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mental health coordinating council

SAFEGUARDS AND MONITORING:

protecting the rights of people receiving care and support in community-managed mental health organisations in NSW

Summary Report and Landscape Review

PREPARED FOR **MENTAL HEALTH COORDINATING COUNCIL**
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TERMINOLOGY

In this document the authors have used the language of lived experience. Where other terminology is used, it reflects the resources cited and referenced.

CONTENTS

Summary Report

EXECUTIVE SUMMARY		**1**
Areas for future action		3
SECTION 1: BACKGROUND		**4**
1.1	Introduction	5
1.2	The policy research question	6
1.3	Project research approach	8
SECTION 2: KEY FINDINGS		**10**
SECTION 3: AREAS FOR FUTURE ACTION		**15**

LANDSCAPE REVIEW

19

SECTION 4: NATIONAL AND NSW POLICY CONTEXT		**20**
4.1	National policy directions emphasise safeguards and monitoring in all delivery settings	21
4.2	NSW policy and strategy expands the role and priority of community mental health services	22
4.3	The NDIS presents opportunities and challenges for the mental health CMO sector	25
SECTION 5: ELEMENTS OF SAFEGUARDING AND MONITORING IN AUSTRALIA		**28**
5.1	Safeguarding and monitoring with national mechanisms	29
5.2	Safeguards and monitoring landscape in NSW	38
5.3	Safeguarding and monitoring landscape in other states	45
SECTION 6: INTERNATIONAL MODELS FOR SAFEGUARDING AND MONITORING		**49**
6.1	Safeguarding and monitoring in selected nations	50
SECTION 7: CONCLUSIONS		**57**
7.1	Limitations of looking at overseas models	58
7.2	General principles to guide good practice	58
7.3	The impact of current policy agendas – national, NDIS and NSW	59
7.4	Gaps and overlaps in safeguarding mechanisms	60
7.5	Points of pressure	60

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

Mental health community-managed organisations (CMOs) play a crucial role in achieving the goals of the Fifth National Mental Health and Suicide Prevention Plan[1] and Living Well: A Strategic Plan for Mental Health in NSW [2] which both envision an expanded role for the community-managed mental health sector with an emphasis on strengthened safeguarding, monitoring and compliance processes.

CMOs are pivotal in providing support for people with mental health conditions living in the community and facilitating improved access to services and programs that embody a trauma-informed recovery-oriented practice approach. Through increased access to these services, the sector aims to support individuals to stay well and out of hospital, while offering greater choice and control.

Major changes to the service delivery environment have increased the focus on ensuring that services are safe and high quality. These changes include:

- the National Disability Insurance Scheme (NDIS) which has a self-contained quality and safeguarding framework, applying to CMOs providing psychosocial supports through the NDIS (but not to other mental health CMOs)
- other community-provided services commissioned by both Primary Health Networks (PHNs) and NSW Health
- many CMOs providing a range of services under different Commonwealth or State funding programs, which are integrated with each other at the point of service delivery
- providers increasingly collaborating and forming partnerships to deliver on the full range of integrated supports people need
- services led and directed by the people using them, and delivered through innovative approaches.

In this context, and at this early stage of an evolving transition, it is timely to examine the function and effectiveness of safeguarding and monitoring and safeguarding mechanisms [3] across community-managed mental health services.

This **project investigated** whether there is a need for the sector to have further or changed safeguarding and monitoring and mechanisms, in the light of transforming service delivery.

Specifically, the project undertook analysis, informed by consultations and a Landscape Review, in order to:

- outline the national and NSW policy context which provides the drivers of change in the operational service delivery environment
- document the safeguarding and monitoring elements and mechanisms in NSW that apply to CMOs providing psychosocial supports
- identify the implications of national and state reforms (including the NDIS Quality and Safeguarding Framework) for NSW mental health CMOs who are registered NDIS providers, and those who are not
- explore and document examples of international and other states' models of safeguarding and monitoring for CMOs providing psychosocial supports
- make tentative conclusions to be tested through further research and consultation.

AREAS FOR FUTURE ACTION

The project identifies the following directions for future consideration and action by all partners in the design, delivery and oversight of community managed mental health services in NSW:

Advocating for good practice principles in the design of safeguarding and monitoring systems, identified from this project's national and international review:

- effective and accessible complaints mechanisms
- strengths-based approaches to building workforce capacity
- oversighting bodies with genuine monitoring and enforcement powers
- transparent reporting of service quality, safety, health outcomes and consumer and carer experience measures.

Revising and developing existing mechanisms, in partnership with consumers and carers, CMOs and the MHCC, in particular:

- the revision of the National Standards for Mental Health Services ensuring that services provided outside major funding programs (and thus not captured by monitoring and reporting frameworks and other contractual requirements) have oversight mechanisms commensurate with the service model and associated risks
- the revisions to the national mental health performance framework to support reporting on performance and quality and its underpinning infrastructure for data collection and reporting.

Addressing gaps in safeguarding mechanisms, in particular by investigating the feasibility and desirability of any additional mechanisms. (No definitive assessment has been made by this project analysis as to whether these mechanisms should be implemented and in what circumstances). The mains gaps identified are:

- the oversight of the use of restrictive practices in this sector and incident management of reportable incidents
- mandatory codes of conduct and employment screening
- extended community visiting schemes—in the light of the national review currently underway, for services for NDIS participants
- systemic overview and public reporting of complaints and reportable incidents.

Further work must give emphasis to the views of consumers and carers.

Addressing overlaps in safeguarding mechanisms, particularly in the areas of:

- standards and accreditation – exploring systems of mutual recognition of standards and 'one-process' accreditation, rather than so-called alignment between sets of standards
- incident management in collaborative partnerships.

Addressing points of pressure for CMOs in this complex regulatory and monitoring environment, specifically:

- meeting multiple sets of standards, including the resource implications of accreditation and auditing requirements
- the cost of partnerships where multiple systems of safeguarding and monitoring apply that are not factored into tender budgets
- accountability for outcomes for which a CMO may only have partial control
- the difficulties the complex NDIS model presents for participants and consumers living with psychosocial disabilities
- the need to build organisational infrastructure and workforce capabilities to work with added monitoring requirements and diverse contractual requirements at provider level.

SECTION 1: BACKGROUND

1.1 INTRODUCTION

It is possible for people with mental health conditions to live well in the community when they have access to the right mix of medical, psychosocial and support services. It is generally accepted by policy makers and practitioners alike, that mental health services are optimally delivered in community settings addressing more than just symptoms of illness. Mental health community-managed organisations (CMOs) play a crucial role in achieving the goals of the Fifth National Mental Health and Suicide Prevention Plan[4] and Living Well: A Strategic Plan for Mental Health in NSW which both envision an expanded role for the community-managed mental health sector.[5]

CMOs are pivotal in providing support for people with mental health conditions living in the community and facilitating improved access to services and programs that embody a trauma-informed recovery-oriented practice approach. Through increased access to these services the sector aims to prevent crises and support individuals to stay well and out of hospital, while offering greater choice and control and supporting decision-making in a way that promotes self-determination and maximises independence.

The benefits to consumers are clear. However, in a rapidly changing and more competitive environment the rigour of clinical governance mechanisms and a focus on consumer rights may become less central to service delivery. A lack of attention in these areas may present opportunities as well as create risks that have the potential to undermine the many consumer benefits. At worst they could result in significant harm and raise questions about the effectiveness of the system to provide consumer protection.

In this context, and at this early stage of an evolving transition, it is timely to examine the function and effectiveness of monitoring and safeguarding mechanisms [6] across community-managed mental health services providing a wide range of psychosocial mental health and support services, at times fully integrated with clinical services provided in partnership or collaborations.

Mental health community-managed organisations (CMOs) are a crucial part of the entire mental health and human services system in NSW, contributing to improved outcomes for people experiencing, or at risk of developing, mental health conditions and psychosocial disability. They play a key role in promotion, prevention, early intervention, and providing the supports that assist people to stay well in the community. These organisations provide a range of services, including self-help and peer support, information, advocacy and promotion, leisure and recreation, employment and education, accommodation support and outreach, family and carer support, primary healthcare, care and service coordination, helplines and psychosocial rehabilitation and clinical services. CMOs receive funding from State, Territory and Commonwealth governments, and deliver services that are planned and commissioned by Primary Health Networks.

In 2010, the Mental Health Coordinating Council (MHCC) conducted the NSW Mental Health Community Managed Organisation Sector Mapping Project to provide a picture of the CMO sector in NSW. A taxonomy of services, was developed with seven core community-managed mental health service functions that are necessary to meet population-based needs within each local area. [7]

Since 2010, the sector has undergone significant expansion and diversification as the recovery-focused trauma-informed approach has been implemented widely within the sector. Service providers are increasingly collaborating and forming partnerships to deliver on the full range of supports a person needs, led and directed by the person and delivered through innovative approaches. Many CMOs now provide a range of different services under different Commonwealth or State funding programs which are integrated with each other at the point of service delivery.

The taxonomy of activity developed for the National Minimum Dataset for Mental Health Establishments in NSW CMOs: Scoping Study[8] is a more flexible approach to looking at 'who we are'. It provides a 'product' list which can be measured. It reflects in part the menu of NDIS costed services a provider may deliver and 'charge' for, so accommodates the most recent 'framework' CMOs must work with.

NATIONAL MINIMUM DATASET SERVICE TAXONOMY

- Care coordination
- Counselling - face-to-face
- Counselling, support, information and referral - online
- Counselling, support, information and referral - telephone
- Education, employment and training
- Family and carer support
- Group support activities
- Individual advocacy
- Mental health promotion
- Mental illness prevention
- Mutual support and self-help
- Personalised support - linked to housing
- Personalised support - other
- Sector development and representation
- Self-help—online
- Service integration infrastructure
- Staffed residential services

As the NDIS is implemented and as more community-provided services are commissioned by both Primary Health Networks (PHNs) and NSW Health, demonstrating that services are safe and high quality is increasingly important. Currently many community-managed mental health services ensure safety and quality through service accreditation processes and a variety of mainstream protections and contractual requirements.

Since 1 July 2018, community mental health services that provide psychosocial supports through the NDIS have their services regulated by the newly established NDIS Quality and Safeguards Commission (the Commission). The Commission is a new independent body that is regulating the NDIS market through provider registration and resolutions of complaints about the quality and safety of NDIS supports and services.

1.2 THE POLICY RESEARCH QUESTION

Monitoring services for safety and quality is an important means of protecting the rights of people receiving services and can drive service improvements. In this new environment there are a number of aspects of the system that are unclear or yet to be determined, including how the design and operation of the NDIS translates to delivery of psychosocial supports to people eligible for the NDIS.[9] [10]

Furthermore, it is unclear how the workforce will be supported with the skills and competencies to appropriately oversight services delivered to people living with psychosocial disability by new entrants to the market such as specialist disability providers. Likewise, how the NDIS Commission will interface with other oversight mechanisms that monitor services provided to people receiving services both inside and outside of NDIS eligibility.

The NDIS is not the only policy reform impacting on the sector—there are major changes at state level outlined in Section 2. Nevertheless, the NDIS has become a major driver of change as psychosocial disability has been recognised as a disability that may arise from living with a mental health condition, requiring supports that can be met within its framework. As a consequence providers have commenced an uneasy and somewhat unplanned entrance into this new disability services 'market'.

In this project, the Mental Health Coordinating Council investigates the need for safeguarding and monitoring the rights of consumers and carers to choice and control and to high quality support, in the light of changes in the operational delivery environment. The main **drivers of change** we canvass are:

- the National Disability Insurance Scheme (NDIS) and its regulatory frameworks
- growth in CMO delivery of mental health services, including mental health care and psychosocial support funded by NSW Health as part of the NSW reform agenda, commissioning of services by Primary Health Networks and other changes to Commonwealth program arrangements.

The policy research question explored: Does the sector and agencies representing consumer and carer interests need additional or amended safeguarding and monitoring mechanisms in the light of a transforming service delivery policy and operational context?

Specifically, the project undertakes analysis (informed by consultations and a Landscape Review to identify next steps within the NSW context with particular reference to:

- analysing the interface between existing mechanisms in NSW and the implications of the new framework of the NDIS Quality and Safeguards Commission for mental health CMOs who are registered NDIS providers, and those which are not, but provide direct psychosocial support
- identifying gaps and overlaps in these mechanisms, comparing both the NDIS framework for registered providers, the existing quality systems applying to all providers and any best practice models or elements identified in the Landscape Review.

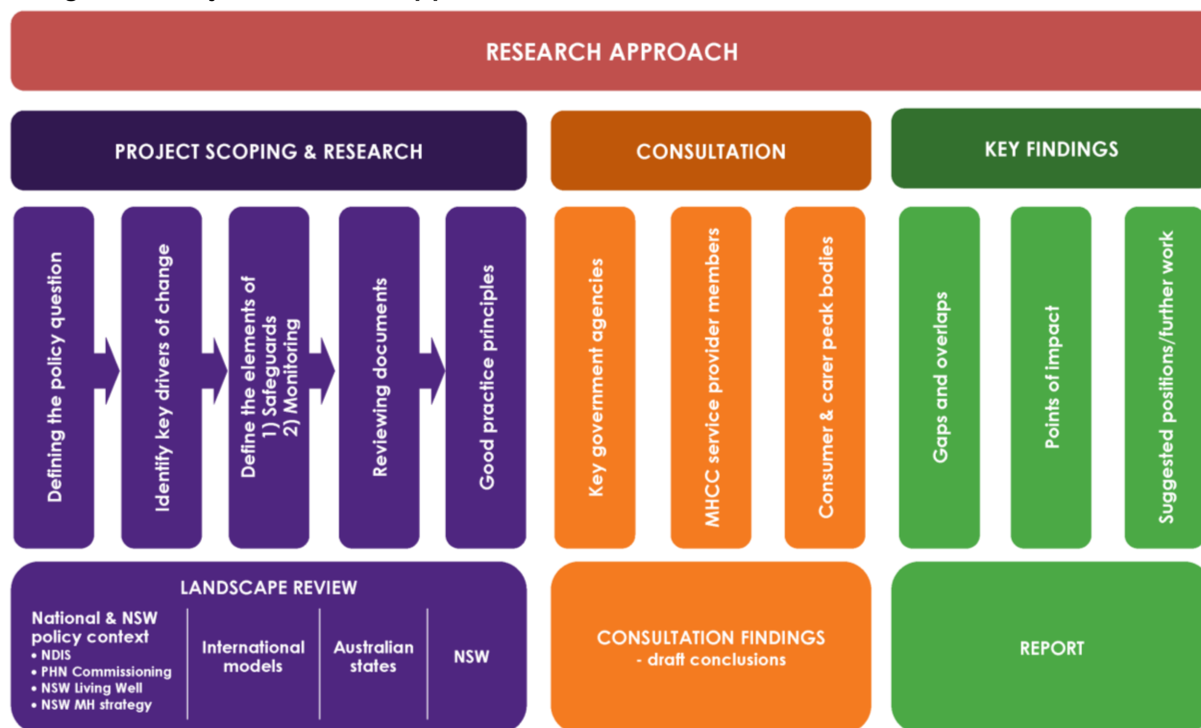
Many NSW mental health CMOs provide programs for NDIS participants and others, often within an integrated recovery-focused framework. These programs are subject to a range of quality mechanisms and external accountability requirements. In this context it is possible that CMOs, or some of their activity, will not be captured by oversight activities to the same degree, or to a satisfactory degree, or that duplication occurs with different requirements for similar programs.

CMOs which provide information, advocacy and health promotion services only are out of scope for this project.

1.3 PROJECT RESEARCH APPROACH

The project approach is illustrated in Diagram 1 below. The project foundation was a comprehensive Landscape Review which provided the stimulus material for a series of consultations with key informants identified in specific NSW and Commonwealth government agencies and for a workshop with MHCC service provider members. Learnings from these two sources of intelligence were then synthesised into the Key Findings presented in Section 1.4 below. The Landscape Review is presented in a companion document to this Summary Report.

Diagram 1: Project Research Approach



The **consultations** were conducted over a three-week period in face-to-face interviews (with some telephone interviews where a face-to-face meeting was not feasible) according to a semi-structured interview format. Interviews were conducted with representatives of:

- Australian Commission on Safety and Quality in Health Care
- Department of Social Services, Disability Advocacy Branch
- Health Care Complaints Commission
- Mental Health Commission of NSW
- NSW Department of Premier and Cabinet, Quality and Safeguards, Social Policy Group
- NSW Health, Community Partnerships, Mental Health Branch
- NSW Health, Partnerships for Community Living Initiative, Mental Health Branch
- NSW Official Visitors Program
- NSW Ombudsman
- NDIS Quality and Safeguards Commission
- Accrediting and auditing companies – in relation to certification and assessment processes.

Representatives of service providers who are members of the MHCC participated in an interactive forum on November 14 at the MHCC offices and also had the opportunity to contribute to the project via an online survey.

The **Landscape Review** uses, as an organising approach:

- the *safeguarding elements* within the NDIS Quality and Safeguarding Framework [11]
- the *monitoring requirements* of funding bodies, which extend beyond safeguarding mechanisms to mechanisms to manage risk and establish accountability.

First it identifies the mechanisms from the NDIS Framework applicable to NSW mental health CMOs which are registered NDIS providers, and the like mechanisms for those providers that are not NDIS providers but do provide psychosocial support services. It also sets out the relevant information about these mechanisms from selected states and other national models (see Diagram 1 above).

We have chosen to focus on the elements from the NDIS Quality and Safeguarding Framework, as these were developed following significant and extensive research and consultation. This Framework provides a comprehensive evidence-based inventory of the elements being implemented in the disability sector and services providing psychosocial supports within the scheme, bringing together research and models from Australian and international jurisdictions. It provides a solid benchmark against which to consider what is appropriate and suitable for mental health CMOs not captured by the NDIS monitoring and safeguarding mechanisms. Consultation with key informants indicated this was a sound approach.

The NDIS Quality and Safeguarding Framework has two main dimensions:

- components are divided into three domains—developmental, preventative and corrective—each with a range of mechanisms or interventions
- the 'target' of the components—the individual, the workforce, providers.

Within this comprehensive set of mechanisms (17 in total plus links to other frameworks), this project focuses on the *preventative* and *corrective* domains across the three target groups - individuals, the workforce and providers. These two domains are the province of national, state and provider-level efforts.

Mechanisms (laws, policies, conventions and charters) which are focused on helping people protect themselves, through knowing their rights and making informed choices, are covered in laws on discrimination and human rights. Information, education, workforce training, levers of an open market, are similarly outside our project scope.

This project is primarily concerned with those mechanisms that keep people who access mental health services in the community safe and provide pathways and processes if something goes wrong. This approach is validated in the Consultation Report documenting stakeholder views and needs for the NDIS Framework. Stakeholders emphasised the need for high-level regulation in a competitive market for disability care and support.

Second, the Landscape Review examined the monitoring and oversight mechanisms impacting on CMOs which are usually reflected in contractual arrangements, to different degrees, depending on the program and the funding body.

SECTION 2: KEY FINDINGS

KEY FINDINGS

The key messages identified by the Project in response to the policy research question are outlined below.

The policy research question explored: Does the sector and government agencies representing consumer and carer interests need additional or amended safeguarding and monitoring mechanisms in the light of a transforming service delivery policy and operational context?

1 National policy directions emphasise safeguards and monitoring in all delivery settings

The national mental health reform agenda impacts on CMO service delivery, governance and internal processes for safeguarding, monitoring and compliance. These impacts are identified in the table below. Each reform area has implications for the NSW CMO sector.

Primary Health Networks:	PHNs have a significant role in planning, commissioning and integrating mental health and suicide prevention services at a regional level through a stepped care model. Collaborative approaches with local partners are required. Mental Health CMOs are viewed as one of a number of potential partners in the commissioning process. Long-term funding is also required to develop long-term solutions and, in turn, to provide longer-term contracts through the commissioning process – currently a short-term approach is being used with short contracts of around 12 – 18 months.
NDIS:	Development of a psychosocial disability pathway. Key implementation issues are how the NDIS will interact with other systems (such as health, education and justice) to provide coordinated support for people with a mental illness, and how consumers will access Continuity of Support and National Psychosocial Supports measures.
Suicide prevention:	The local area suicide prevention trials are an opportunity to gain insights about the process and outcomes of systematic implementation of suicide prevention programs targeted to local at-risk groups, however action is need to close persistent gaps in the collection and distribution of key real-time data. There is also a lack of appropriate care and support for people in crisis, and insufficient training on suicide prevention for people working in the health, allied health and community sectors.
Mental health workforce:	Actions are needed to address high turnover, the need for suicide prevention training, the challenges of rural and remote locations and the need for more peer workers and Aboriginal and Torres Strait Islander representation.
Seclusion and restraint:	Further targeted work is needed to implement the cultural and practice changes that will ultimately lead to eliminating seclusion and restraint.
Consumer and carer participation:	The National Mental Health Commission with its partners continues to focus on promoting participation by and engagement of consumers and carers. Specific strategies to capture and use consumer and carer feedback (the YES and CES surveys) are being developed for national implementation.

Mental health outcomes:	The National Outcomes and Casemix Collection data for Years 2008 to 2016 showed the majority of consumers in both inpatient and community-based mental health settings experienced significant improvement in their mental health and psychosocial functioning. The Your Experience of Service survey was designed to gather information from consumers about their experiences of care. It is anticipated that pooled data from the YES survey will be available for three jurisdictions in 2019, providing valuable insight into the consumer experience of mental health services. The National Minimum Data Set for Mental Health NGOs collects nationally consistent information on the activity of mental health CMOs, and is the subject of further development under the new Mental Health Information Strategy – while not outcome-focussed, it is an important element in a comprehensive information system for policy, planning and operations.

2 NSW policy and strategy expands the role and priority of community mental health services, safeguards and monitoring are one consideration in this expansion

The strategies in the NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022 present opportunities for the CMO sector, through its peak body the MHCC, to engage with the NSW Ministry of Health to ensure that the priorities and requirements of the CMO sector are accounted for.

3 The NDIS presents opportunities and challenges for the mental health CMO sector

The creation of the NDIS has major implications for the mental health CMO sector. It links these providers directly to a framework designed for the established and diverse disability sector, with its own language and approaches to working with consumers and carers, service providers and governance and funding partners. It is a new wholly contained system, with a detailed quality and safeguarding compliance regime. It has the potential to introduce overlaps and inefficiencies for those CMOs operating in dual systems of oversight.

4 Standards and accreditation programs applying to CMOs providing mental health care and psychosocial supports are a major existing element of monitoring and safeguarding mechanisms for NSW service providers. Diversification into new sectors introduces the potential for additional costs for providers. The NDIS introduces scope for duplication

Diversification of service models to better meet needs of consumers and carers has brought many Mental Health CMOs into the orbit of differing standards frameworks—both mandatory and optional. The major standards frameworks identified are:

- National Standards for Mental Health Services
- National Safety and Quality Health Service Standards
- National Standards for Disability Services
- Health and Community Services Standards
- NDIS Practice Standards

Some CMOs are also operating in the aged care sector—aged care quality standards and accreditation programs apply. There are also service standards applicable to operating in a multicultural environment, meeting the needs of Aboriginal people, and other groups such as people who identify as LGBTQI, women and children, people experiencing family violence and others. These standards are generally not associated with formal accreditation programs but represent best practice for particular client groups.

Particular standards compliance, most relevant to MH CMOs operating in NSW, and issues arising with each particular standards set are identified in the Landscape Review and summarised below.

- The National Standards for Mental Health Services (NSMHS) are currently under national review. Many informants consider these should be the primary set of standards applying and tested for compliance by third party accreditation bodies.
- The National Safety and Quality Health Service (NSQHS) Standards are most relevant to NSW mental health CMOs which deliver in partnership models with LHD services. For example, some LHDs have mental health sub-acute units which provide short term residential care in a model of care where psychosocial support is provided by a contracted CMO and the LHD provides clinical care. The NSQHS and the NMHS standards have both recently been mapped to show alignment, and a user guide developed.
- Accreditation under the National Standards for Disability Services (NSDS) has now largely been overtaken by registration as an NDIS provider—requiring certification under the NDIS Practice Standards and assessment and auditing by a third party approved auditing body.
- It is unclear what the future status of the QIC standards and accreditation program is if a CMO using these standards diversified into NDIS provision or tendered for contracts requiring compliance with other sets of standards. Accreditation commercial bodies advise they intend to conduct concurrent but distinct assessment for each set of standards.
- The NDIS Practice Standards seem to be a 'cost to the provider' and do not fully replace other standards and accreditation programs. CMOs may need alternative accreditation providers who can work with multiple sets of standards. This may not be possible for providers who have committed training and resources working within one set of standards or a provider not eligible to provide NDIS auditing services.
- ISO 9001 has been to date an acceptable set of standards to meet requirements for funding agreements in some programs.
- Some PHNs have required conformity with National Practice Standards for the Mental Health Workforce, although evidence, such as accreditation or certifications, are not required. The degree of take up of these standards in the Mental Health sector is unknown.

5 Alignment between sets of standards and efficiency in accreditation processes is critical for CMO providers with diverse activities

The NDIS Practice Standards function as a stand-alone set of standards and assessment requirements. Only some of the approved accreditation (called auditing) agencies are able to assess against all the major standards sets (NDIS, NSMHS, NSQHS, ISO 9001). Notwithstanding the work undertaken to achieve an integrated approach to their business products, this is a more extensive and expensive exercise than single standards assessment for accreditation.

6 Effective monitoring for safety and quality, and for accountability of funded organisations, requires investment in information systems, ongoing training, and accurate and reliable specification of outcomes to be achieved

There is interest and broad support from NSW CMOs in the implementation of the National Minimum Standards Set for NGOs. The current work being undertaken in partnership between the MHCC and the NSW Ministry of Health provides a basis for NSW action on this element. There is interest and intention from NSW Health to progress the comprehensive use of the YES/CES survey and the reporting of at least a single outcome tool – the Living in the Community Questionnaire (LCQ). Mandating would be through funding agreements.

SECTION 3: AREAS FOR FUTURE ACTION

AREAS FOR FUTURE ACTION

The project has synthesised five key directions for future consideration and action by all partners in the design, delivery and oversight of community managed mental health services in NSW:

3.1 Advocating for good practice principles in the design of safeguarding and monitoring systems, identified within this project's national and international review:

- effective and accessible complaints mechanisms
- strengths-based approaches to building workforce capacity
- oversighting bodies with genuine monitoring and enforcement powers
- transparent reporting of service quality, safety, health outcomes and consumer and carer experience measures.

3.2 Revising and developing existing mechanisms, in partnership with consumers and carers, CMOs and the MHCC.

The Fifth National Mental Health Plan has recently established a program of policy development which CMOs and the MHCC will need to actively work with. Within this, the priorities for the MH CMO sector should be with:

- the revision of the National Standards for Mental Health Services
- a revised national mental health performance framework to support reporting on performance and quality and its underpinning infrastructure for data collection and reporting.

Funded MH CMOs are generally required to have a complaints management system as part of service agreements, but no detailed features are usually specified.

The NDIS quality and safeguarding framework has more rigorous requirements for complaints and incident management. These now apply to a subset of MH CMO providers and a subset of people accessing psychosocial supports. The NDIS brings with it complexity, overlaps and gaps in this area of safeguards.

The NSW Health approach to monitoring and enforcing quality and safeguards is through national standards, contractual requirements around safeguarding mechanisms and state-wide reporting frameworks. However, this only captures services provided under major funding programs.

3.3 Addressing gaps in safeguarding mechanisms, by investigating the feasibility and desirability of additional mechanisms. No definitive assessment has been made by this project analysis as to whether these mechanisms should be implemented and in what circumstances. The main gaps are:

- oversight of restrictive practices, incident management in particular for reportable incidents
- mandatory codes of conduct
- employment screening for all workers
- Community Visitors in all settings – the current review may recommend a broad national scheme of oversight – for the NDIS. This will leave a gap in coverage for non-NDIS participants
- systemic overview and public reporting of complaints and reportable incidents.

3.4 Addressing overlaps in safeguarding mechanisms, particularly in the areas of

- standards and accreditation – there is a need to explore mutual recognition rather than alignment between sets of standards
- incident management in collaborative partnerships.

3.5 Addressing points of pressure for CMOs, in this complex regulatory and monitoring environment, specifically:

- meeting multiple sets of standards, including the resource implications of accreditation and auditing requirements
- the cost of partnerships where multiple systems of safeguarding and monitoring apply that are not factored into tender budgets
- accountability for outcomes for which a CMO may only have partial or limited control
- the difficulties the new and complex NDIS model presents for participants and consumers living with psychosocial disabilities
- the need to build organisational infrastructure and workforce capabilities to work with added monitoring requirements and diverse contractual requirements at provider level.

LANDSCAPE REVIEW

LANDSCAPE REVIEW

The Landscape Review informs the Summary Report and:

- Outlines national and NSW policy context which provides the drivers of change in the operational service delivery environment (section 4)
- Documents the safeguarding and monitoring elements and mechanisms in NSW that apply to CMOs providing psychosocial supports (section 5)
- Identifies the implications of national and state reforms (including the NDIS Quality and Safeguarding Framework) for NSW mental health CMOs who are registered NDIS providers, and those who are not (section 6)
- Explores and documents examples of international and other states' models of monitoring and safeguarding for CMOs providing psychosocial supports (sections 5 and 6)
- Makes tentative conclusions to be tested through the next phase of the project (section 7).

SECTION 4: NATIONAL AND NSW POLICY CONTEXT

4.1 NATIONAL POLICY DIRECTIONS EMPHASISE SAFEGUARDS AND MONITORING IN ALL DELIVERY SETTINGS

The Fifth National Mental Health & Suicide Prevention Plan was released in August 2017 to establish a cross-jurisdictional framework for implementing national action over five years. It targets action across eight priority areas. Key elements of the context for the Fifth Plan are:

- the staged roll-out of the National Disability Insurance Scheme (NDIS)
- the establishment of Primary Health Networks to provide primary and specialist mental health care, include commissioning of local integrated services from CMOs.

Overall, the Fifth Plan established a national approach to improve the provision of integrated mental health and related services across Australia, together with state and territory mental health and suicide prevention plans and policy reforms. It continues the focus on lived experience, choice and control, person-centred care and improving physical health – along with trauma-informed recovery-oriented practice, programs and suicide prevention services.

Safety and quality is one of the Fifth Plan's eight priority areas, with actions including:

- Inter-jurisdictional development of a National Mental Health Safety and Quality Framework incorporating:
  - identifying new and emerging national safety and quality priorities and updating the 2005 statement of National Safety Priorities in Mental Health
  - a revised national mental health performance framework to support reporting on performance and quality across all mental health service sectors
  - a guide for consumers and carers that outlines how they can participate in all aspects of what is undertaken within a mental health service so that their role in ongoing safety and quality initiatives is strengthened
  - a process for revising the National Standards for Mental Health Services (NSMHS) that accounts for interfaces with other relevant standards, such as the National Disability Standards
  - inter-jurisdictional development of a mental health supplement to the National Safety & Quality Health Service (NSQHS) Standards to align them with the NSMHS
- monitoring of consumer and carer experiences of care, including the Your Experience of Service survey tool, across the specialised and primary care mental health service sectors
- an updated statement on National Mental Health Information Priorities for information developments over the next ten years.

The Implementation Plan for the Fifth National Mental Health Plan sets out milestones up to 2022 to provide guidance for governments, stakeholders and the health sector. Progress against it is monitored by the National Mental Health Commission. The Commission's recent National Report 2018: Monitoring Mental Health & Suicide Prevention Reform[12] sets out progress in national mental health and suicide prevention reforms, and a separate report is provided on progress with the Fifth Plan.

KEY MESSAGE:
The national mental health reform agenda impacts on CMO service delivery, governance and internal processes for safeguarding, monitoring and compliance. These impacts are identified in the following table. Each reform area has implications for the NSW CMO sector.

4.2 NSW POLICY AND STRATEGY EXPANDS THE ROLE AND PRIORITY OF COMMUNITY MENTAL HEALTH SERVICES

In NSW, the ten year mental health reform agenda for 2014-2024, in response to the Mental Health Commission of NSW's *Living Well* report, has involved an additional $100 million in 2018-2019 and focuses on partnerships with CMOs, consumers and carers. **This figure** shows the reform's five strategic aims.

The five strategic directions of the Reform

1. **Strengthening prevention and early intervention** – with a stronger focus on services for children and young people.
2. **Supporting a greater focus on community based care** – including providing more community based services and a phased transition of long-stay psychiatric hospital patients into safe community care.
3. **Developing a more responsive system** – through improved specialist services for people with complex needs such as borderline personality disorders and those in hospital with physical health care needs.
4. **Working together to deliver person-centred care** – including better integration between mental health services, mainstream health, justice and human services, and Australian Government funded services.
5. **Building a better system** – including developing the mental health workforce, establishing an evidence base and research to support improvement, improving engagement with families and carers, growing and supporting a peer workforce, and increasing NGO capacity to deliver services.

NSW Health commissions CMOs to deliver mental health community support services, and is in the process of moving commissioning processes from block-funded grants towards a competitive, transparent and accountable purchasing framework. Contestability has already been introduced to some mental health programs delivered by community managed services including the larger programs: — Community Living Supports, the Housing and Supported Accommodation Initiative, the Suicide Prevention Fund, and LikeMind.

Community mental health programs funded by NSW Health currently are: [13]

Community Living Supports:	Funded through Local Health District (LHD) mental health services and delivered by CMOs, it as an integrated care and psychosocial support model for people living with a severe mental illness. Includes the Youth Community Living Support and Enhanced Adult Community Living Support.
Family and Carer Mental Health Program:	State-wide initiative delivered in partnership by LHDs, the Justice and Forensic Mental Health Network and five CMOs to support family and carers of people with mental illness.
Housing and Accommodation Support Initiative & Resource and Recovery Support Program:	Delivers community-based psychosocial support. HASI is a partnership between NSW Ministry of Health, Housing NSW and the CMO sector. RRSP delivers low intensity support for people living with a mental health illness to facilitate access to meet employment, educational, recreational and/or leisure needs.
HASI Plus:	Provides 16 and 24 hour per day coordinated housing, clinical and accommodation support services for people living with severe or persistent mental illness to transition to living in the community from long term institutional care.
LikeMind:	A range of clinical and psychosocial services are co-located within LikeMind centres under a three-year pilot program funded by the NSW Ministry of Health delivered by CMOs
Ministerial Approved Grants:	Funding is provided for a range of Aboriginal Medical, Health, Research and Community Services; peer support programs, crisis telephone counselling and community sector development.
Pathways to Community Living Initiative:	A state-led program for 300 individuals who experience severe or persistent illness who have been patients in hospital longer than 365 days. The initial focus is on people who are elderly who require aged care support.
Suicide Prevention Fund:	Eight CMOs deliver community-based suicide prevention strategies, which range from education programs to postvention care. The eight services seek to meet identified local need and are aligned with Lifespan, a systems-based framework for suicide prevention.
Other grants:	A range of service provision including CMO learning and development, National Disability Insurance Scheme training for the mental health sector in NSW, pop-up drop-in centres, suicide prevention activities and Centre for Rural and Remote Mental Health program.

NSW mental health CMOs provide a diversity of care and support for people living with mental health issues. In 2018, of the MHCC's member organisations:

- 38% are registered NDIS providers
- 47% provide residential accommodation – either crisis, short term or longer term.

The recent NGO-E report lists the CMO providers for the principal NSW Health programs – HASI/RRSP, CLS, FCMHP, and LikeMInd, as well as those funded through Ministerial approved grants. The report identifies 9 large diverse CMOs and a further 50 CMOs, some of which provide specialised services (e.g. Aboriginal-controlled) or are community organisations providing a range of welfare, disability and mental health services.

As part of the NSW reforms, the recent (August 2018) NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022: A Framework and Workforce Plan for NSW Health Services provides overarching guidance for NSW Health strategic action over the next five years, and guidance for CMOs and PHNs.

Goal 2- NSW Strategic Framework and Workforce Plan – is for safe, high quality care. Actions include to:

- Embed learnings from improvement processes, including the Your Experience of Service (YES) survey and developing capacity for web-based collections and a CMO trial implementation of YES, and establishing the Mental Health Carer Experience of Service (MH CES) survey in NSW public mental health services and CMOs. *Strategy 5.1:*
- Improve safety and quality monitoring and public reporting, by including monitoring of safety and quality measures in CMO contracts, via the NSW Health System Purchasing and Performance (SPP) Safety and Quality Framework, and by developing a public mental health report with BHI. *Strategy 5.2*
- Develop national guidance and information on safety and quality and experience of care by working with the Commonwealth on the National Mental Health Safety and Quality Framework and its components identified in the Fifth National Plan. *Strategy 5.4:*

The NSW reform agenda has changes to the sector. The MHCC's 2018 scoping study: Implementing the National Minimum Dataset for Mental Health Establishments in NSW CMOs[14] notes that:

- fewer contractual arrangements and the move towards larger providers can be at the expense of the local knowledge and expertise developed by smaller providers and has prompted the amalgamation of smaller and often specialised CMOs
- competitive tendering processes, while aimed at a robust, efficient and dynamic sector, can disrupt service delivery and negatively impact on service users and support workers, local community partnerships, and established organisational infrastructure
- the administrative burden on CMOs to collect data and produce reports is increasingly complex and time-consuming. The funding agencies' needs to focus on accountability, strategic planning, competitive tendering, costs, privacy and outputs can compete with CMOs' focus on individual improvement, outcomes, capacity building, data sharing, community growth, evaluation, planning and service quality improvement.

KEY MESSAGE:
The strategies in the NSW Framework present additional opportunities for the CMO sector, through its peak body the Mental Health Coordinating Council, to engage with the NSW Ministry of Health to ensure that the strategic priorities and requirements of the CMO sector are accounted for.

4.3 THE NDIS PRESENTS OPPORTUNITIES AND CHALLENGES FOR THE MENTAL HEALTH CMO SECTOR

The National Insurance Disability Scheme (NDIS) is primarily a major reform focused on the disability sector in Australia, which presents issues for the mental health providers seeking to enter and operate within its complex policy and regulatory frameworks. Likewise specialist disability providers are moving into the provision of psychosocial supports, sometimes without the experience, understanding and training in the trauma-informed recovery-oriented practice approach that underpins contemporary community-based mental health service provision in Australia.

NDIS and mental health: The NDIS is an Australia-wide scheme to support people with permanent and significant disability which is replacing the current disability support system. It funds long-term high-quality care and support for people living with significant disabilities, improves links between the community and people with disabilities, provides information, and ensures quality assurance and best practice among service providers. With the inclusion of psychosocial disability within the scope of the NDIS, people experiencing ongoing impairments and participation restrictions related to mental health conditions can be eligible for the NDIS – although its original processes were not designed for this group of people.

The August 2017 report of the Commonwealth Joint Standing Committee on the NDIS: Inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition recommended improving planners' knowledge and understanding of psychosocial disability, and increased flexibility in plans to respond to people's fluctuating support needs. Improving the support provided to NDIS participants with complex needs is recognised across governments as a key priority as noted in the report. These issues were reinforced in the NSW Government submission to the NSW Parliamentary Inquiry. (Submission 313). In the Australian Government Response to the Joint Standing Committee on the National Disability Insurance Scheme: Progress Report - General issues around the implementation and performance of the NDIS, the Government responded to the recommendation by agreeing to ensure Operational Guidelines are provided to give practical guidance for decision makers on the interpretation of these requirements and the guidelines are available on the website for public information.

The Productivity Commission's Study Report into NDIS costs recommended improving planner capability, the need for specialist planners, and use of specialised staff for people with psychosocial disability. The recent Independent Pricing Review also recognised the need to improve the pricing framework's consideration of complex need.

Informed by the nationwide consultations and a report by Mental Health Australia in October 2018 the Australian Government announced a NDIS psychosocial pathway to improve the experiences of people living with psychosocial disability entering the NDIS. The National Disability Insurance Agency (NDIA) announced the initial pilot of the participant pathway which commenced in mid-December in two NDIS regions in Victoria.

Safeguarding across the NDIS: The NDIS Quality and Safeguards Commission is an independent Commonwealth body established to oversee the delivery of quality supports and services under the NDIS. The NDIS Commission is implementing the NDIS Quality and Safeguarding Framework.

The Framework came into effect in NSW in July 2018. It sets out standards to support NDIS participants, carers and providers and articulates the rights and responsibilities of participants, providers and their staff.

The NDIS Commission also supports NDIS participants to exercise choice and control, ensure appropriate safeguards are in place for NDIS supports, and establish expectations for providers and their staff to deliver quality support. Choice and control also means that participants are able to make decisions about the level of risk they are prepared to take to make informed judgements about the quality and suitability of providers, and have the tools and information they require to support them make those decisions.

The NDIS Commission brings together various quality and safeguarding functions under a single agency for the first time, including a suite of education and regulatory powers that will apply across Australia and replace many of the existing state-based quality and safeguarding measures—which are managed both through regulation and policy.

Functions of the NDIS Commission

- respond to concerns, complaints and reportable incidents, including abuse and neglect
- promote the NDIS principles of choice and control, and work to empower participants to exercise their rights to access good quality services as informed, protected consumers – consistent with the UN Convention on the Rights of Persons with Disabilities
- require NDIS providers to uphold participants' rights to be free from harm
- register and regulate NDIS providers and oversee the new NDIS Code of Conduct and Practice Standards
- provide guidance and best practice information to NDIS providers on how to comply with their registration responsibilities including how to provide culturally responsive and appropriate disability supports
- monitor compliance against the NDIS Code of Conduct and Practice Standards including undertaking investigations and taking enforcement action
- monitor the use of restrictive practices with the aim of reducing and eliminating such practices
- design and implement nationally consistent NDIS worker screening
- education, capacity building and development for people with disability, NDIS providers and workers.

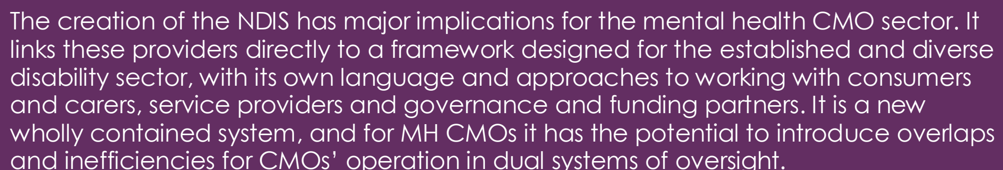
The NDIS Quality and Safeguarding Framework is founded on principles centred on human rights, proportionality and effectiveness.

NDIS Quality and Safeguarding Framework's objectives are to ensure that NDIS-funded supports:

- uphold the rights of people with disability, including their rights as consumers
- facilitate informed decision making by people with disability
- are effective in achieving person-centred outcomes for people with disability in ways that support and reflect their preferences and expectations
- are safe and fit for purpose
- allow participants to live free from abuse, violence, neglect and exploitation, and
- enable effective monitoring and responses to emerging issues as the NDIS develops.

The Framework consists of:

- measures targeted at **individuals**, the **workforce** and **providers**
- for each of these groups:
  - **developmental** measures help to strengthen the capability of people with disability, disability workers and suppliers of supports under the NDIS
  - **preventative** and **corrective** measures help to ensure appropriate responses to issues that arise, as well as identifying opportunities to prevent them in future, either through a regulatory response, or through education and capacity building.

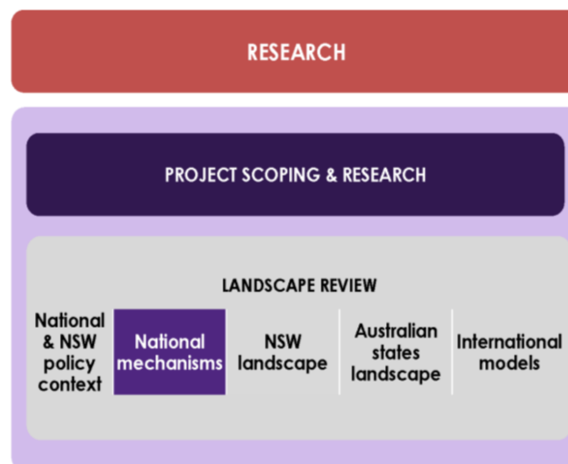


KEY MESSAGE:
The creation of the NDIS has major implications for the mental health CMO sector. It links these providers directly to a framework designed for the established and diverse disability sector, with its own language and approaches to working with consumers and carers, service providers and governance and funding partners. It is a new wholly contained system, and for MH CMOs it has the potential to introduce overlaps and inefficiencies for CMOs' operation in dual systems of oversight.

SECTION 5: ELEMENTS OF SAFEGUARDING AND MONITORING IN AUSTRALIA

5.1 SAFEGUARDING AND MONITORING WITH NATIONAL MECHANISMS

A number of the key elements in the safeguards and monitoring regime are national; or governments have committed to national approaches and schemes with variations at a state and territory level. Therefore an understanding of the national approach and its implementation within states is necessary.



The NDIS Quality and Safeguarding Framework is a national model adopting a consistent approach, when implemented across Australia—but only for a subset of providers and people with mental health conditions accessing services.

Using the elements framework outlined in Section 1, the grey shaded elements have accessible public information on how they apply to the community mental health sector in various states.

Safeguards and monitoring – key elements	
1. Charters of Rights	Targeted at Individuals
2. Complaints Management	
3. Oversight of Restrictive Practices	
4. Official/Community Visiting Schemes	
5. Advocacy services	
6. Employee Screening	Targeted at the workforce
7. Codes of Conduct	Targeted at workers & providers
8. Standards & Accreditation	Targeted at providers
9. Incident Management	
Monitoring systemic	
10. Information systems and monitoring: data, contractual reporting, client outcomes using standardised tools.	Targeted at providers Systemic overview by sector
11. Systemic overviews of complaints and incident management	System

5.1.1 ELEMENTS IN AND OUT OF SCOPE OF FURTHER ANALYSIS

Element 1: Charters of Rights is a high level protection for consumers and drives the language and philosophy underpinning safeguarding. It is not within the project remit to consider or recommend change to these high level instruments. They are merely noted for context and the important foundational role in other elements.

Element 4: **Visiting Schemes** encompasses the existing community visiting schemes in the disability sector and the official visitor schemes for public and private mental health facilities. The place of community visitor schemes in the safety and quality regime of the NDIS has yet to be determined. That is because there is much variation between states and territories in their coverage and operation. One critical variable is whether the visitors themselves are volunteers or remunerated, which influences the objectives of each scheme and suitability for transition to a national scheme with oversight functions.

A review of community visitor schemes, and consideration of a future national oversighting scheme as part of the NDIS Quality and Safeguarding framework, has been commissioned by governments as part of the NDIS implementation structures. The purpose of the review is to evaluate the role, if any, of Community Visitors in a fully operational NDIS, as part of a safeguarding regime for vulnerable NDIS participants. The Mental Health CMOs that are NDIS providers may or may not be captured by a scheme and as a consequence, there may be gaps in oversight for non-NDIS participants.

Element 5: The NDIS Quality and Safeguarding Framework includes funding of advocacy services—formal individual and systemic—outside of the NDIS. The rationale is that effective advocacy must be at arms-length to the provider. The mental health CMO sector comprises some organisations whose primary function is advocacy. The NSW Deputy Ombudsman reports[15] that the question of the establishment of a Public Advocate to respond to neglect and abuse of vulnerable adults in their family home or other community settings is under active policy development by the NSW Government and has not as yet been settled. In the meantime, the NSW Ombudsman's standing inquiry into the abuse and neglect of adults with disability in community settings will continue. It is unclear whether coverage of people accessing psychosocial supports through CMOs will be in scope for a future Public Advocate in NSW which has been an matter of recent discussion and supported by the NSW Ombudsman, the NSW Law Reform Commission and peak bodies such as the Mental Health Coordinating Council [16] and organisations such as the Council for Intellectual Disability. Official Visitors also perform an important advocacy role for individuals.

We have selected the two major monitoring and safeguards elements to provide insights into what happens across Australia. (Partial public information is available on the remainder and could be sourced in a second stage if consultation points to this).

These are **Elements 8** and **10**:

- standards and accreditation programs applying to CMOs providing mental health care and psychosocial supports
- information systems and monitoring: data, contractual reporting, reporting client outcomes using standardised tools.

5.1.2 STANDARDS AND ACCREDITATION SCHEMES

Standards are published documents setting out specifications and procedures designed to ensure products, services and systems are safe, reliable and consistently perform the way they were intended to. They establish a common language which defines quality and safety criteria (Standards, Australia).

Standards are set by recognised bodies, such as the government health departments and statutory committees to ensure consistent and appropriate levels of care and services are provided.

Standards may be accompanied by **accreditation** schemes – which can operate as systems of self-assessment against a guide, verified by a third party through on site visits or document review, be the subject of auditing, and attract graded awards of compliance or achievement—and various combinations of these approaches. Certification is also a term used to describe assessment of performance against agreed standards or benchmarks.

The main sets of national standards relevant to the operations of Mental Health CMOs are:
- National Practice Standards for the Mental Health Workforce
- National Standards for Mental Health Services
- National Safety and Quality Health Service Standards
- National Standards for Disability Services
- Health and Community Services Standards
- NDIS Practice Standards

Some CMOs are working in or entering into the aged care market and are captured by aged care quality standards and recent changes in this sector, including to accreditation processes will be effective from July 2019.

There are national mental health workforce service standards [17] applicable to operating in a multicultural environment, meeting the needs of Aboriginal people, and other groups such as people who identify as LGBTQI, women and children, people experiencing family violence and others. These standards are generally not associated with formal accreditation programs but represent best practice for particular client groups.

A commercial enterprise based in NSW—BNG NGO Services Online—has tapped into the need for service providers operating in diverse consumer markets to simplify their standards assessment and compliance activity. BNG's online Standards & Performance Pathways (SPP) is a tool for understanding and mapping different sets of standards, preparing for audits and sourcing resources for policy development. It works with a wide range of national and state-based standards.[18]

Recent additions to the BNG platform include:
- NDIS Practice Standards (plus the 6 supplementary modules) and NDIS Code of Conduct
- Aged Care Quality Standards
- QIC Health and Community Services Standards (Ed. 7)
- Quality Standards for Early Childhood Education and Care.

Approximately 30% of current membership of the MHCC have active accounts with SPP.

National Standards for Mental Health Services (NSMHS)

The NSMHS, revised in 2010 to reflect changes in the delivery and focus of mental health services, were designed to be implemented across the range of mental health services, including public, private and community-managed sectors.

Implementation of the NMHS has not been mandatory for mental health services nationally, however in 2010 it was anticipated that they would be incorporated into relevant accreditation programs.

States and Territories have made their own decisions on whether accreditation is or will be mandatory for CMO mental health service providers as part of funding agreements. Assessment against the standards may be enforced by regulation but more usually some departments require mental health organisations to undergo assessment as a condition of funding/ service agreements.

Some mental health services choose to undergo NSMHS assessment as this achievement builds their organisational profile and reputation.

As part of the 5th National Mental Health and Suicide Prevention Plan governments have commenced a process of revising the National Standards for Mental Health Services – specifically looking at the interface with National Disability Standards.

National Safety and Quality Health Service Standards (NSQHS)

The NSQHS (1st edition) were released in 2011 and endorsed by Australian and state/territory government Health Ministers, for mandatory implementation in all public and private hospitals from January 2013.

The NSQHS aim to protect the public from harm and to improve the quality of health service provision. However, they do not apply to mental health services in the community-managed sector or the private office based sector, and a method of integrating the standards across sectors is required.

Whilst there are areas of overlap between the NSMHS and the NSQHS Standards they vary in terms of philosophy, language structure and how they are implemented.

A 2014 scoping study looked at the take up of both sets of standards. It identified the barriers to implementing the NSMHS and NSQHS Standards as financial and human resource limitations. Other common barriers were duplication between standards, uncertainty about the applicability of the NSQHS Standards in mental health services, a culture among some service providers resistant to quality improvement and change. The study concluded that the NSQHS Standards, which set mandatory levels of safety for applicable health services, are not directly applicable in the large and growing community managed organisation (CMO) sector of mental health services.

A subsequent accreditation workbook identified the standards where equivalent items and evidence could be documented across the two sets of standards, and then potentially within one accreditation process by a single accrediting agency. The work also identified a range of National Standards for Mental Health Services for which there is no match with the National Safety and Quality Health Service Standards, among them items from very significant domains of activity, foundational to community-based mental health services

The NSQHS (2nd edition) was released in 2017 with a strengthened focus on key safety issues in mental health. The Standards now address the key safety gaps identified in the scoping study. Person-centred care is embedded throughout and this aligns closely to the principles of recovery-oriented service delivery. Actions have been added that directly address processes for preventing and managing self-harm and suicide; predicting, preventing and managing aggression and violence; minimising seclusion and restraint; and recognising and responding to deterioration in a person's mental state. Work on recognising and responding to deterioration in a person's mental state and examining variation in interventions for mental health. References to the NGO residential sector have been removed.

A commitment made to develop a mental health supplement to the NSQHS, to align the NSQHS Standards and the NSMHS, has been deferred until a national review of the NSMHS. This most recent review is to take account for interfaces with other relevant standards, such as the National Disability Standards. (Action 21: 5th National Plan for Mental Health and Suicide Prevention)

Various projects and tools have been developed to identify areas of overlap (complementarity) and gaps between the two sets of standards – see below.

A new mapping tool and user guide for health services that also provide mental health services was released by in November 2018.

KEY MESSAGE:
The NSQHS, and congruence with the NSMHS, is most relevant to NSW mental health CMOs who deliver in partnership models with LHD services. For example, some LHDS have mental health sub-acute units which provide short term residential care in a model of care where psychosocial support is provided by a contracted CMO and the LHD provides clinical care.

National Standards for Disability Services (NSDS)

The National Standards for Disability Services (NSDS) are implemented by the Department of Social Services. In 2014, the Standards underwent extensive consultation, validation and user testing, culminating in a set of six standards that can be applied across a broad range of circumstances. The revised NDS Standards reflect contemporary practices that provide people with disability with choice about their support and services.

They cover:

- Rights
- Participation and Inclusion
- Individual Outcomes
- Feedback and Complaints
- Service Access
- Service Management.

States developed their disability standards to complement the national standards and their own service delivery.

The New South Wales Disability Services Standards (NSW DSS) were updated in 2013 to reflect contemporary practices that place people with disability at the centre of decision-making and choice about their supports and services.

Many states and territories and some Commonwealth programs require funded services to comply with the National Standards/State Standards as part of funding agreements with disability service providers, which includes mental health service providers for specific programs such as the Disability Employment Services.

National Disability Standards were considered an important transitional mechanism for the National Disability Insurance Scheme (NDIS). Until the NDIS is fully implemented, the revised National Disability Standards remain one of the quality and safeguarding mechanisms in place in most states.

Health and Community Services Standards (QIC)

The QIC standards and accreditation program provides a review of organisational systems across governance, management systems, consumer and community engagement, diversity and cultural appropriateness, and service delivery.

It is structured in three sections with 18 standards in total

- S1: Building Quality Organisations
- S2: Providing Quality Services & Programs
- S3: Sustaining quality external relationships

It provides a program of 3-year accreditation against nationally recognised standards developed for the community and health sectors.

It has broad application in the CMO sector including in the MHS sub – sector. Accreditation is available through a single accreditation agency, such as QIP, and its programs can integrate NHMS standards into the accreditation process.

KEY MESSAGE:
Accreditation under the NSDS is largely overtaken by registration as an NDIS provider—which requires certification under the NDIS Practice Standards and assessment and auditing by a third party. It is unclear what the future status of the QIC standards and accreditation program is if a CMO diversified into NDIS provision or tendered for contracts requiring compliance with other sets of standards.

NDIS Practice Standards

The NDIS Practice Standards are designed for providers to assess performance, and to demonstrate how providers deliver high quality and safe supports and services to NDIS participants. Together with the NDIS Code of Conduct, the NDIS Practice Standards assist NDIS participants to be aware of what quality service provision they should expect from NDIS providers. They are a condition of registration as an NDIS provider.

The National Disability Insurance Scheme (Quality Indicators) Guidelines 2018 list the outcomes of the NDIS Practice Standards and also the associated quality indicators NDIS providers can use to demonstrate conformity with the outcomes.

The NDIS Practice Standards consist of a core module and several supplementary modules that apply according to the types of supports and services NDIS providers deliver, and the corporate structure of the organisation. The Core module covers:

- rights and responsibility for participants
- governance and operational management
- the provision of supports, and
- the support provision environment.

The standards are derived from the National Disability Standards and are said to align partially with the NMHS – although language differs

The assessment process against the standards is called auditing not accreditation.

All providers seeking registration will be required to undertake an audit against the applicable NDIS Practice Standards as part of the NDIS Commission's registration requirements. There are two pathways to assess whether an organisation meets the relevant NDIS Practice Standards:

- *Verification*: For individual sole traders and partnerships delivering lower risk or less complex services, providers supply documentation against the four outcomes within the Verification Module. Verification Audits are a desktop audit which can usually be done off-site.
- *Certification:* For higher risk, more complex services and supports, and for organizations that are formed as a 'body corporate', a certification audit is required to examine a body corporate's governance and operational management processes and their ability to deliver quality services.

Many accreditation providers are working on integrated NDIS and other standards accreditation programs, although only six have been approved as auditing bodies.

KEY MESSAGE:

The NDIS Practice Standards themselves seem to be a 'cost to the provider' and do not fully replace other standards and accreditation programs.

CMOs would may need alternative accreditation providers who can work with multiple sets of standards. This may not be possible for providers who have committed training and resources working within one set of standards or a provider not eligible to provide NDIS auditing services.

OTHER STANDARDS

ISO 9001 is an internationally recognised standards and accreditation program used widely in business and in government. For some NFPs, third party certification may be a requirement for some government programs. Some CMOs use it primarily because they operate businesses under social enterprise models.

There are ten sections (called clauses), five of which contain mandatory requirements for a Quality MANAGEMENT System

- QMS requirements, context
- Leadership
- Planning
- Support
- Operation
- Performance Evaluation
- Improvement (clause 10)

All elements are mandatory - can exclude some as not applicable at scope stage.

Annual external surveillance and certification by an external provider is required.

National practice standards for the mental health workforce 2013

These standards are intended to complement the discipline-specific practice standards or competencies of specific professional groups (nursing, occupational therapy, psychiatry, psychology, social work) and to address the shared knowledge and skills required when working in an interdisciplinary mental health environment.

The practice standards provide a guide for education and training curricula. While the practice standards relate to the skills, knowledge and attitudes expected of those who work in mental health services, the National Standards for Mental Health Services (2010) (service standards) apply to the setting in which mental health care is provided. The two sets of standards are intended to work together to support the ongoing development and implementation of good practices and to guide continuous quality improvement in mental health services. The two sets of standards are intended to provide a foundation for the sector.

Using the practice standards in conjunction with the service standards can assist mental health services to develop or review their education and training strategies, ensuring practitioners work towards achieving the practice standards. This may assist services in gaining accreditation, according to the authors. However no formal accreditation or assessment process is suggested or proscribed.

KEY MESSAGE:

ISO 9001 has been to date an acceptable set of standards to meet requirements for funding agreements in some programs.

Recently some PHNs have required conformity with National Practice Standards for the Mental Health Workforce, although evidence, such as accreditation or certifications, are not applicable.

The degree of take up of these standards in the Mental Health sector is unknown.

5.1.3 ALIGNMENT BETWEEN SETS OF STANDARDS AND ACCREDITATION PROCESSES IS CRITICAL FOR CMO PROVIDERS WITH DIVERSE ACTIVITIES

There have been attempts by governments and agencies to align standards with each other to ensure diverse providers can implement them in a coherent single integrated package. The aim is to reduce the duplication of requirements for providers. The BNG NGO services online provides a user friendly commercial product to address this need and may be suitable for most MH CMOs – but take-up is partial to date, possibly due to cost pressures.

The duplication of regulatory, contractual and other legislative requirements in current systems increases complexity and costs. Providers who operate nationally have to understand and comply with the different requirements in each jurisdiction. Those that operate across community service sectors are also required to demonstrate compliance with multiple systems.

Major accreditation agencies have attempted to integrate sets of standards – usually either NSQHSS or QIC HCSS with the NSMHS, which establishes a single integrated framework and accreditation process for organisations working within more than one. However, NDIS Practice standards are stand-alone and systems and certification is via 'auditing'.

While alignment and integration to a degree may be possible, it is complex and inefficient for the accrediting body and the service provider. Systems of dual checklists and complex cross-referencing have emerged.

A nationally consistent system—with mutual recognition of compliance with equivalent or like standards when appropriate— was forecast as part of the NDIS Quality and Safety Framework during consultation. It was not only to reduce duplication for providers but to make it easier for participants to understand what they can expect of workers and providers. It maybe that funding agencies can now undertake the work to consider mutual recognition across sets of standards, either fully or partial, to allow efficiencies in assessment and compliance processes.

KEY MESSAGE:
The NDIS Practice Standards function as a stand-alone set of standards and assessment requirements. Only some of the approved accreditation (called auditing) agencies are able to assess against the major standards sets (NDIS, NSMHS, NSQHS, ISO 9001). Notwithstanding the work undertaken to achieve an integrated approach to their business products, this is a more extensive and expensive exercise than single standards assessment for accreditation.

5.1.4 INFORMATION SYSTEMS AND MONITORING

Effective monitoring for safety and quality, and for accountability of funded organisations, requires investment in information systems, ongoing training, and accurate and reliable specification of outcomes to be achieved.

Some of this work is being progressed at the national level under the auspices of the National Mental Health Policy and Strategy and the five successive National Mental Health Plans.

As the health system as a whole is being driven by coordinated action between levels of government, within a federal system, coordinated change requires both levels of government to participate. As all levels of government contribute to care and support for people living with mental health conditions, it is important the mental health sector, including the CMO sector, participate in national developments.

Any work to improve the safety and quality of health care is dependent on the right information being available. A Mental Health Information Strategy was developed under the First National Mental Health Plan. The strategy was designed to gather basic data on what services were delivered to whom and progressively expanded to provide information about the outcomes of services received by consumers.

Since the **First National Mental Health Plan**, the main areas of work inclusive of the MH CMO sector have been:

- establishing agreement on uniform data to be collected and reported on activities—national minimum data set
- considering and collecting data on the lived experience of individuals, families and carers—the Your Experience of Service (YES) and Carer Experience of Service (CES) surveys for CMOs
- use of standardised tools for measuring clients status and outcomes—HONOS, CANSAS and LCQ , in NSW called the Mental Health Outcomes and Assessment Tools (MH-OAT) and the associated data collection and reporting requirements.

The **Fifth National Mental Health Plan** also commits to a range of actions to be implemented nationally and within states and territories, with potential impacts on NSW CMOs:

- a revised national mental health performance framework to support reporting on performance and quality across all mental health service sectors (Action 21.2)
- monitoring of consumer and carer experiences of care, including the Your Experience of Service survey tool, across the specialised and primary care mental health service sectors (Action 23)
- governments to ensure service delivery systems monitor the safety and quality of their services and make information on service quality performance publicly available (Action 24).

MHCC's current work on Implementing the *National Minimum Dataset for Mental Health Establishments (NGOE) in NSW Community Managed Organisations: Scoping Study* sets out the significance of system-level mechanisms, the evidence for the value they provide funders, providers, the community, consumers and carers and the issues associated with data collection for CMOs.

Although the Mental Health NGO Establishments National Minimum Data Set, focuses on collection of data on activity, expenditure and staffing, alongside the other two initiatives—the YES/CES survey, standardised client outcome tools— this provides a comprehensive monitoring regime of inputs, outputs and outcomes.

KEY MESSAGE:

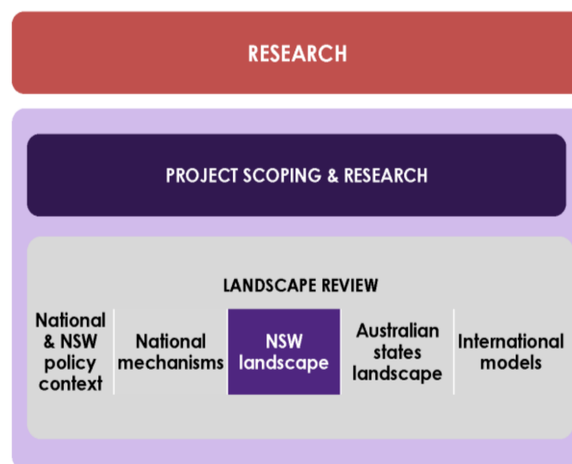
There is interest and broad support from NSW CMOs in the implementation of the NGOE. The current work provides a basis for NSW action on this element.

There is interest and intention from NSW Health to progress the comprehensive use of the YES/CES survey and the reporting of at least a single outcome tool – the Living in the Community Questionnaire (LCQ). Mandating would be through funding agreements.

All three initiatives have financial, technology infrastructure and training implications for MH CMOs.

5.2 SAFEGUARDS AND MONITORING LANDSCAPE IN NSW

Mental health CMOs operate within legislation, frameworks and policies designed for more than one human services sector.



Although mental health services have historically linked to **disability services** at regional or local levels, through cross-sectorial intiatives and integrated models of care, the NDIS has seen the merging of these sectors at the margin, for those wishing to access psychosocial support through the NDIS. The NDIS has provided incentives for mental health providers to operate within the disability frameworks of the NDIS, and incentives for welfare or disability providers to offer psychosocial support, for the first time.

Community-based mental health services have always operated within the broad umbrella of **health services**, although the clinical governance requirements designed for clinical services have generally not applied. With more fully articulated role defintion between clinical care and treatment and psychosocial support, the sector has entered into an era of integrated provision under formal partnerships and collaborations and defined pathways of care and support, for services attracting government funding. Links with public mental health services are the most critical and have been the subject or substantive work over recent years.

Mental health CMOs are a sector well-defined by national and international theoretical approaches, models of support, and innovations which have been adopted widely in service settings. For example, the use of peer support workers has spread with the evidence-base to support effectiveness, followed by professionalisation througn fromal training requirements withi the Australian Qualifications Framework. The inclusion of peer support workers is now required in many tendered programs. The sector is not itself limited to provison of psychosocial support and many partnership models have emerged with clinical and non-clinical services provided in an integrated one-stop shop approach. The sector also has providers of advcoacy, information, health promotion and community education.

An understanding of the monitoring and safeguarding landscape, to identiify interfaces, gaps and overlaps, requires an undertanding of these three sectors. As outlined earlier, the NDIS is a self-contained sector which is used as a comparator.

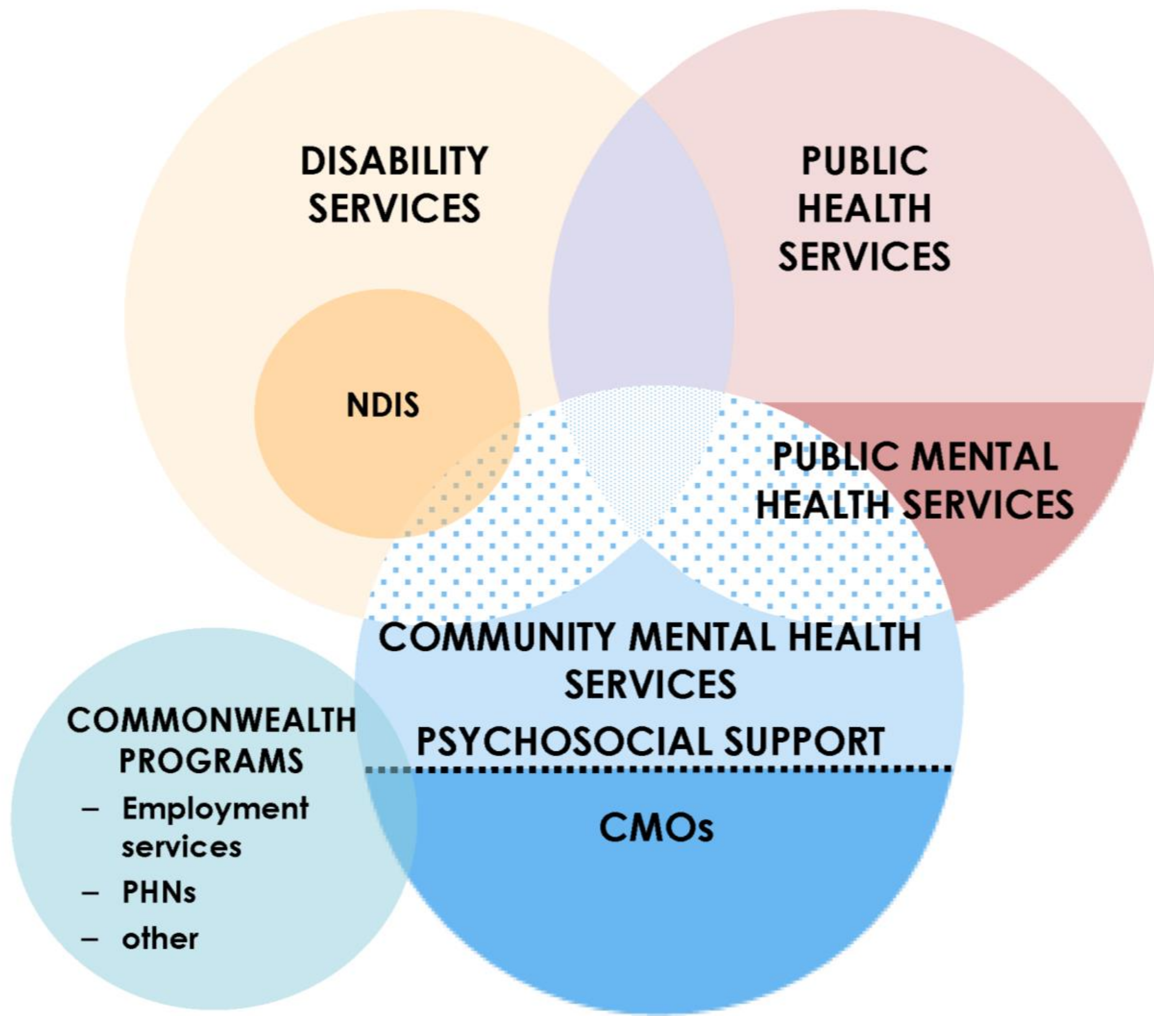


Table 1 on the following page, sets out the safeguarding and monitoring mechanisms that apply to service providers in NSW. Given the overlapping sectors that some mental health CMOs operate in, four sectors are outlined.

Target	Element	NDIS	Disability service providers	Mental Health CMOs	All Health Services
Individual	**Charters of Rights**	Principles of Framework are anchored in UN Declaration of Rights of People with Disabilities.	The Australian Commission on Safety and Quality in Health Care is undertaking a Review of the Australian Charter of Healthcare Rights. Developed in 2008 for voluntary adoption by all health settings, the charter applies to all health settings anywhere in Australia, including public hospitals, private hospitals, general practice and other community environments. It allows patients, consumers, families, carers and service providers to have a common understanding of the rights of people receiving health care. NSW Health Charter for Mental Health Care in NSW 2013 describes the qualities consumers can expect from mental health services. Strengthened consumer rights and recovery principles in the Mental Health Act Amendment (Statutory Review) Act 2014. The Disability Inclusion Act 2014 reinforces human rights of involuntary and forensic patients, people subject to a community treatment order or under detention in a mental health facility.		
	Complaints Management	NDIS providers are required to have a complaints management system in accordance with the NDIS (Complaints Management and Resolution) Rules 2018. Guidelines on complaints systems are available for registered and unregistered providers. A condition of registration with sanctions for non-compliance. Complaints of abuse or neglect are part of reportable incidents hierarchy – higher levels of enforcement action – see 'pyramid'. Public Advocate role is planned for the NDIS Commission's Senior Practitioner.	NSW Ombudsman: complaints function retained for certain categories of services – government and NGO residential accommodation, assisted boarding houses, children in out of home care. Standing Inquiry into matters of abuse or neglect in community settings. To be replaced by a Public Representative (as Public Advocate similar to Vic's OPA) extending to people living in homes or at home – consumer focus. Community Visitors Scheme has a complaints function and complaints are escalated to formal investigation status if warranted, otherwise handled locally or facilitated improvements.	Funded MH CMOs required to have a complaints management system as part of service agreements.	Prescribed health services have mandatory requirements to comply and be accredited against the NSQHS – which include complaints management systems. Health Care Complaints Commission is an independent body that deals with complaints about health service providers in NSW. They receive complaints about individual health practitioners; health organisations, such as hospitals, medical centres or practices.

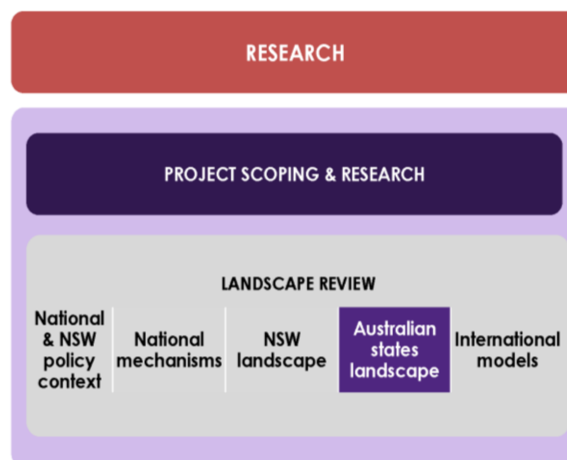
Target	Element	NDIS	Disability service providers	Mental Health CMOs	All Health Services
Individual				The Official Visitors scheme can consider and mediate complaints between an individual and provider– public and private mental health institutions and for people on CTOs – CMO may be captured by this as a provider in a CTO. Visit occurs at local health centre usually, not home.	
	Oversight of Restrictive Practices	Senior Practitioner roles and powers under 'the rules'. NSW to retain powers as authoriser of use of restrictive practices as part of a behaviour support plan.	NSW Office of the Protective Commissioner (working alongside) policies, guidelines and authorisation.	NSW Health for some funding programs – no particular mandate or approach – evidence of policies and procedures. Very limited applicability in MH CMO sector.	Mental health inpatients units – see the recent review on seclusion and restraint.
	Official Visiting Schemes	TBD – under review by consultants Westwood Spice	NSW Ombudsman – Community Visitors scheme	None	Official Visitors Scheme – mental health inpatients and community mental health patients on CTOs.
Workforce	**Employee Screening**	Registered providers: National scheme but state-based units will administer from July 2019. Modelled on the Working With Children Check – more extensive than just criminal record check.	FACS administers a criminal records check which shows convictions for prescribed criminal offences within the meaning of the Disability Inclusion Act 2014 (NSW). The Working with Children Check – whole of community scope. NSW Office of the Children's Guardian undertakes checks of: ▸ national criminal history: convictions (spent or unspent), charges (whether heard, unheard or dismissed), juvenile records ▸ findings of misconduct by a reporting body and notifications made by NSW Ombudsman	Working with Children Check (WWCC) for services working with under 18 year olds. Health screening specific to discipline for most includes registration, scope and mandated professional development, as well as police checks. Individual employers may conduct criminal record checks.	Health screening specific to discipline – for most includes registration, scope and mandated professional development, as well as police checks.

Target	Element	NDIS	Disability service providers	Mental Health CMOs	All Health Services
			▸ a cleared individual will be subject to ongoing monitoring for relevant new records for the five-year life of the clearance		
Providers & Workforce	**Code of Conduct**	Registered NDIS providers and providers of supports to NDIS participants who are not registered providers. ▸ Single Code of Conduct has application to providers and workers in different ways. ▸ Based on these **principles**: respect for individual's rights, privacy, safety, integrity and honesty, timely response to concerns, prevention of violence, neglect and abuse, prevention of sexual misconduct. ▸ For NDIS **providers** it is a condition of registration; to be incorporated in existing employee engagement, human resource and governance arrangements to ensure compliance with the Code. This will include considering whether operational policies and procedures, and training activities reflect the Code. ▸ **Workers** are expected to use Guidance document with policies, procedures and training, in addition to their own professional experience and judgment, to comply with the Code. ▸ **Service users** – NDIS participant or not – can raise a compliant with the NDIS Commission about breaches to the Code of Conduct by a provider or worker.	Reliance on Standards – NDS/NSWDS and Aged Care. NDS has general references to codes of ethics/conduct in Standard: Service Management	Funding agreements may require services to have code of conduct/ethics. The standards relating to consumers in a number of standards frameworks include similar provisions to a Code of Conduct.	Health professional registration requirements Public Health Regulation, Schedule 3 includes a code of conduct for unregistered health practitioners. NSQHS/NMHS frameworks and standards require providers to have codes of ethics/ conduct. For service providers, complaints about breaches can be made internally and to relevant state bodies – NSW Ombudsman, Health Care Complaints Commission – or in person if service is covered by an Official Visiting Scheme.

Target	Element	NDIS	Disability service providers	Mental Health CMOs	All Health Services
Providers	**Standards & Accreditation Standardisation**	Registered NDIS providers must comply with NDIS National Practice Standards: ▸ Audited against the relevant NDIS Practice Standards by approved bodies only (6 in NSW) ▸ **Structure** is core and supplementary modules. ▸ Core: rights and responsibility for participants; governance and operational management; provision of supports; support provision environment. ▸ Supplementary modules: High intensity ADLs; Specialist behaviour support; Implementing behaviour support plans; Early childhood supports; Specialised support co-ordination; Specialist disability accommodation. Each module has high-level, participant-focused outcomes, and quality indicators that auditors will use to assess a provider's compliance with the Practice Standards. A subset of Practice Standards apply to NDIS providers who are individual sole traders or partnerships delivering lower risk or less complex NDIS supports and services – called the verification module covering: human resource management, complaints management, risk management, incident management. Verification is through self-assessment. Certification is for higher risk, more complex services and supports, and for organisations that are formed as a 'body corporate'. Certification follows an audit of the service provider against the standards within scope and is done by a choice of approved auditing companies.	National Disability Standards/NSW DSS – mandatory for funding for certain services. In NSW mostly FACs residual residential accommodation; Commonwealth employment & advocacy services. 6 standards – Rights, Participation and Inclusion, Individual Outcomes, Feedback and Complaints, Service Access, Service Management	National Standards for Mental Health Services – optional, but required for some funding programs – HASI, CLS, PLI (originally for voluntary adoption by all mental health settings) Structure: Rights and responsibilities; Safety; Consumer and carer participation; Diversity responsiveness; Promotion and prevention; Consumers; Carers; Governance, leadership and management; Integration; Delivery of care	National Safety and Quality Health Service (NSQHS) Standards are compulsory for hospitals and day procedures; Community versions. 10 standards: Rights and Responsibilities; Safety; Consumer and Carer Participation; Diversity Responsiveness; Promotion and Prevention; Consumers; Carers; Governance, Leadership and Management; Integration; Delivery of Care
			Other Standards: ISO 9001 QIC Health and Community Services Standards Practice Standards for MH Workforce 2013 Multicultural Framework		

Target	Element	NDIS	Disability service providers	Mental Health CMOs	All Health Services
Providers	**Incident management**	Registered providers are required to implement and maintain an incident management system to identify, assess, manage and resolve incidents that occur during the course of delivering NDIS supports or services and pose a risk of harm to people with disability. Additionally, registered providers must report the most serious of these incidents to the NDIS Commission as reportable incidents. Reportable incidents are defined in the NDIS Act 2013 – Death, Serious injury, Abuse and neglect, Sexual or physical assault, Sexual misconduct, Unauthorised use of restrictive practices. Draft guidance out – mandatory.	Reportable incidents to NSW Ombudsman for certain services including children in care, FACs funded providers for people with disability who live in supported group accommodation. A 'funded provider' includes any organisation receiving financial assistance under the Disability Inclusion Act 2014 to provide supports and services for people with disability living in supported group accommodation.	Funding agreements contain requirements for IMS and in partnership models dual reporting applies. In NSW Health programs for severe and complex clients – incidents must be reported to MoH but no investigatory powers – handled by range of methods, including involvement of Chief Psychiatrist if deemed necessary. External oversight body not specific to mental health service provider but NSW Ombudsman could act against agency or use 'no wrong door approach' to facilitate resolution of complaint. No specific reportable incidents capacity.	NSW Health staff are required to report all incidents (both clinical and corporate), near misses, and complaints into a state-wide Incident Information Management System
System	**Monitoring systems: data on processes & outcomes**	NDIA monitors at system level	Funded programs have various levels of input, output and outcome reporting.	Govt funded services provide data and reporting to MoH, C'wealth agencies, Reporting may include: ▸ client/carer experience ▸ client outcomes – Other reporting is variable by program around MHoAT tools ▸ National Minimum Data Set	National Minimum Data Sets and benchmarking projects
	Safeguard systems in place: complaints and incident management	Monitoring across complaints functions is planned - TBC	NSW Ombudsman systemic reviews	Nil	Various
	Accreditation schemes	Requirements for 3rd party verification for standards of registered providers	As above		

5.3 SAFEGUARDING AND MONITORING LANDSCAPE IN OTHER STATES



The project brief required an examination of other States and Territories' monitoring and safeguarding elements (and the mechanisms through which they are applied) for CMOs providing psychosocial support. Each State and Territory has a number of frameworks impacting on mental health CMOs which deliver both NDIS supports and other services funded by State and Commonwealth governments—as is the case in NSW.

With States and Territories transitioning to the NDIS in a staged approach to 2020, there are transition arrangements in place to use existing state level quality and safeguarding mechanisms. As the transition to NDIS is completed, scope and coverage of mechanisms for non-NDIS providers may continue.

Selected states are included in the Landscape Review as collation of information from all jurisdictions is beyond the project budget.

Elements included in an analysis of other States' activities

In addition to publicly available information, the MHCC project manager has written to chief executive members of the Community Mental Health Australia (the national alliance of all state and territory peak bodies) seeking information in the following three areas:

- mandatory safeguarding requirements on MH CMOs as part of state government funding agreements
- the status of various standards and accreditation programs – i.e. moving towards or compulsory take up of:
  - the National Standards Mental Health Services
  - other standards such as the National Disability Standards
  - local state-developed standards.
- requirements from funding bodies to participate in specific data collections — such as the National Minimum Data Set for mental health, the YES/CES consumer/carer surveys, or participation in a state data collection.

We have selected the two major safeguarding and monitoring elements as providing insights into what happens outside NSW. (Partial public information is available on the remainder and could be sourced in a second stage if consultation points to this).

The key elements are **Elements 8 and 10**: standards and accreditation programs applying to CMOs providing psychosocial supports; Information systems and monitoring: data, contractual reporting, and reporting client outcomes using standardised tools

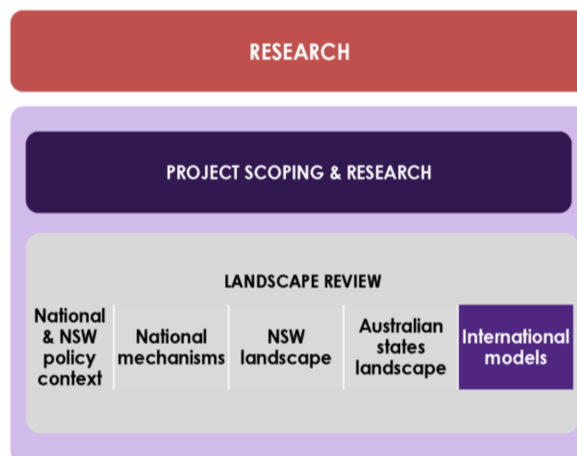
	Victoria	Queensland	Western Australia	PHNs (examples)
Name	**Vic Human Services Standards** **National Standards for Mental Health Services**	**Human services quality standards (Qld)** **National Standards for Mental Health Standards**	**National Standards for Disability Services** **State-based assessment on NSMHS**	
Scope	**For disability and other services** - a single set of service quality standards for department funded service providers and department-managed services. The Standards comprise the department's four service delivery standards and the governance and management standards of a department endorsed independent review body. In operation until the transition to the NDIS. For **Mental Health CMOs** a state-funded program called the Mental Health Community Support Service (MHCSS) programs funds Individualised Client Support Packages, Youth Residential Rehabilitation Services, Adult Residential Rehabilitation Services and Supported Accommodation Services – via a catchment-based intake assessment services. Three large CMOs operate within this system and must	Queensland's existing quality and safeguards system applies to **all Disability Services-funded providers** and to NDIS-registered providers that deliver to participants in Queensland, where the service is listed on the participant's plan. The Human Services Quality Framework (PDF, 1.2 MB) Human Services Quality Framework(RTF, 633 KB) (HSQF) is the quality assurance framework used by the Department of Communities, Disability Services and Seniors and Department of Child Safety, Youth and Women (the departments) for assessing and promoting improvement in the quality of human services. The HSQF applies to organisations delivering services funded under a service agreement with either/ both the departments and providers registered to deliver prescribed disability services for the NDIS. The HSQF incorporates: ▸ a set of quality standards, known as the Human Services Quality Standards, which cover the core	For **disability services**, in 2014, Western Australia adopted the six National Standards for Disability Services that promote nationally consistent quality standards for the disability services sector. Since 1 July 2014, the Standards have applied to all services either funded or delivered by the Disability Services Commission; and National Disability Insurance Scheme providers (registered through the Commission's panel contract) operating in Western Australia. The Standards form the basis of the WA Quality System and are used to assess the quality of services delivered by providers. The Standards promote human rights, encourage good practice and continuous improvement of services. For **publicly funded mental health CMOs**, the WA Mental Health Commission operates an independent monitoring and evaluation process as one part of the Quality Management Framework comprising:	National Standards for Mental Health Services National Mental Health Workforce Standards

	Victoria	Queensland	Western Australia	PHNs (examples)
	meet the NMHS standards and be 3rd party certified. Access to all other mental health community support services is directly via the programs- standards compliance unknown.	elements of human service delivery ▸ an assessment process to measure the performance of service providers against the standards (assessment occurs at organisation level across all in-scope services) ▸ a continuous improvement framework, which supports the participation of customers in quality improvement. **For MH CMOs** Queensland Health requires service providers tendering for provision of psychosocial support services to be accredited against the NMHS and in some instances more than one set of standards. Third-party accreditation to one of the following standards is required: ▸ National Standards for Mental Health Services (NSMHS) ▸ Human Services Quality Standards (HSQS) If an organisation is not able to demonstrate this at the time of application then evidence will also be accepted from services currently delivering psychosocial disability with progress towards the: ▸ National Disability Insurance Scheme (NDIS) quality and safeguards framework.	▸ an annual self-assessment against the National Standards for Mental Health Services and person centred practices (Outcomes and Indicators and Examples of Evidence) ▸ a 12 month continuous improvement plan ▸ management and investigation (as required) of notifiable incidents ▸ Quality Evaluations conducted by a panel of independent evaluators (including carers and people with a lived experience of mental illness). All Commission-funded organisations receive training and information on the evaluation process and requirements for an evaluation once every three years, complete annual self-assessment develop a continuous improvement plan that is updated and revised annually.	

	Victoria	Queensland	Western Australia	PHNs (examples)
National Minimum data set **State-based data collections**		Mental Health Non-Government Organisation Establishment Data Set was made mandatory for all mental health funded organisations in Queensland from the reporting period of 2016-2017. Data collection is quarterly, in line with contract acquittals. A data report is provided to CMOs, however as yet, there are no sector reports for Queensland	All CMO mental health service providers that receive funding are required to complete the MHC Community Activity Data Collection – that is CMOs that provide services under one or more of the service types included in the service taxonomy. There are seven Health Regions in Western Australia, and 14 service types included in the data collection. Twice yearly reporting. Other reporting requirements: Annual standards and outcomes assessment; Carers Recognition Act; Disability access and inclusion plan; financial reporting; and opportunities for service improvement. Data transfer from the NGOs to the MHC is performed through report submission using the MH NGOE SDC web-based reporting instrument. Data which is applicable to the NGOE NBEDS is forwarded to the AIHW annually by the MHC.	NMDS in primary care
YES/CES other consumer survey	To be implemented nationally, current status unknown.	To be implemented nationally, current status unknown.	To be implemented nationally, current status unknown.	Provide evidence that consumer feedback is collected and used.
Client outcome tools			National Outcomes Measurement in the Community Sector Survey, replacing the Outcomes Measurement in the WA Community Sector Survey, which has run annually since 2015.	Depression Anxiety Stress Scales (DASS) Kessler 10

SECTION 6: INTERNATIONAL MODELS FOR SAFEGUARDING AND MONITORING

6.1 SAFEGUARDING AND MONITORING IN SELECTED NATIONS



With multifaceted international differences between government structures and health systems, the roles, funding and regulatory environment of the community-managed or non-government healthcare and mental health sector varies significantly. The literature review that informs MHCC's 2010 Sector Mapping notes that even within international clusters, there are tangible differences in the regulatory, quality and policy regimes within which CMOs operate.

The Comparative Review of International Mental Health Monitoring Mechanisms by Judy Laing and Rachel Murray (2012) [19] as part of an evaluation for the UK's Care Quality Commission describes significant variation in key mechanisms for monitoring/visits, monitoring/strategic direction and complaints. This constrains the identification of a model – or even elements - of good practice with international applicability. Nevertheless, Table 3 below sets out a brief analytical description of international models of monitoring and safeguarding applying to CMOs providing psychosocial support.

Table 3: Descriptors of models in three countries

Target	Element	UK	Canada	New Zealand
Individual	**Complaints Management**	**England's** Care Quality Commission (CQC) monitors and enforces the Health & Social Care Regulations which include Regulation 16 Receiving and Acting on Complaints. To meet this regulation providers must have an effective and accessible system for identifying, receiving, handling and responding to complaints from people using the service, people acting on their behalf or other stakeholders. All complaints must be investigated thoroughly and any necessary action taken where failures have been identified. When requested to do so, providers must provide CQC with a summary of complaints, responses and other related correspondence or information. CQC can prosecute providers or take other regulatory action. **Scotland's** independent Mental Welfare Commission is noted as a good model for a centralised complaints body.[20]	Patient Ombudsman investigates complaints concerning Ontario's health sector organisations including public hospitals, long-term care homes, home and community care services coordinated by the LHIN (Local Health Integration Network).	The Health and Disability Commissioner Act: ▸ established the Health and Disability Commissioner, including a Mental Health Commissioner with the role of promoting and protecting the rights of health and disability services consumers, and facilitating the fair, simple, speedy, and efficient resolution of complaints, and conducting formal investigations ▸ established a national network of independent advocates, under the Director of Advocacy, and an independent prosecutor, the Director of Proceedings to assist the Commission in enforcing the Code ▸ established complaints mechanisms which have become the primary vehicle for dealing with complaints about the quality of health and disability services in New Zealand.
Workforce	**Code of Conduct**	The Regulations do not specify Codes of Conduct but the CQC's Guidance for meeting Regulation 13: Safeguarding service users from abuse and improper treatment includes: ▸ Staff must be aware of their individual responsibilities to prevent, identify and report abuse when providing care and treatment. This includes referral to other providers.	May be in funding agreements. Professional codes of conduct also exist.	The Mental Health and Addiction Workforce Action Plan 2017-2021 is part of an outcomes approach, contributing to achieving the vision of the New Zealand Health Strategy. It includes actions to develop a workforce with the right skills, knowledge, competencies and attitudes needed to design and deliver integrated and innovative responses. Its actions support the development of the primary health care, community and specialist workforce to be well

		▸ Staff must understand their roles and associated responsibilities in relation to any of the provider's policies, procedures or guidance to prevent abuse.		equipped, integrated, competent and capable to focus on improving health and wellbeing. **It is a strengths-based approach that does not stipulate Codes of Conduct or employee screening** but builds the workforce capacity to uphold the knowledge, skills and attitudes that the broader Strategy identifies as essential for all people working in mental health and addiction services in New Zealand.
	Employee Screening	Healthcare providers need their workers to have criminal record checks from the Disclosure and Barring Service (DBS checks).	Unknown	
Providers	**Standards & Accreditation** **Incident management** **Code of Conduct** **Visiting schemes**	▸ From 2013, clinically-led local Clinical Commissioning Groups (CCGs) commission most secondary services including mental health services and most community health services, on behalf of National Health Service England. ▸ CCGs can commission NHS hospitals, social enterprises, charities or private sector providers but must be assured of service quality taking into account both National Institute for Health and Care Excellence (NICE) guidelines and the Care Quality Commission's data about service providers. ▸ Providers regulated by the CQC include independent health care service providers, defined as organisations that are not NHS trusts or NHS GP services (that is, private sector services). Examples are private corporations or companies, charities, social enterprises, voluntary and faith-based organisations and individual providers of care. This includes independent community services and independent mental health hospitals. The CQC:	▸ To ensure that high quality, timely and appropriate home and community care is available now and in the future, a rigorous capacity plan is under development that includes targets for local communities as well as standards for access to home and community care and for the quality of client experience across the province. (This was due in 2017 but does not appear to be released yet) ▸ Health Quality Ontario has recently released a common framework for quality health care with the goal of improving population health, delivering high-value health care and enhancing both patient and provider experience. ▸ Its 2017 report Quality Matters proposes the tangible actions to achieve it, for discussion. This report notes: ▸ "**In the realm of quality care, there are no standards that reflect the patient experience, such as standards guiding referrals or follow-up. Developing consensus on a health care standard is a considerable challenge and takes time; it is a job being undertaken by Health Quality Ontario in collaboration with clinical leaders, experts and patients.** For accountability to become	Community mental health providers are not required to meet the Health and Disability Services Standards 2008. These apply only to hospitals, rest homes and some providers of residential disability care. Community mental health providers are accountable to the Health & Disability Commissioner, the consumer watchdog monitoring and enforcing the Code of Health and Disability Services Consumers' Rights (established in the Health and Disability Commissioner Act 1994) which applies to all providers of health and disability services including hospitals. The Code sets out 10 rights, including the right to be treated with respect, to be free from discrimination or exploitation, to dignity and independence, to services of an appropriate standard, to give informed consent, and to complain.

		▸ monitors and enforces the fundamental standards (set out in the NHS Constitution) and other standards, including on safety, effectiveness, dignity and respect, responsiveness and governance ▸ registers, monitors and reports publicly on providers (including the State of Care Report in mental health services 2014-2017) ▸ has powers to issue requirements, warnings, impose conditions and special measures, and to prosecute cases when people are harmed or placed in danger of harm ▸ receives and addresses information from and protects whistle-blowers. Requirements are in following legislation: ▸ Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ▸ The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015 ▸ Care Quality Commission (Registration) Regulations 2009 Specific requirements for independent healthcare providers are set out here. Regulation 13 is on safeguarding people from abuse and improper treatment. **Scotland has a similar approach with the Health & Social Care Standards**	real, measures need to be available to determine whether or not outcomes are improving as a result of standards being met. This would stimulate improvement among providers and potentially support patient choices." There are 3 organisations that accredit health sector organisations including community sector organisations. Their standards are developed by expert panels. ▸ Accreditation Canada has a strong presence in the community-based mental health and addictions sector in Ontario ▸ CARF Canada accredits 25 organisations in the community-based behavioural health sector in Canada; 4 in Ontario ▸ Canadian Centre for Accreditation Existing Government Standards are clinical only. The previous Guidelines for Home and Community Care Providers have been removed from Ontario Health's website.	

System	Strategic direction and reforms	NHS England's 2016 Five Year Forward View established reforms to health care including mental health, to increase choice via: ▸ Primary care co-commissioning: joint commissioning between NHS England and Clinical Commissioning Groups ▸ Local planning: place-based Sustainability and Transformation Plans ▸ Partnership approach with community-based and voluntary organisations: with capacity-building and support through the Health and Care Voluntary Sector Strategic Partner Programme	Local Health Integration Networks (LHINs) are not-for-profit corporations responsible for planning, delivering and funding local health care to 14 different geographic areas of Ontario. This includes including primary care, home and community care, community health centres, hospitals, long-term care and **mental health and addiction services.** LHINs are based on a principle that community-based care is best planned, coordinated and funded in an integrated manner within the local community because local people are best able to determine their health service needs and priorities. 14 LHINs established by the provincial government through the Local Health System Integration Act (LHSIA), 2006, to plan, fund and integrate health services at the local level. In 2017, in accordance with the Patients First Act, the LHINs mandate was expanded to include responsibility for providing home and community care services delivery. LHINs collaborate with hospitals, community health centres, long-term care homes, mental health and addiction service providers, community support services, patients, caregivers and families, as well as primary care providers and public health units. **Community mental health programs** provide a variety of services to help support people who have serious and ongoing mental health issues living in the community. Services offered include information and referral, advocacy, case management, housing advocacy, rehabilitation, employment assistance, counselling, support groups and social	The Health and Disability Commission's 2018 report identified **various issues of concern within the existing system of safeguards and monitoring in NZ** (Question 4: Am I safe in services?): ▸ Services should be provided in a way that minimises potential harm, including not adding to a person's trauma. Minimising harm is not the same as being free from risk: positive risk-taking gives people freedom and supports their recovery. ▸ Inadequate/inappropriate care is a common issue in complaints to HDC about mental health and addiction services, especially in relation to crisis services, and risk assessments. ▸ Serious adverse events (suspected suicide and serious self-harm) have increased. This may be due to a better culture of reporting and greater transparency. Services need to work together to improve their response to consumers in distress. The HQSC Quality Improvement Programme includes a focus on learning from adverse events and consumer experience. I recommend New Zealand commit to a suicide reduction target. ▸ New Zealand has high rates of compulsion, seclusion, and restraint. These practices are not therapeutic. Seclusion has been reducing over time but is now steadying, and Māori continue to experience seclusion at higher rates. A renewed emphasis on its reduction and eventual elimination is required. I welcome the joint HQSC/Te Pou initiative Pathways to Eliminate Seclusion by 2020. ▸ Reporting on the use of medication to sedate or chemically restrain consumers needs to improve. It is important to ensure

			and recreational opportunities, and peer support services for consumers and survivors. Part of new reforms: **Patients First A Roadmap to Strengthen Home and Community Care** ▸ To help achieve more seamless care, our government is moving forward with a **bundled care approach**, in which a group of providers will be given a single payment to cover all the care needs of an individual patient. Building on strong local examples, we will develop a plan to roll out this approach across the province. ▸ Putting patients first means giving clients and caregivers greater say in choosing a provider and how that provider delivers services. Over the next two years, we will begin to offer a **self-directed care option**, in which clients and their caregivers are given funds to hire their own provider or purchase services from a provider of their choice.	that increased chemical restraint is not an unintended consequence of efforts to reduce seclusion. In 2018 the NZ Govt is moving to establish a standalone Mental Health Commission.
	System monitoring	▸ NHS Improvement oversees and supports NHS foundation trusts, NHS trusts and independent providers delivering NHS-funded care. Through its Single Oversight Framework and monitoring, it supports providers to provide safe, quality, financially sustainable and compassionate care and achieve high CQC ratings by meeting the NHS Constitution fundamental standards ▸ Association of Mental Health Providers is the peak body for community mental health services ("national membership charity for mental health organisations" and	▸ The 2017 Final Report of the Mental Health & Addictions Leadership Advisory Council recommends system-wide quality monitoring. ▸ The Institute for Clinical Evaluative Sciences will develop a scorecard for quality of care for Phase 2 of the ministry's strategy, helping to improve the capacity to monitor and report on the quality of care for mental illnesses and addictions in Ontario ▸ The Common Quality Agenda is a set of measures or indicators selected by Health Quality Ontario in collaboration with health system partners to focus performance reporting and track long-	Community mental health providers are required by the NZ Health Quality & Safety Commission (HSQC) to publish annual Quality Accounts reporting service quality, safety, continuous quality improvement progress, health outcomes and consumer experience. The HQSC's health intelligence program collects quality data and publishes it in various formats including the Dashboard of health system quality at district level. The Health and Disability Commission's 2018 monitoring and advocacy report on mental health services used a monitoring framework is based on its quality measures, which were in turn derived from New Zealand's Triple Aim (the

		"the leading representative body for voluntary and community sector mental health organisations in England and Wales" including small, medium and large providers. Has a role in supporting policy, innovation, quality and regulation. Its Annual Review describes the sector.	term progress in meeting health system goals. The indicators promote integrated, patient-centred care.	simultaneous pursuit of improvement across three dimensions — the individual (improved quality, safety, and experience of care), population (improved health and equity for all populations), and system (best value for public health system resources)). The Triple Aim maps against the US Institute of Medicine's six quality dimensions (an internationally well-accepted framework). The framework consists of 6 monitoring questions: Can I get help for my needs? Am I helped to be well? Am I a partner in my care? Am I safe in services? Do services work well together for me? Do services work well for everyone? The Commission monitors services against these domains using 4 information sources: its complaints data; service performance information; consumer feedback; insights gained from its sector engagement.

SECTION 7: CONCLUSIONS

7.1 LIMITATIONS OF LOOKING AT OVERSEAS MODELS

Given the variation across international health systems (and the roles within them played by CMOs) and between their regulatory, quality and policy regimes, it is not possible to identify a model, or elements, of good practice that have international applicability. There is also a general absence of academic literature examining the monitoring and safeguarding systems within or across jurisdictions. (Exceptions include community visiting schemes which are the subject of a separate consultancy review in Australia).

Internationally and nationally, this is a policy area that is changing rapidly, with key comparable jurisdictions having recently undergone (such as in the United Kingdom), or currently undergoing (such as Canada and New Zealand), major reforms. The English system is a unified, integrated system with a single powerful regulatory body, the Care Quality Commission, enforcing a single set of standards that apply to most providers, so it is unlike our federated system in Australia, with diverse implementation and schemes across jurisdictions.

Given the early stages of the NDIS in Australia, there is a plethora of inquiries and submissions but no evidence as yet as to what constitutes good practice in implementation, applicable to the unique roles of Mental Health CMOs.

While this Landscape Review does not purport to comprehensively assess international or inter-jurisdictional models, it rather takes a pragmatic and focused approach relevant to the policy research question; and it has been able to identify dimensions of best practice. These have been identified with reference to the General Principles of the UN Convention on the Rights of Persons with Disabilities, the strategic elements founding the United Kingdom Care Quality Commission in 2009, and the principles identified to underpin the NDIS Quality & Safeguarding Framework.

7.2 GENERAL PRINCIPLES TO GUIDE GOOD PRACTICE

Dimensions of good practice in safeguarding and monitoring: guiding principles

- *human rights:* upholding and respecting the rights of people with psychosocial disability including the right to dignity and respect, freedom from harm and full participation
- *person-centred:* building a system of care that ensures people make decisions about their own lives, and is compassionate and recovery-focused
- *responsiveness:* facilitating and informed by a transparent flow of information between regulators, funders, providers and consumers and carers, with the flexibility to address variations within the sector
- *utility*: establishing a clear, consistent, comprehensive (gaps?) and accessible jurisdictional framework that actively supports all categories of providers to improve quality and safety within a service delivery context of efficiency and effectiveness
- *collaboration:* developed and implemented in partnership with providers and with consumers and carers

- *minimising burden on providers and consumers:* creating the least burden possible on individuals and service providers while still achieving the agreed quality and safeguarding aims.

Using these criteria, the Landscape Review suggests that the following facets of international systems represent good practice:

Complaints:

- In England, all providers must have an effective and accessible system for identifying, receiving, handling and responding to complaints from people using the service, people acting on their behalf or other stakeholders. All complaints must be investigated thoroughly and any necessary action taken where failures have been identified.
- In New Zealand, the Mental Health Commissioner has the role of promoting and protecting the rights of health and disability services consumers, and facilitating the fair, simple, speedy, and efficient resolution of complaints, and conducting formal investigations

Code of Conduct:

- New Zealand takes a strengths-based approach that does not stipulate Codes of Conduct or employee screening but builds the workforce capacity to uphold the knowledge, skills and attitudes that the broader Strategy identifies as essential for all people working in mental health and addiction services in New Zealand.

Provider-level elements:

- In England, the CQC monitors and enforces the fundamental standards (set out in the NHS Constitution) and other standards, including on safety, effectiveness, dignity and respect, responsiveness and governance, and registers, monitors and reports publicly on providers (including the State of Care Report for mental health 2014-2017) with powers to issue requirements, warnings, impose conditions and special measures, and to prosecute cases when people are harmed or placed in danger of harm.

System monitoring:

- In New Zealand, CMOs publish annual Quality Accounts reporting service quality, safety, continuous quality improvement progress, health outcomes and consumer experience. The HQSC's health intelligence program collects quality data and publishes it in various formats including the Dashboard of health system quality at district level.

7.3 THE IMPACT OF CURRENT POLICY AGENDAS – NATIONAL, NDIS AND NSW

The Fifth National Mental Health Plan has recently established a program of policy development which CMOs and the MHCC will need to actively work with. Within this, the priorities for the MH CMO sector should be with:

- the revision of the National Standards for Mental Health Services
- a revised national mental health performance framework to support reporting on performance and quality and its underpinning infrastructure for data collection and reporting.

Funded MH CMOs are generally required to have a complaints management system as part of service agreements.

The NDIS brings with it a comprehensive quality and safeguarding framework that applies to a subset of MH CMO providers and a subset of people accessing psychosocial supports. It brings with it complexity, overlaps and gaps.

The NSW approach to monitoring and enforcing quality and safeguards is through national standards, contractual requirements around safeguarding mechanisms and state-wide reporting frameworks. However, this only captures services provided under major funding programs.

7.4 GAPS AND OVERLAPS IN SAFEGUARDING MECHANISMS

Section 3 of this Landscape Review reveals key gaps and overlaps.

Gaps to focus research on feasibility and desirability are:

- restrictive practices, incident management in particular reportable incidents, codes of conduct
- employment screening for all workers
- the Community Visitors review may recommend a broad national scheme of oversight – for the NDIS. This will leave a gap in coverage for non-NDIS participants
- systemic overview and public reporting of complaints and reportable incidents.

Overlaps are in the areas of:

- standards and accreditation – there is a need to explore mutual recognition rather than alignment
- incident management in collaborative partnerships.

7.5 POINTS OF PRESSURE

The potential points of pressure for CMOs in this complex regulatory and monitoring environment are:

- Meeting multiple sets of standards, including the resource implications of a limited open market in accreditation and auditing requirements
- Cost of partnerships where multiple systems of safeguarding and monitoring apply that are not factored into the tender budgets
- Accountability for outcomes for which a CMO may have partial or no control
- NDIS model is both new and difficult to work with for participants/consumers with psychosocial disability; many issues remain unresolved
- Infrastructure and staff capabilities around increased monitoring systems and diverse contractual arrangements co-existing at provider level.

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