

# Scoping Study

on the Implementation  
of National Standards in  
Mental Health Services

August 2014



**Australian Government**  
**National Mental Health Commission**

**AUSTRALIAN COMMISSION**  
**ON SAFETY AND QUALITY IN HEALTH CARE**



© **Commonwealth of Australia 2014** This work is copyright. It may be reproduced in whole or in part for study or training purposes subject to the inclusion of an acknowledgement of the source. Requests and inquiries concerning reproduction and rights for purposes other than those indicated requires the written permission of the Australian Commission on Safety and Quality in Health Care:

Australian Commission on Safety and Quality in Health Care  
GPO Box 5480  
Sydney NSW 2001  
Email: [mail@safetyandquality.gov.au](mailto:mail@safetyandquality.gov.au)

Scoping study on implementation of national standards in mental health services, 2014  
ISBN Print: 978-1-921983-76-4  
ISBN Online: 978-1-921983-77-1

Suggested citation: Australian Commission on Safety and Quality in Health Care (2014) *Scoping Study on the Implementation of National Standards in Mental Health Services*, Sydney, ACSQHC.

#### **Acknowledgements**

This resource was developed by the Australian Commission on Safety and Quality in Health Care in collaboration with the National Mental Health Commission.

The Australian Commission on Safety and Quality in Health Care acknowledges the contribution of all of the participants in the study and thanks them for their advice and time. The Australian Commission on Safety and Quality in Health Care also acknowledges assistance in conducting this project by staff from the following organisations:

- Australian Institute of Health and Welfare
- Lesbian, Gay, Bisexual, Transgender and Intersex Health Alliance
- Mental Health Coordinating Council of ACT
- Mental Health Council of Australia
- Mental Health Coordinating Council of NSW
- Mental Health in Multicultural Australia
- National Mental Health Consumer and Carer Forum
- New Zealand Ministry of Health
- Private Mental Health Alliance
- Private Mental Health Consumer and Carer Network
- Safety and Quality Partnership Standing Committee
- Victorian Women and Mental Health Network
- Western Australian Mental Health Commission.

# Contents

<b>Executive summary</b>	<b>2</b>	<b>6 Information from service users</b>	<b>35</b>
<b>1 Introduction</b>	<b>6</b>	6.1 Changes observed in mental health services	35
1.1 Purpose	6	6.2 Opportunities for service users to participate in planning and evaluation activities	36
1.2 Project outline	6	6.3 Safety when accessing mental health services	39
<b>2 Background</b>	<b>8</b>	6.4 Gaps in the standards and ways forward	41
2.1 National Standards for Mental Health Services	8	<b>7 Discussion</b>	<b>45</b>
2.2 National Safety and Quality Health Service Standards	9	7.1 Contexts of practice	45
<b>3 National cohort of mental health services</b>	<b>11</b>	7.2 Implementing the standards	46
3.1 Description of mental health services	10	7.3 The complexities of enabling factors	47
3.2 Mental health service responsibilities for implementation of national standards	11	7.4 Barriers to implementation	47
3.3 Areas where the scope of the standards requires clarification	12	7.5 The accreditation processes	48
3.4 Conclusion	13	7.6 The scope of the standards	50
<b>4 Method</b>	<b>14</b>	7.7 Changes to the current standards	50
4.1 National survey	14	7.8 Conclusion	51
4.2 National focus groups	15	<b>8 Recommendations</b>	<b>52</b>
4.3 Interviews	17	<b>Glossary of terms and acronyms</b>	<b>53</b>
<b>5 Information from service providers</b>	<b>18</b>	<b>Appendix 1: Summary of results from national survey</b>	<b>54</b>
5.1 Levels of implementation of the two sets of standards	18	<b>Appendix 2: Summary of results from focus groups</b>	<b>62</b>
5.2 Factors that enabled implementation	19	<b>References</b>	<b>65</b>
5.3 Barriers to implementation	24		
5.4 Gaps in the standards and ways forward	30		

# Executive summary

The National Mental Health Commission (NMHC) and the Australian Commission on Safety and Quality in Health Care (ACSQHC) each have roles to support, promote and encourage safe and high-quality health services across the country, including for people with lived experience of mental health issues and their support people.

The NMHC and the ACSQHC collaborated on this scoping study focusing on the implementation of the *National Standards for Mental Health Services (NSMHS)*<sup>1</sup> and the *National Safety and Quality Health Service (NSQHS) Standards*<sup>2</sup> in mental health services.

This study involved activities to gain a comprehensive understanding of:

- the levels of implementation of the *NSMHS* and the *NSQHS Standards*
- the enablers, barriers and challenges to their implementation
- potential gaps with respect to safety and quality in the *NSMHS* and *NSQHS Standards*.

Service providers, including directors, quality managers and front-line mental health workers with responsibility for implementing the standards were consulted. Service users, including people with lived experience of mental health issues and their support people, were consulted about their perceptions of the influence of the standards on the mental health services they access.

The report discusses the themes and major messages from both service providers and service users. It makes recommendations in relation to implementation and areas for consideration when future reviews of the *NSMHS* and *NSQHS Standards* are undertaken.

## National Standards in Mental Health Services

The *NSMHS* and the *NSQHS Standards* were developed independently to provide health services with a framework for the implementation of systems to deliver safe care, and continuously improve the quality of the services they provide.

The *NSMHS* were initially released as voluntary standards in 1996 and were revised in 2010 to reflect changes in the delivery and focus of mental health services. They were designed to be implemented across the range of mental health services, including those in the public, private and community-managed sectors. Implementation of the *NSMHS* is not mandatory for mental health services nationally.

The *NSQHS Standards* were developed by the ACSQHC in consultation and collaboration with jurisdictions, technical experts and a wide range of stakeholders, including health professionals and health service users. The *NSQHS Standards* were released in 2011 and endorsed by Australian and state/territory government Health Ministers, for mandatory implementation in all public and private hospitals from January 2013. The *NSQHS Standards* aim to protect the public from harm and to improve the quality of health service provision. Whilst there are areas of overlap between the *NSMHS* and the *NSQHS Standards* they vary in terms of philosophy, language, structure and how they are implemented.

## Methods

The scoping study was conducted in three stages, as described below.

### Stage one: National cohort of mental health services

The study first identified the cohort of mental health services in Australia providing care to people with lived experience of mental health issues and their families and carers. This cohort then formed the basis for identifying which services have responsibility to implement the *NSMHS* and the *NSQHS Standards*. The process of identifying these services highlighted the complexity of the mental health sector, including the range of service types, and the different regulatory and funding arrangements that exist.

### Stage two: National online survey

A national online survey was conducted from April–June 2013. There were 425 respondents. Respondents included 56 (13%) service users (35 people with lived experience of mental health issues, and 21 support people/carers) and 369 (87%) service providers.

### Stage three: National focus groups

Twenty-two facilitated focus groups were held nationally from July–September 2013. Participants included 111 mental health service providers and 39 service users who were people with lived experience of mental health issues, and their support. In addition, nine face-to-face or telephone interviews were conducted with individuals to capture viewpoints from particular stakeholders.

## Results

### Mental health service providers

The data from the national survey, focus groups and interviews were analysed. The key results of this combined analysis are presented below.

Service providers responded to the study questions in the following way.

### The level of implementation of the standards

#### *NSMHS*

Service providers reported overall support for the framework provided by the *NSMHS*.

Service providers reported that the levels of implementation varied across each of the 10 *NSMHS*. More respondents reported that their service had either ‘fully implemented’ or ‘were working towards implementation’ than those reporting they ‘were not currently able to implement’ any of the 10 standards.

The standards that were most commonly reported as being fully implemented were:

- *Standard 1: Rights and responsibilities* (60%)
- *Standard 2: Safety* (59%).

The standards most often reported as not able to be implemented were:

- *Standard 5: Promotion and prevention* (9%)
- *Standard 9: Integration* (5%).

#### *NSQHS Standards*

Service providers reported that the levels of implementation of each of the *NSQHS Standards* also varied. More services reported they were ‘currently working towards implementation’ of the *NSQHS Standards*, and had not fully implemented them. This finding is consistent with the later release date of the *NSQHS Standards*, and the fact that implementation is not mandatory for community-managed mental health services.

### Enabling factors

Service providers identified that the most important factors enabling services to implement both the *NSMHS* and *NSQHS Standards* were:

- having a culture of ongoing quality improvement
- collaboration with consumers and carers
- mandatory standards, accreditation and compliance
- standards awareness development training.

# Executive summary

## Barriers to implementation

The most commonly reported barriers to implementing the *NSMHS* and *NSQHS Standards* were financial and human resource limitations. Other common barriers were:

- duplication between standards
- uncertainty about the applicability of the *NSQHS Standards* in mental health services
- a culture among some service providers who are resistant to quality improvement and change.

## Gaps in the standards and ways forward

Service providers indicated that the two sets of standards together adequately address the safety and quality issues in mental health services, but that neither could stand alone. They identified the following gaps.

The *NSMHS*:

- are not consistently mandated for implementation
- do not apply in general health settings regularly used by people requiring mental health services, including emergency departments (ED).

The *NSQHS Standards* do not address specific safety issues in mental health service delivery, including:

- seclusion and restraint
- sexual safety
- psychological deterioration and recovery principles
- delivery of care in community settings.

A majority (70%) of respondents reported that a combined set of standards incorporating the *NSMHS* and the *NSQHS Standards* would be the best way to ensure safety and quality in mental health services.

## Service users

Service users responded to the study questions in the following way.

### Changes observed in mental health services

Service users were generally aware of the *NSMHS* (64%) and the *NSQHS Standards* (62%). Service users reported noticing changes in their local mental health services since the release of both sets of standards, both improvements and deteriorations, but they were not able to determine if these were in direct response to either the *NSMHS* or the *NSQHS Standards* or other factors.

## Opportunities for service users to participate in planning and evaluation activities

Survey respondents reported having had minimal opportunity to participate in planning or evaluation activities of the mental health services they accessed. In contrast, focus group participants reported they had significant opportunities for collaboration in planning and evaluation activities, including sitting on committees. They also reported, however, that gaps still remained in opportunities to participate at the direct service delivery level – that is, in the care they receive themselves when they access services, or the care of those they supported.

## Safety when accessing mental health services

In the survey, 18 service users reported feeling safe when they accessed mental health services, while 12 reported feeling unsafe.

Respondents reported that the elements that contributed to feelings of safety were both interpersonal and environmental, including:

- feeling that they were listened to by staff
- feeling a sense of engagement and acceptance
- being in a calm environment.

Elements that contributed to people feeling unsafe included:

- feeling that they were not listened to by staff
- being left unsupervised around other people behaving aggressively
- being in mixed gender inpatient units.

It should be noted that although the number of respondents to the survey who were service users was small, many of the issues they raised were confirmed in the focus groups. Other issues that were mentioned in the focus groups as contributing to feeling unsafe included difficulties accessing care for both psychological and physical problems through emergency departments (EDs) and the safety of carers, particularly when at home.

## Gaps in the standards and ways forward

A similar proportion of service users (79%) to service providers also agreed that a combined set of standards incorporating the *NSMHS* and the *NSQHS Standards* would be the best way to ensure safety in mental health services. A smaller number (11%) of respondents thought that mandatory implementation of the *NSMHS* would be the best way to achieve this. Some focus group participants, including people who had participated in the development of the *NSMHS*, expressed concern that aspects of the *NSMHS*, including philosophy of care, and recovery principles, would be diluted in an integrated standard.

## Conclusion

There was a clear message from both service providers and service users that the implementation of both sets of standards is perceived as being important to meet the safety and quality requirements for people with lived experience of mental health issues accessing the mental health sector.

The standards are being implemented across all mental health service sectors. The rates of implementation vary across the two sets of standards, and across individual standards within each set. For example, a significant proportion of service providers reported their service had not fully implemented *NSMHS Standard 2: Safety*. This creates a gap with respect to the specific safety issues of high relevance in mental health services. A lack of specificity and clarity about the mandatory requirements of the *NSMHS* was reported as a barrier to their implementation. There is no indication that the *NSMHS* will be subject to compulsory full implementation in all mental health services in the near future.

The *NSQHS Standards*, which set mandatory levels of safety for applicable health services, are not directly applicable in the large and growing community-managed organisation (CMO) sector of mental health services. The *NSQHS Standards* do not directly address some of the specific safety issues of high relevance in mental health services addressed in the *NSMHS*. In addition, the *NSMHS* do not apply in general health settings regularly used by people requiring mental health services, including emergency departments. These issues in combination with the continued variable implementation of the *NSMHS* create safety gaps.

Work is required to ensure that standards contribute to the implementation of strategies making mental health services safe for both service users and service providers. Consideration is required about how the safety gaps identified in the study could be incorporated in the longer-term review and revision of the *NSQHS Standards*.

Information from this study suggests recommendations should include strategies that will support the consistent implementation of national standards to address the current safety gaps. The *NSQHS Standards* provide a national framework for this purpose. In the longer term, the *NSQHS Standards* should be revised to include items that will address the specific safety and quality issues faced by people with lived experience of mental health issues accessing all health services. Consideration of the role and function of the *NSMHS* is required to determine the best way to support the more quality related aspects of the *NSMHS*.

## Recommendations

1. The ACSQHC should use information regarding the safety issues identified in this scoping study to inform the planned review of the *NSQHS Standards*.
2. The ACSQHC should revise the *NSQHS Standards* to include items that will address the specific safety issues faced by people with lived experience of mental health issues accessing all health services.
3. Jurisdictions and stakeholders with responsibility for implementing the *NSMHS* should consider the role and function of the National Standards for Mental Health Standards.

# 1 Introduction

The National Mental Health Commission (NMHC) and the Australian Commission on Safety and Quality in Health Care (ACSQHC) each have roles to support, promote and encourage safe and high-quality health services across the country, including for people with lived experience of mental health issues and their support people.

The *National Standards for Mental Health Services (NSMHS)*<sup>1</sup> and the *National Safety and Quality Health Service (NSQHS) Standards*<sup>2</sup> have been developed separately to provide health services with a framework for the implementation of systems to deliver safe care, and continuously improve the quality of the services they provide. The standards also provide a way for health services to verify their actions toward these aims in accreditation processes.

The NMHC and the ACSQHC collaborated on this project, the *Scoping Study on the Implementation of National Standards in Mental Health Services*, to explore how these two sets of standards have or are being implemented. The data was collected from January–September 2013.

## 1.1 Purpose

This final report provides the results of the study, including the findings of:

- Stage one: identification of the national cohort of mental health services responsible for implementing the NSMHS and the NSQHS Standards
- Stage two: national online survey
- Stage three: national focus groups and interviews.

The report discusses the themes and major messages from the service providers and service users who participated in the study. It presents recommendations resulting from the scoping study.

## 1.2 Project outline

### 1.2.1 Aim

The aim of the scoping study was to gain a comprehensive understanding about:

- the levels of implementation of the *NSMHS* and *NSQHS Standards*
- the enablers, barriers and challenges to their implementation
- potential gaps with respect to safety and quality in the *NSMHS* and *NSQHS Standards*.

### 1.2.2 Objectives

The project aims were realised through the achievement of the following objectives:

1. Describing the cohort of Australian mental health services providing care to people with lived experience of mental health issues and their families and carers.
2. Identifying the cohort of mental health services across sectors to which both the *NSMHS* and *NSQHS Standards* apply.
3. Undertaking a national survey of relevant mental health services and service users which:
  - provided an understanding of the status and extent of implementation of the *NSMHS* and the *NSQHS Standards* by mental health services
  - identified examples of successful implementation of the *NSMHS* and mechanisms to disseminate this information
  - identified challenges and barriers to the implementation of the *NSMHS* and the *NSQHS Standards* in mental health services
  - identified if the current sets of standards adequately address safety and quality requirements in mental health service delivery
  - identified gaps in the current sets of standards with respect to safety and quality in mental health services
  - provided an understanding of service users' impressions of the safety and quality of care in the mental health services they access.



4. Undertaking focus groups and qualitative interviews which:
  - provided an expanded, context-specific understanding of the challenges, barriers and enablers of the implementation of the *NSMHS* and where applicable the *NSQHS Standards* across all sectors, and identified any gaps in both sets of standards
  - ascertained service users' perceptions of safety and quality in the mental health services they access and the correlation with implementation of standards in those services
  - captured detailed information about aspects of implementation of standards from individuals with specific expertise, including academics and accreditation agency staff.
5. Producing a report on the project findings. This report provides a snapshot of the situation at the time the data was gathered, from January–September 2013. Participation in the scoping study was voluntary, and this document reports on the views of those mental health service providers and service users who participated in the study.

### 1.2.3 Project governance

The project was jointly sponsored by the ACSQHC and the NMHC. The project was managed and conducted by a team from the ACSQHC.

A Project Advisory Group (PAG) was convened to provide guidance to the project team over the different stages of the project. The PAG comprised representatives of the following stakeholder groups:

- National Mental Health Consumer and Carer Forum
- Private Mental Health Consumer and Carer Network
- Australian Government Department of Health (formerly the Department of Health and Ageing)
- Safety and Quality Partnership Standing Committee
- Private Mental Health Alliance
- Community Mental Health Australia
- Public mental health service managers.

The PAG was co-chaired by program directors from ACSQHC and the NMHC.

### 1.2.4 Terms used in this report

Different language and terminology can be used in different parts of the mental health sector. In this report, the following terms are used.

- The term '**respondent**' is used to highlight the fact that this input comes from a person responding to the online survey. Similarly, '**participant**' is used to highlight that the information is drawn from a person who participated in a focus group or interview.
- The term '**service provider**' is used for any survey respondent or focus group participant who identified as an individual who worked in a mental health service.
- The term '**service user**' is applied to survey respondents or focus group participants who indicated they were engaging in the study as someone who uses mental health services. Service users include people with lived experience of mental health issues and the people who support them. The terms '**consumer**' and '**carer**' are used when participants explicitly referred to themselves using these terms.
- The terms '**community-managed organisation (CMO)**' and '**community-managed sector**' refer to non-government organisations providing services to people with mental health issues. These terms have been adopted as the preferred terms by representative bodies in the sector. At times, some participants and documents use the previously accepted abbreviation NGO.

## 2 Background

### 2.1 National Standards for Mental Health Services

The second version of the *NSMHS* was released in 2010, after four years of consultation with key stakeholders in the sector. This latest version of the *NSMHS* reflects changes in the provision and funding of mental health services in the years since the introduction of the first version of the *NSMHS* in 1996. Stakeholders involved in their development included people with lived experience of mental health issues and their support people.

The 2010 *NSMHS* focus on:

- how mental health services are delivered
- whether mental health services comply with policy directions
- whether mental health services meet expected standards of communication and consent
- whether mental health services have procedures and practices in place to monitor and govern particular areas – especially those areas that may be associated with risk to the service user, or which involve coercive interventions
- embedding recovery principles in service delivery.

The *NSMHS* were developed to be applied across the broad range of mental health services. This includes bed-based and community mental health services in the government, community-managed, and private sectors, and also those in primary care and general practice.

When Health Ministers endorsed the *NSMHS* in 2010, these were deemed to be applicable but not mandatory for mental health services (MHS) in the public, private and community-managed sectors. The aim of the *NSMHS* is to assist in the development of appropriate practices and guide continuous quality improvement in mental health services. All of the standards, except *NSMHS Standard 6: Consumers*, were designed to be assessed, and it was anticipated that the standards would be incorporated into relevant service accreditation programs.

Each of the 10 standards comprises a statement of intent and a number of criteria that describe the actions to be taken by the mental health service.

The *NSMHS* are accompanied by three implementation guidelines for the various sectors with a responsibility to implement the standards:

- *Implementation Guidelines for Public Mental Health Services and Private Hospitals*<sup>3</sup>
- *Implementation Guidelines for Non-government Community Services*<sup>4</sup>
- *Implementation Guidelines for Private Office Based Mental Health Services*.<sup>5</sup>

The guidelines provide directions for mental health services on how the criteria of the standards apply to different services.

For each standard, these guidelines include:

- an additional sentence clarifying the intent of the standard
- information expanding on the criteria
- a list of suggested evidence.

In some instances, the expanded information refers to several criteria, and the suggested evidence lists cover whole standards, rather than being linked to individual criteria. This leaves considerable breadth for interpretation on the part of individual services developing evidence of meeting the *NSMHS* for accreditation purposes.

There is variation across the three guidelines in the detail about which of the *NSMHS* are deemed to be essential or aspirational in different mental health services. One example of this concerns *NSMHS Standard 2: Safety*.

The stated intent of *NSMHS Standard 2: Safety* is that: 'The activities and environment of the MHS are safe for consumers, carers, families, visitors, staff and its community.'<sup>1</sup> It includes criteria for: reducing, and where possible eliminating restraint and seclusion; assessing and minimising the risk of self-harm and suicide; and conducting risk assessments at critical shifts in care settings.

The Introduction to the *Implementation Guidelines for Non-government Community Services* states that:

'Some standards and the criteria that support them must always be met in full. Standard 2 (Safety) is in this category. All service providers must be able to demonstrate that their services are safe. While continuous improvement should still be a goal, safety requirements must be met. There is no scope for service providers to be at a 'minimal level' of achievement and 'working towards' achieving Standard 2.'<sup>4</sup>

This requirement that *Standard 2: Safety* must be met in full was not included in the 2010 release of the *NSMHS*, the *Implementation Guidelines for Public Mental Health Services and Private Hospitals*, or the *Implementation Guidelines for Private Office Based Mental Health Services*.

Since the release of the *NSMHS* in 2010, some jurisdictions have made it mandatory for mental health services to implement the full set of the *NSMHS* in specific sectors, either through regulation, or through funding agreements.

### 2.1.1 Current reporting of implementation of the *NSMHS*

Implementation of the *NSMHS* is currently reported in the *National Mental Health Report*<sup>6</sup> in terms of the proportion of services accredited. Jurisdictions report annually on the number of inpatient services, government-operated residential services, and ambulatory services that have been reviewed by an external accreditation agency and judged to have met the *NSMHS*.

Reports on services implementing the *NSMHS* as part of funding agreements in the private and CMO sectors are not currently made public.

The *National Mental Health Report 2013*<sup>6</sup> reports data from the year 2010–11, but does not specify if services have been accredited to the revised 2010 *NSMHS*, or the previous 1996 version of the *NSMHS*.

Information about the experience of mental health services in implementing the *NSMHS*, or their capacity to do so, is not currently reported publicly. This scoping study provides new information about these issues.

## 2.2 National Safety and Quality Health Service Standards

The *NSQHS Standards* were developed by the ACSQHC in consultation and collaboration with jurisdictions, technical experts and a wide range of stakeholders, including health professionals and patients.

The primary aims of the *NSQHS Standards* are to protect the public from harm and to improve the quality of health service provision. They provide a quality assurance mechanism which tests whether relevant systems are in place to ensure minimum standards of safety and quality are met, and a quality improvement mechanism which allows health services to realise aspirational or developmental goals.

Accreditation is recognised as an important driver for safety and quality improvement and Australia's health accreditation processes are highly regarded internationally. The *NSQHS Standards* are integral to the accreditation process as they determine how and against what an organisation's performance will be assessed. The *NSQHS Standards* have been designed for use by all health services. Health service organisations can use the *NSQHS Standards* as part of their internal quality assurance mechanisms or as part of an external accreditation process.

Each *NSQHS Standard* contains:

- the standard itself, which outlines the intended actions and strategies to be achieved
- a statement of intent, which describes the intended outcome for the standard
- a statement on the context in which the standard must be applied
- a list of key criteria; each criterion has a series of items and actions that are required in order to meet the standard.

ACSQHC has a legislated role to promote, support and encourage safe and high-quality care in all healthcare settings. Part of this role includes the development and maintenance of the *NSQHS Standards*, which were endorsed by Health Ministers for implementation in all public and private hospitals and day procedure services, including mental health services.

Australian public and private psychiatric hospitals, including psychiatric wards in general hospitals, commenced accreditation to the *NSQHS Standards* from 1 January 2013.

The *NSQHS Standards* are due to be evaluated and, if necessary, amended in 2015 and fully reviewed in 2017. Information from this project will contribute to ensuring that specific safety and quality issues that affect mental health services are addressed in the *NSQHS Standards*.

# 3 National Cohort of Mental Health Services

The first stage of the scoping study was to describe the cohort of mental health services in Australia providing care to people with lived experience of mental health issues and their families and carers. This description then forms the basis for identifying which services have responsibility to implement the *NSMHS*, the *NSQHS Standards*, or both.

## 3.1 Description of mental health services

In Australia, mental health services are provided in the public, private and community-managed sectors.

The public sector comprises stand-alone psychiatric hospitals, psychiatric units within public hospitals, and a range of community-based services, including assertive outreach, long-term case management, and rehabilitation and recovery teams.

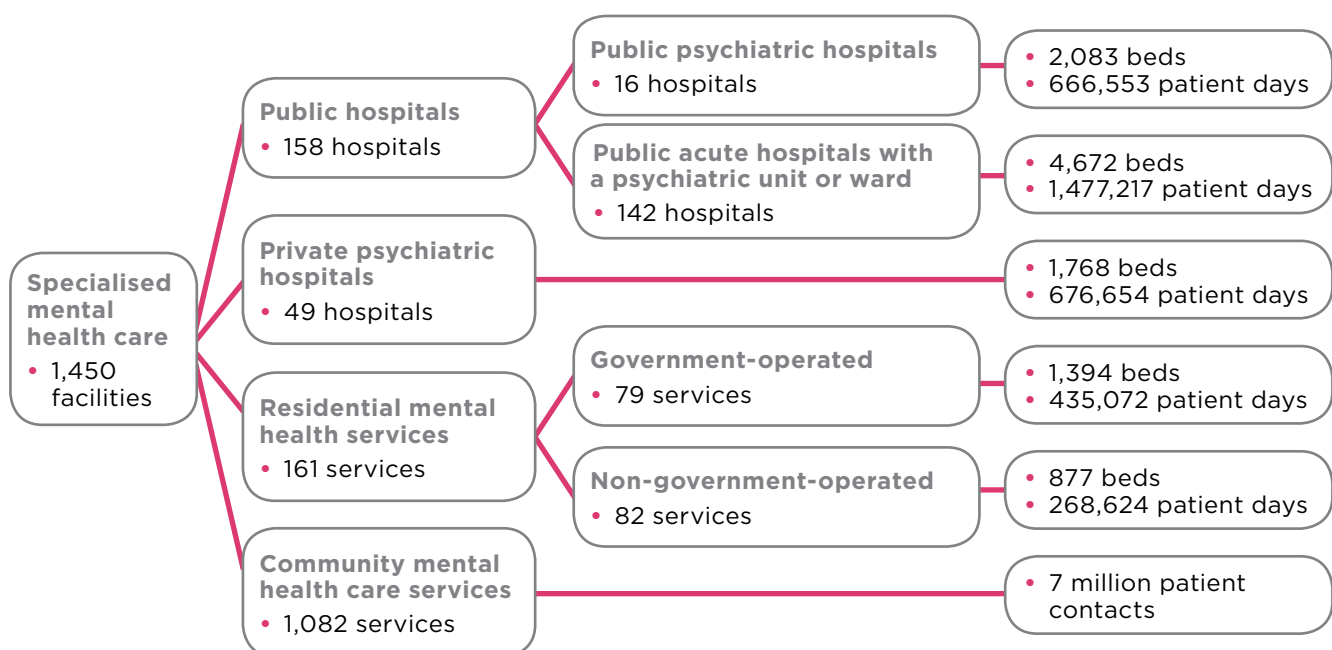
The private sector comprises private psychiatric hospitals, day hospitals providing rehabilitation and recovery services, and private office-based services.

The community-managed sector comprises a range of services provided by community-managed organisations (CMO). These include residential, care coordination, and rehabilitation and recovery services.

There is currently no single national public report that provides a comprehensive description of all services across the public, private and community-managed mental health sectors. This is due in part to the varied nature of mental health services across the three sectors. There are a number of published reports that include information about specific sectors providing mental health services. The most comprehensive description is provided by the Australian Institute of Health and Welfare (AIHW).

The AIHW publishes an annual summary of key findings regarding the delivery of mental health services in Australia, *Mental Health Services – in brief*, excerpted from the more comprehensive *Mental Health Services in Australia*, which AIHW publishes online. The 2013 edition reports on mental health services delivered in the financial year 2010–11. Figure 1 describes a significant part of the mental health sector.

**Figure 1: State and territory specialised mental healthcare facilities**



Source: Australian Institute of Health and Welfare 2013. *Mental Health Services – in brief* 2013, Canberra: AIHW, p.30.

Mental health services that are included in the AIHW report are public and private hospitals, residential services provided by government and non-government services, and community mental health care provided by public sector mental health services.

Government-funded services that are excluded from the AIHW report are:

- services directly funded by the Australian Government that are not represented in Figure 1, including the Better Access scheme, counselling and other psychological services
- approximately 440 non-government organisations in the CMO sector that are funded by state and territory governments to provide mental health services, including psychosocial recovery and rehabilitation services.

The CMO sector providing mental health services is less well defined. There is no current national report describing the CMO sector. Some peak bodies representing the sector at state and territory level have undertaken mapping exercises in order to describe the services in their states.

For example, the Mental Health Coordinating Council (MHCC) of NSW conducted a survey of their members to identify community-managed organisations providing mental health services. The survey was completed by 247 organisations delivering 350 programs. The MHCC of NSW identified three different types of CMOs providing mental health services:

- Type 1 – providing mental health programs only
- Type 2 – providing mental health programs in addition to other programs
- Type 3 – providing mental health support but no specific mental health programs.

The MHCC of NSW survey results show that the majority of these organisations were not exclusively providing mental health services: 35 services identified as Type 1, 102 as Type 2, and 110 as Type 3. The MHCC NSW noted in their 2010 report that, 'finding information about CMOs providing community-managed health programs in NSW is difficult'.<sup>8</sup> The Western Australian Association for Mental Health (WAAMH) commissioned a similar mapping exercise of the community-managed mental health sector in 2012. The authors note similar complexity in delineating the range of services that provide services to people with mental health issues.<sup>9</sup> They also highlight the fact that some services have as few as 10 staff, and that it is very difficult to compare organisations of this size with large national organisations with branches across several states.

The CMO sector has not been mapped nationally in the same way as in NSW and Western Australia. However, discussions in the scoping study focus groups indicated that similar issues exist in each jurisdiction in terms of complexity, with organisations delivering a range of mental health and other services to users with mental health issues.

### 3.2 Mental health service responsibilities for implementation of national standards

An objective of the scoping study was to identify the cohort of mental health services responsible for implementation of the *NSMHS* and the *NSQHS Standards*. Direction about which services should implement each of the standards is relatively clear at a national policy level:<sup>1, 2</sup>

- The *NSMHS* are applicable but not mandatory for all mental health services in the public, private and community-managed sectors.
- *NSMHS Standard 2: Safety* is applicable to all mental health services but is expected to be met in full by the community-managed sector.
- Implementation of the *NSQHS Standards* in mental health services is mandatory for public and private hospitals, but not for the community-managed sector.

Some jurisdictions have now made it mandatory for mental health services to be accredited to the *NSMHS*. To date, this includes the CMO sectors in Western Australia and the Australian Capital Territory, and from 2015, public sector mental health services in Queensland. In addition, for some CMO services and private mental health services, demonstration of adherence to the *NSMHS* is mandatory under funding agreements.

It is therefore possible to state which *NSMHS* apply for a particular service type in a particular jurisdiction, but not possible to make broad statements about national mandatory implementation for the *NSMHS* through either policy or funding arrangements.

A summary of the current applicability of each set of standards in each sector follows.

# 3 National Cohort of Mental Health Services

## 3.2.1 Public mental health sector

There are 158 public psychiatric hospitals or public hospitals with psychiatric wards in Australia which are required to implement and be accredited under the *NSQHS Standards*, as well as implementing the *NSMHS*. But as the AIHW report notes:

‘There were 1,401 state and territory specialised mental health facilities, including hospital, residential and community mental health services. These state and territory facilities were administered by 208 health service organisations, equivalent to the area health services or district mental health services in most states and territories. The most common of these organisations comprised a specialised mental health public hospital service and a community mental health service.’<sup>7</sup>

The governance arrangements for many public mental health sector organisations, including their safety and quality management systems, include both inpatient care and community-delivered mental health services. This can create difficulties for some services as these arrangements do not align with the divisions into hospital and community-based care by which applicability of the *NSMHS* and the *NSQHS Standards* are currently assessed.

The implementation of both sets of national standards in corrective service facilities is not subject to clear national direction. In some jurisdictions, corrective health services are implementing and being accredited to the *NSQHS Standards*, but this is not consistent across all jurisdictions.

Where services are designated as ‘community forensic mental health services’, it is clear that the *NSMHS* apply, and for forensic hospitals both sets of standards apply.

The *National Statement of Principles for Forensic Mental Health*,<sup>10</sup> endorsed by the Australian Health Ministers’ Conference in 2002, and the Corrective Services Ministers’ Conference in 2007, sets out a national framework, ‘to provide cohesion and credibility so that optimal diagnosis, treatment and rehabilitation can be provided to clients of forensic mental health services’.<sup>10</sup> These principles have been incorporated into mandatory policies by several jurisdictions.

## 3.2.2 Private sector

All 49 private psychiatric hospitals in Australia are required to implement and be accredited under the *NSQHS Standards*. They are also required to implement the *NSMHS*, and for the majority, accreditation to the *NSMHS* is a mandatory condition in their funding arrangements.

The *NSMHS* are also designed to be implemented by private office-based psychiatrists, and a guideline has been produced to assist with this.<sup>5</sup> Accreditation to the *NSMHS* is not mandatory, with practice oversight occurring through the Australian Health Practitioner Regulation Agency. Implementation of the *NSQHS Standards* is not required in private office-based practices.

## 3.2.3 Community-managed sector

At least two jurisdictions have made implementation of the *NSMHS* mandatory for the CMO sector as part of their funding agreements.

The majority of CMOs are not exclusively providing mental health services. This creates some confusion as to the applicability of the *NSMHS*. Clearly CMOs only providing mental health services are required to demonstrate implementation of the *NSMHS*. It is unclear if CMOs either providing mental health services in addition to other programs or providing mental health support but no specific mental health services are required to demonstrate implementation of the *NSMHS* across all programs, or only for their specific mental health services.

While CMOs are not required to implement the *NSQHS Standards*, many are required to implement other national standards, including the *National Standards for Disability Services* and the *Community Care Common Standards*.

## 3.3 Areas where the scope of the standards requires clarification

The identification of the cohort of mental health services that are required to implement the *NSMHS* is not straightforward. This is due to the complexity of the way that mental health services are delivered and the lack of clarity for some services about the applicability and requirements for implementation of the two sets of standards. This complexity is illustrated by the following examples.

A significant proportion of mental health services are delivered by private psychologists and social workers under the Better Access initiative funded through Medicare. Currently these services are largely monitored on an individual level under the *National Practice Standards for the Mental Health Workforce*,<sup>11</sup> and through the Australian Health Practitioners Regulation Agency. Complications with this arrangement arise when a government organisation, such as the Veterans and Families Counselling Service, is purchasing these services in bulk. It is not clearly defined if the government organisation has a responsibility to ensure this service provision is compliant with the *NSMHS*.

The Partners in Recovery scheme, funded by the Australian Government to provide coordination of care for people with serious and enduring mental illness in the community, is currently being implemented across Australia. It is widely believed that implementation of the *NSMHS* would be consistent with the types of services the Partners in Recovery scheme was designed to cover, but a clear national directive has not yet been issued.

Emergency departments (EDs) are required to implement the *NSQHS Standards*, as the departments are located within public hospitals. Currently, only those EDs that include a designated mental health sub unit, such as psychiatric emergency care centres, are considered to constitute mental health services, with an obligation to also implement the *NSMHS*. This means that the majority of EDs are exempt from implementing the *NSMHS*, despite being a major service access point for many service users with mental health issues.

The provision of health care to people residing in detention centres awaiting clarification of their immigration status is currently covered by the Standards for General Practices, produced by the Royal Australian College of General Practitioners. These include guidelines about when a general practitioner (GP) should refer a person for more specialist assessment and intervention. The services then provided should be consistent with the *NSMHS*.

### 3.4 Conclusion

The landscape of mental health service delivery in Australia is complex. There are a large number of services in the public, private and community-managed sectors. These services vary in size, location, service delivery and funding models. The *NSMHS* and the *NSQHS Standards* were developed and endorsed nationally for implementation in mental health services. In addition, a number of services are also subject to state and territory regulation, and private or government funding arrangements, and these are not consistent nationally.

There is clear guidance about which mental health services the *NSQHS Standards* apply to and which services need to demonstrate implementation through accreditation activities. There is clear guidance about which services the *NSMHS* apply to, but there is not a nationally consistent mandate to implement the *NSMHS* and demonstrate implementation through accreditation activities.

However, the governance arrangements of many mental health services do not align with the divisions into hospital and community-based care by which applicability of the *NSMHS* and the *NSQHS Standards* are currently assessed.

This section has described the mental health sector in Australia and identified the cohort of mental health services responsible for implementation of the *NSMHS* and the *NSQHS Standards*. This cohort represents the scope of mental health services included in the national survey and focus group stages of the scoping study described in the following sections of the report.

# 4 Method

The scoping study used three data collection approaches beginning with a national online survey followed by focus groups and interviews. These approaches are described below.

## 4.1 National survey

A national online survey was conducted from April–June 2013. The aim of the survey was to gain a broad understanding of the uptake and current implementation of the *NSMHS* and the *NSQHS Standards* by mental health services across all sectors nationally.

### 4.1.1 Survey tool

The survey was developed using Survey Monkey, a web-based survey tool. Survey Monkey enables basic analysis to be conducted and displayed in a range of simple graphic formats, and sub-analysis of responses to be conducted using filters and comparison tools.

### 4.1.2 Survey questions

Survey questions were aimed at achieving the stated study objectives and addressed the following areas:

- the current implementation of both sets of standards by government, community-managed and private mental health services (where applicable)
- the factors that enabled successful implementation of both sets of standards
- challenges and barriers to the implementation of standards
- any potential gaps in both sets of standards with respect to safety and quality
- perceptions about the best ways to guarantee safety in mental health services.

A number of different question formats were used, including Likert scales, multiple choice answers, and open text options. This allowed for the collection of quantitative data for broad comparisons, and qualitative data providing specific local information.

The survey was divided into four sections:

- Section A: demographic questions about respondents, their roles in mental health services, and the kinds of services they work in or access
- Section B: questions about the NSMHS
- Section C: questions about the NSQHS Standards
- Section D: questions about other safety and quality aspects in mental health services.

The survey used 'skip logic' which directs respondents to different sections of the survey based on their responses to certain questions. This resulted in respondents not being required to answer all survey questions.

### 4.1.3 Piloting

The survey was developed and piloted by the ACSQHC. The survey was further refined following feedback from the Project Advisory Group. The survey was launched online on 29 April 2013.

### 4.1.4 Recruitment

The survey was designed to capture information from anyone with an interest in the implementation of standards in mental health services, both service providers and service users.

Prospective survey participants included:

- people with responsibility under governance frameworks for ensuring standards are implemented, such as service directors
- people with direct implementation responsibilities, such as quality managers
- people delivering services and supports, such as clinicians, support workers, peer workers
- people with lived experience of mental health issues and their support people.

Participation in the survey was voluntary. The recruitment strategy included invitations across all stakeholder groups to enable the best opportunity for a representative sample to participate in the survey.

The survey was also advertised on the websites of ACSQHC and the NMHC.



### 4.1.5 Respondents

There were 425 respondents to the survey. There were 35 respondents with lived experience of mental health issues, and 21 support people/carers, giving a total of 56 service users who participated in the survey (13% of the total sample).

Service providers were the majority of respondents with 369 (87%) participating in the survey.

Due to the recruitment strategy, including advertising the survey on national websites, it was not possible to calculate the number of potential respondents. As such, it is not possible to determine the true representativeness of the sample.

### 4.1.6 Results

A separate report containing the results of the survey was produced in August 2013. A summary of the key survey results is included in Appendix 1. The quantitative and qualitative data from the survey have been incorporated into the overall study findings, discussion and recommendations of this report (sections 5, 6, 7 and 8).

The information generated from the survey was used to guide questions for the participants in the national focus groups.

## 4.2 National focus groups

A series of focus groups was conducted from July–September 2013 with service users and service providers throughout Australia.

### 4.2.1 Focus group aims

The aim of the focus groups was to explore the study questions with a specific focus on the key topics identified in the national survey.

The focus groups provided detailed qualitative data to complement and elaborate on the survey data, in particular to:

- gain an in-depth, context-specific understanding of the current implementation of the two sets of standards by mental health services
- gather the perceptions of people with lived experience of mental health issues and support people.

The qualitative data from the groups provided an enhanced view of the enablers, barriers, appropriateness and capacity to operationalise the standards in different mental health service settings; more specifically it has shed light on:

- what implementation processes are working effectively
- what gets in the way of implementation
- the gaps in the standards in terms of safety and quality
- what needs to be put in place to enhance implementation.

### 4.2.2 Focus group participants and locations

From 17 July–18 September 2013, ACSQHC project officers facilitated 22 two-hour group discussions with:

- 111 service providers including representatives from the following sectors:
  - public mental health services (acute and community)
  - private mental health service providers
  - community-managed organisations
  - providers to Aboriginal and Torres Strait Islander communities.
- 39 service users including people with lived experience of mental health issues, and their support people, with specific groups for service users from Aboriginal communities, and representatives of people from culturally and linguistically diverse backgrounds.

A summary of the focus groups is provided in Table 1, and further details are provided in Appendix 2.

# 4 Method

**Table 1: Focus group dates and locations**

Location	Number of groups	Date
Perth Western Australia	3	17 July 2013
Port Hedland Western Australia	1	18 July 2013
Adelaide South Australia	3	25 July 2013
Canberra Australian Capital Territory	2	1 August 2013
Brisbane Queensland	3	7 and 8 August 2013
Sydney New South Wales	2	13 and 14 August 2013
Melbourne Victoria	4	28 and 29 August 2013
Karratha* Western Australia	1	3 September 2013
Hobart* Tasmania	1	11 September 2013
Sydney New South Wales	2	18 September 2013

\*by teleconference

In each location, three groups were planned for each of the service provider types (public, private and community-managed) with a separate group for service users. In practice, it was not always possible to conduct three service provider groups. This decision was dictated by the number of available participants – when there were fewer than three people available to represent any one sector, they were combined with the next largest group.

During the focus groups, participants often talked about the implementation, barriers, challenges and enablers of the standards generally, and did not always differentiate the issues between the *NSMHS* and the *NSQHS Standards*. As such, where participants explicitly addressed a specific set of standards, this is presented in the report; however some issues are presented as being generally attributed to implementation of ‘the standards’.

Discussions in the focus groups were not always confined to the scope of the study. Service users and service providers spoke passionately about their experiences, including the influence of stigma on their access to health care, and the effects of funding for mental health services and mental health legislation on their capacity to provide safe care. Reference to these issues has been included in the report when they have some link to the implementation of standards in mental health services.

### 4.2.3 Results

A summary of the key results from the focus groups is included in Appendix 2. Information arising from the focus groups has been incorporated into the overall study findings, discussion and recommendations of this report (sections 5, 6, 7 and 8).

## 4.3 Interviews

Nine face-to-face or telephone interviews were also conducted with a number of stakeholders. The Project Advisory Group advised that it was important to obtain information from these stakeholders to provide context for some of the issues raised in the survey and focus groups. Interview participants were identified through national stakeholder organisations, via suggestions from members of the Project Advisory Group, and through expressions of interest appended to the national survey and focus group advertisements. These were:

- the Lesbian, Gay, Bisexual, Transgender and Intersex Health Alliance
- the Victorian Women and Mental Health Network
- regional mental health services (service providers and service users)
- service funders
- mental health services in EDs.

Information gathered in the interviews has been incorporated in the overall discussion. This maintains the confidentiality of participants, except in instances where they are explicitly representing a specific stakeholder group.

# 5 Information from service providers

This section reports on the consolidated data from survey responses, focus groups and interviews with service providers. Results are reported in a format that follows the questions that guided the focus groups:

1. levels of implementation of the two sets of standards
2. factors that enabled implementation
3. barriers to implementation
4. gaps in the standards with respect to safety and ways forward.

## 5.1 Levels of implementation of the two sets of standards

Service providers were asked to comment on their perceptions of the level of implementation of both the *NSMHS* and the *NSQHS Standards* in their services. It should be noted that participants frequently spoke of the standards in a generic way, without differentiating between the two sets. This reflected their experience of implementation in the context of their services, where the processes were not always separate. Where participants spoke explicitly about either the *NSMHS* or the *NSQHS Standards*, and where it is clear from the content or context which standard they are referring to, this is noted in the report.

### 5.1.1 *NSMHS*

In the survey, service providers self-reported high levels of 'fully implemented' or 'currently working on implementation' of the individual *NSMHS* and the levels were consistent across the three types of mental health services.

Of note, less than 60% of respondents reported that *NSMHS Standard 2: Safety* was fully implemented in their organisation. This level of implementation may indicate the lack of clarity around the expected level of implementation for *Standard 2: Safety* in services other than the CMO sector where the *Implementation Guidelines* for that sector state that this is a standard that must be met in full.<sup>4</sup> Focus group participants also noted that funding arrangements and individual jurisdictional requirements mean that although the *NSMHS* are nominally voluntary for particular service providers, they are a condition of funding for a large number of service providers, for example the CMO sector in WA and ACT, and, from 2015, the public sector in Queensland.

### 5.1.2 *NSQHS Standards*

Implementation of the *NSQHS Standards* in mental health services is somewhat different. For the *NSQHS Standards*, overall levels of implementation as identified by participants from all sectors for each standard ranged from 87% down to 38%. The lower figures are accounted for in part by the fact that the *NSQHS Standards* do not have to be implemented by services in the CMO sector, and several of the standards are of limited applicability in mental health services. Within public and private mental health services, over 90% of respondents identified that their services had fully implemented, or were working towards implementing, the overarching standards, *NSQHS Standard 1: Governance for Safety and Quality in Health Service Organisations*, and *NSQHS Standard 2: Partnering with Consumers*.

The variations in the implementation of the *NSQHS Standards* may be the result of the *NSQHS Standards* only being mandated in the public and private sectors.

### 5.1.3 Improvement in direct service delivery

More than 40% of survey respondents and many focus group participants agreed that the implementation of standards improved direct service delivery. Service providers particularly noted the increased prominence of recovery principles, and stated that the standards provided an impetus to focus on good quality clinical care for each person. Respondents also noted that these improvements were driven by collaboration with service users.

### 5.1.4 Improvement in administration and other areas

Respondents reported that the standards provide a framework that both reflected current service delivery and allowed for the development and maintenance of safety and quality improvement methodologies.

### 5.1.5 Improvement in governance structures

Service providers reported that the *NSMHS* and *NSQHS Standards* help to formalise pathways and embed consumer and carer representation in an organisation's culture.

### 5.1.6 Implementation focusing special interests

Service providers reported that implementing *NSMHS Standard 4: Diversity Responsiveness* was challenging, but contributed to overall service improvement, as it brought greater focus to the specific local contexts in which mental health services were being delivered.

In 2013 two national bodies, Mental Health in Multicultural Australia, and the Lesbian, Gay, Bisexual, Transgender and Intersex Health Alliance,<sup>12</sup> produced national frameworks to assist mental health services in addressing the needs of their specific populations, and these frameworks align with the standards.

While several services commented that *NSQHS Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care* does not include deterioration in mental state, one service used the framework provided by the standard to develop their own tool for recognising and responding to psychological deterioration.

## 5.2 Factors that enabled implementation

A number of factors were identified by survey respondents and focus group participants as enabling implementation of the standards. These included:

- having a culture of ongoing quality improvement
- collaboration with consumers and carers
- mandatory standards, accreditation and compliance
- training to increase awareness of standards
- sharing of knowledge about implementation strategies across services.

These enabling factors are addressed in the following sections.

### 5.2.1 Culture of ongoing quality improvement

Three-quarters of service providers rated a culture of ongoing quality improvement as the most important factor enabling implementation of the standards. As one participant put it, 'If culture is embedded at the heart of an organisation, you're on a winner.'

Hallmarks of such culture for participants are providing the best care and obtaining good patient outcomes, and safety and quality being part of everyone's job. In this light, it is viewed in the same way as workplace health and safety legislation: everyone is responsible for what is happening in their workplace.

Implementation of the *NSQHS Standards* and *NSMHS* is viewed as ideally occurring as part of normal work processes. Accreditation should not be 'a special time' for an organisation because the standards are embedded in day-to-day work practices and are part of an organisation's reputation surrounding its provision of services.

Focus group participants expressed a range of responses to questions about how an organisation achieves such a culture. These responses ranged from services with clear strategies on constructing and maintaining an embedded culture, to others which regarded quality improvement culture as a matter of luck or passion exhibited by a few key workers.

There was general agreement that culture required time, was best approached incrementally, and needed support. Key elements of a culture of ongoing quality improvement were identified as:

- local quality and safety 'champions'
- application of adequate resources
- high focus on the standards and safety and quality, such as including them on the agenda of regular meetings
- recognition that standards improve services and business
- critical incident analysis and reporting
- senior management support
- recruitment consistent with values of standards.

# 5 Information from service providers

## Local quality and safety ‘champions’

The majority of participants spoke positively about ‘champions’ driving change in general, and in particular enabling services to implement the standards. They were regarded as individuals with specific interests and passion, and could be in roles from leadership to front-line workers.

Some services have trialled the appointment of champions to work on specific developments, and provided support for these appointments, such as designated time away from delivery of clinical services.

A widely recognised limitation of champions for ongoing culture is sustainability – either the key worker may leave their role, and the service have no one to replace their drive, or the champion themselves may ‘burn out’. Some participants commented that it is actually a responsibility of champions to maintain their capacity to function effectively by maintaining a healthy work–life balance, for their own health, and as role models to other staff.

## Application of adequate resources

Participants reported that adequate resources should be devoted to processes including: incorporating the standards into day-to-day procedures, obtaining external benchmarking, implementing worthwhile staff suggestions as quickly as possible, and monitoring safety and quality on an ongoing basis.

## High focus on standards and safety and quality

An overwhelming majority of survey respondents (95%) indicated that a culture that is aware of safety, quality and risk is created in a proactive planned way by having continual training and explaining about safety and quality to all members of the organisation. Respondents identified the standards as providing a framework for this, so that work in different parts of the organisation does not remain in ‘silos’, but rather is communicated across teams.

One strategy adopted by many services is regular focus on safety and quality in meetings. Some services make these meetings mandatory for staff, and other services with staff on rolling rosters have trialled rotating meeting days, or rotating staff designated to attend meetings, in order to keep the broadest number of staff engaged.

## Recognition that standards improve services and business

Participants suggested that people come on board when they understand why the standards are part of an effective and efficient health system. Safety and quality become part of the way an organisation does business and are then incorporated into everyday work practices.

The key issue is showing the relevance of standards implementation to everyday work practices. As an example, it was reported that the implementation of *NSQHS Standard 6: Clinical Handover* was ‘an easy sell’ because it needed to be done and the standard provides a framework. In addition, resources are most likely to be applied to safety and quality projects when a positive impact on client services is demonstrated.

Participants from the private sector noted that implementing the standards and delivering effective and efficient services contributes to profits for the organisation, which is another motivating factor.

## Critical incidents

Critical incidents gain the attention of clinicians and can act as a motivating factor to look for ways to improve service delivery. Successful implementation strategies shift the focus from individual service providers (except in cases of professional misconduct) to systemic issues that can be changed, and standards provide a framework for this approach. Similarly, recommendations from coronial inquiries can result in changes in policy.

It was identified that these processes worked best when a clear link was made between the incident and the change in practice, rather than changes in policy being delivered free of context. It was noted that this strategy is not always appropriate in small and regional services, as it is not always possible to maintain the confidentiality of the people involved in the incident.

## Senior management support

Service providers across the range of roles reported that implementation of the standards is a two-way street between senior management and work teams. They suggested that senior management must lead but also need to appropriately deal with feedback. It was considered that if leadership is not shown, people will reject change and no one will buy into a change process.

The specific roles leadership needs to undertake include recognising values, demonstrating transparency in decision making, and adapting to workforce changes. Specific training in management skills support leaders to do this, and some services provide support in the form of covering Higher Education Contribution Scheme fees for staff to pursue post-graduate studies.

### **Recruitment consistent with values of standards**

Some organisations are attempting to address values as well as skills in recruitment processes. One issue that was raised several times was that new graduate staff recognise safety and quality processes as intrinsic to their roles. This was contrasted to older staff who regarded these processes as 'in addition' to their core roles. Conversely, role modelling was also identified as important and implementation was achieved by people having good examples to follow.

Several participants stated that among mental health staff, workers from certain disciplines are better equipped by their preparatory training, to work with the principles embodied in the standards. In addition, multidisciplinary teams are identified as better able to deliver services consistent with the standards. Conversely, if a team is dominated by staff from one discipline, this can create limitations to its broad effectiveness. Some services strategically recruit to construct and maintain multidisciplinary teams, rather than advertising generic positions.

## **5.2.2 Collaboration with consumers and carers**

Collaboration with consumers and carers was identified as an important enabling factor in implementing the standards by a majority of service providers. It is integral to the *NSQHS Standards*, with *Standard 2: Partnering with Consumers*, identified as an overarching standard. It is also integral to *NSMHS Standard 3: Consumer and Carer Participation*, *Standard 6: Consumers*, and *Standard 7: Carers*.

Collaboration was spoken of in two distinct, but related ways:

- collaboration with the individual service user and their support people on the direct delivery of their care
- collaboration with service user representatives through a range of structured processes.

Certain issues are important across these two approaches, including obtaining and using information effectively, and the need for training, both for service providers and service users.

The goal for a large number of providers was for genuine collaboration in services, but most focus group participants felt that their organisations were at the developmental stage of 'adding on collaboration'. Discussion of this topic demonstrated the most pronounced range of developmental stages for services, with some having established sophisticated processes across the service, while others were struggling with how to begin engaging service users.

### **Collaborating on direct service delivery**

For service providers in the focus groups, the primary sense of collaborating with service users was on the systemic processes of design and evaluation of services. There was less discussion of collaborating on the direct delivery of care. This is in contrast with the service user participants, for whom the two processes are intrinsically linked, if not always effectively. This is covered in more detail in section 6.2.1.

### **Collaboration with consumer and carer representatives**

Collaboration with consumer and carer representatives occurs in a range of ways. One of the simplest and most frequently used methods is conducting surveys. These can be carried out at specific points in a person's episode of care, most often at discharge; alternatively they can be carried out periodically to track trends.

### **Committee and board members**

Focus group participants felt that the presence of consumer and carer representatives on committees and on boards was an essential step in implementing the standards.

Participants thought the involvement of consumer and carer representatives should include being involved in recruitment and as members of selection panels; revising primary care policies; providing feedback on clinical progress; assisting in the design and setting up of facilities; involvement in ward visits and meeting with executives; involvement in the signing off of wellness plans; formulating outcome measures; and in risk management and in the planning process for services.

## 5 Information from service providers

Service providers thought good practices around consumer and carer representatives included: the establishment of clear guidelines for collaboration and participation, the provision of proxies, and rotation of representatives every two years with a transition period of six months.

Recruitment of consumer and carer representatives was identified as difficult for a number of reasons. Carers were simply too busy; engaging specific cultural groups within the community was often challenging; and in corrective and forensic services, service users rarely want to engage in representative roles.

### Payment for participation

One quarter of service providers thought that payment of consumer and carer representatives was essential. Reasons given for not paying representatives included that people have traditionally volunteered for these roles, that there were no funds available for this payment (most notably in the private sector), and that payment may influence representatives not to express criticism of the organisation and 'bite the hand that feeds them'.

### Consumer and carer consultants and peer workers

Several mental health services have been employing consumer and carer consultants for several years. For some consultants, the role is to provide representation on issues within the mental health service. For others, the role is to deliver support to other service users.

A more recent development is the employment of peer workers, whose role is to deliver direct services alongside other front line workers, rather than the more circumscribed support role.

Service providers in the focus groups thought that the use of consumer and carer consultants and peer workers within the mental health system is crucial to improving relationships with service users because these workers often find it easier to collaborate and therefore provide value 'on the ground'. One of the strengths of having consumer and carer consultants is that they identify the underlying issues arising from feedback, and understand what satisfaction ratings actually mean. Consultants may more effectively be able to drill down to find out what is happening when themes emerge from other sources of patient and clinician feedback.

### Obtaining and using information effectively

Service providers identified that while strategies were in place to collect information from service users, these were not always followed up with effective feedback mechanisms. They reported a number of approaches that had been adopted to improve this issue. These approaches included:

- having consumer advisory groups report directly to health service executives rather than having their input mediated through other channels
- developing reporting mechanisms so that changes implemented in response to surveys are fed back to service users
- establishing social media interactions with their community, employing a full-time worker to moderate these interactions
- having service representation at arts festivals
- the creation of a peer worker magazine.

### Training for effective collaboration

Service providers identified that service users and service providers both needed training for collaboration to be effective.

One key element was the language that is used in meetings – service providers need training to check their use of medical terms and jargon, so as not to constrain other committee members' capacity to interact.

Service users require training in being representative of others as well as themselves. Mentoring and supervision were suggested as good models to support this.

It was considered that both service users and service providers need training in recognising and enabling contribution from the full range of their community, including service users from culturally and linguistically diverse, Aboriginal and Torres Strait Islander, and lesbian, gay, bisexual, transgender and intersex groups.



### 5.2.3 Mandatory standards, accreditation and compliance

Half of the respondents reported that when a standard was mandatory, this was a motivating factor for implementation. Accreditation is the mechanism by which implementation of the standards is typically verified.

As noted in Section 3, funding arrangements and individual jurisdictional requirements mean that although the *NSMHS* and *NSQHS Standards* are nominally voluntary for some service providers, they are required for a large number of services.

In relation to accreditation, a number of participants favoured a broader rating system for the *NSQHS Standards* which acknowledged excellence rather than 'yes/no' or 'met/not met' ratings. Earlier rating systems, which included the awarding of an 'outstanding achievement' rating, were credited with motivating team cohesion. These responses indicated that there was a general lack of awareness about the 'met with merit' rating scale for the *NSQHS Standards* among a number of service providers.

Some service providers reported that accreditation gives a service credibility, and promotes competition due to benchmarking. Others were more blunt, and stated that if standards were not mandatory, resources would not be available for their implementation.

The perceived 'black and white' nature of the *NSQHS Standards* was also talked about in a positive way with several service providers commending them as reducing 'fudging'.

Several service providers reported that the *Draft Accreditation Workbook for Mental Health Services* developed by ACSQHC was a useful tool for working through implementation.<sup>13</sup>

### 5.2.4 Training to increase awareness of standards

Targeted training was identified as an important factor in raising awareness for both sets of the standards. It was considered that education and training is required to show the applicability of the standards and how an amendment to work practices to reflect a standard has a direct impact on the client.

The inclusion of education about both sets of standards within curricula preparing workers to work in the sector was identified as being important, but reported to be practically non-existent. Several current and recent students reported that the standards were not discussed in their courses.

Participants also reported that pre-qualification education needed to be followed up with ongoing training once people are working in mental health services.

This was one area where there was a notable difference between respondents from different sectors, with over 90% of CMO sector staff noting the importance of training, compared to 70% of public sector staff, and 44% of private sector staff.

Some jurisdictions have rolled out training on specific standards. For example, one jurisdiction has expanded an existing training program they deliver to the workforce on *NSQHS Standard 9: Recognising and responding to clinical deterioration*, to include deterioration in mental state.

### 5.2.5 Knowledge sharing

The release of the *NSMHS* in 2010 was accompanied by a formal implementation strategy, which included a national forum of key stakeholders, as well as the three implementation guidelines. There were also a number of initiatives funded through the former Australian Government Department of Health and Ageing, and undertaken by jurisdictions either individually or in collaboration. Most of these initiatives were completed and disseminated nationally, including a poster competition to raise awareness of the standards, and brochures containing simplified versions of the *NSMHS*.

Participants, mainly from public and community-managed health services, thought that the sharing of knowledge between organisations enabled the implementation of the standards. It was considered that this reduced the 'reinvention of the wheel' around common documents such as consent forms and enhanced the co-ordination of mental health services.

# 5 Information from service providers

## 5.3 Barriers to implementation

The barriers to implementation reported by survey respondents are summarised in Table 2.

**Table 2: Barriers to implementation of standards**

Barriers - either prevents implementation or significant barrier	Percentage of survey respondents reporting barriers to the implementation of either set of standards							
	NSMHS Overall %	NSQHSS Overall %	NSMHS Public %	NSQHSS Public %	NSMHS Private %	NSQHSS Private %	NSMHS CMO %	NSQHSS CMO %
Financial resources	78	61	94	67	27	25	61	50
Human resources	60	46	53	50	25	31	50	30
Duplication with other standards	25	29	27	31	27	17	25	20
Availability of information/guidance about the standards	21	25	24	27	0	0	18	18
Uncertainty about the applicability of the standards in your service	15	31	19	34	7	28	9	28

Focus group participants largely agreed with the barriers identified in the table, and added the following barriers:

- structural and administrative issues
- barriers to effective collaboration with consumers and carers
- accreditation processes.

Each of these barriers is discussed in detail in the following sections.

### 5.3.1 Financial resources

With finite resources, participants indicated that the time devoted to implementing the *NSMHS* and *NSQHS Standards* is often perceived as time taken away from providing clinical services. Participants reported there is a constant fight for funds for safety and quality projects, and that there is a need to be able to demonstrate that safety and quality work impacts positively on client services to obtain resources.

Funding issues in particular were reported to adversely impact on implementation in areas including education and training, integration of services, 'aspirational' standards, multidisciplinary teams, maintaining accreditation, assessing the value of programs, and acute services in remote and rural areas.

These issues apply generally to both the *NSMHS* and the *NSQHS Standards*. Frequently participants would cite financial constraints to give weight to their concerns about the applicability of various standards. For example, to illustrate the challenges faced by the services, they cited the *NSMHS* deemed more aspirational, such as *Standard 5: Promotion and prevention*, and the *NSQHS Standards* deemed most distant from mental health practice, such as *Standard 7: Blood and blood products*.

The use of resources to implement safety and quality initiatives were reported to cause tensions, as resources are widely perceived to be ‘taken away’ from other parts of the service. This sense persisted, even as participants acknowledged that the redeployed resources resulted in demonstrable improvement to the service.

Respondents from public mental health services rated financial resources as a greater impediment than did the other service types. In the focus groups, participants from public mental health services confirmed that cuts to funding have had substantial adverse impacts on their organisations.

Effective education and training in the standards is an ongoing and substantial undertaking which requires the continuous expenditure of time and money. Service providers perceived this as being a particularly heavy use of resources because in addition to the actual cost and time taken for the training, staff are taken away from their usual duties. However, participants noted that if education and training are not undertaken properly, people are unaware of the rationale for standards, which leads to a ‘tick box’ mentality and standards that are not properly implemented.

Service providers identified that the implementation of the more ‘aspirational’ *NSMHS* is sometimes not undertaken because the finite resources are applied to mandatory standards.

The provision of programs in rural and remote areas was reported to be adversely affected by a lack of resources. It was reported that many projects are started in remote Australia by CMOs that take the initial funding but do not accept the responsibility of providing ongoing services. There can be funding for research and not for service delivery. Some participants queried whether such funds could have been better devoted to providing additional training for existing workers.

Smaller organisations, particularly in the CMO and private sectors, reported that they have difficulties retaining staff in dedicated quality roles in their organisational structures, and this necessitates quality being an ‘add-on’ for staff in other roles, both front line and management.

Finally, it was frequently highlighted by participants that accreditation itself is a costly process, and represented a significant financial burden for health services.

### 5.3.2 Human resources

Limitations in human resources were also identified as a major barrier to implementation of the standards. Participants in all sectors and jurisdictions reported there have been staff cuts. In some cases, examples were given where cuts had resulted in certain roles no longer being undertaken. For example, in one case, the person who the participant used to go to for advice on quality or safety processes was no longer there, and had not been replaced. The number of staff and programs that are available in public mental health services have been reported as being reduced by recent restructures and this has resulted in increased workloads for those who remain, with less time to implement standards. In some services, positions were reported to not be officially deleted, but were left unfilled indefinitely.

The issue of human resources being a barrier to implementation was reported to be most evident in a lack of available time. Service providers did not always think extra staff were needed, but instead extra time for existing staff to do their work comprehensively. Specific problems related to human resources were categorised as being:

- knowledge is not effectively shared
- services lack trained staff
- services can have entrenched workplace cultures.

#### Knowledge not shared

One service provider summarised the situation as, ‘It is a matter of economic necessity that the safety and quality push has to pass from the safety and quality team to be driven by the service teams themselves. You have to spread the work load otherwise it is unsustainable.’ However many service providers reported people in their organisation working in ‘silos’, with limited effective communication. This frequently leads to defensive reactions from workers around quality improvement activities.

Participants noted that tools and strategies were often developed by different organisations but not shared or rigorously evaluated.

It was also noted that, due to time constraints and skills limitations, considerable good and innovative work was being undertaken by services, but not being written up in peer-reviewed journals, and therefore not achieving the designation of ‘evidence-based practice’, which forms a barrier to wider implementation of these innovations.

# 5 Information from service providers

## Lack of trained staff

Service providers stated that mental health is a specialty practice, and mental health service users deserve to have expert staff delivering their services. However, limited training in the speciality of mental health in undergraduate courses, staff cuts, staff turnover and reliance on contractors rather than permanent staff were perceived as having a negative impact on the service capacity to do this.

Training for existing staff was also identified as a barrier because it takes staff off line, which greatly adds to its cost. Other human resource issues that were reported to affect implementation of the *NSMHS* and *NSQHS Standards* include:

- constant changes in personnel, particularly in rural and remote areas, leading to loss of skills and corporate knowledge
- people being unreceptive to change or training
- the disproportionate burden of compliance with documentation on permanent staff, which prompts workers to move to casual employment
- implementation of safety and quality measures because they are regarded as extra work and not part of a person's 'real' job
- a lack of skilled mental health workforce, particularly nurses.

In addition, participants considered that restructures and cuts to the budgets of public mental health services have resulted in poor morale and a lack of resources to write up or undertake administration around implementation of the standards.

One participant highlighted a potential benefit of the staff turnover that characterised regional services: 'You won't have a stable workforce, but you'll have a workforce of bright young things who bring fresh ideas'.

## Entrenched workplace culture

Service providers reported that workplace culture and staff attitudes can be a barrier to implementing standards. While some services have an enabling culture of ongoing quality improvement, there are other services where negative attitudes were reported to prevail. Characteristics of such negative cultures include:

- asserting that quality improvement work is in addition to people's jobs rather than integrated
- general resistance to change
- rejecting the need for targeted approaches for people from specific communities – for example, culturally and linguistically diverse (CALD), Aboriginal and Torres Strait Islander, lesbian, gay, bisexual, transgender and intersex – as 'we treat everyone the same'.

Some service providers reported it as a matter of luck when workers who were perceived to be burnt out leave of their own volition. A few services reported shifts in attitude, even among seemingly reluctant staff, when it has become clear that changes have improved outcomes for service users.

It was reported that the different cultures and demographics of mental health services was a factor in making the integration of services difficult. Tensions around 'gatekeeping' inhibit integration across sectors. Some service providers suggested there have been longstanding issues in the delivery of services to people with comorbid substance use and mental health issues, in part because of different philosophical approaches to compliance with treatment. Participants also reported emerging gaps between mental health and social and emotional wellbeing services.

### 5.3.3 Duplication with other standards

The scoping study was undertaken with the understanding that mental health services in the public and private sectors have to implement the *NSMHS* and *NSQHS Standards*. Participants commented on the many other standards, policies and frameworks they have to implement as part of regulatory and funding arrangements. Some CMOs run different types of programs and therefore have multiple standards to implement. Some organisations have more than one funder, and operate in more than one jurisdiction, and have duplication of reporting mechanisms.

One participant reported he had to complete three different paper journals for accreditation, each around 100 pages. He estimated the overlap of information at around 80%, but because questions were worded slightly differently, it was not possible to cut and paste information.

All participants found the present environment confusing with the existence of different overlapping standards applying to their organisations. There was a perception of information overload, which meant that standards might not be embedded adequately into work practices. Most providers indicated that their usual solution is to focus their limited resources on the basics and decide where they are going to obtain the most effect.

### 5.3.4 Lack of information about the standards

Service providers were generally satisfied that there is adequate information available to guide services in implementation of the *NSMHS* and *NSQHS Standards*. However, some of their comments indicated a lack of awareness of the intent of the *NSQHS Standards* in particular, suggesting that they may not have accessed all available resources to support implementation and the applicability of the standards.

Service providers identified a gap in the broader awareness of the standards, first among service users and support people, and then in the wider community. Service providers suggested that a clear communication strategy of discussing mental health issues in the community was needed so that information was available at the right time and in an appropriate format. They consider that service users should know what to expect from mental health services, including what can be done and what cannot be done.

Participants also noted that stigma prevents community consultation, as people do not want to publicly demonstrate that they or their families have used mental health services.

### 5.3.5 Applicability of the standards

The applicability of the standards in different services, and their appropriateness to different contexts was one of the most heated issues in the focus groups. The tension between the standards as guidelines for implementation and tools for accreditation was particularly highlighted.

Participants criticised the language of the *NSQHS Standards* as being too compliance-oriented, and restricted to medical models. This was considered to make the *NSQHS Standards* inconsistent with the more flexible approaches advocated within recovery principles in mental health.

For both sets of standards, participants described a paradox between meeting universal standards and providing holistic care tailored to the individual.

Both sets of standards were described by some participants as ‘metro-centric’, ‘urban-centric’ and ‘acute-focused’, and difficult to apply to regional mental health services. One participant commented that, ‘Some regional and remote services are better able to benchmark against regional services in Canada than Sydney.’

The relationship between private office-based psychiatrists and other parts of the mental health system was discussed from several perspectives. It was suggested that it was difficult to monitor and assess outcomes for the people they are seeing.

Within the *NSMHS*, *Standard 4: Diversity Responsiveness*, was highlighted as not applicable by some participants, while others argued that such attitudes reinforced the need for this standard. Similar resistance to *NSQHS Standard 5: Patient Identification and Procedure Matching* was voiced around the fact that most mental health inpatient services do not wear identification wristbands. Some participants thought this meant that mental health services are not understood by policy makers, while the majority of participants saw a clear opportunity for applying this standard in mental health services. These different views about *NSQHS Standard 5: Patient Identification and Procedure Matching* provide an example of how some service provider participants appeared to have a lack of knowledge about the intent of the standards and how they apply in mental health settings, while for others the intent was clear and the standard was viewed as an opportunity.

## 5 Information from service providers

Many participants suggested that the applicability issues would be of less concern if there were clearer and simpler exemption processes. Participants did not necessarily think that their service should be exempt from whole standards, such as *NSQHS Standard 10: Preventing Falls and Harm from Falls*. However there was a view that their compliance should be able to be benchmarked against other mental health services.

### 5.3.6 Structural and administrative issues

Over 80% of focus group participants identified that the frequency and extent of changes in the structure of mental health services acts as a barrier to implementation of the standards in general. The reason for this is that services focus on maintaining delivery of core services, rather than the 'extra' task of implementing standards.

Four jurisdictions were reported to have undertaken major restructures of their public health services in the past few years. Many of these changes have not been finalised, so some service providers reported that basic questions such as, 'Who is going to do this work?' have not been resolved. Some of the restructuring has decentralised responsibility from larger areas to services centred on local hospitals, reducing channels of communication and information sharing.

There have also been changes to the standards mental health services need to implement. The *NSMHS* were revised in 2010, the *NSQHS Standards* were introduced in 2011, and there is a perception by some service providers that the introduction of both sets of standards does not necessarily align neatly with existing accreditation and regulatory frameworks. Several jurisdictions have also made recent changes to their mental health legislation, which services must adhere to. The absence of national mental health legislation was considered to present particular problems for services close to state borders, as services were vulnerable to differences in state legislation, when service users move about.

In addition to the revised *NSMHS*, there has also been a revision of the *Mental Health Statement of Rights and Responsibilities* (2012)<sup>14</sup> and the launching of the *National Framework for Recovery-Oriented Mental Health Services* (2013).<sup>15</sup> With this range of new policy frameworks even well-informed service providers and service users reported having difficulty staying up to date.

Service providers suggested some system issues were barriers to implementing *NSMHS Standard 9: Integration* and *NSMHS Standard 10: Access and Recovery Principles*. Participants in one jurisdiction reported a policy change directed all admissions to the mental health system to occur via hospital EDs. This was viewed as inappropriate for some people with mental health issues. In another jurisdiction, certain services provided by the community-managed sector were available to service users who lived in particular postcodes, and not available to people in neighbouring postcodes, who met all the same eligibility criteria. In another jurisdiction, inclusion criteria for a community-managed sector service were dependent on the service user concurrently receiving services from the public tertiary mental health service. Clients who met the public mental health services' internal criteria for discharge, but still met criteria for the CMO service were faced with the decision to exaggerate symptoms in order to qualify for ongoing contact with the public mental health service.

Another example given was that clients with a dual diagnosis often miss out on receiving treatment because of the poor interaction of the organisations providing mental, medical and social support. This problem particularly affects people with mental health issues and drug and alcohol issues or intellectual disabilities. It was suggested that the area has been complicated by the political process which has led to welfare reforms without sufficient consultation with the organisations providing services. In practice, it is difficult for one organisation to effectively address all the issues that a person may have.

Service providers gave a number of examples of where the administration requirements for funding caused issues for them. There can be too many funders, including various Australian Government and state agencies and too many programs including disability and mental health programs. Funding is frequently provided for seeding pilot programs, and when this funding ends, even if the program proves effective, it is not always eligible for ongoing funding. Programs end, and the work they have been doing is transferred to existing services already managing finite resources.

Competitive tendering in the community-managed sector was highlighted in particular as being associated with a number of issues that act as barriers to implementation of the standards. This has led among other things to:

- a proliferation of pilot programs
- different access and accountability systems
- a lack of time to develop and obtain evidence to establish the effectiveness of programs
- a decrease in the cooperation that formerly existed between many mental health services particularly in rural areas
- the poaching of staff to run programs
- smaller community-managed organisations not being able to compete on a unit price or to prepare tenders because they do not have the infra-structure in the first place
- difficulties keeping teams together as funding is not long-term.

In some instances even three-year funding is not indexed. This was reported as being difficult as services are required to maintain services while absorbing increases in running costs.

### 5.3.7 Barriers to collaborating with consumers and carers

Three quarters of the focus group participants reported difficulties in their mental health services' collaboration with consumers and carers. There were issues complying with *NSMHS Standard 3: Consumer and Carer Participation* and *NSQHS Standard 2: Partnering with Consumers*. This does not contradict the earlier finding that this collaboration was a key factor enabling implementation, but provides evidence about specific challenges service providers have encountered in these processes.

Participants reported that some service providers find it challenging to work with service users, at times because they are scared of them. Tensions were reported between some service providers and service users, with each group feeling the other had more rights. The knowledge and expertise of service users was not always recognised by some service providers, where it was suggested they were threatened by a shift in the power dynamic from their position as the acknowledged experts. There was a general lack of knowledge about legislation that could assist carers in having their rights met, for example the *Carers Recognition Act 2004 (WA)*, *Carers Recognition Act 2005 (SA)*, and *National Carer Recognition Act 2010*.

There were difficulties reported in empowering consumer and carer representatives, with not enough mentoring and supervision available. It was commented that sometimes consumers and carers 'get the wrong end of the stick' and can lose credibility in formal meetings and committees. Remuneration for consumer and carer representatives and consultants was reported as being an ongoing issue.

Service providers also reported many attempts at engagement that did not succeed, including surveys with less than 5% response rates, and community-targeted open days that were not attended. For some service providers, these setbacks lessen morale and reduce energy for ongoing engagement, while for others they are evaluated and alternate strategies trialled.

The practical involvement and engagement of consumers and carers in remote and rural mental health services was reported to be hard to establish, with the view expressed that a different model for consumer and carer collaboration was required. One example proposed was a mentoring relationship, so that carers could come together and develop a sense of trust. Once local groups are formed there is a source of representatives available for consultation.

Participants indicated that systemic consumer and carer participation was easier to obtain than true collaborative care planning, and that discussions in committees do not always lead to change 'on the ground'.

### 5.3.8 Accreditation processes

Three quarters of focus group participants were of the view that aspects of the accreditation process did not support effective implementation of the standards.

Issues that have been previously discussed in this report include duplication between standards, the language the standards are written in, the purpose the standards were written for, the difficulty in gaining exemption for non-applicable criteria, the cost of accreditation, and the loss of 'outstanding achievement' ratings.

An issue many participants raised was concern about inter-rater reliability among surveyors. People reported surveys that bypassed the mental health parts of larger services, surveyors who had no experience or knowledge of mental health service delivery, and surveyors with particular 'hobby horses' who focused on narrow concerns only.

# 5 Information from service providers

Accreditation occurring at fixed times was also criticised, with participants suggesting that random audits would give a more realistic picture of how the service is operating.

Accreditation consisting of reviews of documentary evidence was also criticised, with terms like 'lip service', and 'tick and flick' used regularly. The evidentiary requirements of accreditation, assembling proof of meeting between 20 and 50 criteria for each individual standard, was perceived as being time consuming and expensive. It was thought that accreditation should not be about putting together quality journals; rather, surveyors should be able to assess the systems that are in place. There was widespread concern that the system lends itself to being manipulated. There was also concern that quality processes are assessed through largely quantitative means, and that there is a gap in terms of qualitative evaluation of service delivery.

A substantial majority of providers supported a uniform system of accountability for the *NSMHS* and *NSQHS Standards*, which ensures a high level of compliance for all the standards. A well-resourced national evaluation system that recognises the different sizes and types of organisations was suggested as a way to help to lift the credibility and quality of the standards.

Standardised risk assessment tools for each individual standard would allow combined set of standards to be used in general health and mental health areas and in acute and community-based contexts. For example, regarding the collection of physiological observations, it would be possible to shift the parameters of what is an acceptable range of observations to get the correct trigger points in acute and non-acute situations. A 'one-size-fits-all' approach to this issue can mean that triggers are over-sensitive or not sensitive enough. By going through this process, an appropriate system of exemptions could be developed.

## 5.4 Gaps in the standards and ways forward

Focus group participants were asked to identify any gaps in the current versions of the *NSMHS* and *NSQHS Standards*, particularly regarding safety in mental health services.

They were also asked for input on the best way forward in terms of national standards for mental health services.

### 5.4.1 Gaps in coverage of *NSMHS* and *NSQHS Standards*

A significant majority (80%) of survey respondents reported that the *NSMHS* on their own adequately address safety issues in mental health services. Seventy per cent reported that the *NSQHS Standards* on their own address safety adequately.

Gaps identified in the standards generally related to systemic aspects of service delivery, and to recognition of the whole person accessing services. Some gaps that were identified are already included in the standards, but participants felt they were not currently adequately addressed.

Systemic issues where it was considered there were gaps include:

- the environment in which care is delivered
- governance
- service integration
- staff safety, supervision and training.

Gaps identified by service providers that affect service users include:

- not treating the whole person
- the service delivery journey
- recognising diversity
- seclusion and restraint.

Each of these points is covered in detail in this section.

#### **The environment in which care is delivered**

Participants identified that currently the *NSQHS Standards* are focused on acute care settings, and do not transfer easily to community settings, where a large part of mental health services are delivered. The *NSMHS* were also reported as paying too little attention to where care is delivered. Workplace health and safety legislation can be expected to provide some support to staff working in less controlled environments, such as home visits, or homelessness outreach programs. Participants would also like to see similar considerations to these in the standards.

Participants reported it would represent a significant improvement if the delivery of care to people with mental health issues in general health settings, most particularly EDs, was covered by the *NSMHS*, as well as the *NSQHS Standards*.



A critical issue identified by several participants was that physical restraint is being implemented in general health settings, and not documented with the rigour required in mental health settings. This practice prevents benchmarking, so the extent of the problem is not known, and subsequently it is not possible to monitor the issue, implement strategies to reduce the practice, and evaluate if the strategies are working. Incorporating the *NSMHS* standard on restraint into the *NSQHS Standards*, or expanding the scope of the *NSMHS* to other health settings were suggested as ways to address this gap.

Both sets of standards were criticised by service providers from rural and remote areas as being 'metro centric' or 'urban-centric' and it was considered that their applicability to rural and remote services was limited. This was particularly true in relation to safe transport, which often relies upon the Royal Flying Doctor Service (RFDS). The RFDS was reported to prioritise transport of people with physical health emergencies over people with mental health emergencies. If the RFDS is unavailable there can be issues of restraint and sedation involved in the transportation of the person. In addition, there is the issue of how the person returns to their home at the end of the treatment.

### Governance

Participants perceived that the standards deal well with clinical care but do not address issues such as management, administration and finance. It was suggested that funding bodies would not have sufficient confidence that governance was being dealt with properly under the current standards.

To enable mental health services to have adequate information about their service users, it was suggested that standards are required around data integrity (such as outcome statements) and the establishment of state-wide databases. It was also suggested that governance around information and technology (such as e-resources and apps) should be included in such standards.

It was recommended the standards deal more fully with the issue of consent. This includes the boundaries for consent to treatment and how these boundaries can be applied in all contexts.

### Service integration

*NSMHS Standard 9: Integration* was reported by survey respondents as one of the least fully implemented standards. Integration was frequently interpreted by service providers as needing to occur between services, though the standard also sets out criteria that address integration within organisations.

Mental health services all have different cultures and demographics, which makes the integration of services difficult. A number of participants thought that mental health services need to look at the broader picture for their service users and undertake wider case management, similar to that undertaken by drug and alcohol services. Otherwise service users, particularly those with a dual diagnosis, miss out on receiving treatment because of the poor interaction of the organisations providing mental, medical and social support.

Examples of issues with integration include:

- care plans and common records that are not shared between or within mental health services
- interim discharge summaries that do not include all the necessary information about a service user to facilitate continuity of care by the service assuming treating responsibility
- gaps in service delivery when a person is transitioning from inpatient care into community/ GP/psychologist care. If it is not appropriate for them to be referred to a community outreach team, there is a period between discharge and their outpatient appointment where no practitioner has formal clinical responsibility. This is particularly critical when deterioration of physical and/or psychological health issues occurs.

Participants commented that the level of integration between public and private mental health services is often problematic as there are minimal links between private mental health hospitals and community-managed organisations.

Service providers reported that it is unclear in the *NSMHS* and *NSQHS Standards* as to who is accountable for the various steps that are involved in having services properly integrated, and that this is a perceived gap in the current sets of standards.

# 5 Information from service providers

## Staff safety, supervision and training

While the two set of standards make reference to mental health services complying with relevant legislation and standards, including workplace health and safety legislation, and the *National Practice Standards for the Mental Health Workforce*,<sup>11</sup> participants commented that the *NSMHS* and *NSQHS Standards* should be more explicit about staff issues.

Service providers suggested that assaults on staff, other inpatients or visitors need to be recorded and nationally reported in the same way as seclusion and restraint, to enable benchmarking and concerted strategies to reduce the incidence.

In addition to specifying staff safety in all settings where mental health services are delivered, it was suggested that the standards should spell out what training is needed for a competent workforce.

Service providers thought that standards should be taught by educational facilities in all their health courses from undergraduate onwards.

Also, participants commented that the standards could address the area of clinical supervision in more depth.

## Not treating the whole person

Focus groups in particular emphasised the importance of the standards ensuring health services treat the whole person.

The *NSMHS* should deal with physical health issues, including chronic conditions that people experiencing mental health issues are likely to have and dual diagnosis issues with drugs and alcohol. Neither the *NSMHS* nor the *NSQHS Standards* deal with metabolic issues and nutritional standards for service users. It was suggested that the nutritional standards recently introduced in NSW should be part of the national standards.

Many participants suggested that the *NSQHS Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care* should be expanded to cover deterioration in a person's mental state.

Physical illness is often missed and not treated in people who have mental health issues. For example, when a person is entering the mental health system through an ED, the mental health diagnosis frequently takes precedence, even when it is not the presenting problem, and sub-optimal physical investigations are carried out.

Participants commented that the standards should acknowledge and support the concept of optimal development, and consider what people require by the age of 4 or 5 so that they have a reasonable start to life. This was considered to be particularly important for identified children of parents with mental health issues, especially those who undertake a role as carer.

## Service delivery journey

Service providers felt that the *NSMHS* and *NSQHS Standards* revolve around medical models and that greater consideration should be given to the social/community context. It was considered that there was insufficient acknowledgment of a patient's journey from illness to wellness, and the transitions in and out of care, including the issues of managing chronic risk, access to ongoing treatment, transfer of information and liaison with other services. There was also not enough recognition of the enduring nature of some mental health problems.

The *NSQHS Standards* in particular do not specifically address the mental health service journey dealing with issues such as transitioning in and out of care. Participants wanted to see the *NSQHS Standards* include provisions to ensure the care journey is integrated and safe.

While people felt *NSMHS Standard 10: Delivery of Care* deals reasonably well with the service delivery journey, it did not adequately recognise that people move at their own pace.

## Recognition of diversity

There was general recognition that the 'one-size-fits-all' approach was not effective in mental health services, but there was some uncertainty about how to remedy this. Representatives of different stakeholder groups all expressed the view that if a mental health service were to adequately address the needs of their constituents, there would be flow-on benefits for all service users.

Women constitute a majority of service users, and are represented in the majority in most service provider roles, yet mental health services still default to a generic approach, and do not readily offer woman-centred options. Gender is addressed minimally in the *NSMHS* and not explicitly in the *NSQHS Standards*. Existing guidelines, for example the Victorian Chief Psychiatrist's Guidelines on *Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units* were suggested as providing a strategy that could be adopted nationally.

*NSMHS 4: Diversity Responsiveness* was acknowledged by many participants as being the least successfully implemented standard in their mental health services. The challenges providers were facing included: ascertaining the cultural diversity in an area; learning to deal with families rather than just individuals; working with translators and knowing how to engage with various communities; and paying attention to the social context in which mental health services are being delivered.

People coming from CALD backgrounds often have a focus on the family which was seen to be at odds with the individual focus of the European model of mental health. The core of any standards dealing with mental health care should be respectful practice. Adhering to the respectful practice model stops attempts at being culturally appropriate going wrong and acknowledges that racial tensions still exist.

It was considered that a general community stigma about mental health issues prevented a sophisticated discussion about issues surrounding it and the implementation of standards that would deal with both community and inpatient programs and the transfer of people back and forth between the systems. Participants thought that there needs to be a cultural change so mental health issues are regarded in the same manner as other health issues that vary greatly in how they can be successfully managed.

The rates of mental health problems and suicidal ideation among lesbian, gay, bisexual, transgender and intersex (LGBTI) Australians are higher than for the general community. Despite these high rates, participants did not see this translate to representation in service use, suggesting services are not adequately addressing the mental health needs of members of these communities. Neither set of standards was thought to specifically address this imbalance.

Another problem identified by service providers was that some generic services have tended to be particularly utilised by specific communities in the population, such as Aboriginal and Torres Strait Islander people. When these services are cut back, there can be a disproportionate impact on outcomes for service users from these particular groups, which is not reflected at policy level, but has to be absorbed by other existing services.

### Seclusion and restraint

Service providers reported that seclusion and restraint are key elements of safety in mental health services. They noted that these issues are briefly mentioned in the *NSMHS*, and are not addressed specifically in the *NSQHS Standards*. Service providers identified this as a gap with respect to patient safety and quality.

One result of this gap is that principles and procedures practiced in mental health settings are not always followed in general health settings, where participants frequently reported that service users are being restrained without the incident being recorded in their health record, or in any benchmarking activity.

Service providers suggested that public reporting of seclusion and restraint was important for transparency around the practices (AIHW first issued national reports on seclusion and restraint from July 2013, in the middle of the scoping study)<sup>16</sup>. They reported there are still instances where seclusion is used inappropriately, such as when people are refusing medication.

Service providers also reported that seclusion and restraint were treated differently under the different jurisdictional mental health legislation, and this created some difficulty in discussing these practices at a national level.

# 5 Information from service providers

## 5.4.2 Ways forward

There was almost universal support for the existence of standards in some form, both as guidelines for implementation of safety and quality measures, and as tools for benchmarking and accreditation. There was minimal support for the current situation, with mental health services having to implement two sets of standards, and lack of clarity around which elements are mandatory for which particular services.

### One comprehensive set of standards

Over 70% of respondents indicated that a comprehensive set of standards incorporating the *NSMHS* and *NSQHS Standards* would be the best way to ensure safety and quality in mental health services. Public and private mental health service respondents favoured this option more strongly (public 70%, private 75% and CMO 48%). This is consistent with the fact that most of these services have to implement both sets of standards, while the CMO sector is only implementing the *NSMHS*.

Service providers agreed that a combined standard is needed because people with mental health issues are in all health-care settings and it encourages a holistic approach and a sharing of skills. Mental health is everyone's business but it is difficult to create standards which ensure that mental health is seen as part of the general health system. There was general agreement that the *NSMHS* need to be built into *NSQHS Standards* and be treated equally during survey processes.

It was considered that ideally there should be a complete system so there is one set of standards that includes both physical and mental health from cradle to grave, and covers public, private and community-managed organisations. In other words, there needs to be a complete loop so everyone knows how to be safe in all contexts, and issues of responsibility and accountability are clearly expressed. A combined set of standards should include a recovery focus so people disclose all their needs, not just the immediate, usually medical, issues that are often given primacy in acute contexts.

The only concern raised by some service providers about a merged set of standards is that the *NSMHS* could lose their position and be diluted. They thought that the prominence of mental health issues needed to be preserved in any transitional period. This is because mental health issues often lag behind physical issues and a period of affirmative action may be needed.

### Standards should be mandatory

Survey respondents and focus group participants stated that both sets of standards, or a future combination of the two, should be mandatory. This was because it gave credibility to the issue of safety and quality within mental health services and justified the expending of resources to implement standards. They reported that without standards being mandatory there was often a lack of action on the ground, and that service users deserve to know that their services are safe.

Focus group participants reported that the *NSMHS* are in fact mandatory for many services, either through regulatory directives from jurisdictions, or through funding arrangements. Nonetheless, there is still confusion about which standards are mandatory. Service providers also reported that the consequences are not clear if a service is in breach of the standards, and that direction about the consequence of non-compliance is needed. Some service providers expressed concerns about the impact that making standards mandatory would have on mental health services' capacity to be innovative. This relates directly to what are perceived to be the more 'visionary' standards in parts of the *NSMHS* such as recovery.

This section reports on the consolidated information provided by service users who responded to the survey or participated in focus groups.

Groups were structured around four key topics that arose out of the survey responses:

- changes observed in the mental health services they accessed
- opportunities to collaborate in service planning and evaluation
- safety when accessing mental health services
- gaps in the standards and ways forward.

Service users reported significant variation in their awareness of either set of standards prior to participating in the scoping study, with around 40 percent reporting no previous awareness of the standards. However a number of service users were well-informed about the standards and some participants had collaborated on the drafting of the *NSMHS*.

## 6.1 Changes observed in mental health services

The majority of focus group participants reported that there had been changes in their mental health service in the areas the standards address since the release of both sets of standards. These changes were noted for different aspects of the services – sometimes for the better (83% of groups) and for other aspects, the changes were felt to be for the worse (50% of groups). Participants were unable to link these changes directly to either the *NSMHS* or the *NSQHS Standards*.

### 6.1.1 Changes in services for the better

Some of the general improvements included:

- better staffing, including more full-time staff, and the departure of workers perceived to be 'burnt out'
- more home visits
- more translation services
- better documentation for individuals and families about understanding mental health issues
- better service user representation on committees, and consumer and carer feedback now being dealt with. This was described as services' commitment to engage moving from tokenism to real engagement.

Some service users reported the *NSMHS* provided some 'leverage' and were having a positive impact on people in mental health services. Service providers were described as listening more closely to users and gradually opening up to non-medical models of treatment, recognising and involving service users as partners, and talking in terms of recovery rather than treatment. In noting these developments, service users commented that change is a slow process.

### 6.1.2 Changes in services for the worse

Similar to service providers, service users often commented negatively on the constant changes in the landscape of mental health service delivery, often leaving them feeling 'high and dry'.

Approximately half of the participants perceived there had been a level of deterioration in the mental health services they access. Participants raised issues such as:

- an industry has been created around the collection of irrelevant data
- greater risk aversion, with service safety prioritised, resulting in processes being followed diligently without reference to whether they produce the best outcomes for service users or not. This rigid adherence to standards was seen to be particularly at odds with principles of recovery-oriented practice
- some service users being unable to formulate the required recovery plans but still being asked to complete them.

Some service users thought that the services provided by CMO mental health services were variable. In some cases it was thought that these organisations were often better at producing tender documents than delivering services. Service users commented that CMOs often have staff with very low levels of training in mental health services and were unable to provide care that meets the *NSMHS*. Uncertainty about ongoing funding often meant that some developments that would support the implementation of the *NSMHS* and which had been forecast, such as the employment of more peer workers, are indefinitely deferred.

## 6 Information from service users

A number of service users thought that implementation of the *NSMHS* and *NSQHS Standards* was impeded by the fact that two levels of government, Australian and state/territory, are operating in the health area. Private hospitals have to comply with a range of different policies and it is not always clear how all the standards and policies interact. Service users suggested that this results in services for mental health issues not being delivered equitably.

### 6.1.3 No changes observed in services

Participants who had previous knowledge of the standards made several comments about the lack of change observable in mental health services since the release of the 2010 *NSMHS*, or any increased awareness of the existence of standards among service users. They commented that both sets of standards were not accessible to 'grassroots level' service users, that there was a lack of effective implementation of the standards, and a lack of reporting about implementation strategies. It was suggested that 'posters and pamphlets are not enough' and that there needs to be substantial training for both service providers and service users to support implementation.

## 6.2 Opportunities for service users to participate in planning and evaluation activities

Focus group participants confirmed what survey respondents said, namely that collaboration and participation between mental health services and service users and carers was the best way to improve the safety and quality of mental health care. They supported the content of both *NSMHS Standard 3: Consumer and Carer Participation* and *NSQHS Standard 2: Partnering with Consumers* but reported that implementation of these standards still has a way to go.

In similar fashion to service providers, service users talked about collaboration in distinct, if overlapping ways: collaboration with service providers on the planning and delivery of their care; and collaboration with services systemically, as representatives in a range of structured processes.

It was considered that the standards offer the impetus for providers and users to work together to provide the best care for individual service users and address the power imbalances that exist in the mental health system. On many issues providers and users need to collaborate, or as expressed by one participant: 'The doctors and clinicians need to get off their pedestals and patients and carers need to get off their knees.'

### 6.2.1 Collaborating on direct service delivery

Service users agreed with the view of a service provider that: 'Systematic consumer and carer participation is easier to obtain than true collaborative care planning.' Some service users reported that they sit in representative positions in mental health service organisations, and participate collaboratively in systemic planning, only to find little has changed when they engage directly with the service.

Areas identified by service users that remain problematic include:

- communication between service providers and service users, especially carers
- real partnership in decision making around treatment options
- consultation around discharge planning.

Service users thought that in some cases diligent implementation of the standards does not produce the best results for service users. Both public and community-managed mental health services are perceived to be more risk averse and concerned about service accountability than achieving a positive outcome for a person. Service users suggested that this hinders recovery processes because service users do not consider that they have choices about their treatment options.

Medication choice is a clear example of this phenomenon. Service users suggested that clinicians prescribe based on optimal symptom control, regardless of side-effect profiles. Service users may wish to choose a medication which is less effective, but more tolerable for their overall quality of life. However, service users felt that in this situation, it was difficult to have an equal conversation with clinicians about the balance between symptoms, outcomes and side-effects. A frequently reported response from clinicians was said to be 'You do not understand' or 'This is for your own good'; in effect using the person's mental health problem to discount their capacity to make informed decisions.

Service users also raised the issue of the proper tailoring of information to all service users. At present information can be delivered during a crisis situation when service users cannot properly process it. Often there is a lack of adequate subsequent written information which sets out the diagnosis or available options. Service users considered it to be important for service providers to have more training on assessing whether the information they are delivering is being absorbed.

Another overarching issue that was raised by service users was the family of a person living with mental issues. It was their perception that the role of the family is not well recognised in the *NSQHS Standards* and not sufficient in the *NSMHS*. The standards should be couched in the context of a social/wellbeing model rather than purely on an individual treatment model. This is particularly the case for Indigenous people and people coming from CALD backgrounds.

Carers and families highlighted that they need to have their expectations managed when a service user is released from inpatient care. In some cases the person is not going to be 'better' but is rather moving from an acute stage of illness to often a lengthy period of recovery in the community. Service providers need to be very clear about the behaviours that families and carers can expect. In addition to a family meeting upon discharge, families need to be given written information such as how to address difficult behaviours, and who to call if something goes wrong.

The participation of carers in a service user's recovery is more than asking the carer to provide some input. Carers considered that they were often treated as an information provider rather than part of the team. The role of carer is not being seen in the whole picture. It was reported that discharge meetings were often dressed up as family meetings. The pressure is to move people out of inpatient care into the community, but there is no assessment of carers' capacity to look after the service user.

Carers also called for the application of confidentiality in a sensible manner on a case-by-case basis, rather than the right being treated as a blanket prohibition on the sharing of service user information. While this is explicitly addressed in *NSMHS Standard 7: Carers*, participants reported the standard is frequently not being met by mental health services.

### 6.2.2 Service users as committee and board members

Participants stated that service users should be represented at board level of organisations as well as on committees. The aim should be to have consumer and carer representatives on every hospital committee once the right people are available.

Service users had strong opinions about who should represent them. Positions on committees should be via an interview process so only people who can function and contribute are appointed. It was thought that there was a lack of uniform guidance around the qualifications of people who act as consumer representatives.

Some service users expressed the view that if you have not been a recipient of mental health services for 10 years, you should not be representing current users. An example of one service was discussed that had a policy that committee members serve two-year terms. This ensures currency of knowledge and avoids burnout.

There was widespread support for consumer and carer representatives to have proxies to sit on committees when the usual member is unavailable. This recognises that, as well as other reasons why a member may miss a committee (such as holidays), service users may also be dealing with a recurrence of symptoms. For services that reported difficulty in recruiting representatives in the first place, proxies present an additional challenge.

### 6.2.3 Payment for participation

The majority of service users stated that people should be remunerated for participation in committees and on boards. For some, being paid means being treated as an equal and gives respect and empowerment to consumer and carer representatives. A small number of people, notably from the private mental health sector, indicated they were happy to make this contribution on a voluntary basis, and did not support paid participation. Other service users felt it was more important that representative positions be established and maintained than that members be paid.

Service users identified that as a minimum, many services should support committee members with reimbursement for travel. They thought that there should be clear guidelines about reimbursement and that these should be consistent across general and mental health areas.

# 6 Information from service users

## 6.2.4 Consumer and carer consultants and peer workers

Service users were supportive of the availability of paid work as consumer and carer consultants and peer workers in mental health services.

Some of the advantages identified for these roles include that they:

- can provide support that traditional healthcare workers do not always have time to provide
- have experience in navigating the system, including other services like Centrelink
- have knowledge that can be shared, for example, by creating national databases for service users from specific culturally and linguistically diverse backgrounds
- can share knowledge the mental health service may not have – for example, which local GPs have a good understanding of working with people with mental health issues (and which ones to avoid).

This was an area where service users felt mental health services were misrepresenting their implementation of the standards. For example, service users suggested that some providers are not using peer workers due to funding restrictions, but say they are complying with *NSMHS Standard 3: Consumer and Carer Participation* by having their workforce 'work in the peer worker style'. Others were reported to hold a lunch for CALD carers, and use that as evidence of having implemented *NSMHS Standard 4: Diversity Responsiveness*.

## 6.2.5 Using information effectively

Service users reported variable effectiveness in how information is used by their mental health services. Most service users had had some opportunity to provide feedback or consultation. There were large differences in the results of these processes, ranging from some who reported their information 'just disappeared into the system', to others who have seen their input to consultation on facility planning materialise in concrete form.

Service users reported wanting to see feedback linked to outcomes. As one service user put it: 'How many people are you seeing? How many of them are getting better?'

Service users suggested that the most effective way of getting input is to have service users around the table with executive teams, and other mental health workers in mixed groups. These types of committees have real power and can get things done because people see the benefits that come from the interaction of the different perspectives. Service users suggest that proper governance principles should be applied to make these groups effective and that such groups should be convened at local and national levels.

Services users stated that information should be shared so that people are not duplicating work that has already been produced. For example, the frameworks developed by Mental Health in Multicultural Australia (MhiMA), the LGBTI Health Alliance and the Victorian Women and Mental Health Network each provide strategies to help with implementation of both sets of standards, including but not limited to *NSQHS Standard 2: Partnering with Consumers* and *NSMHS Standard 4: Diversity Responsiveness*. These resources have been produced after broad consultation with key stakeholders, and can be readily adapted by mental health services.

Other strategies for disseminating information favoured by service users include:

- externally-run focus groups to evaluate the services provided
- the use of social media including discussion forums and blogs to create a community dialogue.

## 6.2.6 Training for effective collaboration

Service users suggested that both service providers and service users need training for collaboration to be effective.

Service users need training about how to function as a representative of views other than their own. One service user expressed this point as: 'When you serve on a board, you are not necessarily representing your own opinion.' One experienced consumer consultant estimated it took him two years in the role before he was confidently able to represent beyond his own experience. Some service users may need training around committee functions, and the language used in these formal settings. Such training needs to be individually tailored to properly reflect the individual experience of service users, as some have developed high level consultative skills in other parts of their life.

Mentoring was the preferred method for developing skills for consumers and carers in all roles.



Service users suggested that some psychiatrists, psychologists and other service providers would benefit from training in communication skills. Service users also suggested that service providers need to provide more information and instruction about treatment for mental health apart from the medication. It was suggested that they need training on how to communicate with people and teach carers how to communicate with the person they are supporting. Care plans need to be written and should include the carer's role in the plan. Service users were of a view that older service providers were more likely not to know how to work successfully with families.

Service users suggested that university courses in medicine and mental health areas should include training about the *NSMHS* and the recovery framework, otherwise they will not embed in all mental health services. Service users suggested that training of service providers in the *NSMHS* is missing at both an undergraduate and postgraduate level. Service users felt that many service providers do not have a sound grasp of the carer model. It was suggested that a sentence in the standards is not sufficient; service providers need substantive training in this area on how to implement the *NSMHS* model of mental health. This training should incorporate role-plays and scenario training to demonstrate to service providers how the recovery ethos can be incorporated into their everyday work practices. Service users suggested that at present service providers are too geared towards a medical treatment model and do not provide enough therapy. Service users commented that a person experiencing mental health issues very rarely sees psychiatrists or psychologists to talk about what is happening for them. It is all about compliance with medication schedules. Service users thought that often mental illness was being treated mainly with medication and 'care' was focused only on compliance with medications.

A number of carers spoke of the effectiveness of using legislation that recognises the roles of carers to remind service providers about the role they are able to play in service users' treatment, describing them as 'leverage': 'Sometimes registrars and psychiatrists look blank when they are told that a carer has the right to receive information about a consumer.'

Service users from CALD backgrounds reported that there is insufficient appreciation that people from different cultures place different emphasis and meanings on many behaviours and actions, particularly around mental illness. They also felt that service providers too often note only linguistic difference, and assume if a person can speak English, their cultural beliefs are not an important consideration in treatment planning.

## 6.3 Safety when accessing mental health services

In the survey, 30 service users responded to the question 'Do you feel safe when you access mental health services?' Eighteen reported that they did feel safe, while 12 reported feeling unsafe. This issue was of interest to the ACSQHC, although the small number of responses meant that it was inappropriate to generalise. Focus groups participants were asked if they thought these proportions were representative. Most participants thought they were, though a few expressed surprise that the proportion of those feeling unsafe was so high, and a few others that this proportion was so low.

Focus group participants and survey respondents reported very similar personal and environmental issues that either created a feeling of safety or lack of safety for them. The key factor to create safety was service users being treated respectfully and in a holistic way with both physical and mental health issues being addressed.

Focus group participants remarked that safety is a very idiosyncratic thing that depends on the personalities of the people who are in a ward. You cannot always anticipate what is going to happen. The feeling of safety also changes over time, in response to the ward environment, but also in response to internal mental states.

For some service users, it is just 'a fact of life' that mental health wards often do not feel safe because of the unpredictable behaviours of people who are unwell. Others were more optimistic that strategies could be implemented to support safety for all.

### 6.3.1 Things that create a feeling of safety

Service users indicated that safety is created by being listened to by staff, by a sense of engagement and acceptance, by confidentiality being respected and by a calm environment. The level of experience of the staff working on a ward makes a big difference to the perception of feeling safe; the more experienced the staff, the greater feeling of safety. Some service users reported feeling safer when there were male staff around.

A critical element was staff visibility – if staff were regularly available on the ward, interacting and observing, people felt safer than if staff were in offices.

Separate areas for women, especially in secure facilities, were also identified as important contributors to a feeling of safety.

# 6 Information from service users

## 6.3.2 Things that create a feeling of a lack of safety

Service users identified a number of elements that contributed to feeling unsafe. These can be divided into interpersonal and environmental factors.

### Interpersonal

More than half of the focus group participants raised interpersonal issues, which created a feeling of a lack of safety.

The overarching issue was a sense of not being listened to by service providers. Specific issues included the absence of any explicit conversation about safety, their own and others' dignity not being upheld, feelings of lack of control, and overmedication, especially initially, which inhibited their capacity to communicate effectively.

As noted above, staff visibility on inpatient units is a major factor in determining people's sense of safety. Being in an enclosed environment with other people behaving in volatile ways with no staff readily available was highlighted as a frightening experience.

Being secluded or restrained was also identified as a traumatic experience, with people reporting confusion as to why the intervention was initiated by staff, and dissatisfaction with the way in which the intervention was implemented. For those with a history of previous trauma, the effect was strong enough to make them want to avoid mental health services altogether.

Discharge was a point when many service users commented on feeling unsafe. For many, discharge planning was perceived as being rushed and non-consultative, and some service users reported they were discharged before they felt ready. Many carers reported people being discharged from hospital without the carers being ready to care for them.

Carer safety was highlighted as an issue and carers identified the need for strategies of how to protect themselves, including education on how to communicate and behave with a mentally unwell person. If carers know how to manage the person in their care it makes the carer feel safer. The carer can then avoid drama and tragedies. Carers stated that being responsible for a person who is experiencing mental illness can often be overwhelming. This is exacerbated when substance use is involved. Some carers report mental health workers withdrawing when people are acutely unwell in the community in order to protect their own safety, leaving the carer still exposed. They expressed support for the workers' right to safety, commenting rather that it highlighted the dangers carers often face.

### Environmental

A number of participants indicated that presenting to hospital EDs often creates a feeling of lack of safety for them because they perceived ED staff as being unable to see past the psychological issues and not treating the whole person. One participant said: 'The heads need to be put back on the bodies and individuals treated as a whole person in a holistic way.' Participants gave some examples to illustrate these points including service users being left unattended for hours, service users being referred to drug and alcohol services which would be unable to treat the existing medical problems, and a serious underlying physical problem (a blocked bowel) not being treated for a number of days.

Participants identified several reasons for EDs feeling so unsafe for mental health service users. Almost inevitably, EDs are very high-stimulus environments, and when people are experiencing mental health emergencies, such environmental stress is very problematic. ED clinicians are perceived to be geared towards assessing need in a physical way – 'ED staff need to see blood' – before prioritising treatment for someone. Participants considered that this approach can give rise to subjective admission criteria. Service users reported experiencing stigma around mental health issues in EDs. Service users suggested it is not infrequent that people with mental health issues are not seen for some time by specialist staff with training in recognising mental health emergencies. EDs also use security guards with minimal training in how to deal with aggressive behaviour, and it was reported that even where there is training, it may not be appropriate.

Within other health-care settings, facilities without gender-segregated spaces, and designs where staff are not visible were identified as environmental factors that contribute to feeling unsafe.

As more long-term residential services are being provided by the CMO sector, often without 24-hour staff presence, ensuring these environments are safe for service users was identified as an issue. While not in scope of this project, the fact that many people with mental health issues live in unlicensed boarding houses, with no protection from exploitation and aggression, was also raised as a safety issue.

Safe transport for service users in regional Australia was highlighted as a significant problem, particularly the issue of the levels of sedation used during the transport of people with mental health issues. Service users suggest that service providers assume the worst so it becomes impossible to move a person to the appropriate centre for care particularly in rural

and remote areas. Due to the sedation used when transporting people returning from hospital, they often sleep for days. One participant said, 'My little man didn't know where he was; it was a terrifying experience for him.'

## 6.4 Gaps in the standards and ways forward

In the survey and focus groups service users and service providers raised very similar issues around the gaps in the standards, although users were more concerned than providers about gaps concerning lack of accountability if a service is in breach of the standards.

### The environment in which care is delivered

Service users highlighted that the standards do not adequately cover mental health services delivered in the community. Specific issues included safety, 24-hour access and confidentiality, particularly in regional and remote communities.

Service users also noted that the *NSMHS* do not seem to be implemented in EDs. As outlined above, EDs are identified as one of the places service users reported feeling least safe, and the fact that the *NSMHS* are seen by service users as not applicable is problematic. This is particularly pronounced for service users in one jurisdiction where it is now policy that readmission to mental health services is through the ED.

Service users also reported that there is a need for more detailed standards around the transition from inpatient to community care.

### Governance

Service users were focused on seeing actions come from the *NSMHS* and *NSQHS Standards*. They raised the concern that mental health services do not have clear accountability if they are found in breach of the standards. They suggested that an effective evaluation of the *NSQHS Standards* and *NSMHS* needs to be part of the process of implementation. They felt self-evaluation can often be very tokenistic. The point of evaluation is to compare against others and be accountable for the services that are provided. A national evaluation of services would help to lift the credibility and quality of the standards. Evaluations of organisations need to recognise the different sizes and types of organisations.

Service users suggested that effective governance includes the provision of adequate resources for implementation of the standards. One particular area of concern for them was a perception of insufficient funding to properly implement the recovery philosophy of the *NSMHS* by providing adequate training to staff. Other issues influenced by resourcing included obtaining service user input, looking at policy issues, and the proper development of a peer workforce.

Service users stated that regulators in the mental health area need to learn from the lessons that have occurred in the implementation of standards in the aged care sector and ensure they do not repeat them.

Service users were also concerned about services being targeted at people with mental health issues that fall outside the scope of the standards. Community groups who work in the mental health area need to be accountable and be subject to a formal selection process. At present there are no national standards that govern the activities of these groups. An example was given of a suicide prevention group that was established without any qualified mental health professionals as members, offering services to vulnerable people without any clinical supervision or oversight.

Service users identified a gap regarding the standard of documentation by service providers, particularly relating to their engagement with service users around treatment planning. They felt that neither set of standards addressed this area.

Participants also noted service users should be given copies of the standards when accessing mental health services.

### Service integration

Service users reported that integration, though it exists as *NSMHS Standard 9: Integration*, was not being adequately addressed. This applies both to integration between mental health services, and to the integration of mental health services into broader health and other human services. Related to this is the re-integration of people with mental health issues back into their communities. Re-integration is hampered by stigma, and service users reported neither set of standards does enough to address this issue. Premature discharge when people are still unwell can lead them to damage their reputations, and damage attempts to re-integrate. Better education to the broader community about mental health should also be promoted: as one participant said, 'People still think that mental health services are like One Flew Over the Cuckoo's Nest'.

# 6 Information from service users

## Safety

Service users generally reported that the standards adequately address safety issues in mental health services, with the factors that contributed to lack of safety relating to inadequate implementation of the standards.

There were a number of issues that were identified as either gaps in the standards, or issues that needed to be given greater emphasis:

- the provision of medication in corrective services facilities
- the safety of children when their parent or guardian is admitted as an inpatient
- safe transport, particularly the use of sedation as a form of restraint
- sexual safety.

In light of the numerous issues identified as affecting mental health service users when they access EDs, it was suggested that either EDs be regarded as within scope for the *NSMHS*, or the *NSQHS Standards* be revised to include more mental health specific issues.

## Seclusion and restraint

Service users also noted that seclusion and restraint are explicitly, albeit briefly, addressed in the *NSMHS* and that the issues are not addressed in the *NSQHS Standards*.

Service users reported seclusion and restraint were a source of tension between service users and clinicians. They reported that there is a perception that clinicians think that service users have too many rights, such as being able to behave aggressively with impunity. Conversely, there is a perception that clinicians have the power to use seclusion and restraint inappropriately, and service users have little control over this. Service users did note that this is an aspect of the delivery of mental health services where they have noticed a lot of work being done.

## Not treating the whole person

Over 80% of service users reported that mental health services were not providing holistic treatment. Service users perceived that there was a division between 'health' and 'mental health' services which often leads to people with mental health issues being treated as second class citizens. It was considered that service providers often do not deal with how a service user's physical health may affect their mental health.

Service users felt that the standards do not necessarily help with this issue. There is a different type of thinking between integrated/holistic care and a task-based approach. Service users thought that service providers are looking to classify people rather than providing them with a personalised approach to their range of mental and physical issues. Service users are assessed for a diagnosis rather than being treated holistically as a complete person.

Service users thought that the culture of mental health services is often not welcoming and could be improved, and there is often a lack of respect for service users. As one adolescent participant put it: 'At the moment I am treated like a file rather than as a person.' He gave an example of where he was interviewed by four practitioners without any support offered. His impression was that the sole purpose of the meeting was to put a label on his condition so his file could be properly labelled rather than to understand what assistance he needed.

Service users felt that the *NSQHS Standards* do not deal well with the situation of people having co-morbidity. An example was provided of the physical condition of epilepsy, with service providers concentrating on the psychological condition if a person has lived experience of mental health issues.

Service users also suggested that the balance between metabolic disruptions and treatment effectiveness is still not sufficiently discussed with service users, especially when medication is a component of involuntary treatment. They thought service users should be given a real choice in determining the quality of their lives and be able say they are willing to live with a certain level of symptoms. There should be informed choice in relation to drugs that have long-term adverse physical impacts, such as lithium. It was suggested that the use of seclusion and restraint can be inappropriately applied to people who refuse to take medication. Service users do not feel like they have choice because of their lack of power and information compared to service providers.

Service users commented that service providers often do not deal with how a service user's physical health may affect their psychological health. For example, a cancer diagnosis means the service user is likely to suffer added stress, which could exacerbate existing psychological conditions. They further commented that service providers do not have appropriate conversations with either the service user or their carer about how to deal with the impact of physical conditions.

## Service delivery journey

Some service users suggested that the *NSQHS Standards* do not adequately recognise the previous experience of the person accessing services, with the focus being on acute services, and the division into different aspects of care. They felt that *NSMHS Standard 10: Delivery of Care* captures this experience better. Service users pointed out that many people with mental health issues have enduring and/or recurrent episodes, and the standards should reflect this aspect.

Some service users also felt that *NSMHS Standard 9: Integration* and *NSQHS Standard 6: Clinical Handover* do not adequately address needs for people with mental health issues when they move between inpatient and community care. They suggested that standards do not deal very well with the difference between clinical and community treatments.

The areas identified by service users as lacking integration included:

- when a person is transferred between tertiary and primary care such as being exited from the care of a psychiatrist to the care of a GP
- the lack of proper integration between public and private mental health services which often results in physical illness not being treated due to identification of mental health problems
- gaps in communication with carers when a person goes from acute to community care, including assessment of their capacity to assume responsibility for the person's care
- in one jurisdiction, being exited from the mental health system and then re-entering causes a number of issues because it takes place in EDs
- local GP services in rural and remote areas are often difficult to access
- lack of integration between adolescent and adult mental healthcare services
- no co-ordination between medications for physical and mental illnesses with the medication for the mental health condition being withdrawn without any consultation with mental health practitioners.

Service users highlighted a concern that the *NSMHS* do not sufficiently take into account the living conditions of a person living with mental health issues. It was suggested that many families do not have capacity to be a carer, but a service user is still discharged into that family's environment. Service users stated that there need to be alternatives. At present this way of discharging people into the community with inadequate support leads to cycles of discharge and then readmission, which causes

damage to both the family and the service user. It was suggested that ideally, there should be a psychosocial assessment and a burden of care assessment made when a person first enters the mental health system. Local issues often mean national standards are not practically applicable. For example, GP services in rural and remote areas are often difficult to access and expensive because they are tied up doing physical assessments for fly-in fly-out mine workers.

Service users raised the concern that the standards do not cover long-term treatment beyond medication. The emphasis of treatment should move from symptom reduction to overall recovery. Engagement should be less about ensuring adherence to prescribed treatment, and more about restoring people's ability to function in the community.

Service users also reported that standards and accreditation should be more closely linked to outcomes for service users. Without effective outcome measurement there is a risk with user pays principles of having people in the mental health system because they have money for services attached to them. Currently there is also a lack of measures that identify outcomes for carers. Carer evaluation is important because it affects the service users who they are supporting. For example, a carer can be happy that a service user is made an inpatient even though the service user is unhappy about this outcome.

## Recognition of diversity

Service users thought there was insufficient recognition of the issues facing people coming from CALD backgrounds and that *NSMHS Standard 4: Diversity Responsiveness* was not being implemented. Often change is prevented from happening due to the existing culture in organisations. Service user participants commented that some senior mental health workers still expect everyone to assimilate to the mainstream services and are not willing to accept the need for diverse responses to issues for some service users.

Service users thought that the *NSMHS* should deal with CALD issues in each individual standard and not try to deal with the CALD issue in one standard such as *Standard 4: Diversity responsiveness* in the *NSMHS*. Service users suggested that if you rely on one individual standard to address diversity then providers tend to deal with the issue in a token way. For example, an organisation may hold a CALD lunch and an accrediting agency may tick the box that the organisation is providing culturally diverse services.

## 6 Information from service users

A response that was more indicative of an organisational approach to diversity would be having information posters in the languages of all the communities who use that organisation. Service users suggested that an organisation's ability to deal with CALD issues come from its leaders: if the Chief Executive Officer (CEO) of an organisation does not support CALD initiatives then they are unlikely to happen.

The Mental Health in Multicultural Australia (MHiMA) framework was highlighted as a way of closing gaps due to differences between values and culture. Service users thought that it was important to bring together the service providers, service users and carers so that different views are discussed at the one time. Numerous cultures have a very negative view of mental health issues and associate it with a fundamental problem with that person or the person's entire family. Service users suggested that children from a CALD background face the difficulty of having to deal with their parents' cultural beliefs at the same time as trying to negotiate the cultural norms of their school and the community in which they are living. This complexity is not always reflected in mental health service responses.

Service users suggested that society in general requires education about the communities that form it. They thought that people have to be taught cultural intelligence so that everyone is more aware of the range of values that exist within our society. Mental health information for people from a CALD background should not only be in hospitals but in clubs and shops so that the stigma about mental illness is broken down.

### 6.4.1 One comprehensive standard

Three quarters of service users stated that the best option for the future to ensure safety and quality in mental health services would be one combined standard. They had a number of suggestions around how this standard should be constructed:

- A combined standard should be written, in simple English with more detailed explanation in appendices.
- Mental health needs should be at the core of the *NSQHS Standards* and not just an appendix. For example in the ED context, psychological health can be as important as physical health.
- Physical health and mental health issues should be integrated.

- The *NSMHS* should not simply be subsumed into the *NSQHS Standards* as they are both aimed at different things.
- A combined standard should cover the community context.
- The definitions of 'carer' and 'consumer' are different in general health and mental health areas. There should be a consistency around these definitions.

### 6.4.2 Standards should be mandatory

Service users considered that the standards should be mandatory because when they are not mandatory it means policies and procedures are not put in place to assist people. Service users thought that frameworks and guidelines had their place but that mandatory standards were needed so the most vulnerable people were protected. Service users also thought that unless something is mandatory it would not get the funding and resources needed for implementation.

Service users highlighted the importance of mandatory standards in the private sector. This included private mental health office-based practice as well as the private hospital sector. Mandatory standards were needed in these environments to ensure consistency and accountability for implementation of the standards in private practice.

Service users commented that they perceived the current accreditation system for the *NSMHS* was not effective. It was reported that surveyors come through an organisation 'like a cyclone', but the audits are tokenistic, and surveyors do not always check the standards are put into action. Several service users suggested that random audits would provide a more accurate view of real practices. There was limited awareness by service users of the accreditation processes for the *NSQHS Standards* by periodic assessment, which requires demonstrated evidence of implementation through ongoing monitoring, evaluation and action.

Service users also reported there should be more consequences when a mental health service is found to not meet the standards.

This section discusses the key issues raised from the analysis of the information collected in the national survey, the focus groups and the interviews. In total, over 500 people across Australia provided input to the scoping study. Information from both service providers and service users is considered, reflecting their different perspectives, but shared interest in the implementation of the standards. As briefly discussed earlier, the division between being a service provider and a service user did not hold for a number of participants, who embody both roles.

The following discussion is divided into sub-sections, though there is overlap between topics.

The discussion informs the recommendations arising from the scoping study for consideration. These are provided in Section 8.

## 7.1 Contexts of practice

By definition, national standards are developed to cover services across Australia. While they seek to establish agreed standards of service delivery, they also need to be designed with enough flexibility to allow for implementation in local settings. The information generated in the scoping study tells us about how implementation of the standards is occurring in practice.

A consistent element raised by participants is that mental health services are delivered within a context of continuing change. Change is acknowledged as integral to improvement in services, and for providing an effective response to service users. However, two aspects of change were reported to have had an impact on services' capacity to implement the standards: in some instances the sheer rate and scale of change has been so great that services have not had time to adjust; and some changes have occurred with a perceived lack of consultation and coordination.

Examples of large changes included major restructures in public mental health services in several jurisdictions. At the time of the study, these structural changes were not complete, and so there are unresolved questions around very basic issues, such as who is responsible for quality at a service/jurisdictional level.

Participants from the CMO sector identified the increases in competitive tendering for program funds as contributing to persistent uncertainty, and participants also voiced concern about further changes with the introduction of the National Disability Insurance Scheme.

Major changes have also occurred in the legislation which governs mental health services. Several jurisdictions have introduced changes to their mental health legislation, and while there have been developments in mutual recognition of these, there is not national mental health legislation. There have been changes in other legislation as well, including workplace health and safety legislation. In practice, some of these documents are more salient for service providers than either the *NSMHS* or the *NSQHS Standards*.

Nonetheless, there was widespread support for the existence of national standards. For some, the standards provide a useful framework to describe quality and safety processes that already underpin the work of mental health services. For others they exist as a driver of change. While there was critique of the wording, detail and complexity of the existing standards, there was no suggestion that standards should be removed.

For a majority of participants who have the responsibility to implement both the *NSMHS* and the *NSQHS Standards* (mostly in the public and private sectors), the standards are linked. While there was recognition of the different provenance and philosophies of the two sets, practically they form part of overarching quality improvement frameworks for those services implementing them. In terms of adequately addressing the safety and quality issues in mental health services, there was strong feedback that the two sets of standards together would fulfil this function if they were mandatory. However, neither set can stand alone, as they do not adequately address the safety and quality issues faced by people with lived experience of mental health issues.

# 7 Discussion

In a related way, implementation of the standards is closely linked to accreditation for a majority of participants. Participants supported the idea that services should have quality improvement processes, and that service users deserve a rigorous quality assurance process. Both service providers and service users supported this role for the standards, albeit with many recommendations for modification to suit this purpose. In fact, there was widespread support for more transparent accountability and indeed for greater consequences when services do not effectively implement the standards.

## 7.2 Implementing the standards

Accreditation to either the *NSMHS* or the *NSQHS Standards* is the best indicator of the degree of successful implementation of the standards. However, as accreditation is not mandatory for all services across the mental health sector, another indicator to understand the uptake of the standards is the percentage of service providers who identified that their services had fully implemented the standards, or were currently working towards implementation.

For the *NSMHS*, overall levels of implementation self-reported for each standard ranged from 82–93%. These figures suggest a commitment to implementing the *NSMHS* among mental health service providers. The figures also align very closely with the percentage of services reaching threshold standards of accreditation under the *NSMHS*: in 2010–2011, 84% of services nationally were rated at Level 1 – meets all standards, and a further 8% rated at Level 2 – meets some standards.<sup>6</sup>

For the *NSQHS Standards*, overall levels of implementation as identified by participants from all sectors for each standard ranged from 87% down to 38%. The lower figures are accounted for in part by the fact that the *NSQHS Standards* do not have to be implemented by services in the CMO sector, and several of the standards are of limited applicability in mental health services. Within public and private mental health services, over 90% of respondents identified that their services had fully implemented, or were working towards implementation of the overarching standards, *NSQHS Standard 1: Governance* and *NSQHS Standard 2: Partnering with Consumers*. It is not yet possible to compare these rates with external accreditation to the *NSQHS Standards* as mandatory accreditation only commenced in January 2013.

It is important to note that more than 40% of services reported they had not fully implemented *NSMHS Standard 2: Safety*. As previously noted, only the *Implementation Guidelines for Non-government Community Services* state that this standard 'must always be met in full'. This directive does not appear in the *NSMHS* itself, or in the other two implementation guidelines. Participants highlighted the importance of this standard to ensure safety. Clarification of the expectation that this standard 'must always met in full' by all mental health services would assist services to understand the mandatory nature of this standard and act as an enabler for implementation.

Ongoing safety issues encountered by people accessing mental health services were reported in the survey and the focus groups, and these are also reported elsewhere.<sup>17,18</sup> Several of the factors identified by service users as contributing to a feeling of lack of safety are addressed in *NSMHS Standard 2: Safety*, including the practices of restraint and seclusion, and safe transport. It is of concern that services are reporting they have not fully implemented *NSMHS Standard 2: Safety*. There is a need to address the levels of incomplete implementation of this standard by mental health services; this will ensure that systems are in place to address these issues for people accessing mental health services.

## 7.3 The complexities of enabling factors

The most important factors identified by service providers in enabling implementation of the standards were having a culture of ongoing quality improvement, and collaborating with consumers and carers.

Culture is a broad term, and participants reported a variety of attitudes to the concept. Some services reported clear recognition of the importance of culture and their capacity to modify it, through a range of deliberate strategies. For other services, culture was recognised as influencing service delivery, but often viewed as a matter of chance or luck, with systemic responses subsequently being passive, reactive or ad hoc. The standards, particularly the *NSMHS*, which more explicitly address the philosophy of mental health services, were mentioned as a driver and support for culture development, with many services adopting approaches of reviewing one standard per month as a way of embedding them in the service. Another strategy adopted was making certain individuals or teams 'sponsors' or 'champions' for specific standards, and supporting them to disseminate knowledge across the service.



An important aspect of having a positive culture is that quality improvement is ongoing, and not tied to accreditation, though people remarked that it is a distinct advantage when accreditation comes around.

Service providers from the CMO sector consistently reported that implementing the 'new' *NSMHS Standard 10.1: Supporting Recovery* was easier for their services, as their existing culture was directed toward working with service users toward their recovery, compared to public mental health services, where the focus also encompasses acute and coercive care.

It is of note that 'culture' was also ranked as an important barrier to implementation, reflecting the complexity of the term's applicability in mental health services. This is addressed in the following section.

'Collaboration with consumers and carers' was highlighted as another enabling factor, which is a positive sign, as it actually forms an integral part of both sets of standards. Again however, stories about strategies ranged from positive, deliberate and effective, through to negative and stalled.

The capacity for service users to be genuinely representative arose in a number of ways. Issues that were identified by participants as influencing the effectiveness of representatives included existing skills in communication, adequate support in the role, and capacity to understand and represent beyond one's own individual experience. An experienced consumer consultant reported that it took two years in the role before he was able to adequately represent issues other than his own, and that support through mentoring during this period was essential. Other service users reported feeling shut out by existing consumer support mechanisms.

Remuneration for participation by consumers and carers was regarded as an important recognition of the expertise of people with lived experience, and as altering the power dynamic. Remuneration paid directly by the service was also critiqued as potentially co-opting people; it was suggested that it inhibits representatives' capacity to provide critical input about aspects of the service, including governance, diversity responsiveness, and clinical service delivery. An option preferred by some participants is for service user representatives to be paid by a separate body, and thus retain their independence.

For a number of service users, there still exists a considerable gap between what is said at policy level and in service level feedback systems, including committee structures, and the care that is actually delivered to them or the people they support. For those who wear two or more 'hats', both delivering or planning services and accessing them, or supporting others to access them, these disjunctions are particularly noticeable.

## 7.4 Barriers to implementation

Resource limitations were consistently ranked as the most important barriers to implementation of the standards. Service providers expressed their support for implementation efforts, but noted that these efforts themselves required support. It was generally felt that specific targeted resources should be provided, rather than the services having to find resources from elsewhere within their organisation.

Financial resources were identified as less of a problem by participants from private sector mental health services, though it was frequently mentioned that there was 'no money' for some developments, such as remuneration for consumer and carer representatives on committees.

The ongoing impact of competitive tendering on capacity to develop and maintain a culture of ongoing quality improvement was repeatedly raised as an issue by participants from the CMO sector. Specifically, the short duration of contracts was identified as a barrier, as services were unable to guarantee job security for workers, with flow-on effects on retention of staff, and the establishment and maintenance of workplace culture. A related issue was the provision of seed-funding for pilot projects that were not subsequently provided with ongoing funding, resulting in services with demonstrated effectiveness simply ceasing. Competitive tendering was also described as favouring large, often multi-jurisdictional organisations which can devote resources to preparation of tenders, and displace existing, locally supported mental health services.

# 7 Discussion

A prevailing critique of the standards was that they are perceived to take a 'one-size-fits-all' approach to health services. In particular, the standards are criticised for not taking into account the size of organisations. This has relevance for capacity to devote resources to the processes of quality improvement, and then document the evidence for accreditation purposes. A similar critique is that the standards are focused on acute services delivered in metropolitan areas – the specific constraints operating in regional and remote services are not acknowledged, and the expectations are unrealistic. There are still distinct differences in per capita expenditure on mental health services in different states and territories,<sup>6</sup> and this also has an impact on services' differential capacity to implement standards. The ability to adapt the intent of the standards to the individual service is an important enabler. This requires a greater understanding on the part of service providers about how they can flexibly adapt the standards within their services whilst still meeting their intent.

This issue aligns with a critique of services themselves, which many service users reported adopt a 'one-size-fits-all' approach to service delivery. Representatives from population groups including women, Aboriginal and Torres Strait Islanders, people from CALD backgrounds, and lesbian, gay, bisexual, transgender and intersex communities all voiced this concern.

Frameworks have been developed to support services to respond to the diversity in their communities.<sup>19-22</sup> Some services reported innovative practices to address the specific needs of the diverse groups in their local populations, and effectively engage with their communities. However, a number of service providers reported this as still 'aspirational' or 'developmental' for their services, or indeed as sitting in the 'too hard' basket. As a result, service users report receiving mental health services that do not adequately incorporate understanding of diversity. A further consequence of this is the fact that many people do not use mental health services, and there is an unmet need.

The most significant barrier to implementing effective diversity responsiveness was identified as cultural attitudes among service providers that 'we treat everyone the same'. This was criticised by representatives of diverse groups as explicitly not delivering fairness, as this treatment erases difference. One suggestion is that 'respectful practice' should be at the core of care delivery, and this respectful practice would include acknowledgement of factors like multiple layers of stigma, past poor treatment of people by health services, histories of trauma and differences in opportunity.

The question of culture, and whether it is amenable to modification, was raised as a barrier as well as a factor enabling implementation. Resistance to change among service providers was identified as a cultural issue. Such resistance was variously ascribed to different levels of seniority (older workers identified as being the most resistant), different disciplines (medical and nursing staff more resistant, allied health staff more amenable to change) and different roles within organisations (managers and front line workers each professing greater adaptability). These issues were reported widely, and as noted above, services differed markedly in the capacity to address cultural issues.

It was consistently reported that the process of implementing the standards requires additional resources, and there were various opinions as to where these resources come from. Many people reported that in order to implement the standards in their mental health services, resources had to be 'taken away', either from direct service delivery, or other parts of the service. In the majority of cases it was reported that these changes did result in an improvement in the mental health service, though in some instances the gain was not felt to balance the cost.

One distinct group were regional and remote mental health services; they indicated that resource limitations rendered them currently unable to implement all the standards. This issue is linked to comments that the standards themselves do not adequately recognise differences in organisational capacities for services outside metropolitan regions. Conversely, some service users of regional mental health services reported satisfaction with the level of responsiveness and respect shown by their local mental health services. In these cases, a direct link was drawn between the reduced availability of inpatient services and the close collaboration with carers.

## 7.5 The accreditation processes

The scope of the project was focused on the degree to which standards were being implemented. The study considered the views of health service providers about the levels of implementation, rather than focusing on rates of external accreditation. The rationale was that it was not possible to obtain reported rates of external accreditation for the *NSMHS* and *NSQHS Standards* across the mental health sector. However, many participants spoke about the relationship between implementation of the standards and the accreditation processes.

The *NSMHS* were developed nationally, with accreditation explicitly identified as only one purpose. Consistent with this, the three implementation guidelines are not written in a way that matches each criterion with the evidence required for accreditation. At times the guidelines combine criteria, and evidence is suggested for whole standards, rather than matched to each criterion. This was reported as making it difficult to assess implementation at criterion level through accreditation processes.

Subsequent to the *NSMHS* being endorsed by the Australian Health Ministers' Advisory Council, a number of jurisdictions have mandated accreditation to the *NSMHS* for mental health sectors in specific services, often as part of funding agreements. So, while it is possible to state for a specific service at a specific period whether the *NSMHS* are mandatory are not, it is not possible to make statements about a national position on the role of the *NSMHS* in mental health services. This process is ongoing, with further changes forecast for 2014 and 2015.

Service providers reported frustration with the absence of a 'purpose built' audit tool that enabled them to systematically document evidence that they are meeting the *NSMHS* for accreditation processes. Many reported finding the *Draft Accreditation Workbook for Mental Health Services*<sup>13</sup> helpful, and one jurisdiction has developed an audit tool based on this workbook.

If the *NSMHS* are increasingly being used by jurisdictions for the purpose of accreditation, there should be consideration as to the development of a nationally auspiced tool setting out criteria, actions required, and evidence to demonstrate adherence. This would ensure that mental health services, accrediting agencies and regulators have agreed indicators for accreditation to the *NSMHS*.

A frequent criticism of the *NSQHS Standards* is that the size and detail of the standards form one of the barriers to implementation, especially in the areas that are not perceived to be the primary focus for mental health services. Service providers reported frustration at devoting resources to implement and provide evidence for criteria that are of extremely low incidence, which they felt took time away from better implementation of those standards that reflect the organisation's core business. A related comment concerned difficulties with the exemption process for certain *NSQHS Standards*. While there are guidelines in the *NSQHS Standards*, participants perceived that the process is time-consuming and not always easy to negotiate with their accrediting agency. Consideration about how to raise awareness of the accreditation

process among frontline service providers may assist in their understanding the intent and applicability of the standards for their mental health service.

Participants often commented about the accreditation processes. As one senior service provider stated, 'It is important that there be enough trust so that services can report faithfully on implementation levels, and policy makers understand limitations clearly.'

For service users, and a number of service providers, the current system under which accreditation occurs at planned intervals, is problematic, particularly for the *NSMHS*. Many feel the system is too vulnerable to being manipulated, and that a true assessment of how services are being delivered would include random audits. This spoke to an underlying tension around the purpose of accreditation and whether it is designed to catch people out, or to promote and support quality improvement.

Narrowing this gap will be achieved by a focus on sustainable implementation strategies which can be demonstrated at accreditation, rather than accreditation processes directing short-term activity that may not result in ongoing quality improvement.

A frequent critique was the issue of inter-rater reliability among surveyors. At the extreme end were services that reported their mental health service had prepared for accreditation as part of whole-of-health-district/hospital review, and surveyors had not even visited the mental health facilities. Service providers also reported surveyors attending mental health services with no prior experience with mental health.

Many service providers also reported surveyors with particular 'hobby horses' who issue notifications regarding highly specific issues not relevant to mental health core business, and not adequately signalled in the documentation provided. This was reported to be more the case for the *NSQHS Standards*. Suggested refinements around the process of applying for exemption for specific criteria may go some way toward ameliorating this problem.

Representatives of the accrediting agencies also identified some problems. They spoke of similar difficulties as service providers regarding the lack of specificity in the *NSMHS* in terms of documenting evidence of implementation of specific criteria. They reported instances where mental health services have requested accreditation to the *NSMHS* within whole-of-service processes but, due to jurisdictional regulations, the agency has been unable to issue a certificate, and has been limited to providing a letter noting compliance to the *NSMHS*.

# 7 Discussion

## 7.6 The scope of the standards

During the study, a number of participants identified areas they perceived as gaps in the standards. However on inspection the standards often do address the issues raised. It was evident that there is a lack of awareness with some service providers about the intent and contents of some standards. Examples include the role of children as carers, and reporting of adverse medication events. This issue may be a result of a lack of awareness or available education about the standards, or the structure of the standards themselves. Consideration about opportunities to present this information that will contribute to better understanding and applicability may assist with implementation and address these perceived gaps.

Both sets of standards make mention of the fact that services must be able to demonstrate they comply with legislation, and a number of issues that people raised are covered by state-based legislation. Rather than repeat the content of existing documents, the standards refer to them, which may cause confusion for some people.

Questions around the applicability of the standards in specific services remain problematic for many participants, consistent with the issues raised in section 3 of this report. This is less of an issue with the *NSQHS Standards* overall, as there is clear national direction about which services need to implement them, and their status as mandatory. However, several of the *NSQHS Standards* apply minimally in mental health units (for example, *Standard 7: Blood and Blood Products*), but service providers report some confusion about how to confirm exemption. Respondents also requested more flexibility around the exemption process, so that standards may be addressed, but particular criteria exempted.

A converse issue is the lack of applicability. In particular, the fact that the *NSMHS* do not generally apply in EDs was raised repeatedly, in light of multiple reports of people with mental health issues experiencing sub-optimal care. This has occurred when they present with either physical or mental health problems. In one jurisdiction it was reported that re-entry to mental health services was through EDs as a matter of policy. In fact, this could currently be viewed as the mental health service not meeting *NSMHS Standard 10.6.6: The MHS ensures ease of access for consumers re-entering the MHS*. However, it was considered that if the scope of the *NSMHS* were extended to cover all EDs, and not just those with designated mental health facilities, there would be a benefit for service users with mental health issues.

## 7.7 Changes to the current standards

Both service providers and service users favoured simplifying the framework of standards for mental health services. The most common suggestion was that a combined standard, incorporating elements of the *NSQHS Standards* and the *NSMHS*, be developed, and that this be mandated for implementation across all health services.

New Zealand implemented a similar change in 2008,<sup>23</sup> and the NZ Ministry of Health is currently undertaking a review of the success of this process. Initial reports indicate that the amalgamated format has worked well in residential and community services, and less well in acute settings.

As a review of the *NSQHS Standards* is already planned, there is an opportunity to consider how safety gaps in mental health services could be addressed in the *NSQHS Standards*.

Support for this approach is that people with mental health issues access health services for a range of problems, both mental and physical, in settings that are currently only covered by the *NSQHS Standards*. Many people reported experiences of sub-optimal care that could be improved if principles from the *NSMHS* were integrated into the *NSQHS Standards*. For some matters, particularly monitoring of physical restraint in general health settings, the need for change is an important issue.

It was broadly acknowledged that the two sets of standards were written for different purposes, and that this was evident in differences in philosophy, language and operationalisation. Proponents of the *NSMHS* were particularly keen not to see elements diluted in any process of combination.

An ongoing concern is the tension between adherence to standards and innovation. One concern was that while innovations are being trialled, they may not meet existing standards, and if it is mandatory that the standards be met, the innovation may not occur. There is also the question of the evidence base, as many effective innovations are being implemented, but not being documented in peer-reviewed journal articles, and therefore not meeting strict criteria for evidence that would allow the innovation to be adopted elsewhere. This is another area where resources are key, as the practical innovators may not have the skills or time to write academic articles. It was suggested that policy needs to reflect these tensions, and not contribute to them by narrowing the scope of practice for mental health services.

## 7.8 Conclusion

This document has reported on the key issues identified by survey respondents and focus group participants during the scoping study. The study has provided new information about the levels of implementation of the *NSMHS* and *NSQHS Standards* including the enablers and barriers to their implementation. Information has also been provided about the gaps in the two sets of standards with respect to safety and quality.

Responses indicated that there is generally widespread awareness of the standards. However, there are some areas where service providers and services users have limited awareness of the intent and applicability of the standards.

There was a clear message from both service providers and service users that the implementation of both sets of standards is perceived as being important to meet the safety and quality requirements for people with lived experience of mental health issues accessing the mental health sector.

The standards are being implemented across all mental health service sectors. The rates of implementation vary across the two sets of standards, and across individual standards within each set. For example, a significant proportion of service providers reported their service had not fully implemented *NSMHS Standard 2: Safety*, which explicitly addresses the very issues that service users report still contribute to their lack of safety. This creates a gap with respect to the specific safety issues of high relevance in mental health services. A lack of specificity and clarity about the mandatory requirements of the *NSMHS* was reported as a barrier to their implementation. There is no indication that the *NSMHS* will be subject to compulsory full implementation in all mental health services in the near future.

The *NSQHS Standards*, which set mandatory levels of safety for applicable health services, are not directly applicable in the large and growing community-managed organisation (CMO) sector of mental health services. The *NSQHS Standards* do not directly address some of the specific safety issues of high relevance in mental health services addressed in the *NSMHS*. In addition, the *NSMHS* do not apply in general health settings regularly used by people requiring mental health services, including emergency departments. These issues in combination with the continued variable implementation of the *NSMHS* create safety gaps.

Work is required to ensure that standards contribute to the implementation of strategies making mental health services safe for both service users and service providers. Consideration is required about how the safety gaps identified in the study could be incorporated in the longer-term review and revision of the *NSQHS Standards*.

Information from this study suggests recommendations should include strategies that will support the consistent implementation of national standards to address the current safety gaps. The *NSQHS Standards* should be revised to include items that will address the specific safety issues faced by people with lived experience of mental health issues accessing all health services. Consideration of the role and function of the *NSMHS* is required to determine the best way to support the more quality related aspects of the *NSMHS*.

Some of the recommendations arising from the study are directly relevant to the legislated responsibilities of the ACSQHC in providing a framework to ensure safety and quality in the delivery of health services, including mental health services. Other recommendations fall outside the scope of the ACSQHC.

## 8 Recommendations

- 1.** The ACSQHC should use information regarding the safety issues identified in this scoping study to inform the planned review of the *NSQHS Standards*.
- 2.** The ACSQHC should revise the *NSQHS Standards* to include items that will address the specific safety issues faced by people with lived experience of mental health issues accessing all health services.
- 3.** Jurisdictions and stakeholders with responsibility for implementing the *NSMHS* should consider the role and function of the National Standards for Mental Health Services.

# Glossary of terms and acronyms

<b>ACSQHC</b>	Australian Commission on Safety and Quality in Health Care
<b>AIHW</b>	Australian Institute of Health and Welfare
<b>CALD</b>	culturally and linguistically diverse
<b>CMHA</b>	Community Mental Health Australia
<b>CMO</b>	community-managed organisation (replaces NGO: non-government organisation)
<b>DoH</b>	Australian Government Department of Health (formerly DoHA, Department of Health and Ageing)
<b>ED</b>	emergency department
<b>GP</b>	general practitioner
<b>LGBTIHA</b>	Lesbian, Gay, Bisexual, Transgender and Intersex Health Alliance
<b>MHCA</b>	Mental Health Council of Australia
<b>MHCC</b>	Mental Health Coordinating Council (NSW)
<b>MHiMA</b>	Mental Health in Multicultural Australia
<b>MHS</b>	mental health service
<b>NMHC</b>	National Mental Health Commission
<b>NSMHS</b>	<i>National Standards for Mental Health Services</i>
<b>NSQHS Standards</b>	<i>National Safety and Quality Health Service Standards</i>
<b>PAG</b>	Project Advisory Group
<b>Participant</b>	a person who participated in a focus group or interview
<b>PMHA</b>	Private Mental Health Alliance
<b>Respondent</b>	a person who contributed to the study by responding to the online survey
<b>RFDS</b>	Royal Flying Doctor Service
<b>Service provider</b>	a survey respondent or focus group participant who identified as an individual who worked in a mental health service
<b>Service user</b>	a survey respondent or focus group participant who indicated they were engaging in the study as someone who uses mental health services. Service users include people with lived experience of mental health issues and the people who support them. The terms consumer and carer are used when participants explicitly referred to themselves using these terms.
<b>SQPSC</b>	Safety and Quality Partnership Standing Committee

# Appendix 1: Summary of results from national survey

This section provides a summary of the key results of the national online survey. Participation in the scoping study was voluntary, and this document reports on the views of those mental health service providers and service users who participated in the study.

## Service providers

This section reports the survey responses provided by service providers.

### Service provider demographics

The following section presents the responses to questions about the demographic profile for the 369 service providers who responded to the survey. Figure A1 documents the numbers of service providers working in different mental health service sectors. The majority of the respondents who worked as service providers worked in the public mental health sector (75%), while 10% worked in the private sector, and 15% in the community-managed sector.

**Figure A1: Number of service providers by sector**

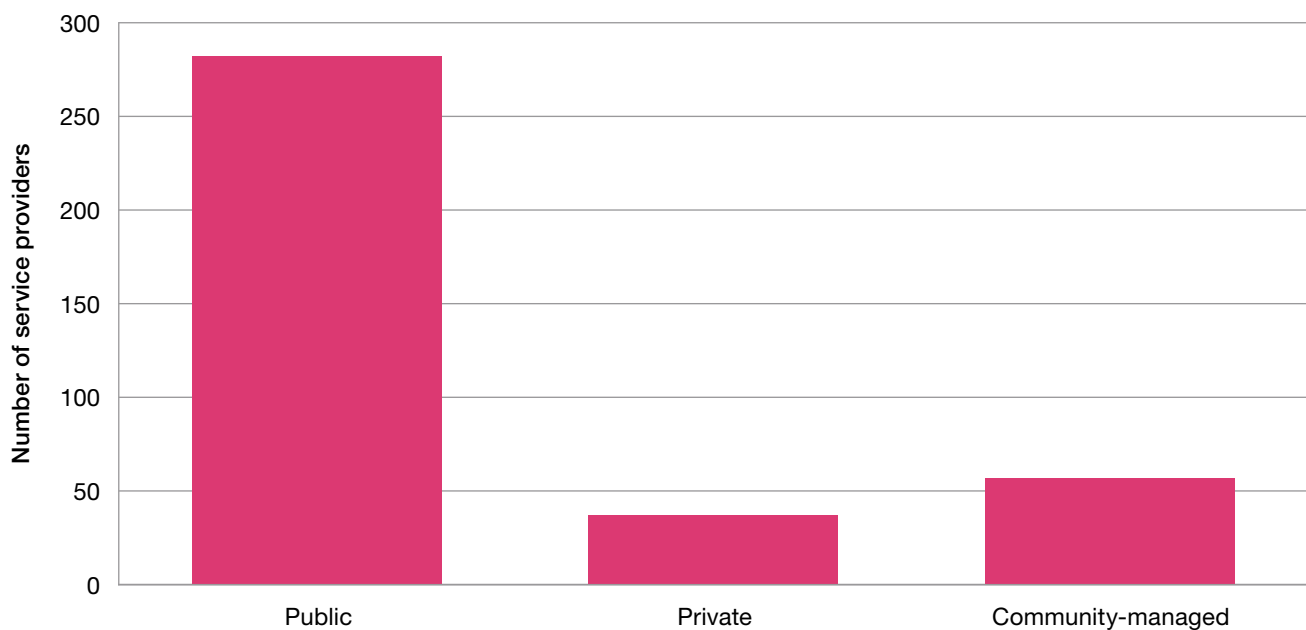
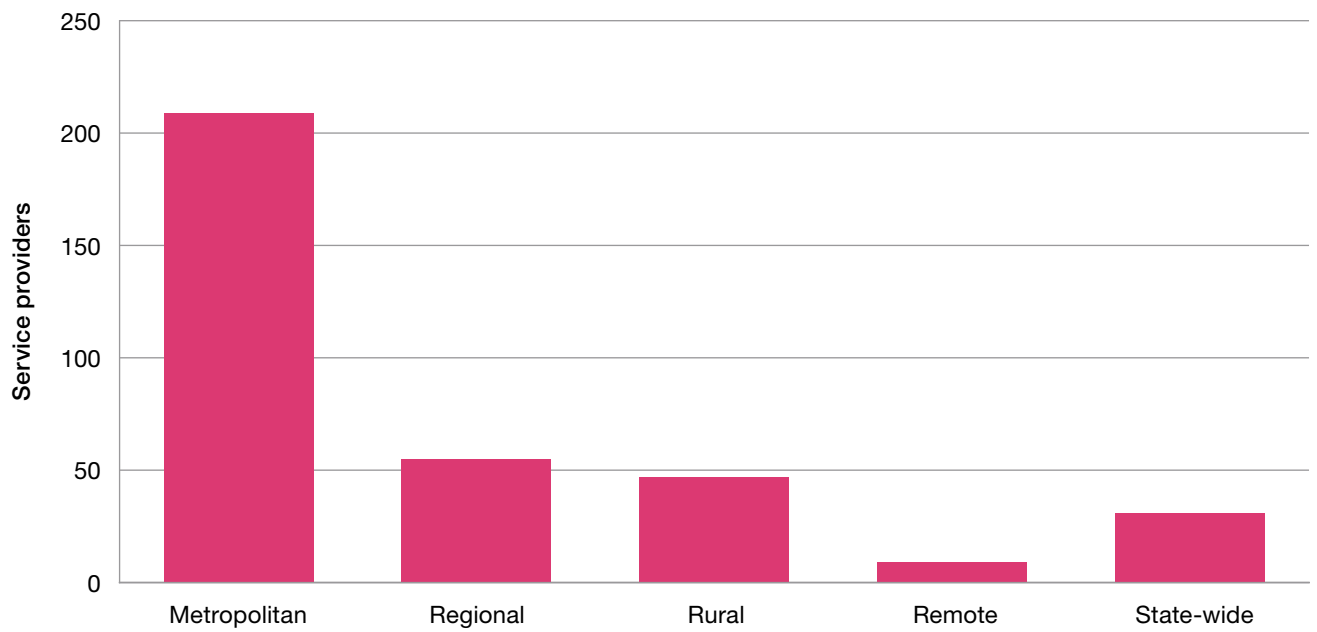




Figure A2 documents the numbers of service providers working in mental health services in different regions. Sixty per cent of respondents worked in a metropolitan mental health service, 15% in a regional service, 16% in rural and remote, and 9% in state-wide services.

**Figure A2: Service providers by region**



# Appendix 1: Summary of results from national survey

## Implementation of the individual NSMHS

The levels of implementation of each of the 10 NSMHS varied. More respondents reported that their service had either 'fully implemented' or 'were working towards implementation' than those reporting they 'were not currently able to implement' any of the 10 standards.

The standards that were most commonly reported to be fully implemented were *Standard 1: Rights and responsibilities* (60%), and *Standard 2: Safety* (59%). Service providers reported that the standards most often reported as not currently being able to be implemented were, *Standard 5: Promotion and Prevention* (9%) and *Standard 9 Integration* (5%).

Figure A3 summarises the levels of implementation of the NSMHS self-reported by service providers.

**Figure A3: Implementation of the NSMHS**

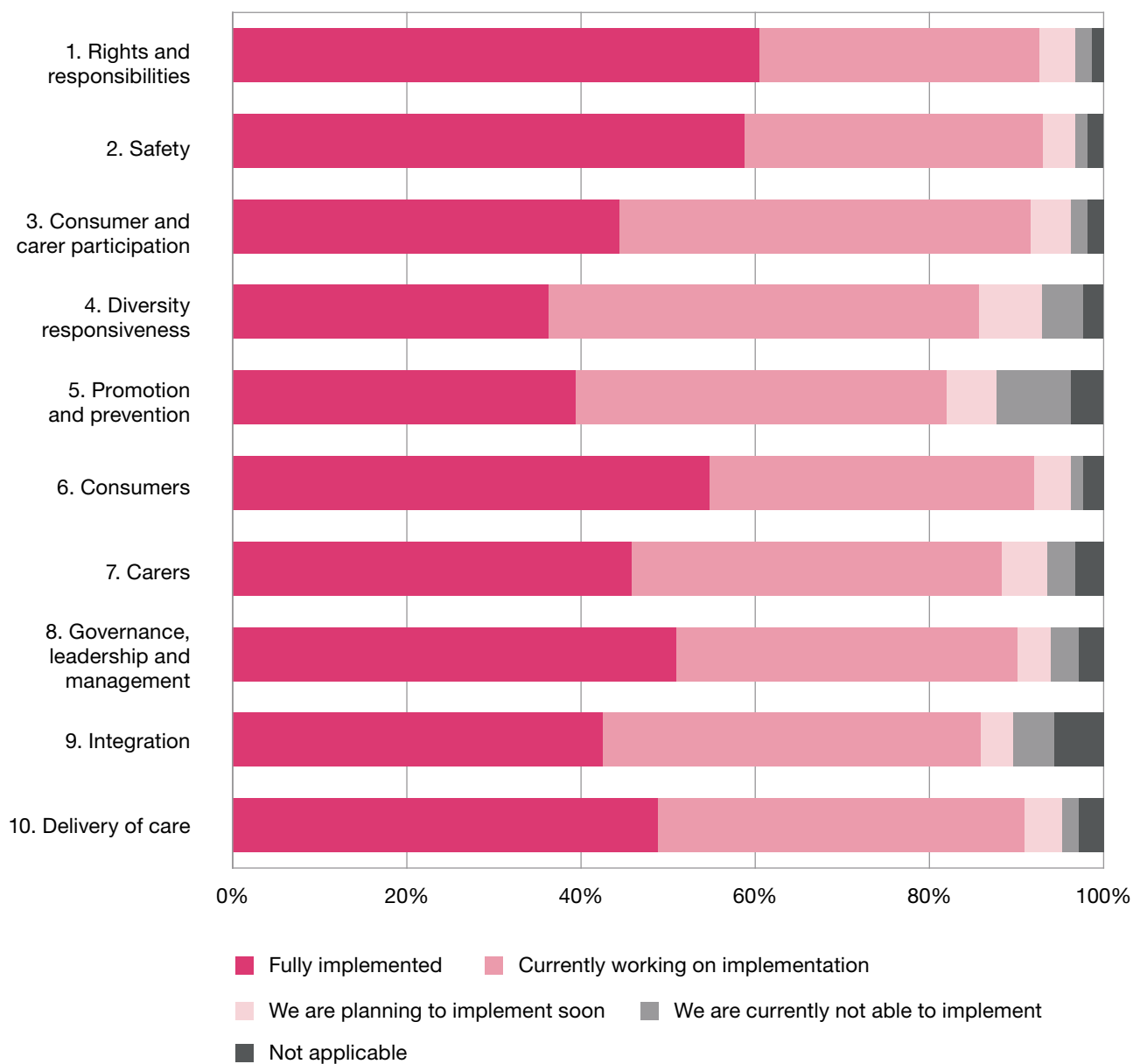


Table A1 documents the proportion of services self-reporting full implementation or working toward implementation of the *NSMHS* by the different sectors.

**Table A1: Implementation of the *NSMHS* by sector**

	<b>Overall</b>	<b>Public</b>	<b>Private</b>	<b>CMO</b>
<b><i>NSMHS</i> 2010</b>	<b>Respondents who reported that they have fully implemented or currently working on implementation (per cent)</b>			
<b>1. Rights and responsibilities</b>	93	91	100	100
<b>2. Safety</b>	93	92	100	97
<b>3. Consumer and carer participation</b>	92	90	100	97
<b>4. Diversity responsiveness</b>	86	83	94	97
<b>5. Promotion and prevention</b>	82	78	100	97
<b>6. Consumers</b>	92	91	100	97
<b>7. Carers</b>	88	86	94	97
<b>8. Governance and leadership</b>	90	88	100	97
<b>9. Integration</b>	86	84	88	94
<b>10. Delivery of care</b>	91	91	100	90

# Appendix 1: Summary of results from national survey

## Implementation of the individual *NSQHS Standards*

The levels of implementation of each of the *NSQHS Standards* also varied. Service providers self-reported more 'currently working towards implementation' of the *NSQHS Standards*, than full implementation and this is consistent with the later release date of the *NSQHS Standards*. The fact that the *NSQHS Standards* are not mandatory in the CMO sector also has an impact on the levels of implementation reported by service providers.

Figure A4 summarises the level of implementation of the *NSQHS Standards* self-reported by service providers. There is a notable variance between standards of those reported to be 'not applicable' to the mental health service.

**Figure A4: Implementation of the *NSQHS Standards***

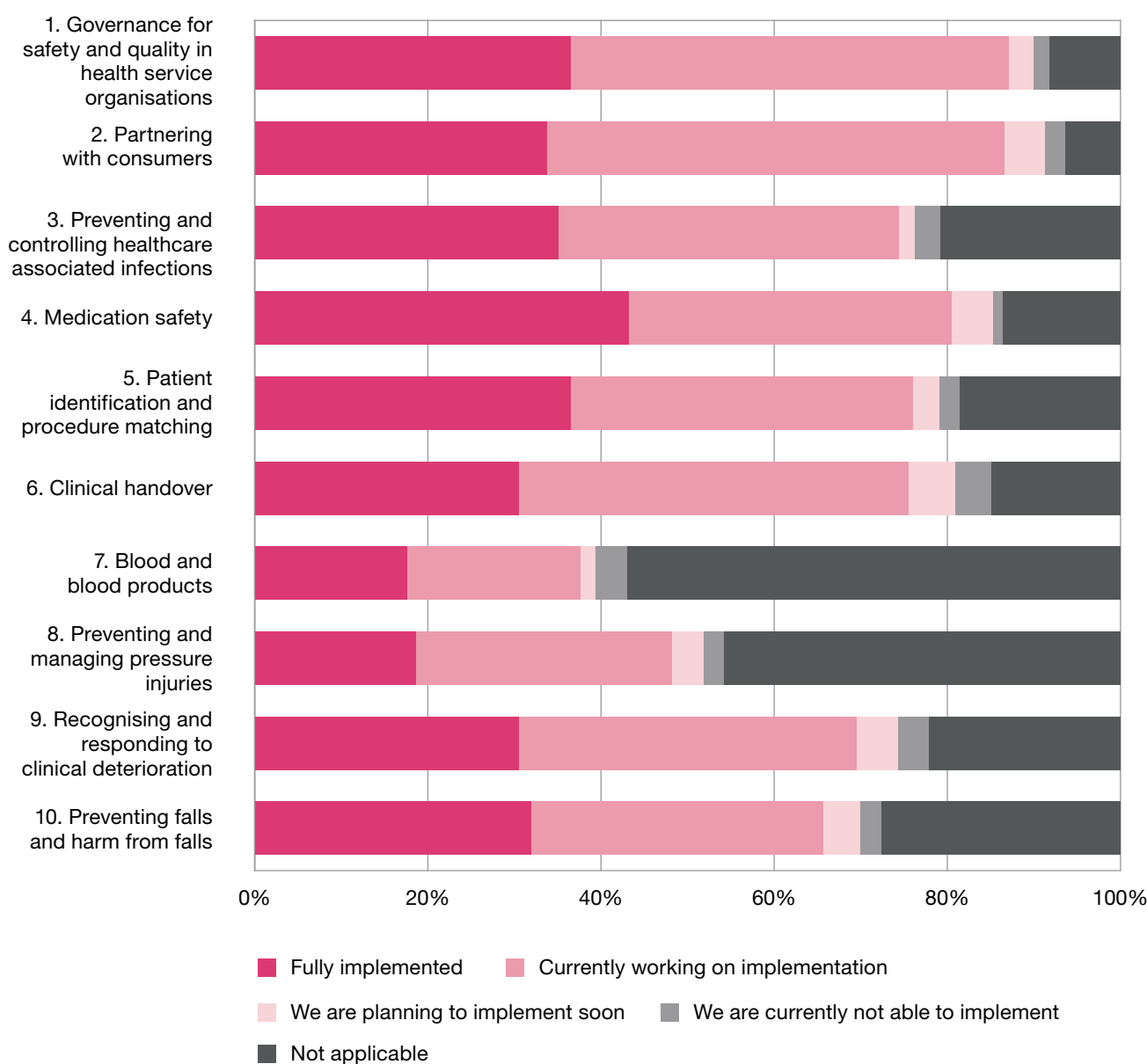


Table A2 reports on the proportion of service providers self-reporting full implementation or working towards implementation of the *NSQHS Standards* by the different sectors. The *NSQHS Standards* currently do not have to be implemented by mental health services in the CMO sector, and this is reflected in the significantly lower proportion of services reporting implementation.

**Table A2: Implementation of the *NSQHS Standards* by sector**

<i>NSQHS Standards 2011</i>	Overall	Public	Private	CMO
	Respondents who reported that they have fully implemented or currently working on implementation (per cent)			
1. Governance for safety and quality in health service organisations	87	92	93	57
2. Partnering with consumers	87	90	93	64
3. Preventing and controlling healthcare associated infections	74	84	71	15
4. Medication safety	80	92	57	25
5. Patient identification and procedure matching	76	88	64	10
6. Clinical handover	75	86	64	15
7. Blood and blood products	38	43	29	15
8. Preventing and managing pressure injuries	48	53	57	5
9. Recognising and responding to deterioration in acute care	69	80	57	10
10. Preventing falls and harm from falls	67	73	57	21

### Enabling factors for implementation

The most common factors reported as enabling services to implement both the *NSMHS* and *NSQHS Standards* were a culture of ongoing quality improvement, collaboration with consumers and standards awareness development training.

### Barriers to implementation

The most commonly reported barriers to implementing both the *NSMHS* and *NSQHS Standards* were financial and human resources. Other barriers identified by respondents included duplication between the *NSMHS* and the *NSQHS Standards*, and uncertainty about the applicability of the *NSQHS Standards* in mental health services.

# Appendix 1: Summary of results from national survey

## Safety and quality in mental health services

Service providers identified some gaps in the *NSQHS Standards* regarding mental health services, including delivery of care in community settings, seclusion and restraint, sexual safety, psychological deterioration and recovery principles.

A majority (70%) of respondents reported that a combined set of standards incorporating the *NSMHS* and the *NSQHS Standards* would be the best way to ensure safety and quality in mental health services.

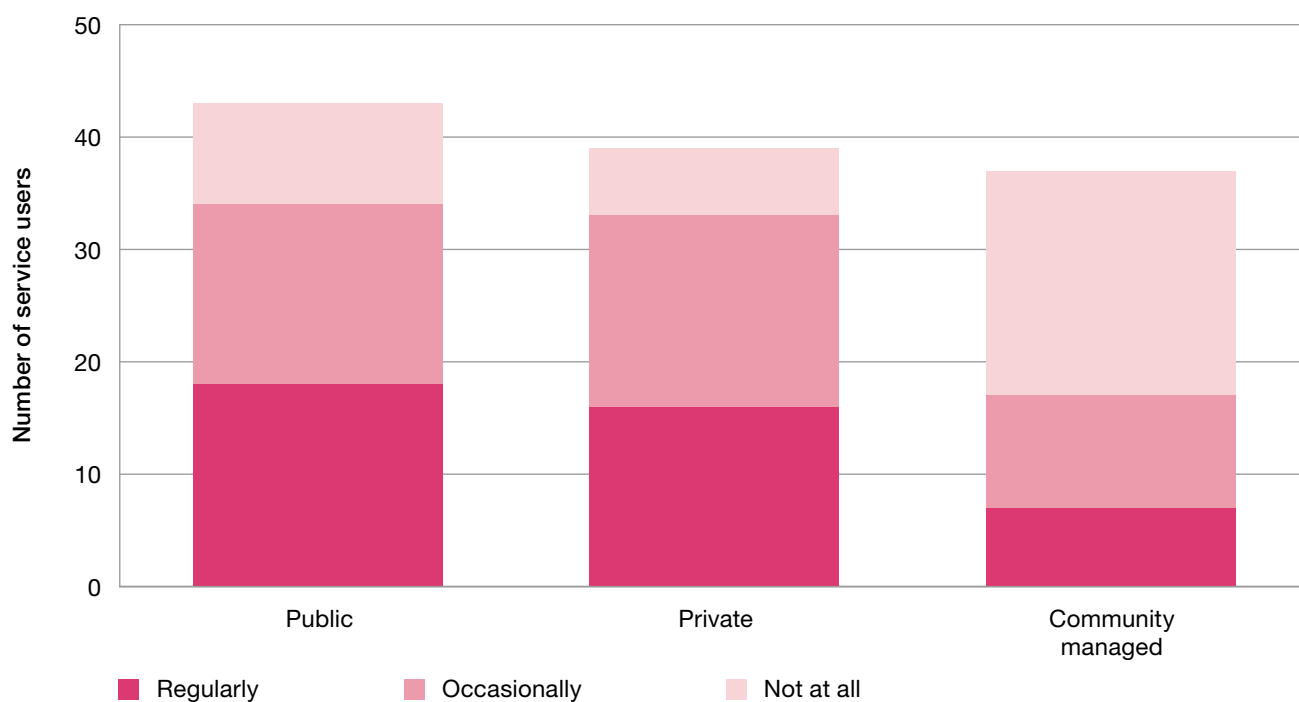
## Service users

This section reports the survey results reported by service users.

### Service user demographics

The demographic profile of the 56 service user respondents is presented in Figure A5 below. Most respondents used more than one type of mental health service. Thirty-four respondents (72%) accessed mental health services in metropolitan areas, while 13 (28%) did so in regional or remote mental health services.

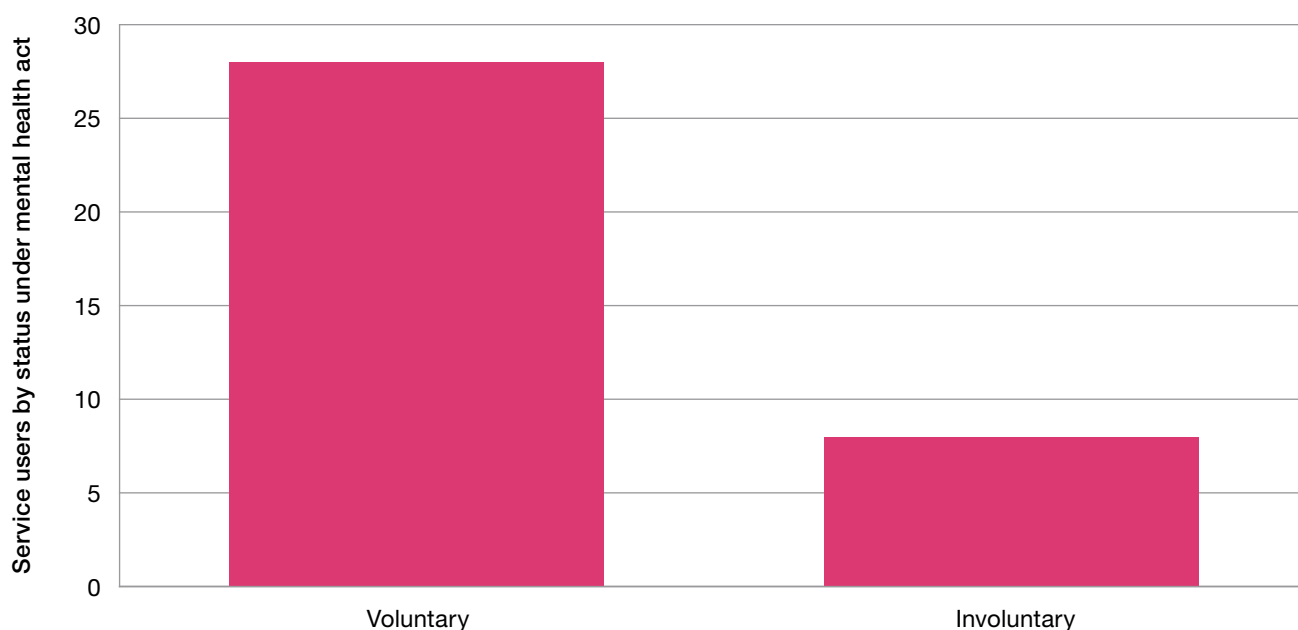
**Figure A5: Service users by type of service accessed**



## People with lived experience of mental health issues

Seventy eight per cent of service users (28/36) indicated that the contact with mental health services they were reporting on was on a voluntary, rather than an involuntary basis (Figure A6).

**Figure A6: Service users by status under mental health legislation**



### Support people/carers

Fifteen support people indicated they were completing the survey about the services the person they supported received. Four support people completed the survey about the services they received themselves as carers.

Thirteen support people indicated they were reporting on voluntary treatment, and five on involuntary treatment. These proportions are comparable to those reported by people with lived experience.

### Awareness of the *NSMHS* and *NSQHS Standards*

Respondents who identified as people with lived experience of mental health issues and support people were generally aware of both sets of standards, with 64% reporting awareness of the *NSMHS*, and 62% reporting awareness of the *NSQHS Standards*. Respondents had noted some changes in the mental health services they accessed, but they were not able to determine if these were in response to either the *NSMHS* or the *NSQHS Standards* or other factors.

Respondents reported they had had minimal opportunity to participate in planning or evaluation activities of the mental health services they accessed.

### Safety and quality in mental health services

Service users were asked 'Do you feel safe when accessing mental health services?': 18 respondents (60%) reported they felt safe, while 12 (40%) reported they felt unsafe. Respondents reported that the elements that contributed to feelings of safety were both interpersonal and environmental. Respondents commented on feeling listened to by staff, feeling a sense of engagement and acceptance, and being in a calm environment. Elements that contributed to people feeling unsafe included feeling that they were not listened to by staff, being left unsupervised around other people behaving aggressively, and being in mixed gender inpatient units.

Service users mostly (79%) responded that a combined set of standards incorporating the *NSMHS* and the *NSQHS Standards* would be the best way to ensure safety in mental health services. A smaller number (11%) of respondents thought that mandatory implementation of the *NSMHS* would be the best way to achieve this.

The results of the survey informed the focus of questions in the third stage of the study, the focus groups.

## Appendix 2: Summary of results from focus groups

This section provides a summary of the key results from the focus groups.

### Focus group locations and attendance

Sixteen groups were conducted with service providers in nine locations, and six groups were conducted with service users in six locations. Group locations, size and composition reflect responses to the recruitment strategies.

**Table A3: Focus group locations and attendance**

Location	Date	Type of group	No. attendees
Perth Western Australia	17 July 2013	Public and private mental health services	11
	17 July 2013	Community-managed organisations	4
	17 July 2013	People with lived experience and their support persons	8
Port Hedland Western Australia	18 July 2013	People with lived experience and their support persons	3
Adelaide South Australia	25 July 2013	Public mental health services	10
	25 July 2013	People with lived experience and their support persons	7
	25 July 2013	Private and community-managed organisations	5
Canberra Australian Capital Territory	1 August 2013	Community-managed organisations	8
	1 August 2013	Public and private mental health services	7
Brisbane Queensland	7 August 2013	People with lived experience and their support persons	3
	7 August 2013	Public mental health services	11
	8 August 2013	Public and private mental health services and community-managed organisations	7
Sydney New South Wales	13 August 2013	Private mental health services and community-managed organisations	6
	14 August 2013	Public mental health services	9



<b>Location</b>	<b>Date</b>	<b>Type of group</b>	<b>No. attendees</b>
<b>Melbourne Victoria</b>	28 August 2013	People with lived experience and their support persons	9
	28 August 2013	Community-managed organisations	5
	29 August 2013	Public mental health services	12
	29 August 2013	Private mental health services	4
<b>Karratha* Western Australia</b>	3 September 2013	Public mental health services	4
<b>Hobart* Tasmania</b>	11 September 2013	Public and private mental health services	4
<b>Sydney New South Wales</b>	18 September 2013	Service users from culturally and linguistically diverse backgrounds	9
<b>Sydney* New South Wales</b>	18 September 2013	Aboriginal and Torres Strait Islander service providers	4

\* via teleconference

## Themes arising from the focus group discussions

Notes were taken at each session and during the interviews. In addition, the sessions and interviews were recorded, with the participants' permission, so that accurate quotes of key comments could be included in this report.

These notes and records were analysed based on the key survey topics and a number of themes were identified. These topics are presented in the following sections.

The information presented was collected from those people who participated in the scoping study, and reflects their stated views. As noted above, the scoping study was conducted on an opt-in basis, and is not able to report on the views of all mental health service providers and service users across Australia.

A number of participants reported during the focus groups that they were 'wearing more than one hat', for example, they worked in the health sector, and also performed a caring role for a family member with mental health issues. These multiple perspectives added to the richness of the group interactions. In the mixed service provider groups, it occasionally became obvious that some key issues were not shared across sectors; however participants were generally able to contribute their own issues. Where possible, these differences are reported in the results of the focus groups.

Of the 150 focus group participants 54 had participated in the online national survey.

# Appendix 2: Summary of results from focus groups

## Service providers

Themes identified for service providers for each of the key questions are summarised in this section.

### Implementation of the *NSMHS* and *NSQHS Standards* has led to:

- improvement in direct service delivery
- improvement in administration
- improvement in governance structures including improved consumer and carer representation at different levels
- improved focus on special interests including the social context in which mental health services are being delivered.

### Enabling factors for implementation include:

- a culture of ongoing quality improvement
- training to increase awareness of standards and implementation strategies
- collaboration with consumers and carers and the need for their greater involvement in service development and evaluation activities
- mandatory standards and accreditation as motivating factors
- knowledge sharing between and within organisations.

### Barriers to implementation include:

- a lack of adequate financial resources
- limitations on human resources
- duplication with other standards
- lack of information and knowledge about the standards
- uncertainty about applicability of the standards in mental health settings
- issues related to the structures and the administration of mental health services
- issues arising when collaborating with consumers and carers.

## Service users

Themes identified for service users are summarised in this section.

### Changes in the quality of mental health services

- Changes in services for better and worse were observed, but not necessarily correlated with either set of standards.

### Opportunities to collaborate with service providers include:

- collaboration on direct service delivery
- representation on committees and boards
- paid participation as consultants and peer workers.

### Commenting on safety and quality in mental health services, service users observed:

- factors that create a feeling of safety revolve around engagement with mental health workers
- factors that create a feeling of a lack of safety are both interpersonal and environmental.

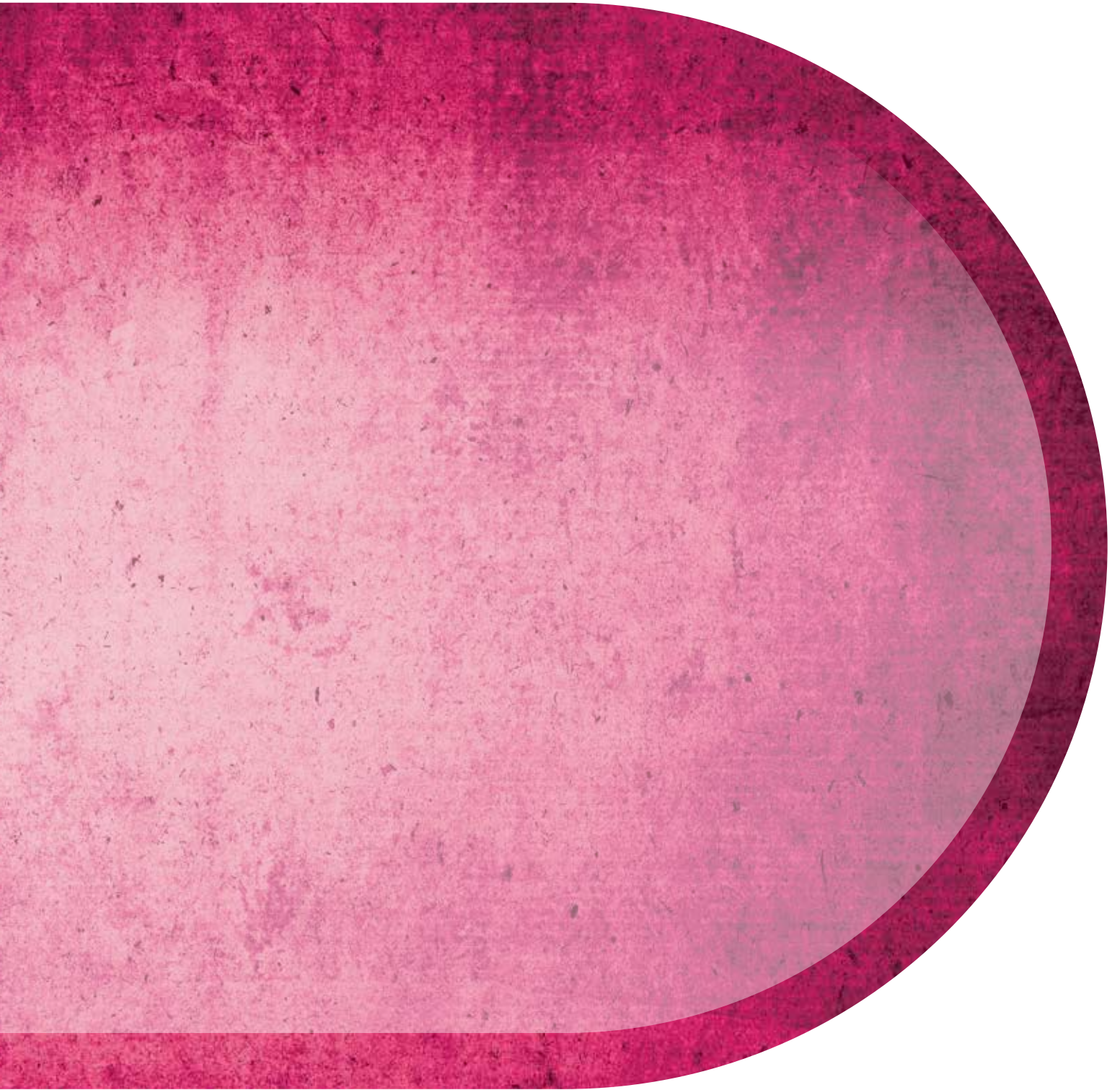
## Service providers' and service users' views on gaps in the standards in relation to safety and quality in mental health services

Both service users and service providers agreed on key ideas related to gaps in the standards and ways forward:

- Neither the *NSMHS* nor the *NSQHS Standards* alone adequately address all of the safety and quality issues in mental health services.
- One comprehensive set of standards incorporating the *NSMHS* and *NSQHS Standards* is the best way to ensure safety and quality in mental health services.
- Standards should be mandatory for mental health services.

# References

1. Commonwealth of Australia. National Standards for Mental Health Services 2010. Canberra. Commonwealth of Australia, 2010.
2. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. Sydney. Australian Commission on Safety and Quality in Health Care, 2011.
3. Commonwealth of Australia. Implementation Guidelines for Public Mental Health Services and Private Hospitals. Canberra. Commonwealth of Australia, 2010.
4. Commonwealth of Australia. Implementation Guidelines for Non-government Community Services. Canberra. Commonwealth of Australia, 2010.
5. Commonwealth of Australia. Implementation Guidelines for Private Office Based Mental Health Practices. Canberra. Commonwealth of Australia, 2010.
6. Department of Health and Ageing. National Mental Health Report 2013: tracking progress of mental health reform in Australia 1993-2011. Canberra. Commonwealth of Australia, 2013.
7. Australian Institute of Health and Welfare. Mental health services – in brief 2013. Canberra. AIHW, 2013.
8. Mental Health Coordinating Council. The NSW Community Managed Mental Health Sector Mapping Report 2010. Sydney, 2010.
9. Gatter B, Penter C. A Project to Map the Community Mental Health Sector in Western Australia. Perth. Western Australian Association for Mental Health, 2012.
10. Australian Health Ministers' Advisory Council Mental Health Standing Committee. National Statement of Principles for Forensic Mental Health, 2006.
11. State of Victoria, Department of Health. National Practice Standards for the Mental Health Workforce 2013. Victorian Government Department of Health. Melbourne, 2013.
12. National LGBTI Health Alliance. Cultural Competency Implementation Framework: Achieving Inclusive Practice with Lesbian, Gay, Bisexual, Trans and Intersex (LGBTI) Communities. Newtown. National LGBTI Health Alliance, 2013.
13. Australian Commission on Safety and Quality in Health Care. Consultation Draft Accreditation Workbook for Mental Health Services. Sydney. ACSQHC, 2012. (Superseded by Australian Commission on Safety and Quality in Health Care. Accreditation Workbook for Mental Health Services. Sydney. ACSQHC, 2014.)
14. Commonwealth of Australia. Mental Health Statement of Rights and Responsibilities. Canberra. Commonwealth of Australia, 2012.
15. Commonwealth of Australia. A National Framework for Recovery-oriented Mental Health Services: Policy and Theory. Canberra. Commonwealth of Australia, 2013.
16. Use of restrictive practices during admitted patient care. Australian Institute of Health and Welfare, 2013. (Accessed 15 May, 2014, at <http://mhsa.aihw.gov.au/services/admitted-patient/restrictive-practices/>)
17. National Mental Health Commission. A Contributing Life, the 2013 National Report Card on Mental Health and Suicide Prevention. Sydney. National Mental Health Commission, 2013.
18. Bureau of Health Information. Patient Perspectives: Mental Health Services in NSW Public Facilities, Volume 1, Inpatient Care, February 2010 and February 2011. Sydney. BHI, 2013.
19. Commonwealth of Australia. A National Framework for Recovery-oriented Mental Health Services: Guide for Practitioners and Providers. Canberra. Commonwealth of Australia, 2013.
20. Mental Health in Multicultural Australia. Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery. Brisbane. Mental Health in Multicultural Australia, 2013. (Accessed 19 June, 2014, at <http://framework.mhima.org.au/framework/>)
21. National LGBTI Health Alliance. LGBTI Cultural Competency Framework: Including LGBTI People in Mental Health and Suicide Prevention organisations. Newtown. National LGBTI Health Alliance, 2013.
22. Australian Women's Health Network. Women and Mental Health: Position Paper 2012. Drysdale. Australian Women's Health Network, 2012.
23. Standards New Zealand. Health and Disability Services (General) Standard. Standards New Zealand, 2008.



**Australian Commission on Safety and Quality in Health Care**

Level 5, 255 Elizabeth St, Sydney NSW 2000  
GPO Box 5480, Sydney NSW 2001

Phone: (02) 9126 3600 (international +61 2 9126 3600)

Fax: (02) 9126 3613 (international + 61 2 9126 3613)

Email: [mail@safetyandquality.gov.au](mailto:mail@safetyandquality.gov.au)

[www.safetyandquality.gov.au](http://www.safetyandquality.gov.au)