this environment which includes specific state and sector legislation, associated regulation, professional regulation, accreditation and employment conditions, purchasing and funding agreements, government policy, service development and accreditation. All of these contribute to and affect the achievement of standards. It is anticipated that the Standards will be incorporated into the relevant service accreditation programs.

However, while accreditation is one mechanism to monitor compliance, it is by no means the only one. Compliance can also be measured through reporting frameworks such as key performance indicators and licensing processes. Importantly, there must be evidence that a service has a commitment to improving the quality of care whether this is through review against the Standards, or other quality improvement processes.

Service development is uneven, and this can create a tension between expectation and current practice. Not all states and territories, or even all areas within a jurisdiction, will be at the same stage of development. Also, not all of these standards will be equally relevant to different service types. Standards that are critical in an in-patient setting, for example seclusion practice, will not be relevant to community based settings. To inform the implementation of the Standards, a series of implementation guides that more clearly outline the expectations for different sectors and service settings will be developed. In addition, where more than one standard applies to an element of service delivery, the implementation guides will provide cross-referencing of the relevant standards.

It is recognised that quality improvement is a continuous process. As services are at different stages, some criteria will be routine practice for some and aspirational for others. In considering implementation attainment and maintenance of the Standards, services will need to be cognisant of their stage of development and model of service delivery, and therefore which standards and criteria are most relevant, and which should be addressed most urgently. It is expected that consumers and carers will be involved in these deliberations.

Demonstration of the delivery of services against these standards ensures that consumers, carers and the community can be confident of what to expect from mental health services. For example, mental health services are expected to ensure that issues around consent are handled in accordance with relevant Commonwealth, state or territory jurisdictional and legislative requirements.

A number of the Standards focus on the experience of consumers and carers (rather than the mental health service) to measure the effectiveness of service delivery. Investment in staff and resources is essential for the provision of services that meet these consumer and carer standards. This includes ongoing professional development, training and support.

Implementation of the Standards will require the involvement of staff, consumers and carers to ensure shared understanding and awareness of the standards to be adopted and met by a particular service. Measurement of levels of achievement against the standards also forms a means of accountability to consumers, carers, community, staff and funders.

The Standards recognise that mental health services provide services to individual consumers, carers and where developmentally appropriate, families and also support communities. How the community is defined varies depending upon the purpose, structure and type of service. The community may be determined by a target population or, in the case of public services, a defined catchment area. The assessment of standards will be undertaken in the context of that given community as defined by the particular service and the national, state and territory mental health policies and legislation applying to similar kinds of services and communities.

Regardless of the type of mental health service, the community or clients it serves, there are a number of principles that apply to the delivery of mental health services, irrespective of the context in which they are delivered.

Key principles

These key principles are consistent with national policy and requirements for the delivery of mental health services in Australia and are embedded in the Standards. Key principles that have informed the development of the Standards include:

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

Finally the Standards describe care that will be delivered in accordance with each of the nine (9) domains from the *Key Performance Indicators for Australian Public Mental Health Services (2005)* as follows:

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

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

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

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

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

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

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

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

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

Standard 1. Rights and responsibilities

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

CRITERIA

- 1.1** The MHS upholds the right of the consumer to be treated with respect and dignity at all times.
- 1.2** All care is delivered in accordance with relevant Commonwealth, state / territory mental health legislation and related Acts.
- 1.3** All care delivered is subject to the informed consent of the voluntary consumer and wherever possible, by the involuntary consumer in accordance with Commonwealth and state / territory jurisdictional and legislative requirements.
- 1.4** The MHS provides consumers and their carers with a written statement, together with a verbal explanation of their rights and responsibilities, in a way that is understandable to them as soon as possible after entering the MHS and at regular intervals throughout their care.
- 1.5** Staff and volunteers are provided with a written statement of the rights and responsibilities of consumers and carers, together with a written code of conduct as part of their induction to the MHS.
- 1.6** The MHS communicates with consumers, carers and other service providers and applies the rights and responsibilities of involuntary patients as per relevant Commonwealth, state / territory mental health legislation and related Acts.

- 1.7** The MHS upholds the right of the consumer to have their needs understood in a way that is meaningful to them and appropriate services are engaged when required to support this.
- 1.8** The MHS upholds the right of the consumer to have their privacy and confidentiality recognised and maintained to the extent that it does not impose serious risk to the consumer or others.
- 1.9** The MHS upholds the right of the consumer to be treated in the least restrictive environment to the extent that it does not impose serious risk to the consumer or others.
- 1.10** The MHS upholds the right of the consumer to be involved in all aspects of their treatment, care and recovery planning.
- 1.11** The MHS upholds the right of the consumer to nominate if they wish to have (or not to have) others involved in their care to the extent that it does not impose serious risk to the consumer or others.
- 1.12** The MHS upholds the right of carers to be involved in the management of the consumer's care with the consumer's informed consent.
- 1.13** The MHS upholds the right of consumers to have access to their own health records in accordance with relevant Commonwealth, state / territory legislation.
- 1.14** The MHS enacts policy and procedures to ensure that personal and health related information is handled in accordance with Commonwealth, state / territory privacy legislation when personal information is communicated to health professionals outside the MHS, carers or other relevant agencies.
- 1.15** The MHS upholds the right of the consumer to access advocacy and support services.
- 1.16** The MHS upholds the right of the consumer to express compliments, complaints and grievances regarding their care and to have them addressed by the MHS.
- 1.17** The MHS upholds the right of the consumer, wherever possible, to access a staff member of their own gender.

Standard 2. Safety

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

CRITERIA

- 2.1** The MHS promotes the optimal safety and wellbeing of the consumer in all mental health settings and ensures that the consumer is protected from abuse and exploitation.
- 2.2** The MHS reduces and where possible eliminates the use of restraint and seclusion within all MHS settings.
- 2.3** The MHS assesses and minimises the risk of deliberate self harm and suicide within all MHS settings.
- 2.4** The MHS minimises the occurrence of adverse medication events within all MHS settings.
- 2.5** The MHS complies with relevant Commonwealth and state / territory transport policies and guidelines, including the current National Safe Transport Principles.
- 2.6** The MHS meets their legal occupational health and safety obligations to provide a safe workplace and environment.
- 2.7** The MHS complies with infection control requirements.
- 2.8** The MHS can demonstrate investment in adequate staffing and resources for the safe delivery of care.
- 2.9** The MHS conducts a risk assessment of staff working conditions and has documented procedures to manage and mitigate identified risks.

- 2.10** Staff are regularly trained to, wherever possible, prevent, minimise and safely respond to aggressive and other difficult behaviours.
- 2.11** The MHS conducts risk assessment of consumers throughout all stages of the care continuum, including consumers who are being formally discharged from the service, exiting the service temporarily and / or are transferred to another service.
- 2.12** The MHS conducts regular reviews of safety in all MHS settings, including an environmental appraisal for safety to minimise risk for consumers, carers, families, visitors and staff.
- 2.13** The MHS has a formal process for identification, mitigation, resolution (where possible) and review of any safety issues.

Standard 3. Consumer and carer participation

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

CRITERIA

- 3.1** The MHS has processes to actively involve consumers and carers in planning, service delivery, evaluation and quality programs.
- 3.2** The MHS upholds the right of the consumer and their carer(s) to have their needs and feedback taken into account in the planning, delivery and evaluation of services.
- 3.3** The MHS provides training and support for consumers, carers and staff, which maximise consumer and carer(s) representation and participation in the MHS.
- 3.4** Consumers and carers have the right to independently determine who will represent their views to the MHS.
- 3.5** The MHS provides ongoing training and support to consumers and carers who are involved in formal advocacy and / or support roles within the MHS.
- 3.6** Where the MHS employs consumers and carers, the MHS is responsible for ensuring mentoring and supervision is provided.
- 3.7** The MHS has policies and procedures to assist consumers and carers to participate in the relevant committees, including payment (direct or in-kind) and / or reimbursement of expenses when formally engaged in activities undertaken for the MHS.

Standard 4. Diversity responsiveness

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

CRITERIA

- 4.1** The MHS identifies the diverse groups (Aboriginal and Torres Strait Islander, Culturally And Linguistically Diverse (CALD), religious / spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age and socio-economic status) that access the service.
- 4.2** The MHS whenever possible utilises available and reliable data on identified diverse groups to document and regularly review the needs of its community and communicates this information to staff.
- 4.3** Planning and service implementation ensures differences and values of its community are recognised and incorporated as required.
- 4.4** The MHS has demonstrated knowledge of and engagement with other service providers or organisations with diversity expertise / programs relevant to the unique needs of its community.
- 4.5** Staff are trained to access information and resources to provide services that are appropriate to the diverse needs of its consumers.
- 4.6** The MHS addresses issues associated with prejudice, bias and discrimination in regards to its own staff to ensure non-discriminatory practices and equitable access to services.

Standard 5. Promotion and prevention

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

CRITERIA

- 5.1** The MHS develops strategies appropriate to the needs of its community to promote mental health and address early identification and prevention of mental health problems and / or mental illness that are responsive to the needs of its community, by establishing and sustaining partnerships with consumers, carers, other service providers and relevant stakeholders.
- 5.2** The MHS develops implementation plans to undertake promotion and prevention activities, which include the prioritisation of the needs of its community and the identification of resources required for implementation, in consultation with their partners.
- 5.3** The MHS, in partnership with other sectors and settings supports the inclusion of mental health consumers and carers in strategies and activities that aim to promote health and wellbeing.
- 5.4** The MHS evaluates strategies, implementation plans, sustainability of partnerships and individual activities in consultation with their partners. Regular progress reports on achievements are provided to consumers, carers, other service providers and relevant stakeholders.
- 5.5** The MHS identifies a person who is accountable for developing, implementing and evaluating promotion and prevention activities.
- 5.6** The MHS ensures that their workforce is adequately trained in the principles of mental health promotion and prevention and their applicability to the specialised mental health service context with appropriate support provided to implement mental health promotion and prevention activities.

Standard 6. Consumers

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

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

CRITERIA

- 6.1** Consumers have the right to be treated with respect and dignity at all times.
- 6.2** Consumers have the right to receive service free from abuse, exploitation, discrimination, coercion, harassment and neglect.
- 6.3** Consumers have the right to receive a written statement, together with a verbal explanation, of their rights and responsibilities in a way that is understandable to them as soon as possible after entering the MHS.
- 6.4** Consumers are continually educated about their rights and responsibilities.
- 6.5** Consumers have the right to receive the least restrictive treatment appropriate, considering the consumer's preference, the demands on carers, and the availability of support and safety of those involved.
- 6.6** A mental health professional responsible for coordinating clinical care is identified and made known to consumers.
- 6.7** Consumers are partners in the management of all aspects of their treatment, care and recovery planning.
- 6.8** Informed consent is actively sought from consumers prior to any service or intervention provided or any changes in care delivery are planned, where it is established that the consumer has capacity to give informed consent.

- 6.9** Consumers are provided with current and accurate information on the care being delivered.
- 6.10** Consumers have the right to choose from the available range of treatment and support programs appropriate to their needs.
- 6.11** The right of consumers to involve or not to involve carers and others is recognised and respected by the MHS.
- 6.12** Consumers have an individual exit plan with information on how to re-enter the service if needed.
- 6.13** Consumers are actively involved in follow-up arrangements to maintain continuity of care.
- 6.14** The right of consumers to have access to their own health records is recognised in accordance with relevant Commonwealth and state / territory legislation / guidelines.
- 6.15** Information about consumers can be accessed by authorised persons only.
- 6.16** The right of the consumer to have visitors and maintain close relationships with family and friends is recognised and respected by the MHS.
- 6.17** Consumers are engaged in development, planning, delivery and evaluation of the MHS.
- 6.18** Training and support is provided for consumers involved in a formal advocacy and / or support role within the MHS.

Standard 7. Carers

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

CRITERIA

- 7.1** The MHS has clear policies and service delivery protocols to enable staff to effectively identify carers as soon as possible in all episodes of care, and this is recorded and prominently displayed within the consumer's health record.
- 7.2** The MHS implements and maintains ongoing engagement with carers as partners in the delivery of care as soon as possible in all episodes of care.
- 7.3** In circumstances where a consumer refuses to nominate their carer(s), the MHS reviews this status at regular intervals during the episode of care in accordance with Commonwealth and state / territory jurisdictional and legislative requirements.
- 7.4** The MHS provides carers with a written statement, together with a verbal explanation of their rights and responsibilities in a way that is understandable to them as soon as possible after engaging with the MHS.
- 7.5** The MHS considers the needs of carers in relation to Aboriginal and Torres Strait Islander persons, culturally and linguistically diverse (CALD) persons, religious / spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age profile and socio-economic status.
- 7.6** The MHS considers the special needs of children and aged persons as carers and makes appropriate arrangements for their support.

- 7.7** The MHS has documented policies and procedures for clinical practice in accordance with Commonwealth, state / territory privacy legislation and guidelines that address the issue of sharing confidential information with carers.
- 7.8** The MHS ensures information regarding identified carers is accurately recorded in the consumer's health record and reviewed on a regular basis.
- 7.9** The MHS provides carers with non-personal information about the consumer's mental health condition, treatment, ongoing care and if applicable, rehabilitation.
- 7.10** The MHS actively seeks information from carers in relation to the consumer's condition during assessment, treatment and ongoing care and records that information in the consumer's health record.
- 7.11** The MHS actively encourages routine identification of carers in the development of relapse prevention plans.
- 7.12** The MHS engages carers in discharge planning involving crisis management and continuing care prior to discharge from all episodes of care.
- 7.13** The MHS provides information about and facilitates access to services that maximise the wellbeing of carers.
- 7.14** The MHS actively seeks participation of carers in the policy development, planning, delivery and evaluation of services to optimise outcomes for consumers.
- 7.15** The MHS provides ongoing training and support to carers who participate in representational and advocacy roles.
- 7.16** The MHS provides training to staff to develop skills and competencies for working with carers.
- 7.17** The MHS has documented policies and procedures for working with carers.

Standard 8. Governance, leadership and management

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

CRITERIA

- 8.1** The governance of the MHS ensures that its services are integrated and coordinated with other services to optimise continuity of effective care for its consumers and carers.
- 8.2** The MHS has processes to ensure accountability for developing strategies to promote mental health and address early identification and prevention of mental health problems and / or mental illness.
- 8.3** The MHS develops and regularly reviews its strategic plan in conjunction with all relevant service providers. The plan incorporates needs analysis, resource planning and service evaluation. This should be developed with the participation of staff, stakeholders, consumers, carers and representatives of its community.
- 8.4** The MHS has processes in place to ensure compliance with relevant Commonwealth, state / territory mental health legislation and related Acts.
- 8.5** Identified resources are allocated to support the documented priorities of the MHS.
- 8.6** The recruitment and selection process of the MHS ensures that staff have the skills and capability to perform the duties required of them.
- 8.7** Staff are appropriately trained, developed and supported to safely perform the duties required of them.
- 8.8** The MHS has a policy and process to support staff during and after critical incidents.

- 8.9** The MHS manages and maintains an information system that facilitates the appropriate collection, use, storage, transmission and analysis of data to enable review of services and outcomes at an individual consumer and MHS level in accordance with Commonwealth, state / territory legislation and related Acts.
- 8.10** The MHS has an integrated risk management policy and practices to identify, evaluate, monitor, manage and communicate organisational and clinical risks.
- 8.11** The MHS has a formal quality improvement program incorporating evaluation of its services that result in changes to improve practice.

Standard 9. Integration

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

CRITERIA

- 9.1** The MHS ensures that a person responsible for the coordination of care is available to facilitate coordinated and integrated services throughout all stages of care for consumers and carers.
- 9.2** The MHS has formal processes to support and sustain interdisciplinary care teams.
- 9.3** The MHS facilitates continuity of integrated care across programs, sites and other related services with appropriate communication, documentation and evaluation to meet the identified needs of consumers and carers.
- 9.4** The MHS establishes links with the consumers' nominated primary health care provider and has procedures to facilitate and review internal and external referral processes.
- 9.5** The MHS has formal processes to develop inter-agency and intersectoral links and collaboration.

Standard 10. Delivery of care

10.1 SUPPORTING RECOVERY

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

CRITERIA

- 10.1.1** The MHS actively supports and promotes recovery oriented values and principles in its policies and practices.
- 10.1.2** The MHS treats consumers and carers with respect and dignity.
- 10.1.3** The MHS recognises the lived experience of consumers and carers and supports their personal resourcefulness, individuality, strengths and abilities.
- 10.1.4** The MHS encourages and supports the self determination and autonomy of consumers and carers.
- 10.1.5** The MHS promotes the social inclusion of consumers and advocates for their rights of citizenship and freedom from discrimination.
- 10.1.6** The MHS provides education that supports consumer and carer participation in goal setting, treatment, care and recovery planning, including the development of advance directives.
- 10.1.7** The MHS supports and promotes opportunities to enhance consumers' positive social connections with family, children, friends and their valued community.
- 10.1.8** The MHS demonstrates systems and processes for consumer and carer participation in the development, delivery and evaluation of the services.

- 10.1.9** The MHS has a comprehensive knowledge of community services and resources and collaborates with consumers and carers to assist them to identify and access relevant services.
- 10.1.10** The MHS provides access for consumers and their carer(s) to a range of carer-inclusive approaches to service delivery and support.

10.2 ACCESS

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

CRITERIA

- 10.2.1** Access to available services meets the identified needs of its community in a timely manner.
- 10.2.2** The MHS informs its community about the availability, range of services and methods for establishing contact with its service.
- 10.2.3** The MHS makes provision for consumers to access acute services 24 hours per day by either providing the service itself or information about how to access such care from a 24/7 public mental health service or alternate mental health service.
- 10.2.4** The MHS, wherever possible, is located to provide ease of physical access with special attention being given to those people with physical disabilities and / or reliance on public transport.

10.3 ENTRY

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

CRITERIA

- 10.3.1** The MHS has a written description of its entry process, inclusion and exclusion criteria and means of facilitating access to alternative care for people not accepted by the service.
- 10.3.2** The MHS makes known its entry process, inclusion and exclusion criteria to consumers, carers, other service providers, and relevant stakeholders including police, ambulance services and emergency departments.
- 10.3.3** The MHS has a documented system for prioritising referrals according to risk, urgency, distress, dysfunction and disability with timely advice and / or response to all those referred, at the time of assessment.
- 10.3.4** The entry process to the MHS is a defined pathway with service specific entry points that meet the needs of the consumer, their carer(s) and its community that are complementary to any existing generic health or welfare intake systems.
- 10.3.5** Entry to the MHS minimises delay and the need for duplication in assessment, treatment, care and recovery planning and care delivery.
- 10.3.6** Where admission to an inpatient psychiatric service is required, the MHS makes every attempt to facilitate voluntary admission for the consumer and continue voluntary status for the duration of their stay.

- 10.3.7** When the consumer requires involuntary admission to the MHS the transport occurs in the safest and most respectful manner possible and complies with relevant Commonwealth and state / territory policies and guidelines, including the National Safe Transportation Principles.
- 10.3.8** The MHS ensures that a consumer and their carer(s) are able to identify a nominated person responsible for coordinating their care and informing them about any changes in the care management.

10.4 ASSESSMENT AND REVIEW

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

CRITERIA

- 10.4.1** Assessments conducted and diagnoses made are evidence-based and use accepted methods and tools, as well as internationally accepted disease classification systems.
- 10.4.2** Assessments are conducted during the consumer's first contact with the MHS by appropriately qualified staff experienced and trained in assessing mental health problems, and where possible in a consumer's preferred setting with consideration of safety for all involved.
- 10.4.3** The MHS, with the consumer's informed consent includes carers, other service providers and others nominated by the consumer in assessment.
- 10.4.4** The MHS actively plans as early as possible in the course of psychiatric inpatient admission, for the discharge of the consumer from inpatient care.

- 10.4.5** The MHS conducts a review of a consumer's treatment, care and recovery plan when the consumer:
- requests a review
 - declines treatment and support
 - is at significant risk of injury to themselves or another person
 - receives involuntary treatment or is removed from an involuntary order
 - is transferred between service sites
 - is going to exit the MHS
 - is observed through monitoring of their outcomes (satisfaction with service, measure of quality of life, measure of functioning) to be in decline.
- 10.4.6** The MHS conducts assessment and review of the consumer's treatment, care and recovery plan, whether involuntary or voluntary, at least every three months (if not previously required for reasons stated in criteria 10.4.5 above).
- 10.4.7** The MHS has a procedure for appropriate follow-up of those who decline to participate in an assessment.
- 10.4.8** There is a current individual interdisciplinary treatment, care and recovery plan, which is developed in consultation with and regularly reviewed with the consumer and with the consumer's informed consent, their carer(s) and the treatment, care and recovery plan is available to both of them.

10.5 TREATMENT AND SUPPORT

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

CRITERIA

- 10.5.1** Treatment and support provided by the MHS reflects best available evidence and emphasises early intervention and positive outcomes for consumers and their carer(s).
- 10.5.2** Treatment and services provided by the MHS are responsive to the changing needs of consumers during their episodes of care that address acute needs, promote rehabilitation and support recovery.
- 10.5.3** The MHS is responsible for providing the consumer and their carer(s) with information on the range and implications of available therapies.
- 10.5.4** Any participation of the consumer in clinical trials and experimental treatments is subject to the informed consent of the consumer.
- 10.5.5** The MHS provides the least restrictive and most appropriate treatment and support possible. Consideration is given to the consumer's needs and preferences, the demands on carers, and the availability of support and safety of those involved.
- 10.5.6** Medications are prescribed, stored, transported, administered and reviewed by authorised persons in a manner consistent with Commonwealth, state / territory legislation and related Acts, regulations and professional guidelines.
- 10.5.7** The MHS actively promotes adherence to evidenced based treatments through negotiation and the provision of understandable information to the consumer.

- 10.5.8** The views of the consumer and their carer(s), and the history of previous treatment is considered and documented prior to administration of new medication and / or other technologies.
- 10.5.9** The MHS ensures that there is continuity of care or appropriate referral and transfer between inpatient, outpatient, day patient, community settings and other health / support services.
- 10.5.10** The MHS ensures that medication and / or other therapies when required, are only used as part of a documented continuum of treatment strategies.
- 10.5.11** The treatment and support provided by the MHS is developed and evaluated collaboratively with the consumer and their carer(s). This is documented in the current individual treatment, care and recovery plan.
- 10.5.12** The MHS facilitates access to an appropriate range of agencies, programs, and / or interventions to meet the consumer's needs for leisure, relationships, recreation, education, training, work, accommodation and employment in settings appropriate to the individual consumer.
- 10.5.13** The MHS supports and / or provides information regarding self care programs that can enable the consumer to develop or re-develop the competence to meet their everyday living needs.
- 10.5.14** The setting for the learning or the re-learning of self care activities is the most familiar and / or the most appropriate for the skills acquired.
- 10.5.15** Information on self care programs or interventions is provided to consumers and their carer(s) in a way that is understandable to them.
- 10.5.16** The MHS endeavours to provide access to a range of accommodation and support options that meet the needs of the consumer and gives the consumer the opportunity to choose between these options.
- 10.5.17** The MHS promotes access to vocational support systems, education and employment programs.

10.6 EXIT AND RE-ENTRY

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

CRITERIA

- 10.6.1** The MHS ensures that on exiting the service the consumer has access to services that promote recovery and aim to minimise psychiatric disability and prevent relapse.
- 10.6.2** The consumer and their carer(s) are provided with understandable information on the range of relevant services and support available in the community.
- 10.6.3** The MHS has a process to commence development of an exit plan at the time the consumer enters the service.
- 10.6.4** The consumer and their carer(s) and other service providers are involved in developing the exit plan. Copies of the exit plan are made available to the consumer and with the consumers' informed consent, their carer(s).
- 10.6.5** The MHS provides consumers, their carers and other service providers involved in follow-up with information on the process for re-entering the MHS if required.
- 10.6.6** The MHS ensures ease of access for consumers re-entering the MHS.
- 10.6.7** 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.
- 10.6.8** The MHS, in conjunction with the treating clinician, has a procedure for appropriate follow-up of all consumers within 7 days after discharge from inpatient care wherever possible, and has a follow-up procedure for those consumers who do not keep the planned follow-up arrangements.

Glossary

Access	Ability of consumers or potential consumers to obtain required or available services when needed within an appropriate time.
Acute	A condition that requires immediate medical attention.
Adverse drug events	A particular type of adverse drug event where a drug or medication is implicated as a causal factor in the adverse event. This encompasses both harm that results from the intrinsic nature of medicine (an adverse drug reaction) as well as harm that results from medication errors or system failures associated with the manufacture, distribution or use of medicines.
Advocacy	Representing the concerns and interests of consumers and carers, speaking on their behalf, and providing training and support so they can represent themselves.
Appropriate	Care, intervention or action provided is relevant to the consumer needs and based on established standards.
Assessment	Process by which the characteristics and needs of consumers, groups or situations are evaluated or determined so they can be addressed. The assessment forms the basis of a plan for services or action.
Available	Information, services and support that is present in the catchment area of the mental health service.
Best available evidence	Pre-appraised evidence such as systematic reviews, clinical practice guidelines and critically appraised papers and topics.
CALD	Culturally and linguistically diverse.
Care	All services and interventions provided to a person with a mental health problem and / or mental illness by health and other sectors, community organisation, family and carers.
Care management	A cyclical process, in which needs are assessed, services are delivered in response, and needs are re-assessed, leading to a changed service response.

Care plan	A written statement developed for entitled persons which states the nursing and other interventions to be undertaken, the health outcomes to be achieved and the review of care which will occur at regular intervals.
Carer	<p>A person whose life is affected by virtue of close relationship with a consumer, or who has a chosen caring role with a consumer.</p> <p>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.</p>
Clinical trial	Any research project that prospectively assigns human participants or groups to one or more health-related interventions to evaluate the effects on health outcome.
Community	How the community is defined depends on the purpose, structure and type of service. The community may be determined by a target population, such as consumers and / or clinicians who access the service or, in the case of public services, a defined catchment area.
Community living	The ability of the consumer to live independently in the community with the best possible quality of life.
Co-morbid condition	Existing simultaneously with and usually independently of another medical condition.
Confidentiality	The restriction of access to personal information to authorised persons, entities and processes at authorised times and in an authorised manner.
Consent	Consumer agreement based on an understanding of the implications of a particular activity or decision and the likely consequences for the consumer.
Consumer	A person who is currently using, or has previously used, a mental health service.

Consumer advocate	People who have been given the power by consumers to speak on their behalf, who represent the concerns and interest of the consumer as directed by the consumer, and seek the outcomes desired by the consumer. Although government and others may give power to advocates, such advocacy is token unless it is directly accountable to the consumer.
Consumer representative	A member of a government, professional body, industry or non-government organisation committee who voices consumer perspectives and takes part in the decision-making process on behalf of consumers. This person is nominated by, and is accountable to, an organisation of consumers. The role of a consumer representative is to provide a consumer perspective.
Continuity of care	Linkage of components of individualised treatment and care across health service agencies according to individual needs.
Coordinate	To bring together in a common and harmonious action or effort.
Culture	A shared system of values, beliefs and behaviour.
Data	Information collected for analysis or reference.
Data collection	A store of data captured in an organised way for a defined purpose.
Diagnosis	A decision based on the recognition of clinically relevant symptomatology, the consideration of causes that may exclude a diagnosis of another condition and the application of clinical judgment.
Disability	A concept of several dimensions relating to an impairment in body structure or function, a limitation in activities (such as mobility and communication), a restriction in participation (involvement in life situations such as work, social interaction and education), and the affected person's physical and social environment.

Discharge / exit planning	<p>A process for ensuring transfer of care of a consumer between service providers.</p> <p>Discharge planning results in a formal written discharge plan, the aim of which is to ensure continuity of services that are necessary for successful community living. The discharge plan is a negotiated enterprise between the consumer, carer or family, referring doctor, community mental health team and the inpatient unit. It includes medical information, follow-up appointments and the desired outcomes of treatment.</p> <p>The process of discharge planning begins at the time of admission. Barriers to discharge are identified at the time of admission and specific planning initiated to address these barriers, for example anticipated difficulties in finding suitable accommodation.</p> <p>The relevant stakeholders who are not directly involved in the discharge planning should also be notified of the anticipated discharge date, for example general practitioner and supported accommodation provider.</p>
Diversity	A broad concept that includes age, personal and corporate background, education, function and personality. Includes lifestyle, sexual orientation, ethnicity and status within the general community.
Documentation	Process of recording information in the health record and other documents that are a source of information; a written, tangible record of care and services provided.
Early intervention	Interventions targeting people displaying the early signs and symptoms of a mental health problem or mental disorder.
Education	Systematic instruction and learning activities to develop or bring about change in knowledge, attitudes, values or skills.
Effective	Producing the intended or expected result.
Efficiency	Achieving desired results with most cost effective use of resources.

Entry	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.
Equitable	Minimising avoidable disparities in health and its determinants, including but not limited to health care, between groups of people who have different levels of underlying social attributes.
Evaluation	Judging the value of something by gathering valid information about it in a systematic way and by making a comparison. The purpose of evaluation is to help the user of the evaluation to decide what to do, or to contribute to scientific knowledge
Exit	When the consumer no longer requires treatment, support, or any other service from the mental health service, and there has been a last 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.
Exit plan	See discharge plan.
Feedback	A communication from a consumer relaying how delivered products, services and messages compare with consumer expectations.
First contact	The first time the consumer makes contact with the mental health service during any episode of care.
Follow-up	Processes and actions taken after a service has been completed.
Funders	State and territory governments, Australian government, private health funds.
Governance	The system by which organisations are directed and controlled. It ensures the power of organisations is harnessed for the agreed purpose. Governance spells out the rules and procedures for making decisions on organisational affairs.
Human resources	The personnel requirements of the organisation.
Incidence	The number of new cases (of an illness or event etc.) occurring during a given period.

Incident	An event or circumstance which led to, or could have, unintended and / or unnecessary harm to a person, and / or a complaint, loss or damage.
Individual health record	Term to cover consumer record, medical record, care record, health care record or record that documents care or service to a consumer. A health record is a legal document that outlines the total needs, care and management of consumers.
Induction	A process of bringing a new employee into the organisation. This program assimilates them into the culture, accepted practices, and performance standards of the organisation.
Infection control	Measures practised by healthcare personnel in healthcare facilities to decrease transmission and acquisition of infectious agents. This includes proper hand hygiene, scrupulous work practices and use of personal protective equipment (PPE)—masks or respirators, gloves, gowns, and eye protection. Infection control measures are based on how an infectious agent is transmitted and include standard, contact, droplet, and airborne precautions.
Information	Data elements that have been organised and analysed and that provide a basis for decision making.
Information system	A system that provides access to information using hardware, software, supplies, policies, procedures and people.

Informed consent	<p>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.</p> <p>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, risks and benefits for the consumer and others.</p> <p>In the context of mental health, this means that the client provides permission for a specific treatment to occur based on their understanding of the nature of the procedure, the risks involved, the consequences of withholding permission and their knowledge of available alternative treatments.</p>
Inpatient psychiatric service	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 health problems and / or mental illness.
Integration	The process whereby inpatient and community components of a mental health service become coordinated as a single, specialist network and include mechanisms which link intake, assessment, crisis intervention, and acute, extended and ongoing treatment using a case management approach to ensure continuity of care.
Interdisciplinary team	Care or a service given with input from more than one discipline or profession.
Intervention	An activity or set of activities aimed at modifying a process, course of action or sequence of events, to change one or several of their characteristics such as performance or expected outcome.
Involuntary	Where persons are detained in hospital or compulsorily treated in the community under mental health legislation for the purpose of assessment or provision of appropriate treatment or care.

Leadership	Ability to provide direction and cope with change. It involves establishing a vision, developing strategies for producing the changes needed to implement the vision, aligning people and motivating and inspiring people to overcome obstacles.
Legislation	The body of laws made by Parliament. These laws consist of Acts of Parliament and Regulations, Ordinances and / or Rules which are also called subordinate or delegated legislation.
Links	Connections, contacts and working relationships established with others.
Management	Setting targets or goals for the future through planning and budgeting, establishing processes for achieving those targets and allocating resources to accomplish those plans. Ensuring that plans are achieved by organising, staffing, controlling and problem-solving.
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 seclusion or ECT.
Mental health	The capacity of individuals within the groups and the environment to interact with one another in ways that promote subjective wellbeing, optimal development and use of mental abilities (cognitive, affective and relational) and achievement of individual and collective goals consistent with justice.
Mental health problems	A disruption in the interaction between the individual, the group and the environment, producing a diminished state of mental health.
Mental health professional	A person who offers services for the purpose of improving an individual's mental health or to treat mental illness. These professionals include psychiatrists, clinical psychologists, clinical social workers, occupational therapists, psychiatric nurses as well as other professionals.
Mental health promotion	Action to maximise mental health and wellbeing among populations and individuals. Mental health promotion is concerned with promoting wellbeing across entire population groups for people who are currently well, for those at-risk, and for those experiencing illness.

Mental health service (MHS)	Specialised mental health services are those with the primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental illness or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function.
Mental illness	<p>A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities.</p> <p>The diagnosis of mental illness is generally made according to the classification systems of the <i>Diagnostic and Statistical Manual of Mental Disorders</i>, Fourth Edition Text Revision (DSM-IV-TR) or the <i>International Classification of Diseases</i>, Tenth Edition (ICD-10). These classification systems apply to a wide range of mental disorders (for the DSM-IV) and mental and physical disorders (for the ICD-10). Not all the DSM-IV mental disorders are within the ambit of the National Mental Health Plan 2003–2008.</p> <p>In Australia, drug and alcohol problems are primarily the responsibility of the drug and alcohol service system and there is a separate, but linked, national strategy. Similarly, dementia is treated primarily in aged care settings. Both are considered important in terms of their co-morbidity with mental illness.</p>
Monitor	To check, observe critically, measure or record the progress of an activity, action or system on a regular basis to identify change.
Ongoing care	The process of care that follows an admission to a health care organisation.
Onset	A beginning or start.
Operational plan	A plan on a short term basis that provides details of how the strategic plan will be accomplished.
Orientation	The process by which staff become familiar with all aspects of the work environment and their responsibilities.
Outcome	A measurable change in the health of an individual, or group of people or population, which is attributable to interventions or services.

Personal and health related information	<p>Any information or an opinion about a person whose identity is apparent or can reasonably be ascertained from the information or opinion. Personal information can include a person's name, date of birth, address, telephone number, family members or any other information that could allow the person to be identified.</p> <p>Health related information includes symptoms or observations about the person's health, prescriptions, billing details, pathology or other test results, dental records, Medicare or health insurance numbers, admission and discharge details, genetic information and any other sensitive information about things such as race, sexuality or religion when it's collected by a health service. In the context of these standards, personal and health related information, where it can lead to the identity of the consumer, is considered in the same way.</p>
Physical	Relating to the body.
Plan	Any detailed scheme, program or method developed for the accomplishment of an objective. Detailed notes of intended proceedings.
Planning	To formulate a scheme or program for the accomplishment or attainment of an object.
Policy	A documented statement that formalises the approach to tasks and concepts which is consistent with organisational objectives.
Prevention	Interventions that occur before the initial onset of a disorder (Mrazek and Haggerty, 1994, p. 23).
Primary care provider	Staff or individuals who, in cooperation with the consumer, assume responsibility for all aspects of care in response to the diagnosis and needs of the consumer.
Procedure	A set of documented instructions conveying the approved and recommended steps for a particular act or sequence of acts.
Process	A series of actions, changes / functions that bring about an end or result.

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. Some mental health services may have only one team which performs all of these functions.
Promotion	See mental health promotion.
Quality	The extent to which the properties of a service or product produces a desired outcome.
Quality improvement	Ongoing response to quality assessment data about a service in ways that improve the process by which services are provided to consumers.
Recovery	A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and / or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability.
Referral processes / pathways	Systems and protocols that ensure linkages between services to support continuity of care and ensure that consumers of services are able to negotiate the system in a seamless and timely manner.
Relapse	<p>A subsequent episode of mental illness. It is a recurrence of symptoms of mental illness similar to those that have previously been experienced. The threshold of symptoms required to identify a relapse varies according to the differing perspectives of the person experiencing the symptoms, their family and carers, and service providers.</p> <p>Relapse is generally agreed to have occurred when the person experiencing the symptoms is not able to cope using their usual supports and requires a greater intensity of intervention. The word 'relapse' is viewed by many as a negative and medicalised term, and the words 'episode' or 'being unwell' may be preferred.</p>
Research	An active, diligent and systematic process of inquiry to discover, interpret or revise facts, events, behaviours, or theories, or to make practical applications with the help of such facts, laws or theories.