[insert organisation name/logo]

Service Coordination Policy

Document Status: **Draft or Final**

Date Issued: **[date]**

Lead Author: **[name and position]**

Approved by: **[insert organisation name] Board of Directors on [date]**

Scheduled Review Date: **[date]**

Record of Policy Review

Review Date	Person Initiating/Leading Review	Other People Consulted

Triggers for Policy Review (tick all that apply)

- ☐ Standard review is timetabled.
- ☐ A gap has been identified
- ☐ Additional knowledge or information has become available to supplement the policy.
- ☐ External factors
  - ☐ Policy is no longer relevant/current due to changes in external operating environment.
  - ☐ There are changes to laws, regulations, terminology and/or government policy.
  - ☐ Changes to funding environment, including requirements of funding bod(y)ies
- ☐ Other (please specify).
- ☐ Internal / organisational factors
  - ☐ A stakeholder has identified a need, eg by email, telephone etc
  - ☐ A serious or critical incident has occurred, requiring an urgent review.
  - ☐ Need for consistency in service delivery across programs and organisations.
  - ☐ Separate, stand-alone policy is now warranted
  - ☐ A near miss has occurred, requiring a review to prevent a serious/critical incident in the future

Additional Comments [*for example, policy now covers details related to new legislation*].

Service Coordination Policy

1. Purpose and Scope

This purpose of this policy is to clarify the service coordination process for **[insert organisation name]** consumers.

This policy applies to all programs operated by **[insert organisation name]** and all employees involved in service coordination.

This policy is to be implemented in conjunction with the Service Coordination Procedures, Service Entry Policy and Procedures, Individual Supports Policy, Personal Records Policy and Service Exit and Re-Entry Policy.

2. Definitions

Cultural safety means "*more or less - an environment, which is safe for people; where there is no assault, challenge or denial of their identity, of who they are and what, they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening*[1]*.*"

Service coordination involves the coordination of all necessary services for a consumer, along the continuum of care, including hospital-based and community-based, medical and non-medical, vocational, social and support services. This may include referrals to services, information about other services or assisting consumers where multiple appointments with government, non-government and local community services are required.

A service coordinator coordinates the planning and delivery of a suite of services to support a consumer's recovery journey. It is assumed the consumer has, or will have, capacity to be their own service coordinator. However, when informed consent from the consumer (or substitute decision-maker) is provided, a mental health worker may take on the role of service coordinator.

Service coordination from a mental health worker is usually needed for consumers who:

- have more complex needs than most other consumers
- need extra help to organise treatment, care and support from more than one agency
- have inadequate community supports, are financially disadvantaged or geographically isolated
- have a carer who is ill or highly stressed

[1] Williams (1999)

[insert organisation name] service coordination may be short term, intermittent or ongoing.

A Wellness / Recovery Plan documents the consumer's personal recovery goals and strategies. It is developed, as much as possible, by the consumer. The recovery plan:

- focuses on personally-valued goals;
- reflects the person's values and support preferences;
- focuses on the individual and their current circumstances;
- builds on the person's strengths; and
- involves independent and joint action much more than passive action.

An Integrated Recovery Plan documents consumer goals and expectations, and provider commitments and responsibilities, across a range of services and supports, such as (but not limited to):

- Accommodation support and outreach;
- Employment, (and) education and other training;
- Leisure and recreation;
- Family and carer support;
- Self-help and peer support;
- Helpline and counselling services;
- Promotion, information and advocacy
- Health services (primary, allied, specialist, complementary)
- Natural supports (eg family, friends, neighbours, clubs, churches, recreation, work colleagues and sporting groups)
- Income support
- Emergency services
- Legal services
- Services related to Diversity-needs (eg early childhood, disability, substance use, immigration, indigenous, GLBTI, CALD, aged care, youth, unemployment)
- Service clubs

A Service Coordination Meeting is a planned, structured meeting which:

- Is usually interdisciplinary, and includes one or multiple internal and external providers and, unless it is not in the consumer's best interests, the consumer, carer/family members/close supports.
- Can be used to
    - identify or clarify issues regarding a consumer's needs and goals
    - review activities including progress and barriers towards goals
    - map roles and responsibilities
    - resolve conflicts
    - strategise solutions

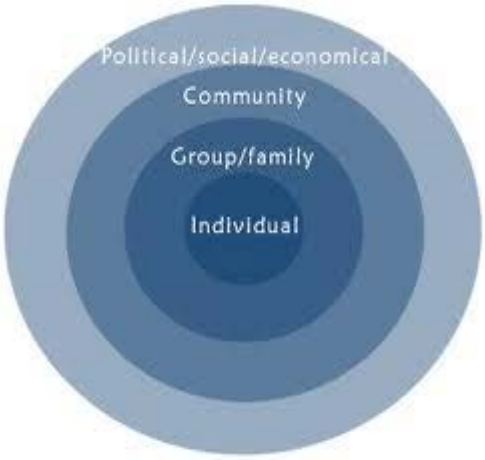
    - adjust current integrated recovery plans.
- May be face-to-face or by phone/videoconference, held at routine intervals or during significant change.
- Is documented in the consumer's record
- Aims to provide holistic, coordinated, and integrated services across providers, and to reduce duplication.

Support Network includes people and organisations who have a supportive relationship with a person; for example, service providers, teachers, employers, and the natural support network.

Natural Support Network includes people who have an unpaid, natural, supportive relationship with a person; for example, family, carers, friends, and neighbours.

3. Principles

"Health" is considered from the consumer's personal, social and cultural context.



Service coordination is underpinned by:

- A primary focus on consumers
- Balancing duty of care, dignity of risk, and informed decision-making
- Active building and supporting community partnerships
- Collaboration with all stakeholders, including carers
- A common language of understanding and consistency of approach
- Sensitivity, flexibility and responsiveness to cultural factors, the needs of indigenous consumers, homeless people, individuals living in rural and remote areas, and people with conditions that may impact on using the service
- Well trained, knowledgeable, and competent staff with exceptional communication skills and a focus on recovery
- Protection of consumer information through compliance with the relevant legislation
- A commitment to holistic health, with an emphasis on physical and mental health

- Actively engaging other health services, (including clinical and primary care), which includes clearly defining roles and responsibilities
- Seeking out, and utilising, mainstream activities, facilities and services

In order to exercise choice and maximise independence, people require access to accurate information that will help them manage their own lives, understand their options and engage with and actively participate in their community.

Service coordination should be carried out by the consumer and/or carer. However, if the consumer and/or carer are unable to carry out service coordination, a mental health worker may formally take on this role.

Service coordination is:

- Person directed, driven and centred;
- Inclusive of family, friends, peers and community;
- Culturally safe and appropriate;
- Recovery oriented;
- Goal orientated, at a pace that is viable for the consumer;
- Socially inclusive and seeking to address discrimination;
- Tailored to the specific needs of the individual; and
- Consistent with individual preferences.

The aim of service coordination is for:

- Consumers, and carers to easily identify, access, use and coordinate various services which support their recovery journey

- Organisations to:
    - Support the consumer and/or carer, to the degree necessary, to identify, access and use services which support the consumer's recovery journey
    - Provide person-directed and centred, systematic, responsive, supportive and integrated services that promote recovery.
    - At sector / system level:
        - Create (if necessary), and be an active participant in, an integrated network or service system
        - Encourage team work, shared knowledge and expertise, practice and integrated responses.

Service coordination is relational and requires strong working relationships between services users and their families, supporters, peers and communities, mental health workers, service provider agencies, funders and policy setters.

When the mental health worker takes on responsibility for service coordination:

- Service coordination offers the consumer and carer a single point of contact with health and community services;

- Service coordinators are not expected to provide all aspects of consumer treatment, care and support; they refer to, and facilitate consumer engagement with, other agencies as appropriate, with a stable relationship based on mutual respect and continuity at its core.

A single point of contact for people relating to the consumer enables consistency, continuity, communication, collaboration, and efficient resourcing.

For mental health workers and organisations, service coordination is both a practice skill set, and a type of service delivery. It requires the cooperation of all participants in equal measure, and a commitment to recovery principles from practitioners and senior staff..

- At the level of the individual mental health worker, service coordination is a practice skill set with application to all service users.
- At the service delivery level and service network or system level, service coordination is a way of delivering services, that in certain instances and for specific reasons might target certain groups, including for example people with severe mental illness and/or with complex needs.

Service co-ordination is particularly important during transitions, such as discharge from hospital to home or transition back into employment, to ensure continuity of (and high quality, safe) care, treatment and/or support. At these times, consumers may be particularly vulnerable. Streaming of services in a seamless way is highly desirable, for example, having community services involved before discharge from hospital.

People with lived experience of mental illness/recovery should be able to access mainstream community programs, services and facilities.

4. Outcomes

Consumers should have access to the right services, at the right time and at the right place.

Strong working relationships between services users and their families, carers, supporters, peers and communities, mental health workers, service provider agencies, funders and policy setters.

Consumers and carers are:

- Able to, and/or are supported by **[insert organisation name]** to, easily identify, access and use services which support the recovery journey.

[insert organisation name] is part of an integrated network / service system which:

- Provides person-directed and centred, systematic, responsive, supportive and integrated services that promote recovery.
- Encourages team work, shared knowledge and expertise, interdisciplinary practice and integrated responses.

5. Functions and Delegations

Position	Delegation/Task
Board of Directors	Endorse Service Coordination Policy.
Management	Compliance with Service Coordination Policy. • Ensure a process in place for co-ordination with other agencies, advocacy and service user organisations in the area • Workload estimation, management and monitoring • Developing, implementing and reviewing guidelines for Service Coordination • Ensure staff fulfil the Interim Standards for Service Coordination
Staff	Compliance with Service Coordination Policy. <u>Recovery Coordinator:</u> • Supporting development and implementation of the wellness recovery plan • Liaison with service providers in the same or another agency dealing with the same consumer • Advocacy to ensure that the consumer has access to the range of services required • Monitoring and reviewing the wellness recovery plan. <u>Service Coordinator:</u> Same range of responsibilities as the Recovery Coordinator, **plus** • Arranging additional services needed by the consumer by means of brokerage, purchase of services, or agreements between agencies; • Organising service coordination meetings if needed; • Actively monitoring for any change of consumer or carer circumstances; • Advocacy (particularly where there is social isolation, cognitive impairment or carer stress); and • Liaison with other services involved with the consumer (such as the GP, allied health services) • Meet the Interim Standards for Service Coordination.

6. Risk Management

Staff with responsibility for service coordination are appropriately trained and/or qualified, and engage in ongoing professional development.

All staff with responsibility for consumer service coordination are introduced to this policy during staff induction/orientation.

[insert organisation name] employees involved in service coordination are provided with ongoing support and professional development to assist them to undertake their duties effectively.

The policy will be reviewed in line with **[insert organisation name]**'s quality improvement program and/or relevant legislative changes.

[insert organisation name] ensures its staff are alert to legal frameworks surrounding the work of service coordinators with consumers in a range of different settings. For example, relevant legislative provisions might relate to involuntary psychiatric inpatient or community treatment, guardianship, protected estates, child protection, the criminal justice system, immigration, income quarantining and other income security issues, tenancy, debt, privacy, industrial relations and professional duty of care and other areas.

7. Policy Implementation

This policy is developed in consultation with staff, consumers and carers and is approved by the organisation.

This policy is part of all **[insert organisation name]** staff orientation processes and all employees, volunteers and students are responsible for understanding and adhering to this policy. Consumers and carers are made aware of this policy during service entry.

This policy should be referenced in relevant **[insert organisation name]** policies, procedures and other supporting documents to ensure that it is familiar to all program staff and actively used.

8. Policy Detail

8.1 Service Coordination with Consumers

It is assumed the consumer has, or will have, capacity to take on the role of service coordinator most of the time, unless they are unwell.

When service coordination is needed and the consumer assumes the service coordination role, a mental health worker may be allocated to support and mentor the consumer in that role. This worker is the **[insert position*, eg Recovery Guide, key worker*].**

The Recovery Guide may also support the carer with service coordination responsibilities if the carer is responsible for service coordination.

When service coordination is needed and the consumer or carer is unable to assume the service coordination role, “service coordination” may be offered by **[insert organisation name]**.

The need for service coordination is identified through comprehensive assessment. A mental health worker may be allocated to take on the role of service coordinator, providing informed consent from the consumer (or substitute decision-maker) is given. This worker is the **[insert position*, eg Service Coordinator*].**

8.1.1 Stages in Service Coordination on Behalf of Individual Consumers

1. Entry to “Service Coordination”, including comprehensive and collaborative assessment
2. Recovery / Wellness Planning, with linked Integrated Recovery and Relapse Planning
3. Integrated Recovery Plan Implementation which includes provision for both direct service delivery and brokerage
4. Monitoring and Evaluation of the Integrated Recovery Plan
5. Exit or “graduation” from “Service Coordination”, including transition to self-directed service coordination by the consumer, with any necessary supports put in place as directed by the consumer.

   See Service Coordination Procedure

8.1.2 Types of Service Coordination

1. Long Term Service Coordination

Long term service coordination involves an on–going relationship between the consumer and the service coordinator that can extend over a number of years. This model is usually applied with **[insert organisation name]** consumers who have conditions or situations that can remain relatively stable over long periods of time when supported by the service coordination process and appropriate service provision. Some of these conditions may also be episodic in nature, despite best practice interventions being place, and require long term service coordination in order for the consumer to minimise a relapse.

2. Episodic Service Coordination

The episodic application of service coordination can be used with **[insert organisation name]** consumers who do not require on–going service coordination services. and can be exited in longer term periods when their situation is stable. This usually occurs when needed support services are in place and working effectively. If the consumer’s situation changes, service coordination services should be quickly reinstated to support the consumer through the unwell

period. When the new situation stabilises, the consumer may again exit the service.

To maintain capacity to accept episodic consumers, individual caseloads of **[insert organisation name]** service coordinators should include provision for consumers to receive episodic service coordination, and the capacity for consumers to be "suspended" from programs with a "safety net" in place so that they can return to full participation in the program if necessary.

It is reasonable to include a proportion of a service coordinator's consumers to be episodic. **[insert organisation name]** service coordination services closely monitors numbers and proportions of episodic consumers to determine a workable mix. It is expected that service provision will incorporate the lastest research findings regarding protective factors that facilitate resilience and recovery, for example, community engagement and not allowing the illness to define the consumer's self identity.

3. Short Term Service coordination

Short term service coordination tends to be intensive and over relatively short periods of time, for example, three months with in–built reviews. Service coordinators use the same skills for these short term situations. After this period, consumers may:

- no longer require external service coordination
- assume service coordination responsibilities themselves
- exit into other service coordination services
- be taken on as longer term consumers, if they require longer ongoing service coordination.

It is essential that service providers are aware of the funding parameters of their programs, as some are time limited and others open ended. It is also important that consumers are aware if their participation in a program is voluntary or mandated.

8.1.3 Service Coordination Load

The **[*insert position eg Manager*]** ensures that service coordinators have a reasonable service coordination load. This may be dependent on factors such as the frequency of visits, carer involvement, location (is travel time required), complexity of caseload, role (community support or clinical/treating professional), complexity, need for use of interpreters, and co-existing conditions.

The standard service coordination load for **[insert organisation name]** full time service coordinators is:

- **[insert number]** consumers (long-term)
- **[insert number]** consumers (short-term)
- **[insert number]** consumers (episodic - current)

- **[insert number]** consumers (episodic – potential re-entry)

8.1.4 Effective service coordination

Effective service coordination by **[insert organisation name]** service coordinators involves:

- clear and open communication between all people involved, taking into account potential barriers to this, for example, cognitive issues, sensory impairment, intellectual disability and cultural or literacy issues.
- clarification of the requirements and boundaries of each person involved, which includes what will be communicated to and by the service coordinator (or team)
- knowledge of other people involved and the nature of their involvement with the consumer
- a written contract outlining:
    - how the consumer remains informed about, and gradually increases responsibility for, their Integrated Recovery Plan.
    - the expectations and boundaries of service provision,
    - methods for ensuring continuity of services during staff turnover,
    - clear lines of authority and control over various aspects of the service coordination process,
    - a formal record of agencies' agreements and responsibilities.

It is expected that service providers will look for innovative ways to ensure effective communication, for example, through the use of visual aids, plain English versions of documents, and other appropriate tools.

8.1.5 Culturally Appropriate Practice in Service coordination

The numbers of older people from culturally and linguistically diverse (CALD) backgrounds (and indeed all members of Australian society) will continue to increase as the Australian population ages. The proportion of older people from CALD backgrounds requiring service coordination services is expected to increase as a consequence.

The major components of cultural competence as applied to service coordination practice include:

- the ability to see each consumer as an individual and not a stereotype, including the need for gender and age appropriate workers.
- awareness of how mental illness is understood by various cultures, including views on stigma and shame
- informed perspectives on particular features of a culture, for example, in certain cultures, male workers being seen as more authoritative and "expert".
- service coordinator's understanding of:
    - how their own cultural values, norms and experiences influence their work with consumers from different cultures

    - how different cultural norms, values and experiences influence use of community care services
    - local Diverse communities, their beliefs and practices, their definitions of family, health, wellbeing and illness – see Diversity Policy
    - culturally appropriate service and community networks
- service coordinator skills in the areas of empathy, verbal and non–verbal communication and advocacy.

Diversity considerations specific to service coordination include:

- Life cycle stage and transition points – ensuring different practice skills and different service coordination strategies are available as mental health practitioners work with people at different stages throughout the life cycle. Specials consideration is also required as people pass through important transition points.
- Cultural context and considerations – Service coordination also needs to respond respectfully, flexibly and appropriately to the cultural beliefs, values and expectations of service users.

For more information on steps **[insert organisation name]** takes in order to address the diverse needs of consumers, see the Diversity Policy.

8.1.6 Fees for Service Coordination

[insert organisation name] may seek a financial contribution from the consumer towards the cost of service coordination support and overall service provided, either directly or through brokerage.

[insert organisation name] has a fees policy **[not developed in Policy Resource]** with the flexibility to reduce or waive fees according to a sliding scale, in situations where consumers are assessed as financially disadvantaged or unable to pay. The range of chargeable fees is from full cost to zero, depending on the consumer's capacity to pay. The fees policy is discussed with the consumer and carer during the assessment process.

8.2 Working in Partnership – Formal Agreements

[insert organisation name] works in partnership with other community care stakeholders. Wherever needed and possible, these partnerships are formalised. See Integration Policy.

8.2.1 Service Agreements for Particular Consumers

Service Agreements are used to formally record agreements made between **[insert organisation name]** and one or more parties in response to a particular consumer's situation, or identified needs for a particular consumer group.

Service Agreements for particular consumers may be made between **[insert organisation name]** and:

- the consumer and/or carer
- services purchased with brokerage funds
- individual or groups of community care service providers working with a negotiated Integrated Recovery Plan.

Generally, service agreements for particular consumers or consumer groups will contain the following types of information:

- basic principles to be followed in the situation. This could include exchange of information, privacy and confidentiality and consumer self determination
- contact details of parties to the agreement
- the roles and responsibilities of all parties to the agreement
- how the parties are going to contact, communicate with and report to each other during the term of the agreement
- how long the agreement is in place before the need to review or end the agreement
- details of how breaches (by either party) in the agreement will be handled.

8.3 Service Coordination at Organisational Level

In order to promote service coordination at organisational level, **[insert organisation name]** supports collaboration and integration through:

- Team and service partnerships
- Articulation of shared roles and responsibilities
- Service agreements
- Communication
- Practice and learning communities.
- Development and implementation of service coordination practice standards within **[insert organisation name]** and more broadly.
- Establishing / nurturing:
    - interdisciplinary teams
    - service networks, partnerships, coalitions or alliances
- Shared safety and quality assurance processes.
- Community and clinical service level agreements.

8.4 Service Coordination at Systems/sector level

In order to promote service coordination at systems/sector level, **[insert organisation name]** services and programs are connected and coordinated within an overarching service network.

[insert organisation name] contributes to an effective and coordinated service system through its:

- commitment to integration
- collaborative approach to resource management
- alternative and innovative funding models
- information management
- service linkages, including participation in:
- service networks,
- interagency meetings
- events such as for Mental Health month
- collaborative case reviews
- ongoing informal reviews of consumer progress between community and clinical care providers
- partnerships,
- partnership appraisal processes
- safety and quality assurance across the service system
- involvement in research both internally, and with other CMO's
- funding independent research

See Integration Policy

8.5 Governance and Leadership

[insert organisation name] contributes to clear governance and leadership across all levels of service coordination by:

- Providing a timely statement of its position on models of governance for service coordination, (eg alliance/shared model; corporate model; and a brokered model through a lead agency or a specifically and purposively created entity).
- At all times focusing on the importance of ethical practice in the range of functions performed, and promulgating this with all staff.
- Utilising and reviewing service agreements/contractual arrangements
- Working in alignment with government guidelines and requirements, protocols, policies and procedures
- Implementing and reviewing its service coordination policy
- Practice and service safety and quality improvement.

8.6 Practice and Professional Development

In developing service coordination expertise, **[insert organisation name]** contributes to the articulation of service coordination as a discrete skill and practice set, and works toward embedding service coordination in practice, training and professional development.

[insert organisation name] builds the practice and skills base of service coordination through:

- Adoption of a vocationally recognised service coordination practice skill set, competencies, attributes;
- Obtaining resources for practice and professional development;
- Adoption and implementation of service coordination practice standards;
- Participation in service coordination in professional development programs throughout the sector and throughout partnerships e.g.:
    - Induction and orientation
    - Professional development planning and support; supervision and appraisal
    - Training opportunities for staff
    - Collaborative interagency, interdisciplinary and cross-sectoral professional development strategies and opportunities;
    - Investment in developing practice development resources;
    - Service coordination communities of practice;
    - Participation in field education programs and initiatives.

- Meeting the practice development and learning needs of non-professionally associated staff and volunteers.

8.6.1 Interim Standards - Service Coordinators

Until sector-wide Service Coordinator Standards are developed and adopted, **[insert organisation name]** requires service coordinators to meet the "Interim Standards for Service Coordinators".

Interim Standards - Service Coordinators[2]

A Service Coordinator will:

1. possess the knowledge, skills, and experience necessary to competently perform service coordination activities
2. use his or her professional skills and competence to serve the consumer whose interests are of primary concern
3. ensure that consumers are involved in all phases of service coordination to the greatest extent possible
4. ensure the consumer's right to privacy and ensure appropriate confidentiality when information about the consumer is released to others
5. take action, at consumer level, to provide and/or coordinate the delivery of direct services to consumers and their families
6. take action, at the service systems level, to:

[2] Adapted from *National Association of Social Workers Standards for Social Work Case Management*

    - support existing service coordination services and to
    - expand the supply of needed services
    - improve access to needed services
7. be knowledgeable about resource availability, service costs, and budgetary parameters and be fiscally responsible in carrying out all service coordination functions and activities
8. participate in evaluative and quality assurance activities designed to monitor the appropriateness and effectiveness of:
    - the service delivery system in which service coordination operates
    - the service coordinator's own service coordination services,
9. carry a reasonable workload that allows the service coordinator to effectively plan, provide, and evaluate service coordination tasks related to the consumer and the system(s)
10. treat consumers, carers and colleagues with courtesy and respect
11. take action to enhance interprofessional, intraprofessional, and interagency cooperation on behalf of the consumer.
12. Where necessary mediate on behalf of the consumer, or link them to appropriate services to do this.

9. References + Resources

9.1 Internal

Abuse and Neglect Policy
Dignity of Risk Policy
Diversity Policy
Feedback and Complaints
Individual Supports Policy
Informed decision Making Policy
Integration Policy
Participation Policy
Personal Records Policy
Participant Manual
Privacy and Confidentiality Policy
Promotion and Prevention Policy
Rights and Responsibilities
Service Entry Policy
Service Exit and Re-Entry Policy
Service Coordination Procedure

9.2 External

Legislation

Anti-Discrimination Act 1977 (NSW)
Community Services (Complaints, Appeals and Monitoring) Act 1993 (NSW)
Health Records and Information Privacy Act 2002 (NSW)
Mental Health Act (NSW) 2007
Privacy Act 1988 (Commonwealth)
Privacy and Personal Information Protection Act 1998 (NSW)
Work Health and Safety Act 2011 (Commonwealth)
Model Work Health and Safety Regulations 2011 (Cth)

Other

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9.3 Quality and Accreditation Standards

EQuIP4

Provided by the Australian Council on Healthcare Standards (ACHS)

Standard 1.1 Consumers / patients are provided with high quality care throughout the care delivery process.

Criterion 1.1.6 Systems for ongoing care of the consumer / patient are coordinated and effective.

EQuIP5

Provided by the Australian Council on Healthcare Standards (ACHS)

Standard 1.1 Consumers / patients are provided with high quality care throughout the care delivery process.

Criterion 1.1.6 Systems for ongoing care of the consumer / patient are coordinated and effective.

Health and Community Service Standards (6th edition)

Provided by the Quality Improvement Council (QIC)

Standard 2.1 Assessment and planning are undertaken at individual and community levels to ensure services and programs are responsive to identified needs.

Evidence Questions: What is the evidence that:

- data collection, needs assessment and analysis are routine and systematic?
- communities, consumers and stakeholders are engaged in planning?
- services and programs are developed to respond to identified needs?
- plans with measureable outcomes are developed and used?
- assessments and plans are executed?
- assessment and planning processes and structures are executed?

Standard 2.2 Services and programs are provided in an effective, safe and responsive way to ensure positive outcomes for consumers and communities.

Evidence Questions: What is the evidence that:

- interventions and actions are based on assessment and planning?

- services and programs are managed to ensure positive outcomes for participants and communities?
- information about the rationale, risks and effect of services and programs is routinely provided to participants and communities?
- consumers and communities participate in decision-making about services and programs they receive?
- services and programs are safe and risks are identified and addressed?
- intake is integrated and priority-based?
- effective referral practices are in operation?
- services and programs follow case/care plans developed with consumers?
- re-assessment occurs after services and/or program is provided to check effectiveness?
- client and community outcomes are documented and clear, accurate and secure client and program records are kept?
- service and program provision are routinely evaluated and the findings used for improvement?
- where appropriate, case closure is planned with the consumer?

Standard 2.5 Services and programs within the organisation are coordinated.

Evidence Questions: What is the evidence that the organisation:

- coordinates services and programs to meet the needs of consumers?
- delivers cross-discipline services seamlessly?
- supports staff working across different disciplines to coordinate services?
- works with consumers to review the effectiveness of coordinated services?

Standard 3.1 The organisation enters into formal service agreements and other less formal partnerships to ensure a continuous and sustainable service.

Evidence Questions: What is the evidence that:

- the organisation works to negotiate service agreements so they are legal, fair and result in quality outcomes for consumers?
- the organisation is accountable through its service agreements and partnerships?
- service agreements and partnerships are reviewed regularly against the values and goals of the organisation and their impact on consumers?
- mechanisms are in place to resolve contractual disputes if they arise?
- contracted services to consumers are reviewed regularly?

Standard 3.2 The organisation collaborates with other organisations and positions itself strategically within the wider service system.

Evidence Questions: What is the evidence that the organisation:

- collaborates with other organisations?
- collaborations contribute to a more effective use of resources?
- avoids unnecessary and inefficient duplication of services?
- reviews the effectiveness of any collaborations in terms of consumer outcomes, available resources and the strategic placement of the organisation?

9.4 National Mental Health Standards

Criterion 6.6: A mental health professional responsible for coordinating clinical care is identified and made known to consumers.

Criterion 6.7: Consumers are partners in the management of all aspects of their treatment, care and recovery planning.

Criterion 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.

Criterion 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.

Criterion 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.

9.5 Recovery Oriented Service Self-Assessment Tool (ROSSAT)

Evidence items are:

Item 1.1: Management and other workers of the organisation identify the following:

- Emerging best practice regarding recovery orientation
- Potential tools and training
- Potential new technologies to assist in provision of recovery oriented services
- Evaluation tools and frameworks

Item 1.2k: The organisation has a strategy for maximising networking opportunities and partnerships with other organisations.

Item 1.8: The organisation values the consumer's right to independently determine who will represent their views to the service, and links people to peer support, peer workers and other advocates in the area.

Item 1.10: The organisation 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 and service level. This is done in accordance with information management and related Commonwealth, State / Territory legislation and Acts.

Item 2.5: Leaders advocate, champion and model:

- Human rights informing service delivery
- The consumers' voice as central to care and service provision
- The belief that recovery is possible and probable for every person
- Hopeful and optimistic attitudes in dealing with workers, consumers and carers.

Item 2.6: Management:

- Is aware of Commonwealth and State policy directions around recovery orientation and integrates these into practice
- Identifies information relevant to the organisation to increase the knowledge base on recovery and recovery oriented practice, including information for consumers, carers and their families.

Item 2.8: Management provide information to workers about other services available in the community relevant to the organisation and consumers.

Item 3.1: Shared hope and optimism for a consumer's future drives service provision.

Item 3.17: Workers support the person, their family and carers to make informed decisions by:

- Sharing information on services, therapies and supports
- Supporting them to find information from other sources.

Item 3.19: Workers support and encourage positive risk taking.

Item 3.20: Workers seek to exchange information with other organisations and agencies to ensure continuity of care (with consent).

Item 3.21: Where a person is not able to access the organisation's services (e.g. not eligible), a reason is provided along with supported referrals to other services.

Item 3.22: Workers are aware of a person's physical health and are able to provide referrals to appropriate health care professionals.

Item 3.23: Workers consider the whole context of a person, and support the person to develop and enhance links in their community (e.g. social networks, peer support groups, education/training, employment, community and rehabilitation services, physical activities, a person's hobbies).

Item 5.3a: Consumers are provided with the regular opportunity to evaluate relationships:

- Their relationship with workers and the organisation
- The appropriateness of the format of communication with their worker
- If their worker presents any barriers to their recovery.

Item 5.3b: Consumers are provided with the regular opportunity to evaluate respectful practice:

- The level of respect they experience from workers within the organisation
- Perceptions of stigma and discrimination experienced from workers within the organisation
- The cultural appropriateness of services received
- Perceptions of how responsive workers are to diversity.

Item 5.3c: Consumers are provided with the regular opportunity to evaluate the consumer self-directed focus:

- The degree to which workers advocate for the persons' centrality in directing their own recovery journey
- The amount of input they have into the services they receive.

Item 5.3d: Consumers are provided with the regular opportunity to evaluate the belief in consumer's recovery:

- Workers attitudes and level of belief they have in recovery
- Support relating to positive risk-taking
- How well their goals have been documented, acknowledged and supported.

Item 5.3e: Consumers are provided with the regular opportunity to evaluate the obtaining and sharing of knowledge and information, the quality and relevance of information provided, the appropriateness of the format information is provided in and the ability to understand information that is provided.

Item 5.3f: Consumers are provided with the regular opportunity to evaluate participation and social inclusion:

- How their worker fosters opportunities for participation
- The worker and organisation's commitment to social inclusion and participation, both within the organisation and in the wider community.

Item 5.4: Consumers, their families and carers actively participate in quality improvement processes including service evaluation, development and decision making.

9.6 NSW Disability Services Standards (DSS)

1.8: Where a service provider is unable to provide a person with a disability access to its service, a referral to another similar service is made, where this exists.

2.3: The service provider, in consultation with each service user, identifies and documents the individual, ongoing and changing needs of the person with a disability and the approaches for meeting those needs.

2.4: The agreed approach for meeting each service user's individual, ongoing and changing needs is implemented and reviewed with that service user within an agreed time frame.

2.7: The service provider considers the appropriateness of general community facilities and services in meeting the individual needs of each person with a disability.

2.8: Each person with a disability is provided with support in a manner which maximises his/her potential to reach personal goals.

5.4: The service provider provides each person with a disability, the opportunity to form and maintain a variety of ties, connections and involvement in the community.

8.12: The service provider has a process of co-ordination with other agencies, advocacy and service user organisations in the area.