Submission on Draft National Safety & Quality Mental Health Standards for Community Managed Organisations

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Introduction

Community Mental Health Australia (CMHA) thanks the Commission for the opportunity to comment on the Draft NSQMH Standards for Community Managed Organisations (CMOs). We also acknowledge and applaud the improvements made to the consultation draft that have taken into consideration the voices of lived experience and the sector.

CMHA concurs with the view expressed by the Mental Health Coordinating Council that further work is required to ensure that the terminology used in the Standards is consistent with trauma-informed recovery oriented language and practice approach widely used throughout the sector.

CMHA also concurs with the following views expressed in the joint submission by Flourish Australia, Mind, Neami, One Door Mental Health, Stride, Open Minds and Wellways (known as the Australian Psychosocial Alliance):

- The new standards should be more explicit about incorporating the principles of trauma-informed recovery-oriented practice approach[1] to service delivery.
- The new standards should emphasise personal (individualised) recovery within the model of care.
- The new standards should have a stronger focus on psychosocial disability support and psychosocial rehabilitation, given these are the specialised services delivered by CMOs.
- Whilst the definition of a CMO has been expanded, the suite of services provided by CMOs is not well-reflected within the standards which contain limited focus on psychosocial rehabilitation.
- Given that CMOs engage in partnerships and collaborations with clinical providers to deliver integrated services within the community, there is a need for expanded consideration of service delivery partnerships, especially under the governance standard.
- The standards do not appropriately recognise the needs of diverse and vulnerable populations, including Aboriginal and Torres Strait Islander people, Culturally and Linguistically Diverse communities, LGBTIQ+ populations, and people who are homeless or at risk of homelessness. There should be separate items in the standards to support organisations to provide high-quality services to diverse population groups.
- That prior to finalising the standards consult with the sector regarding how the Commission intends to support a mutual recognition framework.

Another area for improvement relates to how Lived Experience (Peer) Work is referred to in the draft standards. While the Commission's intention to value and acknowledge the role of peer work is recognised, the way the peer workforce is currently referred to might be perceived as being a "tack on" which in turn might be perceived

[1] Our sector commonly defines a trauma-informed recovery-oriented approach in the following way:

Recovery orientation has been adopted as an overarching philosophy to guide mental health practice and is embedded into policy and standards nationally. An understanding of trauma is integral to a recovery-oriented approach. In fact, developing and implementing trauma-informed systems of care is one of the first steps towards becoming recovery oriented. Critical to this objective is to use language that reduces the possibilities for re-traumatisation and harm within service systems and practice. A trauma-informed recovery-oriented approach is person centred and involves sensitivity to individuals' particular needs, preferences, safety, vulnerabilities, and wellbeing, recognises lived experience and empowers people with lived experience to genuinely participate in decision-making.

as an "othering" of peer work. To address this possible perception, the Commission could consider an upfront statement that recognises the rightful place of peer workforce within the contemporary mental health workforce and its critical role and position in Multidisciplinary teams. Consideration could also be given to requiring services to set targets that demonstrate their commitment to growing a peer workforce. CMHA recommends that the Commission adopt and embed the values, language, definition and approach of the National Lived Experience Workforce Development Guidelines.

Strengthening a human rights-based emphasis within the new standards

The community mental health sector being key providers of psychosocial disability recovery and support services, are required to comply with mental health and other standards and instruments including the Convention on the Rights of Persons with Disabilities (CRPD) to which Australia is a signatory. Guiding principles of the Convention which the community mental health sector seeks to abide by include:

- Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons
- Non-discrimination
- Full and effective participation and inclusion in society
- Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity
- Equality of opportunity
- Accessibility
- Gender equality

CMHA invites the Commission to consider further possible improvements to the new standards, primarily aimed at holding the sector accountable for embedding these principles within practice and service delivery. This would achieve a "new wine in new bottle" approach. Not only would human rights be embedded but so too would be inter-connected principles of recovery oriented, trauma informed and wellbeing-based practice and service delivery approaches to safety (risk) and service quality. The "new bottles" being the creation of standards that push practice toward and hold services accountable for demonstrating they are supporting people to move toward self-defining (or at the least, co-defining) and self-managing (or co-managing) their safety and to becoming true partners in defining quality and shaping quality services.

In short, a human rights-based approach would support choice, decision making, self-determination and self-agency through the co-creating or co-producing of wellbeing, safety, and quality. An example of an evidence-based initiative that seeks to achieve this is the UK National Health Service Co-Creating Health Program. This program worked across eight sites between 2007 and 2012. Each site focused on one of four clinical areas: COPD, depression, diabetes, and musculoskeletal pain. See for example:

- Co-creating health – embedding self-management embed self-management support within mainstream health services across the UK
- Co-producing services - Co-creating health: Tools for Improvement – 1,000 lives

The aims of this NHS program included:

1. *"Giving people with long-term conditions the skills, confidence and support to self-manage."*
2. *"Helping clinicians to develop the skills, knowledge and attitude to support, motivate and inspire people with long-term conditions to take an active role in their own safety and to co-create quality health care."(our emphasis)*
3. *"Changing health systems so that they encourage and facilitate self-management* and to *change and improve the way their health services are designed and operated."*

Also see a film about the initiative and its impacts https://www.youtube.com/watch?v=6ZOjX5IzSJ4

Evaluation reports are also available: Evaluation of First Phase; Evaluation of the second phase: Sustaining and Spreading Self-management.

The aims of the Co-creating Health Program seem apposite to the new standards. Accordingly, CMHA encourages the Commission to reshape the new standards so that people with mental illness are supported to take an active role in their own safety and to co-create quality health care. This would result in people identifying what safety and quality looks like for them and what contributes to them being unsafe. For example, a key and fundamental action within both the Partnering with Consumers and the Model of Care Standard would be services having processes in place for people to co-create safety and wellbeing plans (as against simply having a clinician conduct a risk assessment and then determine how the risks might be addressed). This demonstrates the evidence-based conviction that people are safest when they are actively engaged in being safe and when they are supported to take responsibility for their safety. An example of how mental health safety plans can be co-created is depicted in this following University of Sydney film - https://www.youtube.com/watch?v=JYPhWuUDPcw

Some key practice and service delivery paradigm shifts the new standards could promote

This section outlines some of the key paradigm shifts that CMHA anticipates the new standards will promote.

Paradigm Shift 1 From consumer consultation and participation to lived experience valued and embedded throughout an organisation.

- Practice Governance Standard –
    - Targets for and evidence demonstrating that people with lived experience of mental health issues who are service users are members of boards, safety and quality committees/councils and practice governance committees and other key governance committees;
    - The value and role of lived experience is recognised, acknowledged and incorporated into organisational vison and value statements and other key corporate documents;
    - Targets for people with lived experience becoming co-chairs of committees;
    - There are targets for an increase of lived experience leadership roles and peer workers among the workforce;
    - A budget is in place for lived experience inclusion and engagement throughout an organisation that is reflected in funding models.

- Partnering with Consumers, Families and Carers Standard –
    - Evidence that demonstrates partnerships with consumers and carers;
    - There is a budget and plan for consumer and carer partnerships;
    - Policies and procedures are in place to support and to pay consumers and carers to partner in co-design and co-production processes;
    - Evidence that new services and programs have been co-created.
- Model of Care Standard –
    - Evidence of service co-design and co-production;
    - Evidence that consumers and carers have been included in the evaluation and the co-design processes they are involved with.

Paradigm Shift 2 From a clinician led approach to risk to a person driven approach to safety and wellbeing – a shift from a practitioner being viewed as the only expert best placed to identify, assess, and address risk to a trauma-informed recovery-oriented practice approach whereby a person is supported to be responsible and accountable for, and drive their safety plan. This shift seeks to address a culture of low expectations about the capacity of consumers to self-manage and co-create safety. People with lived experience would no longer be viewed as empty vessels lacking capacity or recipients of passive care for whom risk is assessed and safety is "done for and to". Rather a person's lived experience would be recognised, acknowledged, and valued and safety achieved through collaborative partnership.

Actions and evidence demonstrating progress toward this shift might include the following.

- Practice Governance Standard –
    - Targets for and evidence demonstrating consumers are members of safety and quality committees/councils and practice governance committees;
    - Lived experience led recovery-oriented and trauma-informed practice training;
    - Lived Experience led training about what quality and safety looks like for consumers and carers.
- Partnering with Consumers, Families and Carers Standard –
    - Evidence of consumers and families having co-created:
        - safety & wellbeing planning processes and tools
        - implementation and evaluation processes and tools.
- Model of Care Standard –
    - Evidence of the use of person led safety and wellbeing planning processes and tools e.g., Wellness Recovery Action Plan (WRAP), relapse prevention plans, Safety Plans (e.g. Stanley Brown plan https://suicidesafetyplan.com/forms/);
    - Evidence of recovery oriented and trauma-informed practice models and tools (e.g., CHIME, Recovery Star etc);
    - Evidence of outcome measures and/or practice audits focussed on recovery-oriented and trauma-informed practice;
    - Evidence of collaborative record writing.

Paradigm Shift 3 From organisations establishing services to organisations co-designing and co-creating services with consumers and families. Co-creation is well established in community mental health services. For example, PHNs have long had co-design as a contractual requirement. Co-creation goes a step further and incorporates co-production through the commissioning and implementation phases – this ensures that lived experience input is not lost within the process. A recent example of co-created services is the Urgent Mental health Mental Health Care Centre in SA. The co-created document, **SA Health, A co-created Philosophy of Care** (July 2020) describes the experience SA Health, the CMO sector and what consumers want people to have when they come to the new Urgent Mental Health Care Centre.

Other recent examples of where service designs and models of care have been co-created include:

- Suicide Prevention Outreach Teams and Safe Havens in NSW - https://www.health.nsw.gov.au/towardszerosuicides/Pages/initiatives.aspx
- Lived Experience Telephone Support Service in SA - https://www.letss.org.au

The University of Melbourne Health Sciences document "Co-production: Putting principles into practice in mental health contexts" offers insights into how co-production can work in a mental health context https://healthsciences.unimelb.edu.au/__data/assets/pdf_file/0007/3392215/Coproduction_putting-principles-into-practice.pdf

Actions and evidence demonstrating progress toward this shift might include the following.

- Practice Governance Standard –
    - Evidence demonstrating that people with lived experience of mental health issues who use services are members of safety and quality committees/councils and practice governance committees;
    - Evidence that staff, consumers and carers are offered training in co-design (.g. NSW Government Agency for Clinical Innovation have provided guidelines for Building co-design capacity);
    - Policies and procedures are in place to support and to pay consumers and carers to participate in safety and quality, decision making and co-design processes.
- Partnering with Consumers, Families and Carers Standard –
    - Having a strategy, action and implementation plan for consumer and carer engagement in practice development and service design;
    - Evidence that new services and programs have been co-created.
- Model of Care Standard –
    - Evidence that consumers and carers have participated in co-design and co-production initiatives;
    - Evidence that consumers and carers have been invited to evaluate the co-design and co-production processes they are involved with.

Paradigm Shift 4 From designated Lived Experience (Peer) Work roles viewed as additional and complementary to the recognition that the skill set of people in designated Lived Experience roles is critical to quality and safety. The National Guidelines describe the shift required:

"Lived Experience work needs to be supported and embedded as an integral part of the way all mental health services are delivered. The challenge is not simply to recruit new workers, but to embed a new source of knowledge and new ways of thinking about mental health, into an established service system. A commitment to change, collaboration, and co-development is essential." (p. 4)

Actions and evidence demonstrating progress toward this shift might include the following.

- Practice Governance Standard –
    - The role of Lived Experience/Peer Workers in quality and safety is recognised in governance policy;
    - There is a Peer Workforce Development Plan in place with recruitment targets;
    - Lived Experience/Peer Workers are represented on the Executive and on safety and quality Committees and other key governance and practice committees;
    - Lived Experience/Peer Workers are employed in senior positions;
    - Peer Workers are equitably remunerated and supported.
- Partnering with Consumers, Families and Carers Standard –
    - There are opportunities in place for consumers and carers to routinely access Lived Experience/Peer Workers;
    - There are pathways in place for consumers and carers to train as and become employed as Lived Experience/Peer Workers.
- Model of Care Standard –
    - Lived Experience/Peer Workers, like other practitioners, are acknowledged within the model of care as members of Multidisciplinary Teams.

Shift 5 From services being "welcoming of diversity" to services embodying diversity

While CMHA congratulates the Commission on strengthening the emphasis on diversity, CMHA recommends that services are required to not only welcome diversity but be diverse and reflect local communities and diverse groups using their services. To embody diversity is to include and accept difference and variation among people, but also to embed cultural safety and provide an environment that is safe for all: where there is no challenge or denial of identity of who a person is 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. This requires cultural competence which comprises four components: awareness of one's own cultural worldview, attitude towards cultural differences, knowledge of different cultural practices and worldviews, and cross-cultural skills. Developing cultural competence standards will promote the ability of services to understand, communicate with, and effectively interact with people across cultures. In adopting a trauma-informed recovery-oriented approach in this context is to acknowledge the inherent privilege of race, education, status, gender etc., that a

provider may hold or be perceived to have and reflect on the barriers that privilege may evoke in engaging with people who experience marginalisation and disadvantage in our society.[2]

Actions and evidence demonstrating progress toward this shift might include the following.

- Practice Governance Standard –
    - There is evidence of a place-based approach and a funded organisational strategy for the Board and workforce of a service to become reflective and representative of the local community including marginalised groups;
    - Targets for the recruitment of staff from diverse communities; members of diverse groups are represented on key safety and quality committees and advisor processes;
    - There is evidence of training and professional development for all staff working with and engaging with users of the service.
- Partnering with Consumers, Families and Carers Standard –
    - There is a strategy with targets in place for engaging consumers, families and carers from diverse groups and communities; there is evidence that members of diverse communities are accessing services and are partnering in quality and safety initiatives;
    - Safety and wellbeing plans are available in community languages as well as in easy English formats.
- Model of Care Standard –

There is evidence that members of diverse communities are service co-design, co-production, and co-evaluation partners.

Conclusion

The examples of further possible actions and evidence suggested in this submission are by no means exhaustive and service providers could certainly provide many further examples.

Whilst the standards will not be mandatory, CMHA are encouraged by the CMO sector's engagement in the co-design and development process that has been generously offered by ACSQHC who have been open to all stakeholders and given CMHA and its members across Australia the opportunity to have a voice in what has been a very collaborative and open process. We expect that eventually some funders will require those they fund to align their work to standards as a KPI; and clearly the sector has been keen to be part of developing and adopt a set of standards that reflects their best practice approach to service delivery. This positive approach will continue should the standards be utilised as a KPI, but funders will have a responsibility to contribute to the additional costs organisations may face in meeting the standards.

CMHA wishes the Commission well with the finalisation of the new Standards and is willing to assist in any way possible.

[2] State of Victoria, Department of Health 2013, National Practice Standards for the Mental Health Workforce 2013, Victorian Government Department of Health, Melbourne, VIC.p.13