

CoMHWA



Consumers of Mental Health WA (Inc)

Feedback on the

*National Safety and Quality Mental Health Standards for Community Managed Organisations:
Guide for Service Providers Draft Consultation*

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Consumers of Mental Health WA

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1. Preliminaries

About the Respondents

Consumers of Mental Health WA (CoMHWA) is Western Australia's peak body for and by mental health consumers (people with a past or present lived experience of mental health issues, psychological or emotional distress). We are a not-for-profit, systemic advocacy group independent from mental health services that exists to listen to, understand and act upon the voices of consumers. We work collaboratively with other user-led organisations and a diversity of stakeholders to advance our rights, equality, recovery and wellbeing.

Request for Feedback

CoMHWA works to uphold the dignity and human rights of consumers, through providing advocacy in leading change with and for consumers. We appreciate notification of the outcomes of our submission to this consultation in order to understand and communicate the difference made through our work.

Please provide feedback via the contact details on this submission's cover page.

Language

CoMHWA uses the term mental health consumer throughout this submission. Mental health consumers to refer to people who identify as having a past or present lived experience of psychological or emotional distress, irrespective of whether they have received a diagnosis of mental illness or accessed services. Other ways people may choose to describe themselves include "peer", "survivor", "person with a lived experience" and "expert by experience".

This definition is based on consumers' call for respect, dignity and choice in how we choose to individually identify. As individuals we choose different ways to name and describe our experiences that may confirm or trouble ideas about 'mental illness'.

2. Introduction

CoMHWA is excited to have the opportunity to offer feedback on the 'National Safety and Quality Mental Health Standards for Community Managed Organisations: Guide for Service Providers' (Hereafter referred to as the 'Guide') consultation. Our members and consumers more broadly frequently make use of the support services provided by Community Managed Organisations (Hereafter abbreviated as CMO's), and we accordingly are pleased to offer our feedback on the standards proposed in this Guide. A well designed and managed CMO can make a profound difference to the recovery journey of consumers, and we hope our feedback can contribute to strengthening the quality of CMO services offered to consumers throughout Australia.

3. Discussion and Recommendations

The following feedback has been broken up into three sections, following the structure of the Guide. We have included each Action that we have feedback for in full, and underneath have included our feedback about these Actions as well as their associated Key Tasks and Examples of Evidence. Not every Action has been addressed, as CoMHWA's feedback is focused upon Actions that will primarily affect consumers and peer workers.

Section One: 'Practice Governance Standard' (Page 9-49)

This section of the Guide standards outlines the intention of the standards; their criteria; practice governance, leadership and culture; workforce qualifications and skills; and safe environment for the delivery of care.

We note that the principles listed that should drive the safety and quality of services are ones that we agree with – person-centred; recovery-oriented; culturally competent and secure; and safe and effective.

- **Action 1.01 (Page 10)**

The governing body:

a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture continues to exist within the organisation

b. Provides leadership to ensure partnering with consumers, their families and carers

c. Endorses priorities and strategic directions:

- i. For ethical, safe, high-quality, recovery-oriented care, and ensures these are communicated effectively to the workforce, consumers, their families and carers*
- ii. That recognise, respect, and nurture the unique cultural identities of Aboriginal and Torres Strait Islander people, and provides for the delivery of services that are culturally safe*
- d. Endorses the organisation's practice governance frameworks*
- e. Ensures that roles and responsibilities are clearly defined for the governing body, management and members of the workforce and they are orientated into the organisation*
- f. Fosters a positive culture of reporting adverse incidents and monitors the action taken as a result of analyses of adverse incidents and trends*
- g. Reviews reports and monitors the organisation's progress on safety, quality, performance and effectiveness*
- h. Endorses principles and practices within governance frameworks that support the organisation's ability to adapt to technology as it changes*
- i. Ensures conflicts of interest are proactively managed, and perceived and actual conflicts of interest are documented*
- j. Endorses systems for integrating care with other service providers involved in a consumer's care and monitors the effectiveness of these systems*

Action 1.01 states that the governing body should provide leadership to ensure partnering with consumers, their families and carers. We agree with this and recommend that it goes a step further by naming true co-design processes to be implemented with those groups named.

Action 1.01 neglects to specify the needs of culturally and linguistically diverse groups and LGBTQIA+ groups and we recommend these groups are named moving forward. We note that these groups are specified in Action 1.02 but recommend they are also listed in Action 1.01.

We are encouraged by the inclusion of consumer perspectives and the establishment of Consumer Advisory Groups in the Key Tasks listed on page 11.

- **Action 1.02 (Page 12)**

The service provider implements and monitors strategies that:

- a. Meet its safety and quality priorities for diverse population groups, including Aboriginal and Torres Strait Islander people, people with physical and intellectual disabilities, people from culturally and linguistically diverse (CALD) backgrounds, individuals who identify as lesbian, gay, bisexual, transgender, intersex, queer and questioning (LGBTIQ+) people at risk of homelessness and other diverse population groups*
- b. Provide culturally safe and inclusive services in the planning and delivery of health care by identifying and addressing the specific needs of these diverse population groups and their families and carers*
- c. Identify groups of people who experience mental ill health who may be at risk of harm*
- d. Incorporate information on the diverse and higher-risk groups into the planning and delivery of the service*

e. Demonstrate knowledge of, and engagement with, other service providers or organisations with diversity expertise and or programs relevant to the unique needs of its community

Action 1.02 sets out a comprehensive outline on the importance of how to safely work with diverse cultural and disadvantaged groups. However, it would be beneficial for the section to articulate the need for mandatory cultural training and other training to ensure staff have the knowledge to work with diverse groups. The establishment of a Reconciliation Action Plan is also another way for CMO's to have active buy-in from the Executive level all the way down to the grassroots workforce.

- **Action 1.05 (Page 17)**

The service provider:

a. Has processes to support the workforce to understand and perform their delegated safety and quality roles and responsibilities

b. Engages the workforce in the practice governance of the service

c. Monitors and responds to the needs of the workforce to ensure a mentally healthy workplace

d. Supports the workforce to undertake reflective practice supervision

We note the inclusion of the importance of maintaining mentally health workplaces and the need for practice supervision in Action 1.05. We encourage you to go a step further and look at the role of peer supervision and how this can also assist those working in mental health.

- **Action 1.10 (Page 25)**

The service provider has incident management and investigation systems and:

a. Assists the workforce to recognise and report incidents and comply with the required incident management procedures and mandatory reporting

b. Assists consumers, their families and carers to communicate concerns or incidents

c. Involves the workforce, consumers, their families and carers in the review of incidents

d. Provides timely feedback on the analysis of incidents to the governing body, the workforce, and consumers, their families and carers

e. Uses incident analysis information to improve safety and quality

f. Incorporates risks identified through incident analysis into the risk management system

g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems

h. Has a policy and process to support workers during and after critical incidents

In relation to Action 1.10, we note that incident systems should be trauma-informed and mindful of the wellbeing of consumers, and we thus encourage consumers or consumer advisory groups to participate in the design of these systems.

- **Action 1.12 (Page 28)**

The service provider:

- a. Has processes to seek regular feedback from consumers and their families and carers about their experiences of the service and outcomes of care, and these processes have the capacity to gather feedback from consumers who have left the service*
- b. Uses this information to improve safety, quality, performance and effectiveness*
- c. Provides timely information to stakeholders about feedback received, including service successes*

We support the inclusion of Action 1.12 'Feedback and Complaints Management and Resolution' which states that '*regular collection of consumer feedback is an important element of service quality.*' CoMHWA believes that any feedback received from consumers is comprehensively communicated to the Board, ensuring that feedback and complaints are taken seriously.

- **Action 1.19 (Page 39)**

The service provider maximises the safety and quality of care:

- a. Through the design of the environment*
- b. By maintaining buildings, plant equipment, utilities, devices and other infrastructure that are fit-for-purpose*
- c. Through the design of services, arrangements for use of information technology systems and internal access controls*

We support the inclusion of Action 1.19 'Safe Environment for the Delivery of Care' which rightly states that '*an organisation's service delivery environment needs to be sufficiently flexible to ensure that the supports provided are safe from the perspective of the consumer, and best suited to their individual requirements. When working with consumers, ensuring a trauma-informed approach to flexibility of service delivery is imperative.*' This section has considered many aspects of a safe environment for consumers which we support including their active participation in co-design processes.

- **Action 1.21 (Page 41)**

The service provider demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of diverse population groups including Aboriginal and Torres Strait Islander people, people with physical and intellectual disabilities, people from CALD backgrounds, people who identify as LGBTIQ+, people at risk of homelessness and other diverse population groups

We also support Action 1.21 regarding equitable access to all consumers. We support the task of employment of staff reflecting diversity, noting that those with a lived experience are mentioned.

CoMHWA encourages the Guide to go further by specifying the employment of peer workers as one of the listed examples of this diversity.

Section Two: 'Partnering with Consumers, Families and Carers Standard' (Pages 49-73)

This section of the Guide outlines the standards for engagement with Consumers, Families and Carers, primarily in relation to co-design and governance of CMOs. Our focus in this section was to address potential issues surrounding the inclusion of consumers into the governance of CMO's.

- **Action 2.13: (Page 60)**

The service provider:

a. Partners with consumers, their families and carers in the governance, planning, co-design, delivery, measurement and evaluation of the services

b. Has processes to involve a mix of people that reflect the diversity of consumers, their families and carers.

Action 2.13 references the involvement of consumers with the '...governance, planning, co-design, delivery, measurement and evaluation of the service'. However, we are concerned that the 'Key Tasks' and 'Examples of Evidence' do not include any reference to potential consumer roles in service delivery. Furthermore, the example of a consumer involvement found under this Action is consulting an 'advisory group', which may promote tokenistic involvement. CoMHWA suggests that this option should be accompanied by an example of embedding peer workers into CMO service delivery and evaluation.

- **Action 2.14 (Page 69)**

The service provider provides orientation, support and education to the workforce, consumers, families and carers to support co-design in the governance, planning, design, delivery, measurement and evaluation of the service.

Action 2.14 is designed to promote the consistent training of staff, consumers, families and carers, to help them contribute effectively to the management of the service. The Key Tasks outlined under this Action include the following: 'Develop pathways for consumers and carers to train as and become employed as Lived Experience and Peer Workers.' It is unclear from the wording of this Task as to whether these pathways are required to be developed within the CMO, or whether the CMO is required to support consumers and carers to follow external paths to develop these skills.

Furthermore, the Examples of Evidence regarding co-design with consumers are framed in a simplistic fashion that would allow for counterproductive potentials: firstly, under these terms CMO's could adopt a checkbox approach to peer engagement, meeting with advisory groups in a perfunctory fashion and possibly disregarding any advice. This wording would thus allow for a tokenistic engagement with consumers that does not operate according to best practices, that is to say,

embedding peer workers to help co-design and regularly evaluate all levels of service planning and delivery.

- **Action 2.15 (Page 70)**

The service provider partners with consumers, families and carers on the development and delivery of training and education for the workforce.

Action 2.15 focuses on the utilisation of lived experience workers to provide training for the CMO. There is, however, a level of ambiguity in the wording of the Key Tasks: the 'Employ lived experience trainers and educators, supervisors and evaluators' Task does not specify whether the people employed ought to be contracted on a temporary or ongoing basis, or whether they should be employed within the CMO in a part- or full-time capacity. Furthermore, the examples of evidence for this action include a positive commitment that requires clarification, namely 'Evidence that peer workers are offered career pathways to develop and deliver training to staff including other peers', which once again does not clarify if these pathways should be internal to the CMO or whether this refers to supporting external peak bodies or other peer organisations.

Section Three: Model of Care Standard (Pages 74-124)

Section Three focuses on the standards affecting the model of care developed by CMOs, intending to ensure that support services they provide are congruent with best practice and evidence, support the goals of consumers in their recovery journeys and minimize the potential harm faced by consumers, carers, and their families. CoMHWA's focus in this section was to provide feedback that we feel will strengthen key features of some standards, while also highlighting potential oversights with Actions that might problematically conflict with explicitly non-clinical CMOs.

- **Action 3.01 (Page 75)**

Where the service provider is responsible for establishing the model of care, the service provider:

- a. Partners with consumers, their families and carers in the co-design of the model of care*
- b. Recognises national, state and regional planning approaches and collaborates with relevant funders and policy setters to reduce system fragmentation and strengthen system integration*
- c. Has policies and procedures that specify the intent of the model of care for each service and the context in which it will operate*
- d. Defines the intended consumer demographic and matches the model of care to the consumers, their families and carers*

Action 3.01 describes key features that should be integrated into the CMO's model of care, such as collaboration with other organisations/services, clear description of the model of care, the intended group the model of care is tailored too, and the importance of co-design with consumers, families and

carers. The examples of evidence suggested under Action 3.01 could be strengthened further in order to prevent against tokenistic or checkbox consumer co-design. By explicitly specifying the importance of embedded, ongoing processes of co-design for the whole of the model of care and service more broadly, these standards could ensure that consumers provide a *meaningful contribution* to the process of co-design.

- **Action 3.06 (Page 81)**

The workforce, using a trauma-informed approach, engages consumers, their families and carers in screening conversations on presentation during history taking and when required during care:

- a. To identify mental, physical and cognitive needs and potential risks*
- b. To identify the consumer's social circumstances*
- c. To explore the consumer's recovery goals, values and preferences*

The action 3.06 provides a standard for CMO's to ensure that they develop a 'holistic' approach to understanding the needs and goals of consumers in their care. The explanatory notes for 3.06 describe this holistic approach as a combination of '...the consumer's preferences, their support requirements (including cultural and language needs), strengths, and goals.' Our concern with this description is the backseat that a consumer's personal narrative, that is to say, the discussion with them about recent meaningful life experiences, is somewhat relegated in this framing. It should be emphasised that the aforementioned features of a holistic approach ought to be gleaned from consumers through a dialogue that is not an obvious use of a perfunctory, standardised template.

- **Action 3.13 (Page 91)**

The workforce partners with consumers, their families and carers to:

- a. Identify consumers who may experience distress related to deterioration in their mental state or other circumstances*
- b. Engage with consumers at risk of acute crisis or distress*
- c. Assess possible causes of acute crisis or distress when change in the consumer's behaviour, cognitive function, perception, physical function or emotional state are observed or reported*
- d. Determine the required level of observation to maintain the safety of the consumer and others*

Action 3.13 proposes a standard for CMO's whereby they are required to develop a formalized system of risk assessment for their staff to employ, intended to help them to recognise the possible deterioration of a consumer's mental health. However, programs such as Hearing Voices and Alternatives to Suicide have, as a core feature of their approaches, a rejection of the biomedical, clinical framework and the attendant practice of using risk assessments. CoMHWA believes that

these non-clinical approaches should not be penalised for providing a genuine alternative to traditional biomedical treatments, which provide a crucial avenue for consumers who do not wish to be subject to institutional processing through risk assessments. A recent evaluation of the Alt2Su program, conducted by researchers at Curtin university, puts this as follows:

‘Regarding a non-interventionist approach, Alt2Su has a standpoint position of not escalating people’s experiences of distress into the mental health system...it is not predicated on a clinical model, there are no protocols regarding risk assessment and response, nor are there clinical workers involved in groups, either directly or indirectly.’¹

CoMHWA’s position is that Hearing Voices and Alt2Su offer invaluable alternative path for consumers to exercise their autonomy regarding their recovery journeys, especially with regard to consumers who may have suffered trauma in the institutional setting of hospitals or other clinical spaces that address Mental Health. Accordingly, there should be some kind of ‘carve out’ around risk assessment for peer led services that offer alternative pathways for consumers to address their struggles with mental health.

4. Conclusion

The recommendations and feedback provided above by CoMHWA are intended to strengthen the proposed standards for CMO’s to ensure that consumers have access to the best care possible in their recovery journeys. While there are numerous points of critique in our feedback, it should be noted that CoMHWA is strongly in support of the establishment of the Guide for CMO’s and we are especially encouraged by the focus the Guide places upon trauma informed and recovery-based approaches for CMOs. We are also pleased to see so many references to consumer engagement and co-design in the Guide, and hope that our feedback on this topic may strengthen this admirable feature of this draft even further.

¹Rhodanthe, L., Wishart, E., Watts, L. & Hodgson, D. 2022. *Clarifying the Alternatives to Suicide Approach: An Evaluation of the Theory, Values, Purpose and Practice*. ConnectGroups, Curtin University. https://connectgroups.org.au/wp-content/uploads/dlm_uploads/2023/05/Alt2Su_Evaluation.pdf