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23 September 2026

Written Submissions – NSQHS Standards (third edition)
By email: NSQHSSThirdEdition@safetyandquality.gov.au

To whom it may concern,

**APS submission on draft National Safety and Quality Health Service Standards (third edition)**

The Australian Psychological Society (APS) welcomes the opportunity to provide feedback on the draft National Safety and Quality Health Service Standards (third edition).

The APS supports the continued strengthening of the NSQHS Standards to promote safe, high-quality, person-centred and equitable healthcare across Australia. The APS welcomes the focus in the draft Standards on accessibility, integrated care, workforce capability and equity across different healthcare settings and geographic locations.

**About the APS**

The APS is the leading professional association for psychologists in Australia. We are committed to advancing the science, ethical practice and application of psychology to promote health and wellbeing, prevent issues and deliver early intervention and treatment and recovery.

Our members work across Australia's health system, including in public and private hospitals, community healthcare, mental health services, rehabilitation, disability services and private practice, as well as in research, education and health service leadership.

Psychologists contribute to safe and high-quality healthcare through evidence-based practice in psychological assessments, formulation and intervention, as well as through consultation, multidisciplinary care, clinical governance, service design and quality improvement initiatives. The role of psychology is relevant across the continuum of care, including for people experiencing complex and chronic physical, cognitive, psychological, cultural and social needs.

The APS is invested in ensuring that the revised Standards support equitable access to high-quality, evidence based psychological case across Australia, including for people living with disabilities, and those living in rural, remote and regional communities, and recognises the role of psychologists within multidisciplinary healthcare services.

Please find the APS response to the draft Standards. We consent to this letter and our response being made publicly available. The APS welcomes the opportunity to continue contributing to the development and implementation of the Standards and any other supporting documentation. If any further information is required from the APS, I would be happy to be contacted through the National Office on (03) 8662 3300 or by email at z.burgess@psychology.org.au.

Yours sincerely

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Chief Executive Officer


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# Response to the consultation questions

The APS supports the key points and recommendations made by the National Centre of Excellence in Intellectual Disability Health, see Appendix 1. Review and action on these issues is required to meet the commitments made by Australian governments in response to the Disability Royal Commission, including ensuring "equal access to healthcare services for people with disability throughout life (Commonwealth of Australia, 2023)."

In addition to these recommendations, the APS provides the following feedback under the relevant questions regarding psychological care, workforce capability, clinical governance and equitable access to healthcare across geographic locations.

## 1. Do the draft Standards reflect key safety and quality priorities?

*Relevant draft requirements: 1.13; 1.17; 2.04 and 2.18*

The APS supports the draft Standards' focus on high-quality, person-centred, accessible and integrated care. However, the Standards could more explicitly recognise psychological health and access to psychological care as components of comprehensive multidisciplinary healthcare.

Psychologists contribute across hospital settings through psychological assessment, formulation and intervention. To support high-quality care, health care services should have sufficient access to appropriately qualified psychologists to meet the needs of the populations they serve, across the continuum of care.

This is consistent with the draft Standards' emphasis on aligning clinicians' skills, capability and experience with patient's care requirements (Requirement 1.17), and multidisciplinary approaches to assessment and care. It is also relevant to Requirement 2.04 and 2.18, which requires multidisciplinary teams to use clinical information and assessment, and recognise, assess and manage deterioration in a patient's mental state, respond safely and effectively to suicidal distress and self-harm, support appropriate follow-up care and reduce risks arising from unmet needs.

**Recommendation:**

The APS recommends that the revised Standards are strengthened to more explicitly recognise psychological care as a component of comprehensive multidisciplinary healthcare and require health services to consider whether their workforce composition provides adequate access to appropriately qualified psychologists.

## 2. Could the Standards be strengthened to better support high-quality care and improved health outcomes?

*Relevant draft requirements: 1.15; 1.17; 1.18 and 1.19*

The APS considers the Standards could be strengthened by recognising the importance of appropriate senior professional leadership across multidisciplinary health workforces. Senior psychologists contribute psychological expertise to clinical governance, service design, quality improvement, workforce capability and the development and implementation of evidence-based models of care.

The draft Standards recognise the importance of effective leadership, mentorship and capability development (Requirement 1.15); appropriate clinical supervision and access to senior clinician support (Requirement 1.17); participation of different clinical groups in clinical governance (Requirement 1.18); and clinician involvement in quality improvement initiatives (Requirement 1.19).

Explicit recognition of appropriate senior psychology leadership would support appropriate clinical supervision and capability development within the psychology workforce, while also ensuring psychological

expertise contributes to clinical governance, service design and improvement at a system-level rather than being limited to individual care pathways.

**Recommendation:**

The APS recommends that the Standards recognise the importance of appropriate senior psychology leadership within health services, including participation in clinical governance, service design and implementation and workforce capability development.

## 3. Do the Standards adequately support care delivery and coordination across services, settings and providers?

*Relevant draft requirements: Equity principles and Requirements 2.19-2.21*

The APS supports the draft Standards' focus on coordinated and integrated care across services, settings and providers. However, implementation of these requirements must recognise substantial geographic variation in workforce availability and access to allied health services, including psychologists, across Australia's healthcare services.

The draft Standards recognise equity as including disparities between metropolitan, regional, rural and remote health services and emphasise the need for integrated models of care, continuity, effective transition between providers, and coordination across services and providers.

People living in rural and remote Australia should not experience a lower standard of care because appropriately qualified psychological services are unavailable locally. To support equitable access to coordinated and integrated psychological care, implementation of the Standards should enable flexible approaches responsive to the local context. These may include locally based psychologists, regional or shared arrangements, outreach, and where appropriate, telehealth.

**Recommendation:**

The APS recommends that implementation of the Standards require health services to demonstrate how patients can access clinically appropriate healthcare, including psychological care, regardless of geographical location, while allowing flexibility for rural and remote health services in how this is achieved. Health services should be supported to identify recurrent referral and care coordination issues and use this data to strengthen coordinated care pathways between providers and services.

## 4. How well do the Standards help health services learn, reflect and improve over time?

Relevant draft requirements: 1.28; 1.29; and 1.31.

The APS supports the strengthened focus of the Standards on using data, patient experience and outcomes to support continuous improvement. Requirements 1.28, 1.29, and 1.31 require health services to collect, analyse, and use data to improve care, guide resource allocation, assess the delivery of high-quality care and evaluative how effectively care is integrated across services.

To determine whether the Standards are achieving equitable access in practice, health services should be supported to identify and monitor access, unmet need and outcomes across population groups and geographic locations. This should include consideration of whether Aboriginal and Torres Strait Islander people have access to culturally responsive and safe care, recognising that experiences of and barriers to healthcare may differ across communities and locations.

Collecting relevant service data would capture where workforce shortages may mean that a referral pathway exists, however that this does not necessarily equate to timely access to a qualified health professional. Meaningful data on access and unmet need would support health services locally, as well as

jurisdictionally, to identify service gaps, inform workforce planning and continuous quality improvement, and develop models of care responsive to local needs.

The APS welcomes the stronger provisions in Requirement 1.29 relating to Aboriginal and Torres Strait Islander data governance. The requirement recognises Aboriginal and Torres Strait Islander peoples and communities' right in relation to the creation, collection access, interpretation, dissemination and reuse of data, as well as the importance of collaboration in interpreting and responding on data in culturally appropriate and safe ways. These principles will ensure that data used to identify inequities and inform service improvement are locally meaningful.

**Recommendation:**

The APS recommends that implementation guidance is provided to support health services to identify and use locally relevant indicators that reflect their service context. Implementation guidance would also allow large hospital and health service providers to explore geographic and service level to multidisciplinary care access, including psychological services, and use this data to inform workforce planning and continuous quality improvement. Implementation guidance relating to Aboriginal and Torres Strait Islander data should be developed in partnership with Aboriginal and Torres Strait Islander peoples, communities and organisations to support culturally safe implementation and approaches to data governance, interpretation and use.

## Conclusion

The APS supports the strong emphasis on safe, high-quality, person-centred, accessible, integrated and equitable healthcare of the draft Standards.

In addition to the recommendations of the National Centre of Excellence in Intellectual Disability Health, the APS encourages the Commission to ensure that the next iteration of the Standards recognise psychological care as integral component of multidisciplinary healthcare, support appropriate psychology expertise and leadership within clinical governance and service improvement, and promote equitable access to high-quality psychological care regardless of geographic location.

# References

Commonwealth of Australia. (2023). *Final report of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.* Commonwealth of Australia.

# Appendix 1

## National Centre of Excellence in Intellectual Disability Health Submission

**Key points**

There are approximately 560,000 people with intellectual disability in Australia.

1. A very strong research base shows that people with intellectual disability experience extreme disadvantage in the Australian health care system. This includes twice the usual rate of potentially avoidable deaths, four times the rate of potentially preventable hospitalisations and dying 27 years earlier.

2. Most hospital clinicians have minimal undergraduate or continuing education in the needs of people with intellectual disability. They commonly show inadequate understanding of their needs and often show unconscious bias concerning their needs and quality of life.

3. Hospital clinicians do not routinely think about people with intellectual disability when faced with broader expressions like “equity”, “disability”, “cognitive disability” or “cognitive impairment”.

4. The Standards therefore need to include a specific focus on people with intellectual disability.

5. We welcome the inclusion of a section on “Equity” in the Introduction to the draft Standards. However, for that section to have impact, it requires at least a succinct subsection focused on each equity population, including specifically people with intellectual disability. The section on people with intellectual disability should reflect paras 2-4 above and other key aspects of disadvantage experienced by people with intellectual disability in the health system.

6. The Standards should require hospitals to give ongoing and specific consideration to the needs of people with intellectual disability and each other equity population in implementing relevant Standards. This should include:

   a) A requirement to focus on intersectional needs, for example needs of a First Nations person with intellectual disability.

   b) A requirement to identify and avoid disadvantage related to stigma.

   c) A need to act on relevant ACSQHC user guides, including the Standards User Guide for the Health Care of People with Intellectual Disability, and the Standards User guide for Aboriginal and Torres Strait Islander health.

7. We welcome draft Standard 1.10 c. which requires hospitals to have organisational systems to “provide equitable access to health care for people with a disability and identify and action the need for reasonable adjustments”. However, this requirement is too general so that there will be tendency to focus on physical and sensory disability and not intellectual disability. The Standard should be reworded to read:

Provide equitable access to health care for people with intellectual, physical, sensory and other disabilities and action the need for:

- Reasonable adjustments
- Steps to counter conscious and unconscious bias
- Avoiding diagnostic overshadowing, specifically the assumption that symptoms relate to a person’s disability rather than to a health condition.

9. “Reasonable adjustments” are fundamental to providing equitable care to people with disability but hospital personnel commonly have very limited understanding of them. An additional Standard should be created along the following lines:

**Reasonable adjustments**

Hospitals should ensure reasonable adjustments to meet the needs of people with disability by having systems to:

Identify consumers with disabilities including their types of disability and intersectional needs.

In conjunction with the person and their families, carers and disability support providers, identify reasonable adjustments the consumer needs in relation to matters including communication, time needed for interactions, support for decision making, comfortable environments, waiting times, behaviour support, and support and sedation for intrusive treatments.

Provide identified reasonable adjustments.

Train clinicians in identifying and providing reasonable adjustments.

Monitor and audit to assess whether reasonable adjustments have been made.

10. The need to identify and act on reasonable adjustments should also be restated in draft Standards 2.04 and 2.05 (clinical assessments and plans of care).

11. The draft Standards do not but should include requirements for trauma informed care including in relation to trauma resulting from medical treatment.

12. Behaviours of concern (2.11 and 2.12) – There should be specific requirements in relation to:

Use of positive behaviour support.

The need to comply with legal requirements for consent or authorisation of restrictive practices.

13. Recognising and responding to acute deterioration (2.16-2.18) – A consumer's "usual baseline" should be documented on admission to avoid diagnostic overshadowing. All too often, deterioration is not adequately recognised because hospital staff assume a person's presentation relates to their disability.

14. Coordinated and connected care (2.19- 2.22) –

There should be specific inclusion of any "disability support services" in the list of those to be involved in coordination of care. All too often, this does not occur to the detriment of a person with disability

There should be a specific requirement for hospitals to liaise with disability support services and families to

clarify the disability support needs of a consumer and whether these have significantly altered as a result of a health condition, and

i. resolve arrangements to meet those needs both in hospital and on discharge.

15. Safe environments – Standard 3.01 should be extended by:

Amending the Purpose statement to encompass accessibility. The Purpose statement should read, "Care environments are safe, accessible, culturally welcoming and therapeutic.:

Including requirements to:

Provide hospital environments that will minimise anxiety and maximise psychological comfort for individuals.

Where appropriate, offer ambulatory and outreach models of care.

16. Health care record systems (3.04) – These should record any disability and related needs for reasonable adjustments. (The Single Digital Patient Record currently being piloted by NSW Health incorporates this feature.)

17. Medicines safety and quality (3.10-3.12)- There should be a requirement to comply with relevant authoritative guidelines such as the ACSQHC Psychotropic Medicines in Cognitive Disability or Impairment Clinical Care Standard.

18. The glossary should be amended to include definitions of the following

expressions which will not routinely be understood in hospitals:

Reasonable adjustments

"Disability" and different kinds of disability including "intellectual disability"

Positive behaviour support

Diagnostic overshadowing

19. "Substitute decision maker" is defined in the Glossary as a person authorised to make decisions for a person "who has lost decision-making capacity". This incorrectly indicates that capacity is an all or nothing concept. The words
"who has lost decision-making capacity" should be replaced by "who lacks capacity to make a particular decision".

20. The definition of "bias" should be elaborated on to explain both conscious and unconscious bias.

21. Like the existing Standards, the new Standards should be accompanied by a Guide for Hospitals which has to be considered by hospitals implementing the Standards and by accreditation agencies. The existing intellectual disability User Guide is a valuable document but does not carry sufficient authority to be routinely considered by hospitals and assessors. Considerable material related to people with intellectual disability should be incorporated into the new Guide for Hospitals.

**Fulfilling Government commitments in response to the DRC**

We argue that action on our recommendations is required to meet the commitments of Australian Governments that the revised Standards will "ensure equal access to health care services for all people with disability throughout life".

DRC Recommendation 6.31(a) was to embed the right of people with disability to good health care in key policies and in legislation – the Australian Charter of Healthcare Rights, the National Quality and Safety Health Service Standards and Community Healthcare Standards

In the 2024 joint response of all Australian Governments, they said "Accept" to this recommendation and stated: Governments are committed to ensuring key policy instruments and plans support an inclusive Australian society that ensures people with disability have access to health care services that address their needs. The Australian Government, through the Australian Commission on Safety and Quality in Health Care and in consultation with Commonwealth and State and Territory health governments, will develop a plan to update key policy instruments to ensure they articulate the requirements for safe and equitable access to health services for people with disability.

In their 2025 update on action, the governments said: The ACSQHC will continue to undertake wide consultation with key stakeholder groups and the public when developing the third edition of the Standards and supporting resources to ensure equal access to health care services for all people with disability throughout life.