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The National Safety and Quality Mental Health Standards for CMOs Consultation
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Submission: National Safety and Quality Mental Health Standards for Community Managed Organisations: Consultation Paper

Background information for MHCC Members

The National Safety and Quality Mental Health (NSQMH) Standards for Community Managed Organisations (CMOs) are being developed by the Australian Commission for Safety and Quality in Health Care (ACSQHC, the Commission) in consultation with community managed organisations, peak bodies, consumers, carers, healthcare providers, professional bodies, Primary Health Networks, and other representatives of the sector.

The objective of the NSQMH Standards for CMOs is to promote best practice and improve the quality of care delivered to consumers, carers and their support networks. The consultation paper includes a description of example standards together with explanatory notes that describe the type of actions to be implemented in practice.

MHCC welcome the opportunity to respond to the consultation paper which aims to support interested stakeholders provide input into shaping their development. Whilst the paper sets out the aims of the NSQMH Standards for CMOs, how they will be developed, who should implement them, and "the nature of the associated accreditation process" (pg.4), MHCC note the Commission cannot mandate or authorise accreditation. Nevertheless, it may be that some funders will require alignment to the standards as a required KPI and they could become a necessary part of biannual accreditation processes that are already being undertaken by most CMOs.

The Commission has sought feedback from key stakeholders on the most appropriate approach to developing mental health standards for the CMO sector. Following the consultation process, the Commission will proceed to develop a draft set of standards for CMOs providing mental health and psychosocial support services. It is expected that these draft standards will be released for further consultation in the second half of 2021. MHCC stress the importance of again providing ample time for further consultation with the sector.

The NSQMH Standards for CMOs will be finalised following the consultation on the draft standards, and the approach to implementation will be released along with key supporting tools for assessors and service providers. An implementation date will be set, in consultation with the CMO sector.

Submission

In addition to involvement with Community Mental Health Australia (CMHA) developing a national submission on behalf of State and Territory peak bodies for mental health CMOs; MHCC are pleased to provide its own submission to ACSQHC.

MHCC has conducted a consultation with its member organisations and provide the following comment on the eleven questions that the Commission posed in their consultation paper.

MHCC express their willingness to be further consulted about the standards and look forward to the next stage of discussions. For further information about this submission please contact Corinne Henderson, Principal Policy Advisor at corinne@mhcc.org.au

1. ***How applicable are the example standards of 'Governance', 'Partnering with Consumers' and 'Model of Care' to the quality and safety of community managed mental health services?***

   - **Example 1: Clinical Governance and Operational Management Standard** should be described in terms of **Practice** Governance and Operational Management to reflect the broader best practice approach adopted in CMO service delivery contexts. Services provided, whether psychosocial support or clinical are underpinned by trauma-informed recovery-oriented (TIRO) principles and a practice approach which must be clearly articulated in terms of both organisational culture, and service delivery.
   - The criteria expressed under **Governance, leadership and culture** to improve safety and quality of care must ensure that safety is understood from both a consumer and service provider perspectives; promoting consumer aspirations and dignity of risk; and maximising consumer participation in care and treatment planning .
   - The language and characteristics must be reflected in the actions that likewise should have trauma-informed recovery oriented- principles central to all governance and operational aspects.
   - Leadership must do more than "partner" with consumers and carers. They must ensure that co-design processes are embedded across all aspects of governance.
   - The practice framework[1] must include lived-experience expertise in governance of the service.
   - Likewise, **the Safety and quality systems** must consult with lived-experience experts in evaluating risk management strategies and identify areas for improvement that also acknowledge cultural and environmental safety.
   - Actions must include that incident and investigation systems inform consumers and carers where changes have been implemented.
   - The criterion of **Workforce qualifications and skills** that address responsibilities for safety and quality must also reflect on how the safety and wellbeing of the workforce is dealt with by the organisation.
   - Likewise, actions must include systems that maximise autonomy and self-determination of consumers that also ensure staff safety.
   - MHCC recommend a re-conceptualisation of the Clinical Governance Framework and rewrite it in the context of the practice approach as **Practice Governance** to apply to all services and programs, where the approach is informed by the stated set of principles as discussed earlier.

[1] A **Practice approach** with an action refers to the demonstration of a trauma-informed recovery-oriented approach informed by the **Principles of trauma-informed recovery-oriented practice** which must underpin every aspect of both direct service delivery and organisational governance.

- **Example 2: Partnering with Consumers Standard** The language of partnering is weak and fails to articulate the actions required. The terminology should specifically indicate that codesign is utilised across the domains and represents meaningful consumer/carer collaboration in design, production, implementation.
- In describing strategies to ensure healthcare services collaborate to deliver person-centred care, it must clearly state that the care is likewise person- directed in order to effectively incorporate the views and experiences of consumers and carers into the design, governance and evaluation of services.
- Systems must be based on strength-based practice in line with the practice approach.

- **Example 3: Models of Care** should be considered in the context of a trauma-informed recovery-oriented practice approach that is informed by a set of principles irrespective of the model of care, program or service delivery context. Our preference would be that the terminology amended to reflect a **Practice Approach Standard**. With the intention that CMOs have a clearly defined practice approach, consistent with best practice and evidence, and consumers receive care consistent with the principle and values of that approach.

2. ***What other domains relevant to community managed organisations providing mental health services should be considered for inclusion in the NSQMH Standards for CMOs?***
   - The standards should also be relevant to mental health related human services that work with people living with mental health conditions, their families, carers and support networks.
   - The standards could clearly articulate in terms of addressing the needs across the following organisational domains:
     A. Practice Governance, Management and Leadership
     B. Organisational Policies and Structural Framework
     C. Consumer and Carer/Family Codesign
     D. Direct service delivery
     E. Healthy and Effective Workforce
     F. Outcomes and Evaluation
   - Under the domain of Organisational Policies, it will be important to consider the issue of conflicts of interest, such as where the practice approach is in conflict with clinical advice.

3. ***Are there specific actions you would like to see included within the NSQMH Standards for CMOs? (an 'action' is explained on page 7)***
   - Under Example 2 it is important that an action identifies processes to involve and support representatives that are reflective of the diversity of service users and that recognises what they need to be fully involved in co-design processes.

4. ***Are there specific 'actions' where you would suggest services must demonstrate particular evidence of compliance? (explained on page 8)***
   - This should be altered to read 'a practice approach' rather than mandatory language of compliance.

5. ***Is there terminology related to the CMO sector and the way it operates that should be incorporated into the NSQMH Standards for CMOs? If yes, please list. What terminology would you prefer not to be used?***
   - It is vital that the standards reflect language familiar to the CMO sector workforce and people living with mental health conditions. (See MHCC's Recovery Oriented Language Guide 2) and (A Guide to Working Collaboratively with Australia's First Nations People)

- With regards to continuous quality improvement activities, it would seem important to talk about audit and evaluation rather that accreditation processes, especially since the standards are not mandated.

6. ***Are there other standards that apply in the mental health sector (e.g. the NDIS Practice Standards or NSQ Digital Mental Health Standards) with which the NSQMH Standards for CMOs should have a consistent approach e.g. in terms of language, concepts and structure? If so, please list.***
   - These new standards for CMOs should influence updates of existing standards but also stand alone. However, our preference it to reduce compliance costs and avoid CMOs having to work with multiple sets of different standards.
   - The issue of how risk and dignity of risk must be articulated in the CMO standards. There may be some conflicting elements such as that which relates to services/ programs that need to establish behavioural support plans.
   - The issue of coercive orders and how that might conflict with principles underpinning the standards will need to be reflected in operational aspects of the standards.

7. ***How should a mutual recognition framework work for the NSQMH Standards for CMOs in relation to other standards? Please list the other standards you think are relevant. (Mutual recognition is explained on page 19)***
   - Mutual recognition and alignment should not become a regulatory burden. The standards should represent a mechanism for working better, smarter and achieving best outcomes for consumers and carers and safe working environments for staff.

8. ***What are the important considerations in determining the approach to implementing the NSQMH Standards for CMOs?***
   - It should be made clear that these standards are voluntary and that the use of the standards is promoted as quality improvement activities.

9. ***What accreditation approach would be appropriate for the NSQMH Standards for CMOs? (Accreditation is explained on page 19)***
   - The standards are not mandatory and therefore the process is one of audit and evaluation. If funders require alignment to the standards as a KPI, then the external accreditor will specify the approach necessary.

10. ***What guidance, resources or tools do you feel that assessors might need when measuring services against the NSQMH Standards for CMOs?***
    - Following on from the previous response to Q.9 – No comment

11. ***Any other issues or approaches that you feel are important to consider?***
    - How can organisations demonstrate that they work safely and effectively with cultural diversity?
    - How do organisations effectively refer on and assist safe transition to other services when unable to provide a service themselves?
    - How are codesign processes embedded across all operational and service delivery programs and services?
    - When safety and quality systems are in place, how is accountability demonstrated?

Further comment

1. The Consultation Paper refers to the NSW Mental Health Co-ordinating Council's **NSW Community Managed Mental Health Sector Mapping Report (2010)** and uses the seven core CMO mental health service types identified in the report as seven categories:
   Accommodation support and outreach; Employment and education; Leisure and recreation; Family and carer support; Self-help and peer support; Helpline and counselling services and Promotion, information and advocacy.

MHCC points out that this taxonomy is outdated. More contemporary information can be found within the scope of the **Mental Health Non-Government Organisation Establishments National Best Endeavours Data Set (MH NGOE NBEDS**, see footnote). This refers to mental health-related non-government organisations which provide one or more of the service types included in the service taxonomy in the footnote.

Following information in endnote accessed from:
http://meteor.aihw.gov.au/content/index.phtml/itemId/494729

See the Service Types and Metadata Items spreadsheet for information on actual metadata items required for each service type.[2]

[2] Data Set (MH NGOE NBEDS) is mental health-related non-government organisations which provide one or more of the service types included in the service taxonomy:

1. **Counselling—face-to-face**
2. **Counselling, support, information and referral—telephone**
3. **Counselling, support, information and referral—online**
4. **Self-help—online**
5. **Group support activities**
6. **Mutual support and self-help**
7. **Staffed residential services**
8. **Personalised support—linked to housing**
9. **Personalised support—other**
10. **Family and carer support**
11. **Individual advocacy**
12. **Care coordination**
13. **Service integration infrastructure**
14. **Education, employment and training**
15. **Sector development and representation**
16. **Mental health promotion**
17. **Mental illness prevention**

Mental health non-government organisations are private organisations (both not-for-profit and for-profit) that receive Australian and/or state or territory government funding specifically for the provision of services where the principal intent is targeted at improving mental health and well-being and delivered to people affected by mental illness, their families and carers, or the broader community.

These services focus on providing well-being, support and assistance to people who live with a mental illness rather than the assessment, diagnostic and treatment tasks undertaken by clinically focused services.

2. The Commission propose that the NSQMH Standards for CMOs will describe the safety and quality systems and processes that CMOs should have in place to minimise "the risk of consumer and carer harm, and to provide assurance to consumers and carers that they are receiving high quality care" (pg.8). It is important to additionally demonstrate good outcomes from the perspective of consumers and carers. We would advocate that the standards recommend the use of the YES-CMO Survey (Your Experience of Service) in CMO services.

3. In addition to the items listed (pg.9) reflecting what each standard should contain, it is vital that each standard reflects the principle/s underpinning it. Hence the suggestion that principles of practice are stated in the introductory material to the Standards as a whole.

4. With regards to the "Proposed Terminology for use in the NSQMH Standards for CMOs" (pg.9) MHCC suggest that:
   - the term 'person or people with lived experience' be utilised and that 'mental health condition' rather than mental illness be used where possible, reflecting the holistic aspects of a person's condition.

   - MHCC recommend the inclusion of various terms as a glossary[i] to the standards including:
     i. Cultural Safety
     ii. Mental Health Condition
     iii. Lived experience
     iv. Recovery
     v. Trauma-informed recovery-oriented practice

   - MHCC recommend inclusion of roles described in CMOs (pg.10) to reflect the sector's workforce - 'mental health worker' 'psychosocial support worker' 'peer worker' recovery coach' 'mental health professional'.
   - Rather than referring to 'Healthcare' vs. 'health care' utilise the language of - mental health care vs psychosocial rehabilitation and support services.

5. When discussing in "Systems" (p.11) a "stated goal" it is important to clarify whose goal this refers to and ensure that both organisational/service goals and consumer and carer goals are considered.

[i] **Glossary – suggested inclusions**
Cultural Safety - In the context of trauma-informed recovery oriented practice, cultural safety has been described as providing an environment that is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning, living and working together with dignity and truly listening. It reminds us that people who may not belong to the dominant culture or have lived experience of trauma may have been subject to oppression, abuse, and discrimination.

Mental Health Condition - The term is broad and refers to symptoms that may be caused by life events, genetic factors or birth defects. This condition can be temporary, episodic or lifelong. A mental health condition can include mood, anxiety, personality, psychotic and compulsive disorders. It includes, but is not limited to, those conditions and symptoms recognised as constituting mental illness under states mental health legislation.
Lived experience - Lived experience is the knowledge and understanding acquired from living through or with something. This manual frequently refers to people with lived experience of mental illness; in this context it means

people living with mental health conditions and all this entails (sometimes called consumers) and family or friends supporting someone living with mental illness (sometimes called carers).

Recovery - Individual or personal recovery is defined as being able to create and live a meaningful and contributing life within a community of choice, with or without the presence of mental health difficulties. 'Recovery' can mean different things to different people; but in general it means: gaining and retaining hope; understanding of one's abilities and difficulties; engagement in an active life; personal autonomy; social identity; meaning and purpose in life, and a positive sense of self.

Trauma-informed recovery-oriented practice -Recovery-oriented practice refers to the application of sets of skills and capabilities that support people to undertake the journey of individual recovery. This assists people to recognise and take responsibility for their own recovery and wellbeing, and define their own goals, wishes and aspirations. When recovery-oriented practice is trauma-informed it represents the most contemporary best practice approach based on the principles of safety, choice, collaboration, trust and empowerment. A trauma-informed recovery-oriented practice approach is strengths-based whilst also responsive to the impacts of trauma, emphasising physical, psychological, cultural, social and emotional safety for both service providers and people accessing services.