Joint Submission

Australian Psychosocial Alliance response to the *Australian Commission on Safety and Quality in Health Care* – Consultation Draft on the Guide for Service Providers for Accreditation to the *National Safety and Quality Mental Health Standards for Community Managed Organisations*

August 2023

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Who We Are

The Australian Psychosocial Alliance (APA)

The Australian Psychosocial Alliance (APA) includes Flourish Australia, Mind Australia, Neami National, One Door Mental Health, Stride Mental Health, Open Minds, and Wellways Australia. We are the largest providers of community managed mental health and wellbeing services in Australia.

We have extensive experience providing recovery-oriented care and support which focuses on personal goals, participation and living a meaningful life. This includes support to cope with the ups and downs of mental ill-health, sustain a tenancy, build the skills to live independently, find fulfilling work, and build social connections.

About Flourish Australia

Flourish Australia is a major provider of community-based mental health services in New South Wales, 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 largest providers of community-managed psychosocial services in Australia with a range of residential, mobile outreach, centre-based and online services. We have been providing support to people, and their families, friends, and carers for more than 40 years.

In the 2020-21 financial year, we provided individualised, evidence-based, and recovery-focused support to more than 11,000 people experiencing mental health and wellbeing concerns, including disabilities arising from those concerns – otherwise known as psychosocial disabilities.

We are one of the leading specialist community housing providers in Australia for people experiencing psychosocial disability, and a registered NDIS provider – entrusted to deliver federal and state government funded services across Australia. We are one of the largest providers of NDIS funded supported independent living for people with a psychosocial disability in Australia.

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.

About Neami National

Neami National are a leading organisation in the mental health sector, with over 1,000 employees supporting people in local communities across Australia. Our dedicated teams work in metro, regional and rural communities, supporting over 32,000 Australians a year to make positive changes to their mental health and wellbeing.

We have been providing mental health support for over 30 years. We were founded on an alliance between professionals, individuals and their families. Collaborative recovery remains at the heart of who we are today.

To provide valued and meaningful support, we know that building connections and listening to the expertise, knowledge, and experience of the people we support is key. We work with people with a lived experience of mental health challenges as valued partners in the design, delivery and evaluation of services.

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. 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 an 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 17 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 ACT, New South Wales, Queensland, Tasmania, and Victoria, 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

- 1,900-plus staff across over 100 offices throughout eastern Australia, from Tasmania to Queensland.
- 120 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 Health Care (the Commission) to continue developing to support the implementation of the National Safety and Quality Mental Health (NSQMH) 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 commend the Commission for developing a Guide for Service Providers that addresses each Action within the NSQMHCMO Standards. The Guide is clearly intended to assist service providers with their implementation of the standards and support maintenance of certification once achieved. We recognise that this Guide may benefit CMOs who are in the process of building their safety and quality systems.

There are several aspects of the Guide that we recommend for improvement and consideration.

- The Guide in its current form appears to assume significant resources and maturity of safety and quality systems to meet the Actions. This may disadvantage CMOs who are smaller in scale or scope.
- Throughout the Guide, there are many resources and references which have limited relevance or appropriateness for CMOs. We have provided suggestions to enhance the lists of these resources. We also recognise that some Actions may have limited supporting resources that are publicly available or evidence-based. Where this is the case, we encourage the Commission to consider developing suitable supporting resources.
- References to family, carers and kin need to be consistent throughout, and it should be recognised in all areas that this involvement is where it is agreed to by the consumer.
- Structurally, the headings for Key Tasks and Examples of Evidence could be further developed and clarified, including to articulate where such tasks and evidence may be *essential* for an Action to be met, compared with tasks and evidence that is optional or preferred. Clarity on this will benefit both service providers and assessors.
- Evaluation tasks should be clear, specific, observable and/or measurable.
- The Guide also contains a range of spelling, grammatical, and formatting issues which may be addressed with a thorough proofread.

As mentioned in previous joint submissions on the NSQMHCMOs, we continue to have significant concerns about duplication of effort and the administrative burden of accreditation against multiple sets of standards. We acknowledge that the Commission has referenced to efforts to address this in the Guide, and we welcome future opportunities to work with the Commission on such initiatives.

We have provided further detail in our response to the consultation questions for your consideration. We welcome any further questions or opportunities for consultation on the Guide for Service Providers.

Response to Consultation Questions

The Consultation Paper identified four key consultation questions:

1. **Will the Guide help you implement the actions in the NSQMHCMO Standards in your service?**
2. **What changes or additions could be made to improve the Guide?**
3. **Is there additional evidence you can provide to support implementation of the strategies in the Guide?**
4. **Do you have any other comments or suggestions about the Guide?**

We have provided our responses below.

1. Will the Guide help you implement the actions in the NSQMHCMO Standards in your service?

There are many aspects of the Guide that appear to support CMOs to implement the actions in the Standards. The provision of additional information resources is a welcome step toward assisting service providers who may have limited resources, capability, or existing systems and structures. However, many of the resources are not directly applicable or transferrable to the CMO context. To meaningfully support service providers who may identify gaps in certain Actions, we recommend a thorough review of available supporting resources to better enhance the Guide's utility. Furthermore, there appears to be an absence of resources developed by the Commission for CMOs to support implementation of the Standards. We strongly urge the Commission to consider developing resources where there is a gap in publicly available, robust, and evidence-based resources.

It appears that the Guide for Service Providers primarily targets larger organizations that likely possess more resources, either already implemented, or can implement the various actions outlined in the Standards. The Key Tasks and Examples of Evidence often presume that such organizations possess the necessary capacity and capability to establish robust systems and processes. An example would be setting an organisational requirement for all staff to have First Aid and Mental Health First Aid training, which is often not feasible to provide under current funding arrangements. Whilst the APA members may be able to meet many of the Actions in the standards, it could prove challenging for smaller CMOs. Thus, as per the current Guide, the ability of smaller CMOs to undergo NSQMHS accreditation might be constrained.

In the following section of this joint submission, we have compiled suggestions related to the different actions. While the Guide's structure is generally straightforward, comprehending how Key Tasks and Examples of Evidence might be interpreted by assessors within the accreditation scheme poses challenges. The current presentation of these subsections lacks clarity and could potentially lead to inconsistent interpretations by assessors. Rather than providing clarity on where flexibility could be applied based on the scale and scope of CMOs' services, the current presentation might inadvertently lead to ambiguity.

Concerning the concept of "reducing accreditation burden," it is essential to provide a supplementary resource that clearly explains the extent to which existing certifications may partially or fully align with the relevant standards (e.g., National Standards for Mental Health Services, NDIS Practice Standards, Human Services Quality Framework). Although this matter has been briefly acknowledged on page 7 of the consultation paper, we emphasize the significance of such resources and mechanisms. These resources are crucial for successful implementation of the standards and alleviating the accreditation burden for service providers. We eagerly anticipate potential future

opportunities to further apprise the Commission regarding the needs of service providers in this regard.

2. What changes or additions could be made to improve the Guide?

In relation to changes and additions which may improve the Guide, we have reviewed the various actions associated with the standards and made suggestions below in Table 1.

We further suggest that the structure of "Key Tasks" and "Examples of Evidence" be revised to clarify what is "essential/necessary" for implementation of the standards compared with "optional" considerations depending on the scope and scale of the service provider and their mental health service delivery. In particular, the format of the "Examples of Evidence" appears to be broad to reflect the diversity of a wide range of service providers, however it may be challenging for smaller providers to meet some of the Key Tasks or demonstrate the Examples of Evidence, due to the administrative burden to implement and maintain such tasks. It may be helpful to indicate what may be considered essential for an assessor to mark an action as being 'met' (or the appropriate term for conformity), as opposed to potentially an optional addition.

We would also like clarification about whether some Standards are 'not applicable' to some organisations depending on their scope of supports (e.g.: residential vs non-residential, clinical vs non-clinical psychosocial supports).

Table 1. Suggestions to Improve Guidance to Implement Actions.

Action	Suggestion for Improvement

Action 1.01	• Include additional resources relating to best practice for partnering consumers, carers, families, and kin at the Board level. E.g.
	  ○ https://www.mentalhealthcommission.gov.au/getmedia/afef7eba-866f-4775-a386-57645bfb3453/NMHC-Consumer-and-Carer-engagement-a-practical-guide
	  ○ https://cmhdaresearchnetwork.com.au/wp-content/uploads/2023/04/ACKNOWLEDGMENT-MATTERS-A-GUIDE-TO-LE-ENGAGEMENT-final.pdf

Action 1.02	• It may be beneficial to include additional resources to support engagement with consumers from CALD backgrounds, e.g.
	  ○ https://www.tisnational.gov.au/
	  ○ https://embracementalhealth.org.au/index.php/service-providers/framework-landing

Action 1.03	• The link to the National Practice Standards for Mental Health Services in the Explanatory Notes section is incorrect (currently links to the standards). The correct URL is: https://www.health.gov.au/resources/publications/national-practice-standards-for-the-mental-health-workforce-2013
	• It is unclear where the 4 ethics principles originate. It would be helpful to provide a supporting reference for this, and if the principles are essential or optional for assessment.
	• Many of the supporting resources do not appear to be relevant or appropriate for this action, or a non-partial approach to supporting resources:
	  ○ The inclusion of QIP's accreditation webpage for the NSMHS does not appear to add value as a relevant resource for this action. (link)
	  ○ The inclusion of Lifeline's Directors Code of Conduct and Ethics similarly does not seem like an appropriate supporting resource.
	  ○ The Principles of Biomedical Ethics article has limited transferrable relevance to community managed organisations.
	• We recommend reviewing these resources and providing more suitable options, e.g.
	  ○ https://link.springer.com/referenceworkentry/10.1007/978-981-13-6975-9_2

	○ Codes of Ethics/Conduct for professional associations (e.g. APS, AASW, ACA, PACFA).
Action 1.04	• We recommend providing additional clinical/practice governance framework examples to avoid the perception of favouritism toward Neami as an example of a CMO's framework. Additional examples may include: ○ https://headspace.org.au/assets/EOI/ATTACHMENT-C-headspace-Clinical-Governance-Framework.pdf ○ https://www.missionaustralia.com.au/documents/resource-sharing/1305-clinical-and-care-governance-framework
Action 1.05	• Some additional supporting resources for practice/clinical supervision may be beneficial, e.g.: ○ https://clinicalsupervision.org.au/resources/
Action 1.06	• We recommend adding links to supporting references to support cross-referencing legislative compliance requirements, e.g. Austlii – http://classic.austlii.edu.au/
Action 1.07	• The YES-CMO survey is a good example of a validated measure to obtain feedback from consumers and develop quality improvement activities. A minor clarification is that the YES-CMO is used more broadly than just in NSW. • The explanatory notes should expand on what the relevant measures may include (e.g. safety measures, outcome measures, satisfaction-based feedback surveys).
Action 1.08	• With the exception of the VIC Dept of Health link, there is an absence of applicable and meaningful supporting resources and information to better guide CMOs regarding effective reporting and information sharing of the performance of safety and quality systems. We recommend the Commission consider reviewing publicly available resources further or developing tailored resources to support CMOs.
Action 1.09	• Some additional resources that may be helpful to include: ○ https://www.orygen.org.au/Training/Resources/digital-technology/Clinical-practice-points/Managing-risk-in-telehealth-tips-for-mental-health/Orygen-Telehealth-tips-managing-risk?ext=. ○ https://www.hse.ie/eng/services/publications/mentalhealth/riskmanagementinmentalhealth.pdf • We recommend a language change. CMOs operate from a recovery-oriented lens, and reference to "consumers who have a history of behavioural issues and may present a risk to staff" could be reframed in a more recovery-oriented approach. • Similarly, talking about "identifying, reporting and responding to risks" needs to be accompanied by talking about "maintaining safety" or even better "co-creating safety". • Further resource should include: ○ https://mhcc.org.au/wp-content/uploads/2022/10/Recovery-Oriented-Language-Guide-3rd-edition.pdf
Action 1.10	• Further supporting resources for incident management would be beneficial, e.g.: ○ https://clinicalexcellence.qld.gov.au/sites/default/files/2018-01/clinicalincidentguide.pdf
Action 1.11	• Open Disclosure is well established in hospitals and healthcare services, but less so in CMOs. It may be helpful to consider if additional resources to support the implementation of Open Disclosure in CMOs would be beneficial.
Action 1.14	• This section may further be strengthened with reference to the OAIC's page for health service providers, which has lots of relevant content for CMOs (e.g. taking photos of "patients", MHR, data breaches). https://www.oaic.gov.au/privacy/privacy-guidance-for-organisations-and-government-agencies/health-service-providers

	• Additionally, further resources to support consent issues relating to young people and people with limited consent capacity may be helpful. E.g.: ○ https://headspace.org.au/assets/download-cards/CT-Capacity-to-Consent.pdf ○ https://www.oaic.gov.au/privacy/privacy-guidance-for-organisations-and-government-agencies/health-service-providers/guide-to-health-privacy/chapter-7-disclosing-information-about-patients-with-impaired-capacity
Action 1.15	• Refers to 'competency training in providing for cultural safety.' Examples of evidence could further explore diverse communities such as Aboriginal and Torres Straight Islander Communities, and the LGBTQIA+ Community. • "Where to go for more information" could include further resources / training available for such diverse communities (For example – Aboriginal Mental Health First Aid).
Action 1.15	• The Qld Centre for Mental Health Learning offers a number of eLearning options worthwhile for CMOs. We would recommend adding a link to the list of training options. https://www.qcmhl.qld.edu.au/
Action 1.16	• Clarity about "values" is needed. • The following needs to be written more specifically: "this may mean ensuring staff hold certain formal education or work experience". It is unclear what is being asked here. Does this apply to all staff in an organisation? • "Scope of practice" is a term that is traditionally applied to clinical staff so this needs to be phrased differently or elaborated on. • Suggest something like "process to ensure staff have all of the relevant professional attributes needed for them to carry out their duties in a way that is safe, competent, and ethical". • Where to go to for more information: could expand on resources for Working With Children Checks (where relevant). These are generally State Based Requirements and therefore the resources provided could link to the Gov. websites to assist staff on how to apply for the checks.
Action 2.03	• For consistency, we recommend changing the use of the term *patient* in "Identifying a patient's capacity for making decisions about their care" to *consumer*.
Action 2.06	• This is a good intervention most of the time but should be led by the consumer. The way this is phrased is a bit values-laden. • Replace "family" with "chosen family". Change "and" to "and/or". • Add "in accordance with the consumer's preference".
Action 2.08	• Usually processes about decision-making capacity are already determined by relevant state Mental Health Acts, and under most Acts you have to assume that the person has decision-making capacity unless it is proved otherwise. Their decision-making skills are irrelevant unless there has been an assessment made that they lack capacity. This point needs to be workshopped to clarify what is meant.
Action 2.10	• The explanatory notes describe principles of co-design. These should be supported with a link to an appropriate authoritative guiding reference on co-design. • Furthermore, co-design principles often incorporate some aspect of *Review and Continuous improvement*, and this may be helpful to include. ○ https://mhaustralia.org/sites/default/files/docs/co-design_in_mental_health_policy.pdf ○ https://www.orygen.org.au/Training/Resources/Service-knowledge-and-development/Guidelines/Co-designing-with-young-people-The-fundamentals/Orygen-Co-designing-with-YP-the-fundamentals?ext= ○

Action 2.16	• The example of evidence: “Supporting the promotion and prevention of mental illness” is unclear. Recommend re-phrasing to: “promotion of wellbeing and prevention of mental illness” and clarifying what kind of evidence may be useful. E.g. a policy document, marketing and communications plans, commitment to the National Communications Charter.

Action 3.02	• A clear definition of program logic may be useful as this term may be considered new/emerging for some service providers.
	• Additional references to resources for program logic may be beneficial. Some suggestions:
	  ○ https://www.health.nsw.gov.au/research/Publications/developing-program-logic.pdf
	  ○ https://ijmhs.biomedcentral.com/articles/10.1186/s13033-016-0111-5
	  ○ https://www.sciencedirect.com/science/article/pii/S0149718923000277

Action 3.09	• Key tasks section:
	  ○ This is too prescriptive, because there are situations where this is not appropriate, for example when working with survivors of family violence. Even though they might consent to their family member receiving communications and being part of decision-making, it is often still not appropriate because of the need to maintain safety for the consumer. There must be staff discretion here.
	  ○ Family should be defined to include non-biologically related or legally related family
	  ○ Furthermore, the client's consent to have their family members and carers involved is not always a blanket consent, it is often specific and services should ensure the consumer is the one making the decision about having others involved, every time.
	• Examples of evidence section:
	  ○ Add evidence of family, carer, and kin involvement, where appropriate.
	• Where to go for more information section:
	  ○ Why is the WRAP linked under section 3.09 and not 3.10?

Action 3.14	• In the examples of Examples of Evidence for Evaluation, some additional options may include validated outcomes measures (e.g. K10, LiCQ, AQoL, CANSAS, LSP-16) and incident indicators (e.g. frequency and severity of incidents). A risk register typically relates to systemic or service-wide risks, rather than individual consumer risks. It may not be relevant (or could be confusing) to include risk register as an example of evaluation evidence.
	• More consistency is needed around terminology used throughout this document:
	  ○ "Care and recovery plans", "recovery plans", and "safety plans" are referenced under various actions. They aren't defined.
	  ○ Care plans and recovery plans appear to be referring to the same thing, so it is unclear why the terms alternate.
	  ○ It is also implied that consumers need both a care/recovery plan AND a safety plan. These might all be the same document. Therefore, it is not clear what is being asked.

Action 3.15	• Providing first aid to consumers is not always standard in community mental health service delivery, and is not currently an expectation of most funded services. The Key Task that states: “Periodically refresher first-aid and CPR training is provided to all staff” should potentially be clarified to “provided to all identified staff as required” or similar wording that more clearly allows for the applicability of requirements in line with service delivery requirements.

Action 3.19	• The language around this entire action is not trauma informed and needs to be reviewed.
Action 3.21	• The Mental Health Act provides significant guidance and rules around the use of restrictive practice. Although each jurisdiction has different requirements under the Mental Health Act, the Act still needs to be referenced and linked back to – this can be done under “where to go for more information”. • RP is an area of high risk and this action can be strengthen with better guidance, explanatory notes and information from the relevant state Mental Health Act. • The requirements of individual consent need to be further developed and described.
Action 3.25	• Falls prevention and management depends largely on the service type and individual consumer risk profile. As such, the Key Task for: “Provide access to equipment and devices that support mobility and reduce risk of falls” should be clarified as “where applicable/indicated” or a similar qualifier that denotes this should be in place when required. • Is this asking for a falls risk screen for all consumers in all services, to identify whether a person is "at a high risk of falls" and therefore requiring intervention? Screening tools are only validated for particular populations/settings. • What if there are not guidelines about falls for a particular context or service setting? There is a wide variety of service contexts that these standards will apply to, where there aren't validated falls risk screening. • Can this be accompanied by more clear explanatory notes?
Action 3.29	• Under key task sections: - Medication Regimen not Regime
Action 3.36	• Scope of practice is different for administering medication vs supervising medication. Non-nurses can sometimes supervise medication (i.e. hand the consumer the blister pack and witness them self-administering the medication). Can supervision of medication be included and clarified in this action? • This doesn't really tell us the standard for a medication history though. What is the minimum requirement for a compliant medication history?
Action 3.37	• Key tasks section, specifically last point: ○ Not sure what this last point means? Are they saying that PRN medication is mandatory? Or that CMOs are responsible for making sure people take their medication? Needs deletion or rephrasing.

3. Is there additional evidence you can provide to support implementation of the strategies in the Guide?

In the previous section, we have provided additional resources relevant to various actions. However we do encourage a full review of the resources to ensure their relevance and value-add for service providers.

4. Do you have any other comments or suggestions about the Guide?

Overall, the Guide for Service Providers document would benefit from a thorough review and particularly attention to formatting and grammar. We noted many inconsistencies in formatting and spelling and grammar issues throughout the document. A more detailed table of contents would be useful as well. Many of our suggestions also relate to references aren't relevant or appropriate, and phrasing or headings that can be confusing.

We recommend through a proofread of the Guide before publication. Additionally, for the sake of consistent language, we recommend reviewing all occurrences of the term "service user" and changing to consumer unless there is a legitimate rationale for using the more generic "service user" term.

We recommend the glossary of definitions to be reviewed. Specifically:

1. Scope of practice: There are a lot of non-clinical staff that this will apply to. Scope of clinical practice is more easy to define than scope of practice for non-clinical staff, because scope of practice is a term that comes from clinical contexts.
2. Restraint, coercion and or restrictive practices.
    A. Coercion needs to be defined on its own
    B. Restraint is a form of Restrictive Practice - therefore suggestion "Restraint and Seclusion"

Lastly, the acronym NSQMHCMO is quite cumbersome. We acknowledged that the standards have already been launched, however it may be beneficial to review this acronym and consider a shortened version (e.g. NSQMH).