Mental Health Coordinating Council
Submission to the Australian Health Ministers' Advisory Council

A NATIONAL CODE OF CONDUCT FOR HEALTH CARE WORKERS

Submission Template

Name: Corinne Henderson, A/CEO – Mental Health Coordinating Council

Address: PO Box 668, Rozelle, NSW 2039

Email: corinne@mhcc.org.au T: 02 9555 8388 #102

Are you a:
Consumer of health services
Health care worker (please specify type)
Registered health practitioner (please specify type)
Employer of health care workers
Professional association
Education provider
Regulator
Other – Please state:

The Mental Health Coordinating Council (MHCC) is the peak body for non-government community managed organisations providing services to people affected by mental health conditions in NSW. MHCC represents the interests of more than 200 member organisations across NSW. MHCC's membership consists of over 200 organisations whose business or activity is wholly or in part related to the promotion and/or delivery of services for the wellbeing and recovery of people affected by mental health conditions. They provide a range of psychosocial and clinical services, and support programs, as well as advocacy, education, training and information services with a focus on recovery orientated practice. We work in partnership with both State and Commonwealth Governments by participated extensively in policy and sector development and facilitate linkages between government, community and private sectors in order to affect systemic change. MHCC also manage and conduct research projects and develop collaborative projects on behalf of the sector. MHCC is also a registered training organisation (MHCC LD) delivering nationally accredited mental health training and professional development to the workforce. MHCC is also a founding member of Community Mental Health Australia (CMHA) the alliance of all eight State and territory community sector mental health (MH) peak bodies. Together we represent more than 800 CMOs delivering MHSs nationally.[1]

Additional comments quantifying and describing the community sector mental health workforce are below.

If you are a professional association, can you provide an estimate of the number of health care workers you believe to be practising in your profession or field?

While the community mental health sector workforce does not have a representative professional association, peak representative bodies and Health Workforce Australia have some workforce

[1] Community Mental Health Australia, 2012, *Taking Our Place — Community Mental Health Australia: Working together to improve mental health in the community.*

information. However, community sector and unregistered practitioner data collections for the mental health workforce are far from adequate.[2]

MHCC's most recent sector training needs analysis (2006) indicated that there were about 5,000 workers in the community managed mental health sector in NSW. Since that time, this number has grown commensurate with significant increases in government policy and funding directions for community sector organisations to play a much greater role in delivering mental health programs (e.g., COAG National Action Plan for Mental Health 2006/11, 2001/12 budget commitments and the subsequent COAG National Roadmap for Mental Health 2012/22).

In 2009/10, it was estimated that there are 15- 26,000 community sector workers providing services to people affected by mental illness nationally.[3] Community Mental Health Australia (CMHA) conservatively estimates this to equate to approximately 12,000 FTE. The same report found that 43% of workers identified as having health qualifications — mostly in social work, psychology or nursing — and about half of those reported being registered health practitioners. 34% of workers reported having a vocational qualification with the majority of these being at the Certificate IV and Diploma levels. This indicative data, along with the absence of a recognised professional association, tells us that approximately 80 % of community sector mental health workers are unregulated and unregistered.[4]

Section 2.2 – Proposed terms of National Code

How should the class or classes of person that are to be subject to this National Code be identified?

Definitions

Health and/or community service practitioner.

Is the term 'health care worker' an acceptable term to use to describe to whom the National Code applies, or is another term such as 'unregistered health practitioner' or 'health practitioner' preferable, as in NSW and South Australia?

No, health and/or community service practitioner is preferable.

Application of this Code

Is the proposed scope of application of the National Code acceptable?

No. There is a need to further clarify the applicability of the proposed Code of Conduct to community sector workers (i.e., to more clearly address the Codes applicability in 'social care' settings). While 'mental health' is listed as being in-scope for the code, its' applicability to community sector practitioners requires clarification. The codes applicability to other community sector work roles also requires clarification (e.g., drug and alcohol, aged care, disability, etc.).

[2] Health Workforce Australia 2013, *Mental Health Workforce Study: Mental Health Workforce Data Planning Inventory*.
[3] National Health Workforce Planning and Research Collaboration 2011, *Mental Health Non-Government Organisation Workforce Project Final Report.*
[4] Australian Health Ministers Advisory Council 2013, *Options for the Regulation of Unregistered Health Professionals: Final Report.*

Is it preferable that the National Code apply to all health care workers whether registered or not? If so, what are the potential advantages and disadvantages of this approach?

Yes – the advantages are uniformity in safe practice standards across a range of work settings and work roles where 'health services' are provided. These will largely compliment and/or lead to quality improvements in required and/or voluntary Codes of Conduct that may exist for specific professions and/or workforces. The disadvantages are that some unregulated/unregistered practitioners may not be aware of their obligations under the code.

Specific comments about the proposed code:

1. Health care workers to provide services in a safe and ethical manner Should the National Code include a minimum enforceable standard that addresses the provision of services in a safe and ethical manner?

Yes. This should be compliance with the requirements of the code.

If so, do these subclauses cover all the principal professional obligations that should apply to any health care worker, regardless of the type of treatment or care they provide?

Yes.

2. Health care workers to obtain informed consent Should the National Code include a minimum enforceable standard that addresses informed consent? If so, then how should it be framed and how should the complexities of informed consent in emergencies and with respect to minors be dealt with?

Yes. This needs to be more strongly linked to 14 (compliance with privacy laws).This also needs to acknowledge legislative exceptions to obtaining informed consent (e.g., National Disability Insurance Scheme/NDIS Act Sections 55-57).

Is this clause expressed in a way that will best capture the conduct of concern?

No – refer to preceding comment. In addition the preferred requirement for written consent needs to be noted. Consideration needs to be made surrounding a person's need to provide 'informed' consent, and their capacity to do so, as well as the need to promote supported decision-making.

3. Appropriate conduct in relation to treatment advice Should the National Code include a minimum enforceable standard that addresses the provision of treatment advice?

Yes.

If so, is this clause expressed in a way that will best capture the conduct of concern?

Yes.

4. Health care workers to report concerns about treatment or care provided by other health care workers Should the National Code include as a minimum enforceable standard a mandatory reporting obligation for all health care workers to report other health care workers who in the course of providing treatment or care place clients at serious risk of harm?

Yes.

If so, is this clause expressed in a way that will best capture the conduct of concern?

No. This is too vague. Needs to be clearer on what is 'notifiable conduct'.
Regarding clause c) ……impairment <u>that which prevents them from appropriately providing care and treatment.</u>
Regarding clause d)……accepted financial standards <u>(such as financial misconduct in relation to the provision of care and treatment).</u>

Should the wording more closely reflect the mandatory reporting provisions imposed on registered health practitioners under the National Law?

Yes. Also, include subclause to prohibit complaints that are frivolous, vexatious, lacking in substance, etc.

5. Health care workers to take appropriate action in response to adverse events Should the National Code include a minimum enforceable standard that addresses appropriate conduct in dealing with emergencies and adverse events?

Yes.

If so, is this clause expressed in a way that will best capture the conduct of concern?

Clause d) needs to better define 'relevant authority'.

6. Health care workers to adopt standard precautions for infection control Should the National Code include a minimum enforceable standard that addresses the adoption of infection control procedures?

Yes.

Regarding 6.1 - There is some concern that some cosmetic practices including body piercing and tattooing fall outside of these standards. MHCC advocate that they be included in this code of conduct.

If so, is this clause expressed in a way that will best capture the conduct of concern?

Yes.

7. Health care workers diagnosed with infectious medical conditions

Should the National Code include a minimum enforceable standard that addresses health care workers diagnosed with infectious medical conditions?

Yes.

If so, is this clause expressed in a way that will best capture the conduct of concern?

Yes.

8. Health care workers not to make claims to cure certain serious illnesses

Should the National Code include a minimum enforceable standard that addresses claims to cure or treat life threatening and terminal illnesses?

Yes.

If so, is this clause expressed in a way that will best capture the conduct of concern?

Yes.

9. Health care workers not to misinform their clients

Should the National Code include a minimum enforceable standard that addresses misinformation and misrepresentation in the provision of health products and services?

Yes.

If so, is this clause expressed in a way that will best capture the conduct of concern?

Yes.

10. Health care workers not to practise under the influence of alcohol or drugs

Should the National Code include a minimum enforceable standard that addresses the provision of treatment or care to clients while under the influence of alcohol or drugs?

Yes.

If so, is this clause expressed in a way that will best capture the conduct of concern?

No. The term ‘unlawful drugs’ need to be changed to also capture abuse of medications that may or may not be prescribed. Consider ‘substance misuse’.

11. Health care workers with certain mental or physical impairment Should the National Code include a minimum enforceable standard that addresses health care workers who suffer from physical or mental impairments that may impact their provision of treatment or care to their clients?

Yes. However the language used to capture this concept requires review and greater sensitivity. The way this clause currently reads is stigmatising and possibly discriminatory. Many people living with impairments/disability work including in the health care sectors. Current Australian government policy directions, including but not limited to the NDIS, encourage more people with disability to work. In the mental health context, the ‘peer workforce’ is rapidly growing. ‘Peer Workers’ are people with lived experience of mental illness and recovery that provide support to others learning to live with mental illness. Advanced directives are a mechanism often used for managing/supporting workers who may be experiencing difficulties with their capacity to work, due to a range of possible health and social issues.

If so, is this clause expressed in a way that will best capture the conduct of concern?

No. Refer to preceding comment above.

Is subclause 2 necessary, or does subclause 1 sufficiently capture the behaviour of concern?

Subclause 1 is not sufficient. This whole section requires review and rewriting. Consider:

Health care workers with impairment

1. A health care worker must not provide treatment or care to clients while impaired (e.g., acutely unwell, mentally disordered as a consequence of substance use/misuse, etc.) that places or is likely to place clients at risk of harm
2. Without limiting subclause 1, if a health care worker has an impairment that could place clients at risk, the health care worker must seek advice from a suitably qualified health practitioner to determine whether, and in what ways, he or she should modify his or her practice, including stopping practice if necessary.

12. Health care workers not to financially exploit clients Should the National Code include a minimum enforceable standard that addresses financial exploitation of clients?

Yes.

If so, is this clause expressed in a way that will best capture the conduct of concern, particularly in relation to the treatment or care of elderly, disabled and seriously or terminally ill clients?

No. Regarding Clause 2 c) Whilst we wholeheartedly agree with this statement, we draw attention to the fact that the medical profession regularly accepts what we regard as financial inducements, such as subsidised conferences and events sponsored by drug companies. This is particular

pertinent in relation to psychiatric medications which are strongly promoted to psychiatrics by pharmaceutical companies.

13. Health care workers not to engage in sexual misconduct Should the National Code include a minimum enforceable standard that prohibits sexual misconduct by health care workers?

Yes.

If so, is this clause expressed in a way that will best capture the conduct of concern?

No. The term 'close personal nature' is ambiguous. The 'boundary' issues are complex and different when providing preventative community based care and support (i.e., social care) to that of clinic/office or centre-based programs where more traditional boundaries must be clearly maintained. When your 'workplace' is a client's home or community there are differences in the nature and quality of the professional relationship, which must be considered, including cultural aspects.

Regarding subclause (3) – MHCC suggest that a specific time should be set to have elapsed before contemplating a personal or sexual relationship with a previous client. This is especially sensitive if personal care or extensive personal information has been shared as a consequence of the professional relationship. MHCC would advocate that a period of at least 2 – 5 years should have elapsed, and that there is no possibility that the client might require to access the service in the future.

Should the draft National Code be strengthened to specifically address sexual or physical assault in the health care setting, or is the preferred approach to expand the definition of 'prescribed offences' and rely on clauses 3 and 4?

The definition of 'prescribed offences' must be clarified with examples.

Clause 3 is problematic from a mental health sector perspective (it suggests the possibility that it is OK to have sex with a previous client who may need you services again at some point in the future).

14. Health care workers to comply with relevant privacy laws Should the National Code include a minimum enforceable standard in relation to breaches of client privacy by health care workers?

Yes.

If so, is this clause expressed in a way that will best capture the conduct of concern?

This clause must be reconciled against the NDIS Act 2013, Sections 55-57 that allows for the sharing of client information without consent, which is in our view highly inappropriate and unethical practice. Some NDIS trial sites (i.e., Tasmania and the ACT) have been advised not to comply with this legislative requirement). MHCC's advice to members has been that written consent to share information should always be obtained and, where this is not possible, the reasons for this clearly documented.

15. Health care workers to keep appropriate records

Should the National Code include a minimum enforceable standard in relation to clinical record keeping by health care workers and client access to and transfer of their health records?

Yes.

If so, is this clause expressed in a way that will best capture the conduct of concern?

No. The word 'clinical' is redundant as the proposed Code is intended to cover both health and social care (i.e., the 'social care' may or may not be clinical in nature, some workers in 'health settings' are not clinicians, etc.).

Are subclauses 2 and 3 necessary, or does subclause 1 sufficiently capture the conduct of concern?

Subclauses 2 and 3 are necessary. Many health care workers still do not understand or accept the principle that the client owns their own health information.

16. Health care workers to be covered by appropriate insurance

Should the National Code include a minimum enforceable standard in relation to the professional indemnity insurance obligations of health care workers?

Yes.

If so, is this clause expressed in a way that will best capture the conduct of concern?

Yes.

Is this clause likely to impose unreasonable compliance costs on health care workers?

No.

17. Health care workers to display code and other information

Should the National Code include a minimum enforceable standard in relation to display of the National Code, their qualifications and avenues for complaint? If so, is this clause expressed in a way that will achieve this intent?

No. This is particularly problematic where the 'workplace' is a client's home or the community (i.e., not an office or facility based). However, where a client visits an office/ clinic etc., the standards under which they practice should be clearly visible.

Should there be a requirement, as in the SA Code, for health care workers to display their qualifications?

No. Once again this is not realistically achievable where the 'workplace' is a client's home or the community (i.e., not an office or facility based). Not all health and social care (i.e. health and community sector practitioners) have either university of vocational qualifications. However, where a practitioner has qualifications, association memberships etc, these should be clearly visible.

Are the exemptions to the requirement to display the National Code and qualifications appropriate?

Yes. In the situation where the 'workplace' is a client's home or the community (i.e., not an office or facility based) these circumstances need to be accommodated.

Items not included in the draft National Code of Conduct

1. Sale and supply of optical appliances Is this an acceptable approach to dealing with regulation of the sale and supply of optical appliances?

Yes.

2. Health care workers required to have a clinical basis for treatments Is the proposed approach adopted in this draft National Code appropriate given the complexities of determining what treatments do and do not have 'an adequate clinical basis'?

No. This is particularly complex with regards to mental health matters. While complex, this requirement lacks consumer protection and accountability. Moreover, there must be respect for alternative treatments that consumers may choose to avail themselves of, and that traditional models do not necessarily support.

Should the National Code include an additional clause along the following lines 'A health care worker must take special care when a treatment they are offering to a client is experimental or unproven, to inform the client of any risks associated with the treatment'? If so, how should complexities with identifying which treatments are 'unproven' be dealt with?

Yes. The 'complexities' can be addressed through discussion and practice that is truly about informed consent. This will also facilitate further development of an agreed evidence base. Issues of capacity and supported decision making must be taken into account in this context.

Section 3.2 - Scope of application of the National Code

Definition of a health care worker What terminology is preferred to identify and define the class or classes of person who are to be subject to the National Code?

Health and community service practitioners.

Is the term 'health care worker' acceptable, or is another term preferable?

No. Health care worker is insufficiently inclusive of community sector practitioners who work to improve health and wellbeing (i.e., what is referred to in the discussion paper as 'social care'). MHCC's preferred terminology is health and community service practitioners.

Definition of a health service
How important is national consistency in the scope of application of the National Code, particularly with respect to the definition of what constitutes a 'health service'?

Very important, especially as this relates to the inclusion of community sector 'health' and 'disability' practitioners.

If consistency is considered necessary, how should 'health service' and 'health care worker' be defined?

Both health and community sector practitioners working to support people's health and wellbeing need to be included. The silos that currently exist between health/mental health and disability/community care need to be eradicated in line with the World Health Organisation's (WHO) definitions of 'best practice' including the social determinants of health.

Is there a need to include a reference to 'volunteer' in the definition of provider/health service provider?

Yes.

Section 3.3 Application of a 'fit and proper person' test

Should there be power to issue a prohibition order on the grounds that a person is not fit and proper to provide health services where they present a serious risk to public health and safety?

Yes.

Is there a preferred option for enabling the application of a fit and proper person test?

Option 2

Is consistency across jurisdictions considered important in the approach adopted?

Yes.

Section 3.4 - Who can make a complaint?

How important is national consistency in who may make a complaint?

Very important

If consistency is considered important, is there a preferred approach for specifying in legislation who may make a complaint?

Any person may make a complaint and at any time.

Section 3.5 Commissioner's 'own motion' powers

How important is national consistency with respect to the power for a Commissioner to initiate an investigation of a matter on his or her own motion, without a complaint?

Yes – important. MHCC endorses the recent amendments in NSW to the Health Care Complaints Commissioner legislation enabling - Own Motion powers.

If consistency is considered important, should all state and territory Commissioners have such 'own motion' powers?

Yes.

Section 3.6 Grounds for making a complaint

How important is national consistency in the grounds for making a complaint?

Yes – important.

If consistency is considered important, is there a preferred approach for defining the grounds for making a complaint and what terminology is preferred?

MHCC prefer the NSW approach, including compliance with all relevant national practice standards (i.e., National Mental Health Workforce Standards to be achieved within two years of commencing employment in mental health work).

Section 3.7 Timeframe for lodging a complaint

How important is national consistency in the timeframe within which a complaint must be lodged?

Yes – important.

If consistency is considered important, is there a preferred approach, that is, should a timeframe be specified, and if so, what should it be and should there be discretion to extend it an in what circumstances?

No timeframe for lodging complaints.

Section 3.8 Interim prohibition orders

How important is national consistency with respect to the issuing of interim prohibition orders?

Yes – important.

If consistency is considered important, what is the preferred approach with respect to the grounds for issuing an interim order, the process and the maximum time period?

MHCC commend the NSW approach but with a timeframe of 12 weeks and suggest that the clause include the Queensland approach to 'show cause'.

Section 3.9 - Who is empowered to issue prohibition orders?

How important is national consistency with respect to the body that is conferred with powers to issue prohibition orders?

Yes – important.

If consistency is considered important, which body should have the power to issue ongoing prohibition orders, the Commissioner or a tribunal?

The Commissioner

Section 3.10 Grounds for issuing prohibition orders

How important is national consistency in the grounds for issuing a prohibition order?

Yes – important.

If consistency is considered important, is there a preferred approach?

The NSW approach

Section 3.11 Publication of prohibition orders and public statements

How important is national consistency in the publication of public statements that include the details of prohibition orders issued?

Yes – important.

If consistency is considered important, is there a preferred approach?

No preferred approach.

Section 3.12 Application of interstate prohibition orders

How important is national consistency in achieving application across Australia of prohibition orders and interim prohibition orders issued in each state and territory?

Yes – important.

If consistency is considered important, is there a preferred approach for achieving mutual recognition of prohibition orders?

The concept of ‘Mutual recognition’ should be introduced into the legislation.

Section 3.13 Right of review of a prohibition order

How important is national consistency with respect to review rights for practitioners who are subject to a prohibition order?

Yes – important.

If consistency is considered important, is there a preferred approach?

Application for a review or appeal within 28 days

Section 3.14 Penalties for breach of a prohibition order

How important is national consistency with respect to the offences and penalties that apply for breach of a prohibition order?

Yes – important.

If consistency is considered important, what is the preferred approach?

Maximum fine $22,000

Section 3.15 Powers to monitor compliance with prohibition orders

How important is national consistency with respect to powers to monitor practitioner compliance with prohibition orders issued?

Yes – important.

If consistency is considered important, is there a preferred approach?

Time-limited episodic checking of health and/or community service practitioners by compliance body and mechanisms including triggers related to subsequent complaints.

Section 3.16 Information sharing powers

How important is national consistency with respect to the sharing of confidential information between HCEs and with other regulators?

Yes – important.

If consistency is considered important, what is the preferred approach?

NSW.

Section 4.1 Mutual recognition

What is the preferred option for making publicly accessible information about prohibition orders that are issued in each state and territory?

Option 3

Are there any issues that need to be considered when designing and implementing such arrangements?

Monitoring client safeguards and confidentiality

Any other comments?

Do you have any other comments to make about the draft National Code, policy parameters or administrative arrangements?

No

Would you like to be informed of the outcome of the consultation?

Yes - MHCC wish to thank AHMAC for proving the opportunity to comment on this important consultation and express their willingness to be further consulted on any matters raised in this paper.

1 May 2014