Consultation on the National Safety and Quality Mental Health Standards for Community Managed Organisations

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Submission

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Introduction

This submission commences by outlining the CMO sector's understanding of the current opportunity provided by ACSQHC consultation to develop a fit for purpose new safety and quality standard designed specifically for the sector. After providing a checklist of recommended high-level principles to guide the development of the new standards, responses to the Consultation questions are then provided. A list of relevant frameworks and documents examined during the preparation of this submission are provided in the Appendix. Key or interesting features are noted.

The opportunity for ACSQHC and the CMO sector

The consultation process provides ACSQHC and the CMO sector with the opportunity to design together fit for purpose safety and quality standards that:

- Are co-designed with people who use services offered by the community managed sector and which recognise human rights and people's service aspirations and priorities, and which are written in a language they prefer
- Encourage ad reinforce the philosophy, values and principles and culture required of the CMO sector to deliver recovery-oriented services and practice
- Are relevant to the sector's raison d'être or reason for being – supporting people to self-direct live their lives – an autonomous life of their choosing
- Are relevant to the roles of the CMO sector and the type of services they offer and be sufficiently flexible to encompass new and emerging service types and delivery modes
- Be consistent with the WHO Guidance on Community Mental Health Services: promoting person-centred and rights-based approaches and United Nations Convention of the Rights of Persons with Disabilities (UNCRPD)
- Incorporate best practice frameworks and models across the diverse sector
- Be relevant and readily understood by people using CMO sector services and local communities as well as people employed within this sector

To be fit for purpose, CMHA advises that the new standards should be consistent with the philosophy, values and language of new national directions including for example the National Mental Health Commission's Vision 2030. This new vision envisages all Australian mental health services being contextualised within two broad yet integrated approaches to mental health: a social and emotional wellbeing approach and a balanced community-based approach. The new standards should be crafted with sufficient flexibility to reflect or accommodate the rapidly changing landscape of mental health reform in Australia and the service delivery and accreditation contexts of the CMO sector.

What is meant by fit for purpose safety and quality standards?

Quality and safety standards in health care are generally dense, complicated and written in medically-based language. They tend to focus on acute clinical settings, and procedures and processes. The language used is generally inaccessible to people using health care services, which results in "easy English" versions and explanations targeting practice with specific population groups being developed after the fact.

The development and drafting of fit-for-purpose standards as safety and quality standards is driven by the "end users" of the services to which the standards apply. The standards should be focussed on the outcomes sought and desired by service users (i.e., consumers and families and carers)) and based on an evidence-based approach (that represents trauma-informed recovery-oriented practice approach).

Fit-for-purpose standards are specific to both the people using the services (and their families and carers) and to the service providers. They are not simply lifted from another setting and then re-badged with minor changes to wording or emphases. They are relevant and reflect what the sector actually does; the principles underpinning implementation and the contexts in which services are provided.

The aspirations as well as the significant health and social inequities of priority populations are not addressed in one-line statements or in passing. Rather, the relevance of the standards to priority populations is a key conversation throughout the development of the standards. Priority populations must lead these conversations and provide their guidance as to how the CMO sector offers relevant support to them in ways that are accessible, safe, and meaningful.

Fit-for-purpose standards are also interoperable; recognising the multiple contexts and layers of CMO service provision requires compliance with several different sets of service standards – some state/territory-based, others national and yet others, program-based.

Fit-for-purpose safety and quality standards also specify the avoidable harms the standards are seeking to address and how the actions required prevent these harms and provide redress where necessary. In this way, standards enable continuous real-time monitoring and quality improvements. Fit-for-purpose standards also inspire engagement among service users and inspire a workforce committed to making every moment and interaction count for service users.

Why are a new type of quality and safety standards required for the CMO sector?

The CMO sector has traditionally largely provided psychosocial social services. While service providers might outreach or in-reach to clinical settings, the sector works on the ground in local communities and people's homes and sometimes, workplaces. Some CMOs are also providing psychosocial residential rehabilitation services including some that are classified as health facilities.

The CMO sector works at the points where mental health and other co-occurring health and social issues intersect. It is here where the significant impacts of human rights infringements and the social determinants of health and wellbeing are frequently observed. And for this reason, the services offered by the sector have sought to be human rights-based and have sought to counter stigma and discrimination. Guiding frames for service delivery and practice are the WHO Guidance and the UN Convention on the Rights of People with Disability.

A related service delivery focus of the CMO sector is addressing social determinants impacting most on people's mental health and wellbeing and personal recovery. The new standards will need to reflect these important roles & priorities of the CMO sector, which are different to those of service providers within acute care and/or inpatient-based settings.

The sector has also led on several key practice principles including:

- Elevating the voice and expertise of lived experience
- Elevating autonomy and self-direction
- Partnership and collaboration
- Trauma informed recovery-oriented practice and language
- Intersectionality
- Locally flexible and innovative.

While also being important principles within medical and/or bio-medical settings, their primacy and application in the CMO sector is different. This difference needs to be reflected in the new standards.

The Consultation Papers suggests that core CMO mental health service types have included: Accommodation support and outreach; Employment and education; Leisure and recreation; Family and carer support; Self-help and peer support; Helpline and counselling services; Promotion, information, and advocacy.

More recent service types include:

- Alternatives to Emergency Departments or Urgent Mental Health care centres
- Peer support-based warm lines
- Step-up step-down services and other sub-acute services

- Expanded access to psychological therapies
- Physical health related supports
- Service coordination
- Early intervention
- Safe Havens and other suicide prevention, outreach and aftercare services
- Recovery colleges
- Recovery coaching
- Mental health support for people over 65 years

Increasingly, there is a focus on providing digital services. Community Managed organisation are also specialising in providing services to specific populations including: young people; older people; First Nation peoples; immigrants, asylum seekers and refugee communities; survivors of sexual assault and other abuse; LGBTIQ+; veterans and serving defence force members; rural and remote communities; and people interacting with the CJS, etc. Condition specific services are also being provided e.g., depression and anxiety; eating disorders; co-occurring mental health and physical health conditions; and PTSD etc.

An important development in recent times is the growth of Lived Experience run CMO organisations and services. Accompanying this development has been the growth of Lived Experience workers within the CMO workforce.

The diversity of CMOs clearly demonstrates that it will not be possible to simply lift safety and quality standards applicable to acute health care settings, for example, and expect that they will be fit-for-purpose for this sector. Standards are required that are equally relevant for each of the key service types above, irrespective of their intended service users, location and the medium of their delivery e.g., equally relevant to recovery coaching as to helplines and counselling services. The new standards must also, where appropriate, provide specific provisions to support the continuing development of Lived Experience run organisations and services and to ensure the workplace safety of the rapidly growing Lived Experience workforce. CMHA notes the significant body of evidence concerning the effectiveness of this workforce (see for example, Mental Health Peer Workforce Study; Peer Workforce Study: Mental Health and Alcohol and Other Drug Services ('Peer Workforce Study'; Queensland Framework for the Development of Mental Health Lived Experience Workforce).

The new standards need to inspire change and drive quality and safe services and practice. To achieve this, the relevance of the standards and their day-to-day applicability will need to be clear to the wide range of people working and/or volunteering in the CMO sector. The relevance to people using CMO services also needs to be clear so that people can understand what they can expect i.e., what quality and safe services look and feel like. The language of the standards also need to be a language that is familiar and understood by both people using services and service providers.

Another key set of differences that needs to be recognised by the new standards is – culture, philosophy and values of the CMO sector that arises from their raison d'être or reason for being – helping people to live their lives – a life of their choosing.

Recommendations for high level checklist of principles to guide development of the standard

The following high-level principles are collegially offered as a resource to guide the development the new standard.

A driver of change

- The new standard inspires change and drives quality and safe services and practice.
- The new standard and its scheme support autonomy and self-direction of consumers, families, and carers.
- The new standard reflects and brings to life the culture, philosophy, and values of the CMO sector that arises from their raison d'être or reason for being – helping people to live their lives – a life of their choosing.

Based on outcomes for service users

- The new standard serves and works for the end user i.e., people using the service.
- The relevance to people using CMO services is clear and assists people to understand what they can expect i.e., what quality and safe services look like and feel like.
- The relevance of the standard and its day-to-day applicability is clear to people working and/or volunteering in the CMO sector and to the management and Boards of organisations.
- The concept of quality and the domains of the standard are based on outcomes for consumers, families, and carers as against system or organisational level needs and priorities.
- The relationship between domains, actions, evidence, and service outcomes is clear and readily understood by all stakeholders.
- The new standard contains specific actions for First Nations, people from immigrant, refugee, and asylum-seeking backgrounds and for diversity more generally rather than added on guidance or guidelines.

Familiar, relevant and easily understood language

- The new standard is written in language that is readily understood by people using CMO sector services, their families and carers and service providers (rather than an Easy English version being provided as an accompanying resource).

- The concept and language used to define safety is framed through trauma informed recovery-oriented, dignity of risk and quality of life lenses and is informed by Lived Experience, First Nations, and diversity perspectives.
- The concept and language of clinical governance is relevant to and understood by the sector.

A service provider friendly and enabling standard with a flexible scheme

- The new standard is interoperable with other key standards.
- The standard's scheme is flexible, offers options, and is scaled, phased and/or proportionate to the size of CMOs and to the range and complexity of services provided.
- Technology is used in an innovative and enabling way to support organisations to undertake accreditation.

A fit for purpose consultation process

CMHA invited discussion throughout the sector on what processes should be recommend for elevating the voice of lived experience as well as CMO service providers throughout the design of the standards.

CMHA advises that it is important for those using services as well as those who will be applying and upholding the standards to be central to the design and road-testing of the standards. CMHA is concerned that a genuine co-design process will not be achieved through one round of consultation. Rather, genuine co-design requires an iterative and multi-phased and multi-layered approach. A recent example of such a process is the approach undertaken by the NMHC to develop the 2030 Vision – the details can be found on the NMHC's website. Acknowledging consultation processes of this nature have been the usual practice of ACSQHC, CMHA urges the Commission to not depart from this proven and trusted multi-phased and multi-layered consultation process in this instance.

The question of language

CMHA asked the sector a series of questions about language: How relevant and appropriate is the language in the existing standards and in Consultation Paper's suggestions? Can you provide examples of ill-fitting language and concepts that the submission should identify and propose alternatives for? How will relevant and appropriate language be achieved? Who decides and how?

Preferred language

From this discussion the following advice about preferred language arose and is provided to the Commission.

The language of the new standards needs to be consistent with the generally, non-clinical, strengths-based language preferred by the Lived Experience movement and adopted and promoted by the CMO sector. It is essential that the language be:

- non-stigmatising
- non-pathologising
- person-centred and directed
- recovery-oriented
- trauma informed
- strengths-based

A good starting point, is the language used in an example of key documents and initiatives, discussed below.

SA Health, A co-created Philosophy of Care (July 2020) – The Philosophy of Care describes the experience SA Health and the CMO sector want people to have when they come to the new Urgent Mental Health Care Centre. Emphasis is on non-pathologising and non-stigmatising language – "*what we say is care full*". It is language developed through deep conversations with lived experience of emotional distress and mental health issues. Examples include -

- People - Help seeker, carer, family - People experiencing "times of distress and crisis, when life is most challenged and frightening"
- Vulnerability, resilience and strength
- Healing
- Care and support – rather than treatment
- Feeling safe – safety not surveillance, promoting "safety for all with a commitment to de-escalation and wise decision-making practices (regarding security)"
- Safety needs - rather than risk assessment
- "Members of the staff eliciting trust and having the skillset (specifically to support a calm environment in times of extreme distress)"
- Leaving – instead of discharge

Vision 2030: Blueprint for Mental Health and Suicide Prevention, National Mental Health Commission *(in progress)* – while CMHA understands that this work is still underway, it understands that the Blueprint will promote a shift in both the language and culture of mental health sectors. Like the Co-created Philosophy of Care, there is a shift in language toward human rights-based, person-centred and more inclusive language. The language used reflects the shift to a social and emotional wellbeing approach and to a balanced community-based approach. e.g.

- Integrated wellbeing approach – connectedness of social, emotional, spiritual and cultural, physical, nutritional, economic and mental wellbeing of individuals and of communities
- Mental health care and support

- Wellness and wellbeing
- Mental wealth in the community
- Aboriginal and Torres Strait Islander Social and emotional wellbeing inclusive of "relationships between individuals, family, kin and community, as well as the importance of connection to land, culture, spirituality and ancestry, and how these affect the individual"
- Positive life experiences
- Quality of life

National Stigma Reduction Strategy – Language of the new CMO sector needs to consistent with language recommendations arising out this national strategy being led by the National Mental Health Commission, a national initiative announced by the Prime Minister in December 2020. It is likely that the language will be human rights-based, non-stigmatising and inclusive.

Recovery-oriented language guide, Mental Health Coordinating Council (2018) – The language is this guide has been widely adopted throughout the CMO sector. It has also been adopted by public health services including for example by the NSW Ministry of Health with its establishment of NSW Suicide Prevention Outreach Teams (SPOT) across the state – see for example the NSW Health Statewide Requirements (pp. 3-4). Development of the Guide was informed international and Australian literature on trauma-informed recovery-oriented practice; consultation with the mental health practitioners across service sectors; and, most importantly, through listening to the voices of people with lived experience concerning their recovery journeys.

National Guidelines for the development of the Peer Workforce - Under the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan), the Commission is leading the development of Peer Workforce Development Guidelines by 2021. The guidelines will provide formalised guidance for governments, employers and the peer workforce about support structures required to sustain and grow the workforce. Although local and regional peer workforce frameworks exist, the development of national guidelines will ensure consistency across Australia. National guidelines will also be a step towards professionalisation of the peer workforce. It is important, that new standards consistent with the soon to be released Guidelines.

CMHA members also emphasised the need for language to be inclusive of families and carers and relationships. It is important that the new standards recognise that many family members who interact with CMO services will not identify with the term carer or be identified by services as a carer.[1] Furthermore, there are many inconsistent definitions of a "carer", which contributes to confusion among both families and professionals around who

[1] Variations of the term "carer" are included and defined differently in mental health statutes across Australia.

is technically a carer or not a carer (e.g., definitions of a "primary carer" by the ABS and of a "principal" and "designated carer" by the NSW Mental Health Act 2007).

Young people and children who are affected by relatives' mental illness often are not captured by the term "carer". Furthermore, people who were carers often need support from mental health services to transition when their caring roll ends. Family members who are bereaved by suicide are also not captured by the term carer. CMHA has been advised by members that a possible solution is for the new standards to refer to both "carers and family members". Both terms should be clearly defined with families being defined in an inclusive way. The definitions could helpfully specify that these terms are inclusive of young people, kinship groups and non-"nuclear" families.

The concept and language of safety: a fit for purpose framing

It is important that the concept of safety and the defining language are not just lifted from the existing the National Safety and Quality Health Service (NSQHS) Standards. Rather the concept needs to be framed through trauma informed recovery-oriented principles and practice, dignity of risk and quality of life lenses.

The concept and language of safety needs to combine both service users and service provider perspectives.

Reflecting key difference of the sector - Key differences of the work and contexts of the CMO sector need to be reflected. For example, while CMOs work with people subject to involuntary orders, engagement with CMO services and programs is voluntary (except in a small number of cases) and focussed on encouraging and supporting autonomy and self-direction. It is important that the new standards are framed in a way suited to voluntary service delivery and voluntary engagement.

Lived Experience guidance concerning the concept and language of safety - The Lived Experience movement and its workforce is uniquely positioned to provide guidance. This workforce understands the trauma and lack of safety experienced by many people accessing mental health services, particularly in inpatient settings. The Lived Experience movement and its workforce, supported by CMOs, have played a significant role in raising understanding of the traumatic and life limiting impacts of involuntary practices (including restrictive practices, and approaches to safety and risk management within mental health policy, legislation, and services). The Lived Experience movement has also been instrumental in raising awareness of the impact of deficit-based language on people's recovery. For these reasons it is essential that the voice and knowledge of the Lived Experience movement and peer workforce is reflected in the new standard's approach to the concept and language of safety.

First Nations guidance concerning the concept and language of safety - The concept and language of safety in the new standard should also be inclusive of Aboriginal and Torres Strait Islander concepts of, and concerns about safety. In addition to the Gayaa Dhuwi (Proud Spirit) Declaration, which is discussed below in section 8, key sources of guidance on safety for First Nations people include:

- National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023
- National Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016-2026
- MHCC 2020, Working Collaboratively with Aboriginal and Torres Strait Islander People: A Guide to culturally safe practice.

The concept and language of clinical governance: a fit for purpose framing

While the concept and language of clinical governance as provided in the National Safety and Quality Health Service, is relevant to some work conducted CMOs (for example those providing clinical programs or operating health facilities), it is not fit for purpose for many CMOs. The concept and language of quality governance used in the Victorian Community Services Quality Governance Framework provides better and a more fit-for-purpose starting point (included in the Appendix). Quality governance is defined as: "*the integrated systems, processes, leadership and culture that are at the core of safe, effective, connected, person-centred community services, underpinned by continuous improvement.*"

The goal of quality of governance is described as: "Delivering safe, effective, connected, person-centred community services is a shared goal of all community service providers.

Safe, effective, connected, person-centred community services are described as:

- Safe: free from preventable harm including neglect or isolation.
- Effective: incorporates contemporary evidence, providing appropriate services in the right way, at the right time, supporting the right outcomes for every person.
- Person centred: people's values, beliefs and situations guide how services are designed and delivered. People are enabled and supported to meaningfully participate in decisions and to form partnerships with their service providers.[2]
- Connected: services work together to achieve shared goals; people experience service and support continuity as they move through the service system.

[2] CMHA notes that the sector advocates for a person's agency and autonomy. Recovery, in the view of the sector, is about people taking charge of their own recovery – not just being a participant. This view is consistent with the WHO Guidance and the CRPD.

The quality governance principles and what they look like in practice are also instructive and assist to flesh out the concept itself. Some examples from the Victorian Framework are:

- Excellence in client experience always - Commitment to a positive experience for clients every time (safe, effective, connected and person-centred)
- Continuous improvement - Rigorous measurement of performance and progress that is benchmarked and used to manage risk and drive improvement in the quality of services and experience
- Partnership with clients and families - Client engagement[3] is actively sought and supported at all levels, from engagement in direct service provision, service design and delivery to governance and oversight
- Clear accountability and ownership - Accountability and ownership for quality and safety is demonstrated by all staff.

The CMO sector has long been concerned that the concept of "Partnering with consumers" or its application may not adequately convey or promote a consumer led, person centred approach in practice. Having said that, a quality governance approach incorporating genuine partnership would sit well with and could be embraced by CMOs.

The overall approach to governance in the Victorian Community Services Quality Governance Framework, would also support the tailoring of the systems, structures and processes to support quality governance to reflect the size of CMOs and the scale and complexity of services delivered. It might also offer the CMO sector the opportunity to learn and grow through quality governance.

The importance of a glossary

The new Standards will need to include a glossary of terms. CMHA notes that MHCC have made some recommendations in their submission to the Commission.

Confirming the language of the standards

CMHA considered with members the questions of: How will relevant and appropriate language be achieved? Who decides and how?

Based on advice received from members, and as discussed earlier, CMHA recommends an expanded set of consultations and discussion in the next phase with a view to confirming the language of the standards with key stakeholders.

[3] CMHA nots that the sector advocates for more than engagement. It advocates for people being supported to express and exert their will and preferences.

Underpinning Philosophy, values and principles

CMHA considered with members the question of: What philosophy, values and principles should the new standards reflect?

Members advised that the philosophy of the new standards should be contemporary, reflecting current aspirations and the shifts that are occurring across the mental health sector (e.g., Vision 2030). The new standard should also reflect the unifying philosophy of the CMO of recovery and inclusion within the community.

Values and principles that are important to the CMO sector include:

- The elevation of the voice and rightful standing of Lived Experience
- Respect for and valuing of First Nations people
- Respect for and valuing of diversity
- Active commitment to the human rights of people using our services
- Recovery oriented and trauma informed, person-centred support and care
- Inclusive of social and emotional wellbeing
- Active commitment to action on the social determinants of health including racism, stigma and discrimination
- Relevant to today while also looking forward to the future

Quality and safety should be measured according to an organisation's outcomes for service users.

CMHA commends the approach to both philosophy and values of SA Health's *A Co-created Philosophy of Care* to the ACSQHC. The philosophy of care for the new urgent mental health service is viewed as the "guiding light" and is intended to *"… underpin every aspect of the Centre and provide staff of the Centre a reference point when making all decisions; keeping them equally accountable and invested."*

Within the Philosophy of Care a value statement is articulated for each component or domain of the Philosophy of care.

- WHO WE ARE, Culture, roles & people – "We Value that people truly feel valued and respected by a team of staff who willingly embrace and comfort people and each other"
- OUR HEART, Lived Experience, "We Value the presence, inspiration, leadership and expertise of lived experience including the people who seek support and the peers who provide it, including carers"
- FEELING SAFE, Safety, not surveillance, "We Value a Centre with a mental health specific focus that promotes safety for all with a commitment to de-escalation and wise decision-making practices (regarding security)"

- WHAT WE SAY, is 'care'full, "We Value language and approaches that are connecting, compassionate and kind"
- OUR VALUES IN ACTION, Values driven practice, "We Value a Centre committed to values driven practice, where all people matter and understanding experience is personal"
- EVERY MOMENT COUNTS, "Leaving is a crucial step, "We Value genuine connection with peers and clinicians and linking people to what they need so they feel stronger and more hopeful."

The new standard should incorporate or reflect the Recovery principles of the National Mental Health Service Standards; principles to which the CMO sector has long been actively committed to living out. The anticipated principles of the Vision 2030 are also instructive:

- Overall - Human rights-based and person-centred (inclusive of families, community and kinship networks)
- Practice Principles - Recognition of Lived Experience knowledge; Partnership and collaboration; balanced community-based approach; flexible solutions; innovation; bet practice care; and a trauma informed recovery-oriented practice approach.

CMHA hopes that like the SA Health Philosophy of Care, the new standards can capture the CMO sector's intent or aspiration i.e., what's in the CMO's heart. For example, the Canadian Quality Mental Health Care Framework, commences with a statement of aspiration to "the potential to spark change and improvement."

Key domains

CMHA invited comment and discussion on the following questions. What domains or clusters of standards (high level) should CMHA suggest? What would a fit for purpose standards framework for the CMO sector comprise? Look like? How would it be different? How applicable are the example standards of 'Governance', 'Partnering with Consumers [CH1]' and 'Model of Care' [CH2] to the quality and safety of community managed mental health services?

Possible domains for a fit for purpose standards framework for the CMO sector

An approach the CMO sector would like to see the Commission explore is basing the safety and quality domains on the outcomes desired by service users i.e., what people want from their engagement with CMOs. An approach of this nature would lead to person-centred safety and quality domains that are based on service outcomes. This approach has been previously adopted, for example by the WA Mental Health Commission through the Quality Management Framework for Community Managed Organisations (CMOs). With the

Framework's guidance, CMOs in WA who are publicly funded, evaluate and monitor their service safety and quality against The Mental Health Outcomes statements which are mapped to the National Standards for Mental Health Services. The mental health outcome statements provide a common understanding of the purpose of mental health services. Importantly, the Outcome Statements describe the main aims people are seeking to achieve in their lives. CMOs in WA are required to demonstrate that their practices are aligned to the Outcome Statement.

- Outcome: Health, Wellbeing and Recovery - People enjoy good physical, social, mental, emotional and spiritual health and wellbeing and are optimistic and hopeful about their recovery.
- Outcome: A home and financial security - People have a safe home and a stable and adequate source of income.
- Outcome: Relationships - People have enriching relationships with others that are important to them such as family, friends and peers.
- Outcome: Recovery, learning and growth - People develop life skills and abilities, and learn ways to recover that builds their confidence, self-esteem and resilience.
- Outcome: [Human] Rights, respect, choice and control - People are treated with dignity and respect across all aspects of their life and their [human] rights and choices are acknowledged and respected. They have control over their lives and direct their services and supports.
- Outcome: Community belonging - People are welcomed and have the opportunity to contribute to community life.

These statements are consistent with the Recovery Principles of the National Mental Health Service Standards, the National Framework for Recovery Oriented Services and with influential recovery models including for example CHIME and its domains of Connectedness; Hope and optimism; Identity; Meaning and purpose; and Empowerment.

CMHA commends the WA's Quality Management Framework's acknowledgement and embrace of the United Nations Human Rights Council's resolution 32/18 on mental health and human rights. Having traditionally seen a significant role for itself in supporting people's realisation of their human rights, the CMO sector welcomes this approach.

The new draft NDIS Outcomes Framework (that has just finished a round of consultation, is also relevant). In the most recent draft, the original 2014 list of 8 domains has been reduced now to 6 outcome domains. See link here: Improving outcomes for people with disability under the National Disability Strategy and the National Disability Insurance Scheme (dss.gov.au)

The domains of the new standard should also be consistent with the anticipated role of the CMO sector in implementing Vision 2030's integrated wellbeing approach and balanced community-based care approach. Like the WA Outcome Statements, Vision 2030 is expected to take a human-rights-based approach and to emphasise the social, emotional,

spiritual and cultural, physical, economic and mental wellbeing of a person and their families and carers. Like the WA approach, it also recognises the impacts of social determinants of health including housing, economic, poverty, employment, environment and social trends on mental health and wellbeing. For example, Vision 2030 is expected to acknowledge the role of mental health sectors with addressing poverty, disadvantage, social exclusion, and marginalisation. Vision 2030 is expected to promote a role for mental health service providers with contributing lasting improvements to a person's quality of life, positive life experiences, protective factors and capacity to self-manage challenges.

A further possible domain, anticipated to arise from Vision 2030, is that of Collaboration and Integration or creating pathways with other service systems e.g., as housing, education, justice, suicide prevention and alcohol and other drugs, family support etc.

Some further considerations, which can possibly be mapped to the above Outcome Statement Domains, and drawn from CMHA's examination of relevant and similar standards (see Appendix 1) and from consultations include:

- Responsive to diversity – See ACTCOSS Good practice standards for community service organisations; See Western Australian Network of Alcohol and other Drug Agencies Alcohol and other Drug and Human Services Standard: Evidence Informed | Culturally Responsive (June 2019) which embeds culturally security practice rather than a stand-alone section
- Community engagement – see Community engagement: improving health and wellbeing (NICE, UK)
- Stigma free and inclusive (Canadian quality mental health care framework) – "*Care addresses drivers of mental health stigma and prevents stigma practices in mental health care. Healthcare providers are comfortable in coming forward with their mental health problems and illnesses at work. Addresses multiple layers of stigma (individual, interpersonal, intersectoral, and structural). A need to better support individuals who have experienced stigma and discrimination. Individuals feel respected and valued.*"
- Staff skills, expertise and morale – Ireland Quality framework for Mental health services, or alternatively, A responsive workforce (Ireland National Standards for Adult Safeguarding)
- Work-Life environment (Canadian quality mental health care framework) – "*A healthy workplace environment supports provider wellness and promotes psychological safety.*"
- Service user co-design and co-production.

Similar to the Irish National Standards for Adult Safeguarding, Leadership, Governance and Management could comprise a separate domain or be included in the standard as actions where relevant for particular domains.

CMHA recommends that the number of domains be few as possible - no more than 5 or 6.

Responses provided to CMHA to the domains in the Consultation Paper

Several responses provided to CMHA focussed on families and carers.

Question: 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?

Standards should be written in a way that is inclusive of families and carers and relevant to organisations that support families and carers and nurture relationships. For example, the safe environment for the Delivery of Care standard only refers to consumers and is not inclusive of carers or families. Carers and family members should be able to expect that service environments are safe for them as well, even when the primary service user is the consumer.

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

The "Partnering with consumers" domain should have three sections: "Partnering with consumers", "Partnering with carers and families" and "Partnering with consumers and carers in co-design and governance". Each of these sections requires a different focus and distinct set of actions from organisations.

Relevance of specific standards of the National Safety & Quality Health Service Standards

As stated earlier, there are a growing number of CMO services that might be classified as clinical in nature. Some CMOs are also providing services classified as health facilities. For these CMOs the following NSQHS Standards are relevant:

- Medication Safety
- Blood management
- Recognising and responding to acute deterioration.

The new standard for CMOs could cross-reference these specific NSQHS standards and CMO's could indicate their relevance or otherwise. Where relevant, a CMO would then demonstrate their meeting of the criteria and implementation of the relevant required actions.

The new world of delivering services during a pandemic like COVId-19, has emphasised the importance of the Standard Preventing and Controlling Healthcare - Associated Infection. Similarly, the CMO standard could cross-reference this standard and CMOs could demonstrate their meeting of the criteria and implementation of the relevant required actions.

Specific actions you would like to see included within the NSQMH Standards for CMOs?

Advice provided by members about actions in the standard include the following.

- The new standard should comprise as few as possible actions for each domain (an online Delphi process with a cross section of stakeholders might be used to rate actions according to importance, relevance, and clarity).
- Actions should be focused on the impact and outcomes for people using the service.
- Actions should be wholistic and reflect the link between mental health and wellbeing (emotional, relational, social and physical).
- There should be a clear line of sight between the domains, actions and service outcomes – readily understood by stakeholders.
- The relationship between actions, evidence and service outcomes should be clear (e.g., this is to avoid the situation where a service might demonstrate compliance with an action but have poor outcomes for service users).
- The Commission could avoid reinventing the wheel and starting from scratch with identifying actions by adopting or adapting from existing standards including the National Mental Health Service Standards and other standards highlighted and discussed in this document (See Appendix).
- The new standard should contain specific actions for First Nations, people from immigrant, refugee, and asylum-seeking backgrounds and for diversity more generally rather than added on guidance or guidelines.

Examples of specific action areas for inclusion include the following.

Actions for providing culturally safety for Aboriginal and Torres Strait Islander people – for example recognising the importance of Aboriginal and Torres Strait Islander leadership and implementing the Gayaa Dhuwi (Proud Spirit) Declaration and reflecting its intent in practice.

Organisational and workplace actions to support the development of the Lived Experience (Peer) Workforce - The soon to be released guidelines will provide formalised guidance concerning the support structures and organisational culture, processes and

practice required to sustain and grow the workforce and to ensure the safety and nurturing of Lived Experience Workers. It is important that key actions contained in the new guidelines are included in the new standards including for example actions to prevent Lived Experience (Peer) Workers being adversely impacted by stigmatising and limiting workplace beliefs and attitudes about their roles, skills and competencies.

Actions on the social determinants of mental health and wellbeing – The Commission could draw on indicators in the WA's Quality Framework's Quality Management Framework for Community Managed Organisations including for example, the indicators for the Outcome Statements of:

- A home and financial security, and
- Community belonging.

Actions for Human Rights, respect, choice and control – Again, actions could be drawn from the WA quality framework e.g., addressing stigma within service delivery and in the workplace.

Safety and dignity of risk – Actions required to demonstrate a trauma-informed and dignity of risk-based approach to safety could be drawn from the following sources:

- The MHCC's Trauma-informed Care and Practice Organisational Toolkit (TICPOT)
- Rainbow Health Victoria's Rainbow Tick Standards
- The actions for supporting consumers to take risk to enable them to live a life of their choosing in Standard 1 Consumer dignity and choice of the Aged Care Quality
- Standard 2 Safety of the National Mental Health Service Standards

Actions for Diversity and cultural responsiveness and safety – Actions required to demonstrate a responsiveness to diversity including gender and for cultural safety could be drawn and/or adapted from the following sources:

- Recommendations for a culturally responsive mental health system (ECCV and VTMH, 2020)
- Standard 4 Diversity Responsiveness of the National Mental Health Service Standards
- The actions for delivering culturally safe care and support in Standard 1 Consumer dignity and choice of the Aged Care Quality Standard.

Actions for partnering with families and carers - CMHA was advised by members that actions for "partnering with carers and families could be developed with reference to the "Practical guide for working with carers of people with a mental illness". This guide was developed by Mind Australia based on evidence of best practice and on consultations with carers and organisations that support carers. The guide has been endorsed by Helping Minds, Mind Australia, Mental Health Australia, Mental Health Carers Australia and the Private Mental Health Consumer and Carer Network. The guide presents a detailed set of

standards that all mental health organisations should implement to appropriately engage families and mental health carers in their services. It also includes information for specific services including community managed organisations. There is currently work in Victoria to develop an updated standards for carer engagement for mental health services.

Other actions for inclusion suggested by members included risk management; Incident management and reporting; and quality improvement.

Specific 'actions' where you would suggest services must demonstrate particular 'evidence of compliance'?

CMHA advises that use of the term "compliance" is problematic, given the envisaged, current voluntary nature of the new standards.

CMHA recommends to the Commission the approach to evidence of the WA Quality Framework Quality Management Framework for Community Managed Organisations. The examples of evidence provided for domain indicators have been grouped into three perspectives:

1. The potential feedback from individuals and/or their families and carers about the quality of their services – what Individuals, families and carers can confirm or provide feedback about
2. Support worker and management knowledge, practices and understanding of how to support individuals and their families/carers to meet individual needs (Outcomes) – what staff can demonstrate their commitment, knowledge and understanding and active implementation of; and
3. The organisation's approach to person-centred, outcomes-focused services supporting recovery – what a CMO, its Management and Board can demonstrate.

Other standards applying to CMOs

The response of members and other stakeholders to the question of what other standards they are required to be accredited against, was a swift, "*numerous other standards.*" Quite a lengthy list emerged. Examples provided include those now discussed.

The Victorian Human Services Standards. This standard applies to providers funded by the Department of Health and Human Service (DHHS). The HSS Policy describes the scope and rules, along with some of the audit approaches. Generally, HSS certification is a precondition of registration to deliver some service types, e.g., child safety. This standard is a bit different to other standards in that organisations have to 'bolt on' an additional management system standard e.g. AS/NZS ISO 9001:2006 or **QIC standards** to cover the governance and management requirements of the standard. Having said that, some

members consider the standard to be well designed – it has a strong emphasis on choice and control, safety and person-centred approaches. It also emphasises the need to respond to First Nations people, cultural and gender diversity.

The **Queensland Human Services Quality Framework (HSQF)**. Here is the link to the standards and their scope. This standard is owned by the Queensland Department of Seniors, Disability Services and Aboriginal and Torres Strait Islanders. As is the case in Victoria, certification to this standard is often a precondition of registration or licencing to provide state funded services. The HSQF has a logical structure which focuses on an outcome and supporting criteria. The HSQF standard is also supported by several helpful resources and tools. It is regulated by the **Human Services Scheme, which is approved by JAS-ANZ.**

Australian Community Industry Standard (ACIS 2018). This standard is JAS-ANZ registered and is owned by the Australian Community Industry Alliance (ACIA). Certification to this standard is usually a precondition for registration to provide attendant care services to people with disability through funding provided by no fault insurance schemes such as WorkCover, iCare, TAC, MAIB or the NIISQ etc. Members advise that this standard is logical and is largely the same since the first version in 2008.

The NDIS Standards. These standards were modelled on the ACIS standard as well as the National Standards for Disability Services.) The structure of both ACIS and the NDIS standards follow an outcome and criteria approach. Both also have a strong emphasis on governance and management systems. However, members advise they are not readily adaptable to most CMOs.

Other standards currently applying to a range of organisations throughout the CMO sector include:

- The National Mental Health Service Standards
- NSW Disability Service Standards
- Victorian Standards for psychiatric disability rehabilitation and support services
- South Australian Psychosocial Rehabilitation Support Services Standards
- Victorian Aged Care Standards
- National Aged Care Quality Standard
- Evaluation and Quality Improvement Program (EQuIP)
- Australian Council on Healthcare Standards (ACHS)
- Quality Innovation Performance (QIP)
- Australian Service Excellence Standards
- Australian Clinical Care Standards (relevant to a small number of CMOs)
- Queensland Child Safety Standards
- ISO 9001 Quality Management
- Australian Early Psychosis model, an 80-item Early Psychosis Prevention and Intervention Centre Model Integrity Tool

The six Mental Health Outcome (MHO) Statements provide non-government/community managed mental health services in WA with significant quality guidance. Although

accreditation against the MHO Statements is no longer required, they are a part of an organisation's Service Agreement with the WA Mental Health Commission.

CMHA notes that this is not an exhaustive list of standards applying across the CMO sector. In summary, a CMO might currently have to be accredited against international, national and/or state or territory-based standards and might need to demonstrate consistency with program specific guidelines or outcomes. Some CMOs are also voluntarily undertaking accreditation against population or issue specific standards/guidelines including for example the Rainbow Tick and TIC-POT (both discussed above).

Standards applying in the mental health sector with which the new Standard should have a consistent approach

CMHA invited discussion of the question: 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?

A key priority for the CMO sector is that there is not conflict between any sets of standards (e.g., requiring conflicting actions). While CMHA is not suggesting there is any existing set of standards that could be identified as the "master set" with which the new standard should conform to in terms of language, concepts or structure, CMHA does provide suggestions in the text below and in the table in the Appendix.

The CMO sector is possibly most comfortable with the language, concepts and structure of the National Mental Health Services Standard. Some CMOs are of the opinion that this standard should be updated rather than a new quality and safety standard being created. If maintained, Standard 10 is thought to be overly large and in need of condensing.

While the language of the NDIS Practice Standards is largely acceptable to the sector, it is not sufficiently accessible to NDIS participants. The Standards themselves are overly complicated and contain an onerous and possibly excessive and unnecessary number of questions. Many of the questions are related to services, systems and processes rather than to outcomes and improvement quality of life for participants.

The structure of several international standards is worth considering including the following (see details in Appendix).

- Canadian Quality and Patient Safety Framework for Health and Social Services – structured around 5 goals for which there are objectives, indicators and outcomes
- Quality Framework for Mental Health Services in Ireland – structured around 8 themes, relevant standards for each theme against which performance is measured, and criteria which are measurable elements of service provision.

- NICE UK Community engagement: improving health and wellbeing – has a simple structure comprising 4 Quality Statements with a rationale and a set of quality measures for each.

Interoperability and mutual recognition

How should a mutual recognition framework work for the NSQMH Standards for CMOs in relation to other standards?

CMHA considers this a difficult question to answer without further information. CMHA recommends to better answer this question, that the Commission consider doing three things:

1. Conduct an inventory/survey to determine what are indeed the most common and widely used sets of standards that CMOs must comply with
2. Based on the findings of the inventory, conduct a mapping exercise to extract what might be the shared set of Actions across those most common sets of standards
3. Initiate the necessary discussions to attempt to align the accreditation processes and requirements for these common/shared actions (i.e., thereby creating a kind of modularity and inter-operability of accredited actions).

Having said that, CMHA provisionally suggests that mutual recognition is required with at least:

- The NDIS Practice Standards
- The National Mental Health Service Standards
- The NSQ Digital Mental Health Standards

Additionally, the CMO sector would be assisted if mutual recognition could be negotiated with QIC Health and Community Services Standards (QIC Standards) and ISO 9001 Quality Management.

Accreditation scheme and processes

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

While CMHA notes the Commission is not able to mandate the standards, the points made above in Sections 12 and 13 are relevant. The standards, actions and evidence of this new standard need to be mapped to other standards and where possible, the accreditation scheme achieve mutual recognition with the schemes of other standards.

The accreditation scheme needs to be made as simple and streamlined as possible. It is important that the Commission understands and recognises the resource intensive nature of accreditation processes for CMOs both financially and human resource wise. CMOs are rarely funded for accreditation purposes and the funds must be sourced internally. While larger CMOs have "bitten the bullet" and employed designated quality managers, smaller

CMOS are unable to do this and must take key staff offline. For some CMOs the cost of accreditation is at the point of being prohibitive and unaffordable.

The accreditation scheme should be structured so that service users and families and carers are invited and able to talk about what they want from the organisation, services and staff compared to what they are receiving.

The CMO invites the Commission to consider ways in which the scheme could offer processes that are scaled or proportionate to the size of CMOs and to the range and complexity of the services they provide. One approach is to offer the option of accreditation via a participatory observation, whereby an auditor spends time in the service observing, having conversations with service users and families and carers, staff, volunteers, managers and Board members. A participatory observation approach may be of assistance to suit smaller and less well-resourced organisations.

CMHA invited CMOs to provide their wish or dream list for an accreditation scheme suited to their needs and situations. The wish listed included the following:

- A sample-based approach to accreditation whereby not all organisations need to be accredited at one time but are accredited within a 3-4 year cycle.
- A staggered approach whereby some standards required demonstration of being achieved more regular than others or a process whereby the achievement of all standards can be demonstrated in an iterative or progressive fashion over a set time frame.
- Explore opportunities for lining up timelines for the accreditation schemes of key sets of standards.
- Integrate sources of evidence the sector already has e.g., YES and CES surveys, Outcome Star, Recovery Assessment Scales.
- Mutual recognition of fidelity or model of care reports i.e., so that this only needs to be done once.
- Structure the accreditation reporting process so that it is a collaborative process and a learning opportunity for the organisation and its board, management and staff.
- Make sure service users and family and care involvement in the auditing process is genuine, meaningful and participatory (e.g., a small list of meaningful questions rather than a long list of repetitive questions where the answer is yes/no).

Some comments received include the following.

“Organisations with current accreditation against other Standards should be able to wait until they are due for renewal before being required to be accredited with the new Standards.”

“The first audit against these new Standards should be approached as a learning experience rather than a punitive experience. “Rather than you’ve failed, it’s “these are the areas where you need to improve” and we’ll come back and review that in 6 months” so

that CMOs that may not have gone under these Standards previously have time to do that." CMOs can then reflect on whether they want, and can manage, to get accredited against the Standards. This approach would encourage more organisations to work in alliance with the Standards and get accredited, "rather than a pass or fail and you've set out all this money and time and effort. It's more a learning experience and a positive experience to be accredited. Actually supporting organisations to be accredited."

"Please avoid an overkill of actions and mind-boggling repetitive questions as is the case with the NDIS Practice Standards."

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

Suggested resources

- A living online accreditation portal that enables organisation to update or upload information throughout an accreditation cycle (just not during the accreditation process).
- The portal should be self-contained with all necessary information, guidance, tools and resources required for the accreditation process including help or Zendesk widgets; enabling organisations to readily access and go back and forth between standards, actions, indicators and sources of evidence.
- Easy English definitions
- A set of explanatory and training videos with a certificate of completion
- Practical and action oriented (tools, checklists)
- Similar to the Canadian Quality an Patient Safety Framework provide easy to read and use online resources for key stakeholder groups including service users, families and carers, teams, management, Boards and policy makers
- Australian Charities and Not-for-profits Commission providing funding to an independent and suitably experienced or purposed organisation to provide CMOs with accreditation support e.g., like Probono Australia.
- A self-assessment tools and supports
- Safety and Incident Management Toolkit including ideas and resources for exploring the key aspects, tasks ad competencies of quality improvement and risk management

Guidance

- Guidance about what is meant by governance of support and care – what a governance framework looks like for CMOs

- Guidance providing necessary guidelines and tools for a participatory observation approach
- Checklists
- Information for consumers and families and carers about the accreditation process and what the organisation is accountable for, what they should expect from the service and, if they get less than what they should expect, where to go.
- 'What to expect' guides and videos for different stakeholders
- Resources to support an internal audit process, including a self-assessment tool. "We could use it quarterly to ensure we're on top of everything because we are very time poor."
- A "suggested document list" of suitable types of evidence for particular Standards.
- When it is a requirement for funding to be accredited against Standards, funding should be provided to cover the costs.

Next steps and implementation

What next steps should CMHA recommend to ensure the resulting standards and implementation process are fit for purpose?

- Confirm language with Lived Experience movement
- Consider a Delphi process to finalise Domains
- Progress exploration of interoperability and mutual recognition through the steps recommended above in Section 12
- Pilot – test of validity and fidelity of Domains, actions, and evidence
- Co-design the scheme with CMHA and relevant stakeholder peaks and/or networks or alliances
- Ensure flexibility in how implemented proportionate to size, location etc.
- Phased and staged approach to implementation which is co-designed with the sector e.g., baseline, intermediate and advanced.

Appendix Examples of safety and quality standards, service standards or guidance

Below are examples of various safety and quality standards, service standards and guidance of a more general nature. Most of which have been discussed above.

Standard	Source	Domains	Principles	Features of interest
WA Mental Health Commission a Quality Management Framework for Community Managed Organisations (CMOs	WA Mental Health Commission	Safety and quality are assessed against the following person-centred outcome statements that are mapped to the National Mental Health Service Standards. 1. Health, wellbeing, and recovery 2. A home and financial security 3. Relationships 4. Recovery, learning and growth 5. Rights, respect, choice and control 6. Community belonging Indicators and examples of evidence are grouped into three perspectives: 1. The potential feedback from individuals and/or their families and carers about the quality of their services; 2. Support worker and management knowledge, practices and understanding of how to support individuals and their families/carers to meet individual needs (Outcomes); and 3. The organisation's approach to person-centred, outcomes-focused services supporting recovery.		The person-centred outcome based approach It is recognised that some Outcome areas may be difficult for organisations to support directly. Organisations are encouraged to form partnership arrangements with other community organisations, mental health services and any other key stakeholders to be developed and formalised (where possible) to support a holistic approach to meeting individual needs.
SA Health A co-created	The Office of the Chief Psychiatrist	The intention was to discuss and design what a *Philosophy of Care* needed to say in order to inspire the experience we want people to have	A Philosophy of Care is a theory or attitude that acts as guiding principles for values and behaviour.	Co-designed Language is accessible and reflects language

Standard	Source	Domains	Principles	Features of interest
Philosophy of Care	(OCP) invited the SA Lived Experience Leadership and Advocacy Network (LELAN) and the Australian Centre for Social Innovation (TACSI) 2020	when they come to the Urgent Mental Health Care Centre, 'the Centre'. The hope was that the creation of a *Philosophy of Care* would guide every element of the centre's design and existence moving forward. It can also serve to underpin many of the other lived experience related service design components in the SA Mental Health Services Plan 2020-2025. Key components of the philosophy of care: **Who we are** – culture, roles and people – "We Value that people truly feel valued and respected by a team of staff who willingly embrace and comfort people and each other" **Our heart** – Lived experience – "We Value the presence, inspiration, leadership and expertise of lived experience including the people who seek support and the peers who provide it, including carers" **Feeling safe** – safety not surveillance – "We Value a Centre with a mental health specific focus that promotes safety for all with a commitment to de-escalation and wise decision-making practices (regarding security) **What we say is 'care' full** – "We Value language and approaches that are connecting, compassionate and kind" **Our values in action** – values driven practice – "We Value a Centre committed to values driven practice, where all people matter and understanding experience is personal" **Every moment counts** – leaving is critical (connection?) "We Value genuine connection with peers and clinicians and linking people to		used in the CMO sector – some of the language and concepts could be incorporated into the new standards Each component or domain is illustrated with a direct quote of a person with lived experience Makes sense - Clear line of sight between what is valued: • Why it's important • What the centre will do/offer/operate • What people can expect to experience The key components might be worked up into a set of domains/family/cluster of standards – possibly

Standard	Source	Domains	Principles	Features of interest
		what they need so they feel stronger and more hopeful"		
Development of quality mental health care framework See also: HSO/CPSI Canadian Quality and Patient Safety Framework for Health and Social Services	**Canada**	A thorough review of the selected frameworks that address quality health care, interviews with health experts, and insights from People With Lived Experience led to a definition and identification of critical dimensions that encompass quality mental health care, emphasising both patient and provider perspectives. Quality mental health care is: Accessible, appropriate, promotes continuous learning and improvement, integrated, people-centred, recovery-oriented, safe, stigma-free and inclusive, trauma-informed, and ensures that health care providers have a safe and comfortable workplace environment. "Solutions must address comprehensive mental health care for patients while also considering the mental health care needs of the providers. Ultimately, what quality mental health care means is "the right care, at the right time, by the right team, in the right place." There are five customized guides, one for each key stakeholder group: • The public. • Health teams, which include patients and families. • Health leaders. • Board members. • Policy makers.	A stated aspiration of the framework is "the potential to spark change and improvement" Though referring to patient in the title, usually refers to 'people'	Quality mental health care domains is presented in a neat and clear graphic. The work underway is contemporary and is off the back of developing quality statements for mental health in workplaces – i.e., coming from a community lens The existing Patient Safety Framework for Health and Social services is fresh and accessible – the 5 domains or goals, outcomes and actions aren't overly complex; has an emphasis of "being in it together" Includes statement of what people can do and expect under each goal e.g. "As a member of the public, you can: • Request access to your personal health information; • Advocate for political support of IT solutions that make it easy and unfettered for

Standard	Source	Domains	Principles	Features of interest
				patients to access their electronic health records."
Quality Management Framework for Community Managed Organisations National Standards for Adult Safeguarding (See poster)	**Ireland**	**Quality framework themes:** 1. Provision of a holistic seamless service and the full continuum of care provided by a multidisciplinary team 2. Respectful, empathetic relationships are required between people using the mental health service and those providing them 3. An empowering approach to service delivery is beneficial to both people using the service and those providing it 4. A quality physical environment that promotes good health and upholds the security and safety of service users 5. Access to services 6. Family/chosen advocate involvement and support 7. Staff skills, expertise and morale are key influencers in the delivery of a quality mental health service 8. Systematic evaluation and review of mental health services underpinned by best practice, will enable providers to deliver quality services **Standards for Safeguarding themes:** 1. Person-centred care and support (includes rights) 2. Effective care and support 3. Safe care and support 4. Health, wellbeing and development 5. Leadership, governance and management		For each Quality themes there are a set of standards (or criteria) Reasonable emphasis on rights Language is contemporary despite its focus on clinical services Contains graphic presentation of themes and standards There was implementation plan for the Quality Framework – it was led by the Mental Health Commission and was staged and progressive; an audit toolkit was provided for services

Standard	Source	Domains	Principles	Features of interest
		6. Responsive workforce 7. Use of resources 8. Use of information		
Service user experience in adult mental health services: Quality statement (QS14)	NICE UK	Comprises 8 Largely inpatient based quality statements. Relevant statements: Statement 1 People using mental health services are treated with empathy, dignity and respect. [2011, updated 2019]; Statement 2 People using mental health services are supported in shared decision making. [2011, updated 2019]; Statement 3 People using mental health services are asked about their experiences and their feedback is used to improve services. [2011]		Services have a duty to take reasonable action to avoid unlawful discrimination and promote equality of opportunities. There is a Pilot Guidance And Quality Standard Equality Impact Assessment Form. The purpose of this form is to document that equalities issues have been considered in the recommendations of guidance and quality standard.
Community engagement: improving health and wellbeing (QS148)	NICE UK	Statement 1 Members of the local community are involved in setting priorities for health and wellbeing initiatives. Statement 2 Members of the local community are involved in monitoring and evaluating health and wellbeing initiatives as soon as the priorities are agreed. Statement 3 Members of the local community are involved in identifying the skills, knowledge, networks, relationships and facilities available to health and wellbeing initiatives.		This quality standard covers community engagement approaches to improve health and wellbeing and reduce health inequalities, and initiatives to change behaviours that harm people's health. This includes building on the strengths and capabilities of communities, helping them to identify their needs and working with them to design and

Standard	Source	Domains	Principles	Features of interest
		Statement 4 Members of the local community are actively recruited to take on peer and lay roles for health and wellbeing initiatives.		deliver initiatives and improve equity. Has equality and diversity statement as well as discusses what the standards mean for different audiences. The structure is simple and has a small number of well-chosen quality measures for each statement.
National Mental Health Commission, Vision 2030	Aus	Two key approaches: integrated wellbeing; and a balanced community-based care approach Overarching principles: • Partnership • Human rights • Collaboration • Recovery oriented approach • Intersectionality informed • Best practice evidence • Flexible solutions • Innovation	Practice principles: Recognition that recovery and healing is inclusive of a person's relationships and communities. Incorporation of lived experience and carer participation at all levels of policy and service development and delivery. Taking a human rights-based approach and acknowledging each person's autonomy in determining their strengths and goals and in choosing, planning and controlling their own care. Taking a recovery-oriented and trauma-informed approach. Including parents, families, carers and connected kin in care planning and delivery as equal and important team members as appropriate.	The multi-layered and multi-phased phased design process

Standard	Source	Domains	Principles	Features of interest
			Enhancing a person's connection to their family, kin, social and community networks. Ensuring continuity of care within a person's community. Providing culturally appropriate care. Individualised care planned and delivered through community-based services across the spectrum. Autonomy; family and carers; connection; continuity; strengths and goals; recovery; culturally appropriate; person-centred	
SA Psychosocial Rehabilitation Support Services Standards (2008)	SA	Standard 1 – Delivery of Services Standard 2 – Rights & Responsibilities Standard 3 – Safety Standard 4 – Consumer, Carer and Community Participation Standard 5 – Promotion of Positive Mental Health, Early Intervention, Prevention and Community Acceptance Standard 6 – Acceptance of Diversity Standard 7 – Working Together Standard 8 – Organisational Governance and Management	Equitable access; Strengths-based; Recognising the unique physical, emotional, social, cultural and spiritual dimensions of each consumer and their carer; Promoting personal responsibilities and valued roles for consumers in their families and communities; least restrictive; empowering consumers; Supporting consumer and community participation in mental health service development; partnerships enabling continuity of care etc	Strong diversity provisions Approach to the question of governance- "*The psychosocial rehabilitation support service has governance, management and human resource development practices that maximise organisational efficiency, transparency and effectiveness in order to ensure accountability and sustainability*."
Health and Disability Core standards	NZ	Consumer rights Organisational management – the quality and safety component Continuum of service delivery	Recovery principles are matched to values of: person orientation; person involvement; self-determination and choice; and growth potential.	Criteria from the NZ National mental health sector standard were incorporated into this standard in 2007;

Standard	Source	Domains	Principles	Features of interest
		Safe and appropriate environment		recovery principles incorporated at that point. Currently being reviewed as a partnership project between Standards New Zealand and the Ministry of Health (MOH). For more information. Language is possibly dated but there being only four domains is a positive.
Community services quality governance framework: Safe, effective, connected and person-centred community services for everybody, every time	Victoria, Aus	The systems are organised into five domains of quality governance that are underpinned by continuous monitoring, evaluation and improvement: • leadership and culture • client and family partnerships • workforce • best practice • risk management.	Excellence in client experience always Continuous improvement Partnership with clients and families Clear accountability and ownership Effective planning and resource allocation Proactive collection and sharing of information Openness and transparency Empowered staff and clients Workforce leadership and engagement	Sets out Quality governance roles and responsibilities for: clients and families; • the department; • Boards and Directors; • Executive; • Operational managers and team leaders; • frontline staff and volunteers.
Article: Recovery for all in the community; position paper on principles and key	In 2016, representatives of mental health care service providers, networks, umbrella		The position paper describes what high quality community mental health care looks based on six principles Human rights Public health actions to achieve equity	Includes human rights and peer expertise

Standard	Source	Domains	Principles	Features of interest
elements of community-based mental health care	organizations and knowledge institutes in Europe came together to establish the European Community Mental Health Services Provider (EUCOMS) Network. This network developed a shared vision on the principles and key elements of community mental health care in different contexts.		Recovery Effectiveness of interventions Community network of care Peer expertise	
NDIS Practice Standards		The core module covers: • rights of participants and responsibilities of providers • governance and operational management • the delivery of supports, and • the environment in which supports are delivered. The supplementary modules cover: • High intensity daily personal activities • Specialist behaviour support, including implementing behaviour support plans • Early childhood supports		Division of core and supplementary. Very complex – the Core Module has 26 questions and over 100 indicators

Standard	Source	Domains	Principles	Features of interest
		• Specialised support co-ordination, and • Specialist disability accommodation.		
Good practice standards for community service organisations, 2002	ACTCOSS	Two sets of broad standard clusters: governance and management; and working with clients and communities	Principles that underpin good practice in community service organisations: • Respect for individuals • Equity in access • Participation • Empowerment • Fairness and social responsibility • Recognising cultural diversity • Respect for Indigenous culture and heritage • Privacy and confidentiality– • Quality of work environment • Partnerships and. • Quality and integrity of outcomes	Each standard has an explanation of features of good practice
Alcohol and other Drug and Human Services Standard Evidence Informed | Culturally Responsive June 2019	Western Australian Network of Alcohol and other Drug Agencies	Understanding and responding to Community Needs and Expectations Rights and Responsibilities and Inclusive Practice Evidence Informed Practice Human resource management Service management Organisational governance	Based on the principle that every member of the community has the right to access safe, quality, evidence informed, and culturally responsive services, the intent of the Standard is to: • support continuous quality improvement at an organisational and sector level; • be flexible to meet the needs of a diversity of service types; • enhance responsiveness to high risk individuals and population groups; • provide a comprehensive structure that guides and supports sound clinical/practice governance; • support	The Standard is supported by a separate Interpretive Guide and Self-Assessment Tool that provides examples of the way in which each criterion may be applied in practice and guides the self-assessment process. Mutual recognition and interoperability - The Scheme provides direction for accredited certification bodies in their approach to certification against the WANADA Alcohol and other Drug and Human Services

Standard	Source	Domains	Principles	Features of interest
			research translation into practice and development of practice evidence; • enhance viability and sustainability through recognition of service quality and increased community confidence; and • improve outcomes for the consumer and the broader community.	Standard and the ATCA Standard for Therapeutic Communities and Residential Rehabilitation Services.
European Framework for Action on Mental Health and Wellbeing	Europe EU Joint Action On Mental Health And Wellbeing Final Conference - Brussels, 21 - 22 January 2016		The principles to be applied in action are: 1. Adoption of a public mental health approach, addressing promotion, prevention and treatment in all stages of life (with a particular emphasis before adulthood given majority of lifetime mental disorder arises in early age) and emphasising early interventions; 2. Incorporation of a whole of government, multisectoral approach; 3. Promotion of a human rights-based approach, preventing stigmatisation, discrimination and social exclusion; 4. Develop quality-based, recovery-oriented, socially inclusive and community-based approaches; 5. Empowerment and involvement of patients, families and their organizations; 6. Ensuring that policy and actions are supported by robust research evidence and knowledge of good practices.	