Joint Submission

Response to the Australian Commission on Safety and Quality in Health Care – National Safety and Quality Mental Health Standards for Community Managed Organisations consultation paper.

flourish AUSTRALIA
Where mental wellbeing thrives

mind
Help, hope and purpose

Neami National
Improving Mental Health and Wellbeing

OneDOOR Mental Health

openminds
Mental Health • Disability • Specialised Supports

STRIDE For better mental health

wellways

Who We Are:

About Flourish Australia

Flourish Australia is a major provider of community-based mental health services in NSW, Victoria and South East Queensland operating continually since 1955. We operate in 72 locations with over 955 staff on an operating budget over $84 million and support 9,000 people annually. 26% of the Flourish Australia workforce are peer workers and 54% of our workforce have lived experience of a mental health issue.

We have extensive experience supporting people to engage with clinical and community services, manage activities of daily living and be part of local recovery-based activities. We have successfully delivered supports individually and within group settings through community and centre-based psychosocial rehabilitation and recovery programs, as well as through small outreach teams similar to this model. We are experienced in delivery of flexible individualised hours of support that can be adjusted in response to the person's needs over time.

A major focus of our work is opening participation pathways for people with a lived experience. Our services provide the support people need for

- Connection and community – supports that enable people to connect with others and to connect with supports and services that meet their needs, both inside and outside of Flourish Australia.
- Support with health, wellbeing and daily living – supports that improve people's ability to manage their health, wellbeing (both emotional and physical) and daily lives.
- Access to a home – support to access and maintain a safe home that meets a person's needs.
- Help to find and keep a job – supports

About Mind Australia

Mind Australia Limited (Mind) is one of the country's leading community-managed specialised mental health service providers. We have been supporting people who are dealing with the day-to-day impacts of mental ill-health, as well as their families, friends and carers for 40 years. Our staff deliver a range of services and supports to people challenged by mental ill-health, in psychological distress, at risk of suicide and those with suicidal thoughts and intentions. In the last financial year, Mind provided recovery focused, person centred support service to over 11,000 people, including residential rehabilitation, personalised support, youth services, family carer services and care coordination. Mind also operates as a provider of services and supports to individuals who have NDIS funding packages in multiple locations across Australia.

We also work with people to address poverty, housing, education and employment. It is an approach to mental health and wellbeing that looks at the whole person in the context of their daily life, and focuses on the social determinants of mental health, as they play out in people's lives. We value lived experience and diversity and many of our staff identify as having a lived experience of mental ill-health.

Mind significantly invests in research about mental health recovery and psychosocial disability and shares this knowledge, developing evidence informed new service models, evaluating outcomes, and providing training for peer workers and mental health professionals. We also advocate for, and campaign on basic human rights for everyone; constantly challenging the stigma and discrimination experienced by people with mental health issues.

About Neami National

Neami National (Neami) is a community mental health service that provides rehabilitation and recovery support services across Australia. We support people to improve their health, live independently and pursue a fulfilling life based on their strengths and goals.

As one of Australia's largest providers of community mental health services, we work in diverse communities across Australia, ranging from the inner-city suburbs to regional and remote areas. Drawing on the knowledge, capacity and expertise of a national organisation we work in partnership at a local level, to deliver services that meet individual and community needs.

Our evidence-based approach supports innovation, improvement and the quality of our services. Guided by the participation of consumers in shaping our services, and our peer workforce, we know the benefit that lived experience brings to the quality and integrity of our services.

Over 30 years, we have built partnerships with hospitals, clinical mental health services, non-government services, universities and community health services. Together, Neami and Me Well, a division of Neami National, focusing entirely on NDIS services, support more than 21,000 individuals to achieve greater independence.

About One Door Mental Health

One Door Mental Health is the new name for the Schizophrenia Fellowship of NSW. Through One Door, people living with mental illness and their families can find an inclusive community, innovative services and advocacy support. Creating a world in which people with a mental illness are valued and treated as equals is at the heart of everything we do.

For more than 30 years, One Door has designed and delivered expert mental health programs that are now accessible through the National Disability Insurance Scheme (NDIS). One Door Mental Health is a leading mental health service provider specialising in severe and persistent mental illnesses such as schizophrenia, bipolar disorder, obsessive compulsive disorder, post-traumatic stress disorder, psychosis, schizoaffective disorder, borderline personality disorder.

Over half of our team have lived experience giving us unmatched expertise in mental health. Our community creates a safe place that connects people. The services we offer are supported by many years of experience making us the NDIS mental health experts. And our advocacy work is putting an end to stigma and makes your voice stronger every day.

About Open Minds

We are a leading provider of mental health and disability support services in Queensland and Northern New South Wales. With more than 100 years of history, Open Minds is committed to its purpose of enabling an independent and positive future for people living with mental illness and disabilities. Open Minds is also a registered NDIS (National Disability Insurance Scheme) provider, with more than 500 employees.

Our NDIS Services

- Daily Living – support to develop life skills to achieve goals, independence and to navigate choices.
- Supported Independent Living – live as independently as possible in your own home or get access to stable accommodation.
- Support Coordination & Specialist Support Coordination – operating independently to other Open Minds services, we provide options on the best type of services to get the most out of your NDIS plan
- Positive Behaviour Support (PBS) – we have qualified and experienced staff to ensure complex support needs are understood by everyone, to create a rewarding plan

About Stride

Stride Mental Health (Stride) is Australia's longest-established mental health organisation (established in 1907 as Aftercare) providing mental health services to people with mental health needs across the health continuum. needs. Stride's mission is 'helping people have a better day, today and tomorrow'. We work in partnership with consumers, their family and carers, governments, and partners to support people with mental health conditions to lead fulfilling lives each day.

Stride's strategic plan focuses on early intervention, integrated supports, 'best people', and evidence informed services. Stride is expert in leading integrated, consortia and multidisciplinary team care services, with a range of partnership models, co-locations, in-reach, outreach, and collaborations operating from our 13 integrated Hubs.

Stride is a leader in the establishment and co-design of Safe Spaces, our after-hours, welcoming and peer-led service model that allows people experiencing distress to access timely and responsive support as an alternative to their local Emergency Department.

Stride currently works in 63 communities across New South Wales, Victoria, ACT, and Queensland and has extensive experience in place-based approaches, strong collaboration, and co-designing integrated services across a range of communities with varying needs.

About Wellways Australia

- 1,800-plus staff across over 100 offices throughout eastern Australia, from Tasmania to Queensland.
- 158 people working in peer support roles
- 189 volunteers contributing over 14,000 hours
- Our services reach thousands of people every year

Originally established in Victorian in 1978, today Wellways Australia is a provider with over 40 years' experience and a recognised specialise in mental health, disability support and carer services. We dedicate resources to advocacy, to ensure systems are responsible and equitable, and society is inclusive. To us recovery means all Australians lead active and fulfilling lives in their community. We work with individuals, families, and the community to help them imagine and achieve better lives. We provide a wide range of services and assistance for people with mental health issues, disabilities and those requiring community care, as well as carers as a Carer Gateway regional delivery partner throughout Queensland and the New South Wales regions of South West Sydney and Nepean Blue Mountains.

Our vision is for an inclusive community where everyone can imagine and achieve their hopes and potential. Our vision underlies the many direct services we deliver to thousands of people each day across the Australian eastern seaboard.

Executive Summary

Flourish, Mind, Neami, One Door Mental Health, Stride, Open Minds and Wellways (hereafter referred to as the Australian Psychosocial Alliance) jointly present this submission to assist the Australian Commission on Safety and Quality in Healthcare (ACSQH) to develop its approach to drafting safety and quality standards for Community Managed Organisations (CMOs). As the largest providers of community managed mental health and wellbeing services in Australia, we have combined our experience, practice wisdom and expertise into a single submission.

We are supportive of the aim of the National Quality and Safety Mental Health (NSQMH) Standards for CMOs to continuously improve the quality of mental health and wellbeing service provision and protect service users from harm. Our organisations provide support to people affected by mental health issues, who often have complex needs. We firmly believe in always providing the best possible care to those we support, which is why we are already accredited against a number of standards.

We have real concerns about duplication of effort and the administrative burden of accreditation against another set of standards. Between our seven organisations we are already accredited against 15 different sets of standards, with accreditation against a median of six standards. It is likely these NSQMH Standards for CMOs will have similarities to other standards against which we are already accredited.

We strongly encourage the Commission to ensure there is mutual recognition between different sets of standards, regardless of the owner or certifying body, to avoid unnecessary duplication of effort. Whilst continuous improvement is an essential part of our day-to-day business, it should not come at the expense of service provision.

We believe the development of the draft standards could be strengthened by improving the terminology and language to be more focused on the person and their recovery, and less clinical.

Further, the scope of services that CMOs provide needs to be expanded in order to comprehensively reflect the suite of services our organisations offer, and the standards must consider the partnerships we engage in to deliver integrated services within the community.

Future standards must also be more sensitive to the diverse needs of different groups, including cultural and spiritual needs.

We have provided further detail in our response to the consultation questions.

Response to Consultation Questions

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?

We make general comments regarding the example standards, with specific feedback on separate standards below.

The example standards are applicable to the quality and safety of CMOs. However, some of the detail and actions around partnering with consumers may need to be modified, and we have outlined this below.

The language used in the standards should be more person-centred. Person-centred treats the individual as a person first, puts them at the centre of services and ensures they are active participants in their recovery.

The key to person-centred care is that it assists an individual to make significant and meaningful changes to their lives which are driven by their values. This is through encouragement of connectedness and relationships, fostering hope, promoting physical health, and supporting self-management so that an individual can remain at home and thrive.

The draft standards should be strengthened by further focus on diversity, inclusion, including consideration of cultural and spiritual needs, disability, gender, age, and sexual orientation.

a. Governance

We are supportive of the intention of this standard. However, we believe the language should be changed to accurately reflect the scope of services provided by community managed organisations.

We believe it would be more accurate to use the term 'Practice and Clinical Governance', instead of clinical governance. This more precisely describes the processes and structures which are needed to deliver safe, high-quality mental health and wellbeing services in a community setting. This terminology is also more familiar to our staff and is therefore more likely to be followed.

b. Partnering with Consumers

We are supportive of standards encouraging organisations to have systems in place for supported decision-making and taking purposeful action to ensure consumers are partners in their own care.

Fulfilling consumer partnership in designing services is incredibly important. We should be aiming to partner with consumers in planning, design, delivery, measurement, review and evaluation. However, we are concerned that some of the examples of consumer and carer partnership in designing services may be difficult to implement in all circumstances and would appreciate further guidance on actions under this standard.

Separating the focus on consumers and carers also suggests that one can be implemented effectively without the other. However, organisations need to approach engagement with consumers and carers in an integrated and systemic fashion.

c. Model of Care

We are in principle supportive of ensuring CMOs have a clearly defined model of care, consistent with best practice and evidence, and that consumers receive care consistent with this model of care.

It is a worthwhile proposal that organisations document, implement, monitor, and evaluate an evidence-informed Model of Care. It is equally important there be criteria relating to the implementation of this Model of Care. The proposed criteria could be improved if they were to be restructured and augmented with actions relating to:

- intake and access to services:
    - this should define management and prioritisation of waitlist, as well as onward referral (if not eligible)
    - requirements for a service agreement for ensuring people have access to information and support to understand their rights and the services on offer.
- collaborative, person-centred assessment of needs and risk (and onward referral if needs are beyond scope and capacity)
- joint care planning with participants and carers
- recovery oriented and trauma-informed practice
- tailored/dependable/reliable service delivery which is responsive to individual identity
- review and evaluation of support
- exit, transfer, relapse, and re-entry processes
- review and exit (and re-entry).

2. What other domains relevant to community managed organisations providing mental health services should be considered for inclusion in the NSQMH Standards for CMOs?

There are several domains relevant to CMOs providing mental health and wellbeing services which should be considered for inclusion in the NSQMH Standards for CMOs. They include restrictive practices, services to members of diverse communities, people who identify as Aboriginal and Torres Strait Islander, as well as interactions with third party partners and carers/families.

- ✧ *Diversity and Inclusion*

The draft standards should be more explicit about incorporating trauma-informed practice and recovery-oriented service delivery. Whether these are separate domains, or actions which flow across several domains, should be considered.

There is also a need for standards to address services to Culturally and Linguistically Diverse (CALD) communities. Some communities may have poor mental health literacy and high levels of stigma around mental health issues. This domain may include actions relating to the provision of services in different languages, a culturally diverse workforce, and culturally sensitive practices. This may include providing interpreters for a consumer, as well as evidence of activities supporting cultural sensitivity from CMO service providers.

There should also be more said in the standards about service delivery to Aboriginal and Torres Strait Islander consumers and carers. Aboriginal and Torres Strait Islander communities often have higher than average rates of mental distress or mental illness. Cultural sensitivity is particularly important, as is the use of language and awareness of intergenerational trauma. Standards should contain actions to support the delivery of culturally safe and sensitive services by CMOs.

- ✧ *Restrictive Practices*

The draft standards should deal more explicitly with challenging areas of mental health and wellbeing service delivery, in particular the governance of restrictive practices and Community Treatment Orders in the context of services provided by CMOs. This is especially pertinent where service delivery may be in partnership with clinical or other service sectors.

Restrictive practices may include restriction via physical restraint, chemical restraint, and emotional restraint. In general, restrictive practices should only be used as a last resort to prevent harm to the consumer, other consumers, or staff. CMOs may also be involved procedurally or physically in the application of Community Treatment Orders.

Again, this may involve over-riding the consent of the consumer and again requires appropriate and compassionate regulation. The draft standards should also consider restrictive practices which are regulated under relevant mental health and disability legislation.

- ✧ *Child safety*

The standards should include domains or principles that address the abuse, neglect and exploitation of people, and which is complementary to National Child Safety Principles, as well as State and Territory legal frameworks for reporting concerns.

- ✧ *Family and domestic violence*

Family and domestic violence is a major national health and welfare issue which can have lifelong impacts and devastating consequences for women, children and communities, including adversely impacting mental health and wellbeing. The standards should seek to encourage holistic support by CMOs providing mental health and wellbeing services.

- ✧ *Service Delivery and Partnerships*

The standards must deal with interactions between the CMO and third parties, external people, and organisations. In particular, the standards should mention interactions between the consumer, CMO, and police, such as may be the case during forensic mental health interventions. Other parties may include NDIS providers and workers, as well as external clinicians.

- ✧ *Comprehensive and Integrated Care*

We are supportive of this domain being included in the draft standards, as suggested in the consultation paper. This domain should mention interactions with support facilitators, patient and peer navigators and hospital concierge roles.

- ✧ *Carers*

We are supportive of this domain being included in the draft standards, as suggested in the consultation paper.

This domain should mention:

- the need for carers to be informed of incidents or changes to service for the person they care about with client consent.
- being involved in co-design
- being included in service decisions for the person they care about with client consent
- protocols regarding information sharing and confidentiality.

The Commission may wish to refer to Mind's approach to working with families and carers for further information and detail.

- ✧ *Responding to acute deterioration*

We are supportive of this domain being included in the draft standards, as suggested in the consultation paper.

If this is to be included it must reference trauma-informed care and include actions on forming strong relationships with third parties, including, but not limited to acute admission units, clinics, police, ambulance, and crisis teams. The standards should also differentiate between acute physical and mental deterioration and address the interplay between the two.

3. Are there specific actions you would like to see included within the NSQMH Standards for CMOs? (an 'action' *is explained on page 7*)

The domains outlined in our response to Question 2 provide some examples of actions which may fall under additional domains.

We support the inclusion of key systems, such as feedback and complaints management and healthcare records within the 'safety and quality systems' criterion. However, we encourage the addition of the following systems within this criterion:

- compliance management
- risk management.

Further, it is unclear whether work health and safety management is included in actions under the 'safe environment for the delivery of care' criterion. This should be clarified, with actions for work health and safety management included under 'safety and quality systems' and/or 'safe environment for the delivery of care'.

The 'workforce qualifications and skills' criterion are an important inclusion but would be more complete with the inclusion of actions to support broader aspects of workforce management. This includes recruitment of appropriate persons to roles, clinical (practice) and line supervision to ensure physical and mental wellbeing of staff and that behaviour and conduct are ethical and supports achievement of outcomes. We believe this is an important omission and does not respond to many of the issues raised in recent Commissions of Inquiry about unsuitable employees, insufficient training and supervision and its linkages to abuse and neglect.

We believe it is critical that the standards include a criterion which responds to abuse. The proposed actions should require that services establish and monitor processes to prevent abuse and neglect, to encourage reporting and manage any incidents. This should include processes to manage unapproved restrictive practices.

4. Are there specific 'actions' where you would suggest services must demonstrate particular 'evidence of compliance'? (evidence of compliance is explained on page 8)

The standards, criteria and action should follow an expanded version of the system definition given on page 9 of the discussion paper. This definition should be expanded to recognise systems are comprised of interconnected processes and systems. Therefore, standards should reflect the plan-do-check-act cycle (PDCA) approach so that:

- The system is planned and documented (there are objectives, plans, policies and procedures).
- The system is implemented (there is record of implementation).
- The system is monitored and evaluated (there are reviews to determine performance toward objectives and compliance is checked through audits).
- Action is taken when system elements are not meeting objectives or are not compliant.

Some of the actions within the criteria follow these principles, but not consistently.

It is suggested the standards adopt a similar design to the NDIS Practice Standards and Australian Community Industry Certification Standard (ACIS; 2018) by incorporating an 'outcome'. Outcomes clearly express the desired result of an action and would enable measurement of the quality and effectiveness of the standards, especially client outcomes. At present, the objective and desired outcome of the standards is not clear.

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?

The concept of what CMOs do is extremely limited. For instance, the definition does not adequately cover the scope and complexity of integrated services, such as delivery of clinical assessment and interventions, group work, and accommodation services. These types of services need to be included and acknowledged in defining the scope of CMO operations.

There needs to be a clear definition of what is and is not a 'Community Managed Organisation.' The standards go some way to achieving this, whilst recognising the diversity in size, governance, and goals of CMOs.

Many organisations in the CMO sector explicitly focus on incorporating 'trauma-informed' practice and 'recovery oriented' or 'change oriented' service delivery. These terms, and the treatment philosophy behind them, should be incorporated into the NSQMH Standard for CMOs with clear actions.

The language 'healthcare provider' may not be palatable for all community based mental health and wellbeing organisations. Suggested alternatives could be 'service provider', 'mental health service' or 'mental health and wellbeing service'.

Further, the following terminology should be considered and defined:

- safety and quality systems
- corporate governance
- operational governance systems.

Terms around quality management should be made clearer. This should include definitions of:

- quality improvement
- quality management and quality management system
- quality assurance.

The standards also need to clarify the scope and terms relating to the 'risk management approach.' Is this enterprise level or clinical risk?

Other terms that must be explained are:

- social determinants of health: these are the circumstances and systems which act together to improve or undermine someone's health and wellbeing, such as socioeconomic position, social support, and power.
- the principles of mental health recovery: a set of guiding principles that assist an individual with mental ill health to gain hope and live a fulfilling life in the community.
- social inclusion: is the ability to participate and contribute to all aspects of society including economically, socially, and psychologically. For individuals living with mental health issues, social inclusion can play a central role in recovery.
- trauma informed approaches: are those that acknowledge trauma can affect the lives of all individuals and communities and is taken into consideration to ensure an individual receives the type of care that maximises their potential for recovery.

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.

If these standards are intended to subsume the existing National Mental Health Standards this should be made clear to reduce confusion at having a new set of voluntary standards. Regardless, it should be made clear how the sets of standards relate to each other.

Further, for organisations which provide services under the NDIS, there is a competing set of standards which apply. The NDIS Standards apply to registered service providers who provide support to clients (participants) of those services. The standard is generic in nature and is not designed to regulate services to a specific cohort such as people with as psychosocial disability.

A consistent approach between the NSQMH Standards for CMOs and the NDIS Standards would be useful. While it is unlikely that the NDIS quality and safety commission will recognise the NQMH Standards for CMOs for mutual

recognition purpose, we believe a mapping document would be extremely beneficial. We note the NDIS is developing a Recovery Framework for NDIS participants with psychosocial disability. This new Framework should be reflected in the NSQMH Standards for CMOs.

Table 1 (below) provides a list of standards in the mental health sector against which our respective organisations are currently accredited.

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*)

From a practical and ethical position, a mutual recognition framework would be useful. We support the notion of a mutual recognition framework and encourage the Commission to work with relevant organisations and regulators to investigate the mechanisms to reduce the administrative burden associated with accreditation to multiple sets of standards. The Commission should ensure that the mutual recognition framework recognises similarities across standards to prevent duplication of effort. This should include a framework to govern conflict or duplication of standards, setting out where the NSQMH Standards for CMOs apply over-and-above another standard.

Harmonising accreditations would enable efficient use of time and resources for CMOs, who already face significant administrative burden in terms of being accredited against multiple standards.

Most organisations are already accredited against the National Standards for Mental Health Services (NSMHS) which are regulated by the Commonwealth Government. We would welcome the integration of the current NSMHS, the NSQMH Standards and the draft NSQMH Standards for CMOs, as well as the NSQ Digital Mental Health Standards. If an organisation is recognised against one standard, it should be made clear whether they will be required to demonstrate evidence for compliance against similar parts in other standards, such as the NSQMH Standards for CMOs.

The possibility of achieving mutual recognition against other standards is questionable. Most other standards are registered and regulated through stringent scheme rules which do not readily recognise other standards. Examples of these standards with schemes are:

- Australian Community Industry Certification Standard 2018 (ACIS 2018)
- National Disability Insurance Scheme (Quality Indicators) Guidelines 2018 (Commonwealth)
- AS/NZS ISO 9001:2016 Quality management systems – Requirements
- Human Service Quality Framework Standards 2010 (Queensland)
- Human Services Standards (Victoria).

The proposed NSQMH Standards for CMOs must include arrangements to recognise these other standards. This might be supported by mapping these standards back to identify 'the gap' from which one might determine the scope of certification. For example, if an organisation already has NDIS registration against the NDIS Practice Standards, then this should give mutual recognition against certain parts of the NSQMH Standards for CMOs.

Table 1 provides a list of standards our organisations are accredited against (accurate as of date of submission).

Table 1: Accreditations held by Alliance organisations

	Neami	**Mind**	**Flourish**	**Stride**	**OneDoor Mental Health**	**Wellways**	**Open Minds**
Human Service Standards (VIC)	✓	✓				✓	

	Neami	Mind	Flourish	Stride	OneDoor Mental Health	Wellways	Open Minds
NDIS Quality and Safety Commission Practice Standards and Rules	✓	✓	✓	✓	✓	✓	✓
National Standard for Mental Health Services (NSMHS)	✓	✓	✓	✓	✓	✓	✓
National Safety and Quality Service Standards (NSQHSS)	✓						
Human Services Quality Framework (HSQF)(QLD)	✓			✓		✓	
Australian General Practice Accreditation				✓			
Headspace Model Integrity Framework		✓	✓	✓	✓		✓
Quality Improvement Council		✓					
ISO 9001: 2015 Quality Management System	✓		✓			✓	
Australian Community Industry Standard						✓	
National Standards for Disability Services (NSDS)			✓				
ISO 14001:2015 Environmental Quality Management System (EMS)			✓				
OH&S AS/NZS 4801:2001 Safety Management System			✓				✓
Suicide Prevention Australia Standards for Quality Improvement				✓			
National Safety and Quality Digital Mental Health Standards				✓			

8. What are the important considerations in determining the approach to implementing the NSQMH Standards for CMOs?

The standards will need to provide clear information about how accreditation processes will apply when organisations are working in partnership with other providers, third parties or external people/organisations.

There needs to be consideration and further information provided on the certification cycle. Organisations should be advised whether this will be the standard three-year period, or if there will be a midterm review and/or annual surveillance audit.

We also require further information as to the audit methodology, and whether audit scheme[1] documents will be drafted to ensure audits are valid and reliable.

[1] For example, the NDIS Approved Quality Auditors scheme invokes ISO/IEC 17065:2012 – conformity assessment – requirements for bodies certifying products, processes and services as a normative reference.

Schemes detail the specific requirements which must be met before certification is granted by an approved auditing organisation or certifying body. These define the rules for things such as determining audit scope, audit approaches, sampling methods, criteria for non-conformity and so forth.

The development of a scheme ensures that auditing and certification decisions are consistent and in line with the audit methods that are applied using rules of evidence. They also generally include strategies to verify systems which are documented, implemented, evaluated and continually improved.

This may involve:

- Document reviews: examination of policies and procedures.
- Checking implementation through file audits, interview with relevant staff, and participants, etc.
- Checking evidence of reviews, including file audits, incident reporting, and complaints management.
- Improvement activities, such as improvement registers, records of corrective action, meeting records.

9. What accreditation approach would be appropriate for the NSQMH Standards for CMOs? (*Accreditation is explained on page 19*)

Many standards are a point in time accreditation. We believe a structured cycle of review would create a culture of quality improvement and embed standards and principles into an organisation.

As an alliance, we are not opposed to 'without notice' visits to CMO locations as an element in the accreditation audit approach. However, our preference would be for a more structured approach which can assess the content of daily service provision and culture in CMOs.

As is the case with all other standards, these must be supported by an Audit Scheme and audits must be undertaken by a JAS-ANZ[2] accredited Certification Body (CB) who are approved to audit the standard according to the scheme.

It is suggested that at the conclusion of an audit, the CB would recommend an organisation for certification against the NSQMH Standards for CMOs and that the ACSQHC (as the owner of the standard) would ratify this decision and confirm certification.

It is suggested that the NSQMH Standards for CMOs Scheme contain specific key considerations including, but not limited to:

- the certification cycle
- scope determination
- the audit methodology, including rules for sampling
- audit reporting requirements
- rules relating to non-conformities and the timeframes for corrective action.

It is suggested that the NHQMH Standards for CMOs adopt a three-year quality certification cycle with surveillance audits scheduled at the mid cycle point (18 months) or 12-month mark.

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

- There is a need for a consistent approach to collecting data and information. Collecting data on organisation performance against standards would create a dataset which could be used to create benchmarks and create a culture of continuous improvement.
- There is a need to develop a mapping documents system which 'maps' the NSQMHS to other standards.

[2] The Joint Accreditation System of Australia and New Zealand (JAS-ANZ) being the body responsible for the accreditation of Certification Bodies (CBs) and schemes.

- There is a need to develop an evidence guide. Evidence Guides provide an explanation on requirements needed to meet each criterion and provides guidance for providers on preparing evidence to demonstrate requirements have been met.
- There is a need to develop an audit scheme approved by the relevant body.
- It would be beneficial to develop tools for auditors for document reviews and file audits.

Conclusion

The Australian Psychosocial Alliance acknowledges the Commission's commitment to the rights of people with a lived experienced of mental health issues and the need to increase and ensure safety and quality in the provision of mental health and wellbeing services.

We are supportive of the aim of the NSQMH Standards for CMOs to continuously improve the quality of mental health and wellbeing service provision and to protect service users from harm. We firmly believe in always providing the best possible care, which is why we are already accredited against several standards.

However, we strongly encourage the Commission to ensure there is mutual recognition between different sets of standards, regardless of the owner or certifying body, to avoid unnecessary duplication of effort. Whilst continuous improvement is an essential part of our day-to-day business, it should not come at the expense of service provision.

We commend our responses to the Commission and are happy to provide further comment and assistance as the National Quality and Safety Mental Health (NSQMH) Standards for CMOs are further developed.