
SUBMISSION

**Draft National Safety and Quality Mental Health (NSQMH)
Standards for Community Managed Organisations (CMOs)**

Consultation

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Introduction

Lived Experience Australia (hereafter LEA) is a national representative organisation for Australian mental health consumers and carers, formed in 2002 with a focus on the private sector. Our core business is to advocate for systemic change, empowerment of consumers in their own care, promoting engagement and inclusion of consumers and carers within system design, planning and evaluation and most importantly, advocating for consumer choice and family and carer inclusion.

We appreciate the opportunity to provide commentary on the Australian Commission on Safety and Quality in Health Care's *Draft National Safety and Quality Mental Health (NSQMH) Standards for Community Managed Organisations (CMOs)*

Overview

LEA is very supportive of the work the Commission has undertaken with the intent and actions articulated within this Consultation Draft.

We note from the Commission's Consultation Report that the sector is concerned around implementation, with these proposed standards needing to align with the National Disability Insurance Scheme (NDIS) Practice Standards which LEA supports. We also note the feedback indicated these standards are used as an alternative to the National Standards for Mental health Services which we also agree with as long as the critical aspects of those standards are indicated within the National Safety and Quality in Health Care Standards 2nd Edition, and these CMO standards.

These would be particularly:

- *Standard 1 - Rights and responsibilities*
- *Standard 7 – Carers*
- *Standard 10 – Delivery of care*
 - *10.2 Access*
 - *10.3 Entry*
 - *10.4 Assessment and review*
 - *10.6 Exit and -re-entry*

In regard to the NSQMH CMO standards and our concerns with the standards above, we believe that greater emphasis and attention should be given to:

Rights and Responsibilities – noting Partnering with consumers in their own care 2.01 a. talks about the use by the service provider of a *charter of rights* and refers to the Australian Charter of Healthcare Rights, but there is no mention of this being given to a consumer, family or carer. We believe this is critical.

Standard 7 – Carers seems to lack specifics within the CMO Model of Care, Partnering with Consumers in their own care etc except for 1 mention within the Delivering the model of care 3.10 f. LEA has for a long time championed the improved engagement of families and carers within a consumer's journey. We developed the "Practical Guide for Working with Families and Carers of People with a Mental Illness", and through that extensive consultation process, the one thing that emerged as a key issue was that information was not shared with the family or carer, and should be shared where applicable and appropriate consent from the person is given. This can very easily be addressed by the consumer nominating who they would be happy to have involved in their care including to what extent that would cover. Communication with families and carers is also critical for better outcomes for consumers. Confidentiality is still being used as a barrier to best practice

communication and this can be easily addressed with these CMO Standards, but it needs to be articulated in numerous places.

Standard 10 – Delivery of care we believe is captured in the most part in the CMO Model of Care Standard.

Specific comments

The manner in which these CMO Standards have been written is clear, covers the description and intent, sets out criteria and actions required to meet each standard, and LEA is, overall, very supportive of the content.

LEA believes the Commission has captured the 3 primary Standards relatively well, with other crucial areas subsumed within these primary standards.

In saying this, however, we believe a clear statement of values upfront would add weight to the intent of the standards. This statement could capture core issues of human rights and social justice. We also believe that the document could have more of an inclusive feel to reflect the greater diversity of individuals and populations serviced by the CMOs. Cultural, gender and age diversity, in particular, could be more apparent.

Application of the CMO Standards

As mentioned above, whilst a period of ‘grace’ should be provided for CMOs to become familiar with these CMO Standards, including working toward implementation, mandatory accreditation against them will be needed in at some specific time the future. Mental health services delivered within the CMO sector is no different from the clinical services in terms of accountability, responsibility and dealing with vulnerable people. Support provision and any required training to CMOs to ensure they are able to take on the processes involved will be important.

Practice governance, leadership and culture

The first comment LEA raises with regard to this standard is whether professional development and supervision by appropriately qualified staff should be included perhaps in the Care Leadership section or this could be incorporated within the Workforce qualification and skills.

We believe more could be said about ‘culture’ here. An area missing in the current draft is that of organisational accountability to create mentally health workplaces for their staff. As mental health service providers, having a measurable aspect on this serves to model a strong supporting culture from which a strong model of service delivery can arise. This could be added to the Care Leadership item perhaps.

Another general comments that LEA would make is the need for CMOs to offer training to consumers and carer for their involvement in service planning, design, evaluation and consultation more broadly, especially for any service committees.

A further general comment is that the current text isn’t clear on how the Governing Boards of CMOs are accountable to including consumers, carers and families. There is a potential gap between the Governing Board understanding and awareness of service delivery and the day-to-day awareness of the CMO workforce.

Safety and quality systems – Page 11

1.17 (a)

LEA suggests consideration is given to change the work 'Identify' to 'Implement' or similar given the use of outcome measures are a widespread practice within the mental health sector, with numerous different measures being used within jurisdictions. It would be useful for these to be aligned within a jurisdiction i.e., where Kessler 10 is being used by mental health services, the CMO sector would use the same etc.

1.19 (a)

LEA raised the need to identify specifically and include 'data breach' risks as CMOs do hold a great deal of information about the consumers they serve including for some residential individuals for example, financial details.

We also have some concern about the expectation of 'monitoring' that the current wording and its intent might convey to CMOs and that they may perceive that this does not align with their model of care or philosophy of care. Is 'safety planning' a more appropriate term?

1.23

LEA believes that more could be said in this section about seeking feedback and using information to improve service. Our Missing Middle research was deliberate in asking people why they sometimes leave services (even though they may still need them) and what it would take for them to re-engage with services. These are questions that services rarely ask; once a person leaves, they are often invisible to the service. Hence, services aiming to improve their processes, but which fail to investigate and answer these 2 questions are only getting half of the picture, so any improvements may be limited by a service-driven view.

1.24

We believe that there could also be a measure of how a CMO celebrates what is going well, in more positive language, rather than always focusing of gaps and problems.

Workforce qualifications and skills – Page 14

1.27 (a)

A further reference should be made within this section about relevant checks for the workforce for 'working with vulnerable people'

1.34 also refers to policies in place to minimise the risk of harm for children and young people consistent with the National Principles for Child Safe Organisations.

We again refer to the 'working with vulnerable people' or people in vulnerable circumstances as a necessary addition with LEA noting that currently we cant find any national principles other than the ACNC's Governance Toolkit: Safeguarding vulnerable people <https://www.acnc.gov.au/for-charities/manage-your-charity/governance-hub/governance-toolkit/governance-toolkit-safeguarding>

Partnering with Consumers, Families and Carers Standard

LEA is delighted to see reference to 'Consumers are partners in their own care, **with** their families and carers and applaud the Commission. LEA believes this is the essence of the 'Triangle of Care' © UK Carers Trust and on which LEA's Practical Guide for Working with Carers of People with a Mental Illness is based.

We also acknowledge that not all consumers have a close relationship with families or no contact with them, but they may consider some community friendships important.

LEA also applauds the Commission for the articulation of effective partnership and notes reference to (5)¹ Pg 17.

2.09 and 2.11

RE Health literacy - Here are examples of where the wording slips into only referring to consumers; whereas, these points are equally important for carers and families.

Making a complaint

LEA suggests that there seems to be no reference to providing information to consumers, families and carers about how and where to make a complaint. Whilst this is usually noted within any Charter of Rights, we think specific reference would be warranted here

2.13

Are there typos in this section? If not, it seems repetitive and perhaps clarification is needed.

2.14

LEA would like to see reference made to including the workforce's participation in training **BY** consumers, families and carers. This would be consistent with the NSQHS 2nd Edition Standard 2 – Partnering with Consumers.

Model of Care Standard

LEA strongly supports this Standard, and the description, intent, criteria, actions etc.

Establishing the model of care – page 24

In the introduction, after 'goal-directed' should 'recovery focussed' be added? LEA suggest this is relevant in today's discourse around recovery principles/framework etc.

Delivering the model of care – page 26

3.10 (f)

LEA believes the word 'document' should follow Identify. As discussed at the beginning of this Submission, this seems to be the only reference to the identification of carers.

3.12 (b)

LEA believes 'other care providers' should include informal carers and families as communication with them is a key aspect of integration to ensure actions are followed through in the person's lived environment.

Recognising and responding to acute deterioration and minimising harms – Page 27

LEA's general feedback on this entire section is that it seems very clinically-focused and risk-focused, which is not likely to align well with the values and philosophy of many CMOs, especially those that employ significant numbers of lived experience workforce.

¹ Institute for Patient- and Family-Centered Care (US). Advancing the practice of patient- and family-centered care in primary care and other ambulatory settings: how to get started. Bethesda (MD): IPFCC, 2008

We also wonder if 'deterioration' is the right word to use here. Within CMOs, words that may resonate better are 'crisis' and 'distress'.

3.14 (a)

This is an important section and consistent with current focus for the NSQHS 2nd edition; but, although we have sought clarification of 'delirium' and it seems to be the right descriptor here, it does relate to clinical services/clinicians. A peer worker or support worker for example, may not relate to this. Perhaps consider adding a little more in the text under the heading.

3.18 (a) small typo 'careers' rather than carers.

3.23 (a)

Whilst this action refers to training members to 'understand' practices, LEA considers that more should be articulated here rather than just understanding.

We suggest reference to undertaking training in safely containing aggression or similar should be included and also made mandatory. There are numerous training modules currently within clinical mental health services which are mandatory training.

3.23 (a)

The word 'treat' is included here and again we query this inclusion as we believe treatment is something which a clinician is required to undertake. If so, there this should be made clearer.

3.23 (d)

LEA again emphasises the importance of involving the consumer and their carer/family in support plans. We draw on the concept of behaviour support plans, when constructed in collaboration, being more effective and less coercive.

3.23 (f)

LEA believes that it is not enough to involve consumers and carers in the review of incidents; there needs to be an explicit statement in this standard about what the CMO will do or has done to learn from an incident i.e., what processes it has put in place as a consequence of that learning.

Communicating for safety – Page 29

3.28 (d)

We query whether the CALD community should also be identified along with the Aboriginal and/or Torres Strait Islander peoples.

3.31 (c)

This would also be a good reference point for the identification and documentation of the carer.

Infection prevention and control systems – Page 30

3.34 refers to the workforce screening and immunisation systems to prevent and manage infections but no reference is made to consumers. LEA believes this is critical at this time of COVID-19 where people with severe mental illness could be easily missed. These are the individuals which current research indicates are more vulnerable to COVID and more likely to die if infected than the general population.²

² Association Between Mental Health Disorders and Mortality Among Patients With COVID-19 in 7 Countries A Systematic Review and Meta-analysis

Conclusion

LEA is very supportive of the focus and content of these *Draft* National Safety and Quality Mental Health Standards for Community Managed Organisations.

Thank you for the opportunity of providing comments and we are pleased to assist the Commission in facilitating the organisation of relevant focus group/s with people with a lived experience across Australia.

LEA is always very pleased to assist and support the Commission in the work undertaken. Please feel free to contact the below should you wish any further clarification on our comments.

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(JAMA Psychiatry November 2021 Volume 78, Number 11) covering period December 2019 to July 2020 showed mental health disorders were associated with increased COVID-19 related mortality.