QAMH RESPONSE PAPER: NSQMH STANDARDS FOR COMMUNITY MANAGED ORGANISATIONS CONSULTATION PAPER

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Who we are?

Queensland Alliance for Mental Health (QAMH) is the peak body for the community mental health sector in Queensland. We represent more than 100 organisations and stakeholders involved in the delivery of community mental health services across the state.

At a federal level, we collaborate with Community Mental Health Australia (CMHA). We work alongside our members to build capacity, and systematically advocate on their behalf on issues that impact their operations and service users in our communities.

Executive Summary

The introduction of National Safety and Quality Mental Health (NSQMH) Standards for Community Managed Organisations (CMOs) is likely to impact QAMH members. Accordingly, QAMH gained feedback from members on the questions posed in the Australian Commission on Safety and Quality in Health Care's consultation paper. In addition, we asked members to comment on perceived opportunities arising from the development of these Standards as well as their concerns. Feedback was obtained in May and June 2021 through focus groups, individual interviews, and an online survey. The online survey was developed in collaboration with CMHA and our fellow state and territory peak bodies for community managed mental health organisations. Only results from Queensland participants are included in this submission.

Feedback indicated that while QAMH members saw benefits in developing Standards appropriate for CMOs there were also concerns, particularly by large organisations, regarding the burden and complexity additional separate Standards would incur. Members suggested it would be more helpful for existing Standards to be updated or for one set of national mental health Standards to be developed that encompassed all mental health service delivery types. In developing Standards relevant to the CMO sector members provided the following key feedback:

- Ensure the development process aligns with CMO sector culture and is person-led.
- Ensure Standards for CMOs meet the needs of the sectors diverse range of organisations, service types and users and models recovery-oriented and person-centred approaches and language.
- Ensure implementation and accreditation processes reduce the resource burden of accreditation on organisations.

This response includes a summary of the feedback received from QAMH members for each question and, where relevant, key recommendations.

Please note, feedback from members highlighted the importance of using appropriate terminology in the Standards. In alignment with this, rather than use the terms “consumer” and “carer” in this submission, the term “people” is used followed by a descriptor (e.g., people who experience mental illness, people with a lived experience of care).

Feedback Summaries and Recommendations

Question 1: Regarding the development of NSQMH Standards for CMOs, what do you see as the opportunities and what concerns do you have?

Members agreed accreditation against Standards was important for all organisations to ensure quality and safety and to legitimise operations. Many members also agreed developing mental health Standards specific to CMOs would be beneficial if they were "fit for purpose" for the sectors diverse range of organisations, service types and users and modelled recovery-oriented and person-centred language. In that instance, it was felt CMOs unable to identify with existing mental health Standards would have an opportunity to become accredited. Members also hoped Standards developed in this way would be used as a model for other mental health Standards.

However, members also voiced various concerns regarding the development of new separate Standards. Some were unclear on the reasoning for, and therefore expenditure on, developing completely new Standards rather than updating existing and largely appropriate versions such as the National Standards for Mental Health Services 2010. Others expressed concern the development process was not person-led and saw this approach as essential, in alignment with CMO sector culture and necessary in order justify the development of new Standards rather than use existing versions.

Members delivering multiple mental health service types (e.g., clinical, psychosocial and digital) and already accredited with various state and national Standards pointed out additional separate Standards would only add to existing and significant overlap. They also expressed concern regarding the burden of becoming accredited with additional Standards. These members suggested the development of one set of national mental health Standards encompassing all types of mental health services as a more efficient approach. They posed that, like the structure of the NDIS Practice Standards, the mental health Standards could have core Standards relevant to all organisations and additional Standards relevant to the specific services delivered.

The resource burden of accreditation was also raised by small organisations. They reported being "overwhelmed" with the number of Standards and pieces of legislation they were obliged to comply with, the time required and the expense of consultants and accreditors. The challenge for smaller organisations to become accredited was considered a significant risk to the sector. Members argued small and homegrown service providers are essential to ensure service users, particularly those from diverse groups, have choice and control about who delivers their services.

Regardless of organisation size, members argued if funders required accreditation, they should be required to provide funding to assist with costs, so it did not impact on service delivery.

Recommendations

1. As an alternate to developing new, separate Standards, consider:
   - updating existing and largely appropriate versions such as the National Standards for Mental Health Services 2010.
   - developing one set of national mental health Standards encompassing all types of mental health services. Include core Standards relevant to all organisations and additional Standards relevant to specific service provided.

2. In developing/updating Standards for CMO's:
   - the process must align with CMO sector culture and be person-led.
   - they must be appropriate for the sectors diverse range of organisations, services and service users and model recovery-oriented and person-centred language.

3. Funders requiring accreditation against Standards must provide adequate funding to cover costs.

Question 2: 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?

Member feedback focused on the example "Clinical Governance and Operational Management Standard" and the terminology used. While it was agreed a Standard covering governance and operational management should be included and incorporate the support provided to service users if their mental health deteriorated, there was almost unanimous agreement the term "clinical" be excluded. Only one member believed clinical components of care still needed to be provided in nonclinical settings and that the term should remain.

In general, the use of the term "clinical" in Standards designed for nonclinical services created significant discussion and further feedback will be provided in the terminology section. For the purposes of this question, members suggested alternate titles excluding that term including:

- Safe and High-Quality Care
- Governance and Operational Management
- Operational Management
- Care Governance
- Client-facing governance

Other feedback for this example Standard related to ensuring the requirements were appropriate and relevant to varying sizes and types of organisations, including small homegrown services.

Feedback to the example "Partnering with Consumers Standard" again related to terminology, with members feeling it did not reflect a person-centred approach. Members felt strongly the Standards should use person-centred, recovery-oriented language and this would shift the title to include a term such as "person-led". One member advised the health literacy criterion included in this Standard was positive.

Feedback on the example “Model of Care Standard” related to the “Communicating for Safety” criterion and the action “routinely ask consumers if they identify as being Aboriginal and/or Torres Strait Islander origin…” was to ensure organisations also ask the person whether they identify as Culturally and Linguistically Diverse (CALD) and/or LGBTIQ+.

Recommendations

1. Clinical Governance and Operational Management Standard

- Include a Standard relating to Governance and Operational Management but do not include the term “clinical”.
- ensuring the requirements in this Standard are appropriate and relevant to organisations of varying size and type, including small homegrown services.

2. Partnering with Consumers Standard

- Incorporate person-centred approach and terminology. This would change the title to reflect activity as “person-led” as opposed to “partnering with”.
- Retain the health literacy criterion.

3. Model of Care Standard

- Ensure service users are invited to advise if they identify as CALD and/or LGBTIQ+ as well as being a First Nations person.

Question 3: What other domains relevant to CMOs providing mental health services should be considered for inclusion in the NSQMH Standards for CMOs?

Members urged the Commission to consider existing mental health Standards and their overlapping domains, to inform what may be relevant to include. Other suggestions included:

- Rights and Responsibilities
- Comprehensive and Integrated Care. This domain should reflect the importance of the person being at the centre of care and care teams, including those from other organisations and sectors, collaborating and sharing resources to benefit the person.
- People with a lived experience of care
- Human Rights
- Risk management. This domain needs to be relevant to nonclinical services and require information on escalation points etc. but may also relate to people accessing services taking supported risk to enable growth.
- Peer work
- Digital mental health services
- Recovery-oriented practice
- Employee safety and rights

Question 4: Are there specific actions you would like to see included within the NSQMH Standards for CMOs?

Members suggested a range of actions that have been categorised below either under a domain name, if that had been identified in question 3, or a category name, if a domain had not been suggested.

- Domain: Recovery-oriented practice

Suggested actions related to organisations ensuring use of:

  - recovery planning
  - a person-centred approach (e.g., the participant has chosen their own goals) and
  - evidence-based outcome tools (e.g., tools are used to help participants monitor their progress and demonstrate outcomes for the nonclinical sector).

- Domain: Governance and operational management

Suggested actions included organisations ensuring:

  - They have business continuity plans for lockdown events (e.g., COVID-19) describing how services will continue to be provided and safety of staff and people accessing services managed.
  - They maintain their "scope of practice".
  - There is an appropriate worker to service user ratio.

Suggested actions relating to workforce included:

- Staff participate in reflective practice to ensure people accessing services have been provided services appropriately.
- People with a lived experience of mental illness and of caring for a person with mental illness are involved in staff education.
- Frontline workers have soft skills in addition to professional technical skills.
- Staff training is scenario based.
- Organisations take on a percentage of students with a lived experience to support workforce development.

- Appropriate support, including education and training, is provided to peer workers.
- Staff retention activities are undertaken including appropriate remuneration.
- Staff safety practices.
- People with a lived experience of mental illness, of caring for a person with a mental illness and family members who act as consultants are paid an appropriate rate for their contribution.

Suggested actions relating to service users included:

- People accessing services are involved in service design.
- There is equitable, culturally safe and effective support for diverse groups (e.g., First Nations, CALD, LGBTIQ+ peoples).
- Documentation regarding service users is written collaboratively by the person and the worker and is person-centred with the person able to keep copies.
- Each person accessing services has an MOU that articulates how they wish services to be delivered to them, their story and needs and barriers, that organisations should sign.
- Open disclosure
- Ensuring people accessing services who wish to make a complaint do not experience problems with ongoing access as a result.

Question 5: Are there specific 'actions' where you would suggest services must demonstrate particular 'evidence of compliance'?

Comparatively less feedback was received for this question. As per the general feedback for all questions, members from one focus group agreed that people with a lived experience of mental illness should be consulted with regarding their perspective of appropriate evidence of compliance.

Additional feedback from individual members includes:

- All actions should require evidence of compliance with the Commission considering the fact that what is measured is what improves.
- Evidence of collaboration with the person by the whole care team.
- Evidence codesign and evaluation of services is genuinely person-led.

Question 6: 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?

Most feedback received in our consultations related to terminology. Without exception members agreed it was critical the Standards model terminology used by CMOs and be recovery-oriented, person-centred, normalising of mental illness and inclusive and reflective of the diversity of CMOs and people accessing services. Some members expressed concern with the currency and appropriateness of terminology used in the consultation paper including "psychosocial" and "mental health" ("we now talk about mental wellbeing").

Regarding the term's "consumer", "carer" and "people with a lived experience", feedback was unanimous that a diverse range of people experiencing mental illness, including First Nations, CALD and LGBTQ+ people, as well as those that care for them and their family members, should decide the terms used to refer to them in the Standards rather than this being decided by others. It was also suggested the Commission look to the significant amount of work that has previously been undertaken in this space by the National Disability Insurance Agency (NDIA) and Mind Life.

Regarding the term "clinical", the majority of feedback strongly indicated a preference it is not used in Standards for CMOs. It was felt the term is medical and alienating and as such limiting and contrary to the holistic manner in which CMOs deliver services.

Regarding terminology to describe staff delivering services, feedback stressed the importance of using terms that put staff on an equal footing. Referring to staff as either "clinical" or "nonclinical" was considered inappropriate as it insinuates different levels of proficiency. Some members preferred the term "practitioner", but it was generally agreed people with a lived experience of mental illness and of caring for a person with a mental illness should decide the terms used to refer to staff they work with.

Recommendations

1. Standard terminology should model that used by CMOs and be recovery-oriented, person-centred, normalising of mental illness and inclusive and reflective of the diversity of CMOs and people accessing services.

2. A diverse range of people experiencing mental illness, including First Nations, CALD and LGBTQ+ people, as well as those that care for them and their family members, should decide the terms used to refer to them and staff in the Standards.

3. Do not use the term “clinical” in the Standards as it does not reflect the holistic culture of CMOs.

Question 7: 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.

Our consultation indicated QAMH members are accredited with a range of national and state mental health specific and non-mental health specific Standards (see list in question 8).

Members from large organisations were accredited with several Standards, hence their concern described in question 1 regarding the development of an additional set of new Standards using a different style than those they are currently accredited with, as opposed to one set of national mental health Standards covering a range of mental health services (similar to the approach taken in the NDIS Practice Standards), which would enable consistency and efficiency.

Other members suggested the approach and terminology in the National Standards for Mental Health Services 2010 and those in the Aged Care Quality Standards as largely appropriate. Other feedback indicated the Standards should incorporate the Human Rights framework and trauma-informed principles.

Recommendations

1. Consider the approach and terminology in the Aged Care Quality Standards.

2. The Standards should incorporate the Human Rights framework and trauma-informed principles.

Question 8: 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.

QAMH members advised of being accredited with the following mental health relevant Standards:

- NDIS Practice Standards
- Human Services Quality Framework (required by QLD Health)
- National Standards for Mental Health Services 2010
- For CMOs delivering services in other states, state specific Standards were cited e.g., NSW Disability Service Standards

Feedback from members was unanimous regarding the importance of the Commission developing a mutual recognition framework that mapped the overlap between the various Standards to assist with organisational efficiency in establishing processes and gathering evidence to demonstrate compliance.

Recommendations

1. Develop a mutual recognition framework mapping the overlap between mental health related Standards including those listed above.

Question 9: What are the important considerations in determining the approach to implementing the NSQMH Standards for CMOs?

Feedback from members indicated the most significant considerations regarding related to communication to, and supporting resources for, CMOs.

Members requested clear communication regarding any changes to the expectations they be accredited against the Standards. They noted that while the Standards are not currently mandated, they need to be advised if this status changes and clarity regarding whether funding bodies would require accreditation against them.

Members also requested a range of resources that would assist with implementation. Many related to explanatory information about the Standards. For instance, training resources for staff and students that explain the Standards, actions, and evidence of compliance as well as the benefits of Standards to both staff and service users. One member suggested a resource similar to that used to upskill staff on the NDIS Practice Guidelines would be useful. This resource includes a series of training videos for which staff receive a certificate of completion. Members also suggested a resource for service users that explains the responsibilities of organisation as per the Standards, what they should expect from the organisation and what they should do if they feel the organisation is not providing services in a way that should be expected. Assistance and resources for organisations led by people with a lived experience of mental illness was also requested.

Members also requested resources to assist with efficiency and accuracy in implementing the Standards. A popular request was a self-assessment tool that enables organisations to review each Standard and action and conduct a gap analysis and action plan. Some members requested this self-assessment tool be a matrix and incorporate a range of relevant Standards and actions so they could self-assess evidence across a range of Standards. One member requested resources to support the development and implementation of a governance framework.

Members also suggested the evidence of compliance should include a range of documents that would be relevant to diverse CMOs would be helpful. One member suggested examples (video or written) from organisations considered to be highly compliance with the Standards would be helpful.

Other members, reflecting the feeling of being overwhelmed with requirements, felt a list of Standards and legislative requirements they may need to comply with, along with a descriptor and what was suitable for which organisation would be helpful so they could be sure they were aware of them all.

Recommendations

1. Communicate with CMOs regarding any changes to the mandatory status of the Standards.

2. Develop resources explaining the Standards suitable for people with a lived experience of mental illness delivering services, service users and for upskilling staff.

3. Develop resources to assist organisations to implement the Standards efficiently. This includes a self-assessment matrix tool, incorporating a range of relevant Standards and actions enabling self-assessment of evidence across a range of Standards. It also includes a resource to support organisations to develop and implement a governance framework.

Question 10: What accreditation approach would be appropriate for the NSQMH Standards for CMOs?

QAMH member feedback indicated a preference the accreditation approach to the new Standards initially be voluntary and conducted as a learning experience rather than a "punitive" experience. Members felt it would be helpful for accreditors to not "fail" organisations, particularly those who have not previously undertaken an accreditation process, but rather identify areas for improvement and provide a reasonable time frame for those improvements to be made. It was felt this approach would have several benefits. For instance, as it would be a more positive and supported approach it would encourage more CMOs to work in alliance with the Standards and get accredited. And although it is hoped the Standards are developed in a way that supports even small organisations to gain accreditation, the approach also provides CMOs time to reflect on whether they want and have capacity to gain full accreditation as opposed to spending a significant amount of time and money and "failing." It was also hoped that if the Standards do become mandated, organisations with current accreditation against other Standards can wait until the date of renewal before being required to be accredited against new Standards.

Other member feedback on the accreditation approach to be taken reflected concerns about the resource burden accreditation entailed and suggestions for reducing this, including:

- Resources to enable organisations to undertake a desktop audit prior to the attended audit (as occurs with the NDIS Practice Standards) to minimises the time, and therefore cost, of the auditing process.
- Aligning the accreditation processes by the various governing bodies as much as possible to reduce the costs to organisations of having repeated external accreditations for overlapping Standards.
- Accreditation of lead/peak bodies rather than the multiple smaller organisations they represent.

Members also agreed that while processes and policies should be assessed, feedback from service users should be a mandated component of the accreditation process with the results having the most significant weighting on the accreditation outcome. They recommended a process that ensured service users were

chosen randomly and where their experience of the service was investigated. As one member articulated "[Standards]……. lead you in the direction but it's about how they are applied and at the end of the day it's a human service and it's about how people are treated and their experiences…".

Recommendations

1. The accreditation approach to the new Standards should initially be voluntary and conducted as a learning experience rather than a "punitive" experience.

2. In the event the Standards become mandatory, organisations with current accreditation against other Standards should be able to wait until the date of renewal before being required to be accredited against the new Standards.

3. Approaches to reduce the resource burden of accreditation on organisations should be used including resources to support self-conducted desk top audits, aligning the accreditation processes with other Standards, and accrediting lead agencies rather than each smaller organisation.

4. Assessment should include a review of policies and processes but feedback from service users should be a mandated component that has the most weighting on the accreditation outcome.

Question 11: What guidance, resources or tools do you feel that assessors might need when measuring services against the NSQMH Standards for CMOs?

Members suggested the following resources for assessors:

- user guides, workbooks, risk matrices, fact sheets, resources for medication management in supported accommodation,
- Communication with services on geographical, cultural and place placed knowledge to enhance and validate their assessment. Sensitivity to where people are at in the care continuum.