Accreditation to the National Safety and Quality Mental Health Standards for Community Managed Organisations: Consultation

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Introduction

Lived Experience Australia Ltd (LEA) is a national representative organisation for Australian mental health consumers and carers, formed in 2002 with a focus on the private sector. All members of our Board and staff have mental health lived experience as either a consumer, family carer or both.

Our core business is to advocate for systemic change to improve mental health care across the whole Australian health system. This includes advocating for empowerment of consumers in the broad range of issues that impact their mental and physical health, empowering consumers in their own care and contact with health and social services, 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 and wellbeing.

We welcome the opportunity to provide our submission to the Australian Commission on Safety and Quality in Health Care (ACSQHC). Our submission comes from the perspectives and experiences of people with lived experience of mental health challenges, their families, and carers. Our comments focus on the two key questions proposed for this consultation (below) as they relate to lived experience perspectives of the accreditation process.

> What issues need to be considered to ensure that accreditation to the AHSSQA scheme provides for safe and effective care?
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> What issues do you wish the Commission to consider in the implementation of the accreditation process?

What issues need to be considered to ensure that accreditation to the AHSSQA scheme provides for safe and effective care?

We applaud the CMO Standards for their ability to provide an overall structure to help guide CMO services in the governance, planning and delivery of care. Our comments below relate to broad considerations within each of the 3 Standards:

(1) The intention of the **Practice Governance Standard** is that services implement a practice governance framework that ensures consumers and their families and carers receive safe and high quality care. This will be supported by ensuring integrated systems and adequate attention to workforce qualifications, skills and values:

The accreditation process will need to account for, and potentially show some flexibility with, the significant variation in CMOs' size, location, and capacity and resources to access training for their staff. Smaller CMOs located in rural areas may struggle compared with metropolitan-based CMOs. Also, many CMOs must compete with other mental health services to attract qualified staff across most disciplines, including managers with sufficient experience and skills to lead and set the values desired within this sector. There are also particular considerations for the peer workforce, given that CMOs employ a disproportionately high ratio of this new workforce. These considerations include, for example:

- Training and experience still catching up with demand for peer workers, and recovery coaches in particular who are in short supply
- The transient nature of the current peer workforce which impacts on service consistency and ultimately the quality of care and support provided, and also impacts on training and orientation to the role when human resources are continually in flux

- CMOs still ‘learning’ how to integrate this workforce fully into daily service and organisational ethos alongside other disciplines

(2) The intention of the **Partnering with Consumers, Families and Carers Standard** is that services demonstrate true partnership across all aspects of service.

The accreditation process will need to be mindful of token involvement under the guise of partnership and be clear, firm but also educative about this Standard, supporting CMOs with sufficient constructive feedback on how they can do better at partnering. This will mean that accreditation needs to account for the diversity of people who use the service and that there will be quieter and louder voices.

The accreditation process should also avoid the common and unintended consequence of health literacy being wholly understood as the person who is receiving services having gaps in their information, understanding and knowledge, that they need to have addressed. The services and providers also require health literacy. It works both ways.

The issue of co-design is also a contentious one, with many activities defined by service providers as co-design which are actually ‘consultation’.

(3) The intention of the **Model of Care Standard** is that consumers receive supports that are consistent with a clearly defined model of care which is grounded in best practice and evidence, and with the consumer’s expressed recovery goals and needs.

The accreditation process will need to be mindful that some CMOs are still developing sufficient structures and experience with monitoring and accountability around the actual delivery of care aligned with the model of care, supporting and developing their workforce, and the effective use of supervision to support that staff accountability. This again, is particularly relevant to CMOs that are building their capacity and understanding of delivering NDIS support packages. Clinical mental health services have likely honed these processes within services and within established disciplines over many years. CMO may not have had this degree of time and experience, particularly with the newer peer workforce.

Again, size and location of CMOs will likely impact their capacity to resource the gathering of evidence and to establish systems to evaluate their ongoing impact on care quality and outcomes of their model of care. Some organisations will have stronger processes in place for continuous learning and improvement in this regard.

The ability of a CMO to respond to acute deterioration, crisis and distress and minimising harms may also be contingent on the quality of their relationships with clinical services in their area. That is, the context in which CMO services exists will be important and nuanced and assessors will no doubt need to take this into consideration.

What issues do you wish the Commission to consider in the implementation of the accreditation process?

We are particularly mindful that the mental health sector, in general, is still developing its capacity and understanding of how to embed the peer workforce. Peers are in a unique role; they sit in an ‘in-between’ space for which the traditional structures of services may struggle to accommodate smoothly because it requires a flexibility that they have not hitherto been used to. Peers are employees of the CMO but they are also advocates for service users, bringing their lived experience to the role. That ‘in-between’ space is valuable to services because it is there that peers bring the self to the role in order to enhance trust and engagement, often acting as a bridge between the person and the services.

Peers may therefore be ‘torn’ when being interviewed by assessors because they sit in this liminal space. Theirs is also a workforce that is notoriously highly casualised or people may be on short contracts and have significant job security concerns. If there are concerns in how the CMO is meeting the Standards, some peers may feel pressure to remain silent because of job insecurity; but they may also feel that they need to also speak up where they see poor practice. They may experience adverse repercussions for speaking up or for remaining silent. Assessors may need to consider these potential scenarios in the context of ensuring safe, confidential interviews.

Contact

We thank the ACSQHC for the work it is doing on this important national issue. We wish you every success with the next steps. We would be keen to discuss further, any clarification or issues raised here with you.

Your sincerely

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