APS Response to the Australian Commission on Safety and Quality in Health Care

National Safety and Quality Primary Healthcare Standards.

January 2021

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Overview

As the largest peak professional organisation representing over 25,000 psychologists, the APS welcomes the opportunity to provide feedback to the Australian Commission on Safety and Quality in Healthcare (ACSQ) about the draft National Safety and Quality Primary Healthcare Standards (NSQPHS).

The APS supports strengthening clinical governance and views strong governance as essential for ensuring there is genuine effort to maintain best practice and set a continuous improvement culture for the quality and safety of healthcare. The APS generally supports the need for the NSQPHS, yet recommends that certain aspects of the current draft be improved to ensure the standards are fit for purpose and implementable for mental health practices – now, and as mental health reforms roll out.

In 2018, the APS developed the 3rd edition of Private Practice Management Standards for psychological practices based on Australian Safety and Quality Framework in Health Care (December, 2010), the Australian Commission on Safety and Quality in Health Care's National Safety and Quality Health Service Standards (2nd edition) (November, 2017), and an extensive review of practice standards for psychologists and other allied health professions in Australia and internationally.

The current draft NSQPS do not provide sufficient focus on mental health care. For example, grouping all mental health services into one category while the 12 other - predominantly physical health professional services - are specifically listed, downplays the nuances and heterogeneous nature of mental health services and professions. The language and actions within the standards appear to be a retrofit to medical and physical healthcare standards. Our submission answers the consultation questions and provides recommendations aimed at uplifting the safety and quality of mental health services to support strong governance and sustainable reform within the mental health system.

In this submission the APS call upon the ACSQ to:

1. **Develop National Safety and Quality Primary Mental Healthcare, and other standards that are fit for purpose for the diverse range of mental health practices and clinicians across the mental health system**
2. **The ACSQ in collaboration with the National Mental Health Commission (NMHC) develop a change management process that addresses the following aspects: language; flow-on impacts; viability; evidence to inform implementation and continuous improvement; leveraging technology to streamline processes; and education and training**.

In relation to the specific consultation questions, the APS provide recommendations to generally improve the standards and specifies where some standards are not fit for purpose for mental health services.

APS Recommendations

1. Develop National Safety and Quality Primary Mental Healthcare standards that are fit for purpose for a reformed mental health system.

Mental health and wellbeing is widely recognised as being just as important as physical health and wellbeing, for individuals and across the wider community. Several evidence-based studies including the Productivity Commission's inquiry into mental health, the work of the National Mental Health Commission, the appointment of chief allied and mental health commissioners over the past 5 years, and the significant concerns about the growing mental health problem documented across many inquiries, consultations, emerging frameworks and government investments in mental health, have highlighted this. More recently there is also concern about a mental health crisis emerging from the multiple disasters that the Australian community is grappling with, including bushfires, floods and the COIVD-19 pandemic.

In their current form, the NSQPHS will be difficult to implement and complex to interpret. Some aspects are ambiguous, which can potentially restrict the implementation of the standards into a 'compliance' mentality or a 'tick and flick' exercise. By addressing these issues in a timely manner, there is a genuine window of opportunity to strengthen the safety and quality of our mental health system as it is being reformed. Ensuring that mental healthcare governance standards are fit for purpose will also enable a firm foundation for a stronger, safer and higher quality mental health care.

The APS believes there is a need for policy-makers and regulators to recognise the substantial importance of mental health by developing specific mental health standards, rather than retrofitting mental health into standards designed for medical and physical health care. This will also ensure the longer-term sustainability of the system-wide reform of mental health services that are currently underway, and better inform clinical care expectations across the system.

The current draft standards do not support the significant diversity between mental health services as they group the broad range of mental health professionals into one category, while the wide range of allied health professions focusing primarily on physical health care, for example, audiology, dental, Chinese medicine, chiropractic, physiotherapy, podiatry, speech pathology, dietetics and exercise physiology, are listed individually. A single category for mental health services also implies that they are homogenous, which they are not - for example, psychologists, social workers, lived experience/peer support workers, community mental health nurses etc. will meet the standards in different ways as they have different legal, ethical, regulatory and best practice requirements.

The lack of recognition of the diversity of mental health services also means some standards will not be appropriate for new and/or innovative mental health services that emerge from the system-wide reforms being implemented over the next five or ten years. For example, standard 3.18 (focused on planning and delivering comprehensive care) does not provide for the nuanced and varied roles and services associated with mental health care. Family therapy, as an example, may not involve diagnosis while some mental health services delivered by lived experience mental health support workers, may not require risk screening or clinical assessment. A single category for mental health thus underestimates the importance and diversity of mental health care compared with other health care professions.

Develop fit for purpose standards for mental health

The APS recommends that the ACSQ:

- Remove mental health services from these standards
- Develop specific standard for mental health service delivery in primary care
- Ensure that governance standards for mental health services are tailored across the diverse range of mental health care, and adjusted to remain fit for purpose as the ongoing mental health reforms are implemented.

2. Develop, in collaboration with the National Mental Health Commission, a robust change management process for governance, to ensure consistency with ongoing mental health reforms

Given the desire for the NSQPHS to assist primary healthcare services to minimise the risk of harm and improve care for patients, the APS recommends addressing some key barriers to their implementation. The first is the need to ensure that the standards can be tailored to the variety of practices that fall within the mental health system (now, and as it continues its' reform agenda), and the diverse range of professionals who work within the system, including psychologists, psychiatrists, mental health nurses, social workers, and lived experience workers among others.

The APS is also concerned that the NSQPHS may be underutilised, and uptake rates remain low, restricting the ability to support meaningful change to governance, as the draft standards:

- Do not provide sufficiently nuanced information across the full range of mental health services
- Include requirements (for example the open disclosure framework) which do not fit all mental health services
- Could overburden mental health services if potential implementation, audit and cost barriers are not reduced.

The ACSQ in collaboration with the National Mental Health Commission (NMHC) should develop a change management process that:

- **Adjusts the language**. The language in the standards remains medically oriented. This is especially true within the explanatory notes where many of the examples specifically relate to medical services and procedures that are not applicable to most mental health services. This needs to be revised so that the standards align with the language used in mental health care.
- **Assesses flow-on impacts.** The impact of the NSQPHS needs to be assessed, for their applicability across different mental health services, settings and professions. The APS is concerned that these standards will be used by multiple agencies for very different purposes - for example, by PHNs when they commission services, as well as by the Australian Health Practitioners Regulation Agency as part of new risk assessment requirements for notifications, where restorative actions

through strong governance must be considered when a complaint is made. Cross-agency consultation will be needed to ensure that the NSQPHS can align with the purpose these agencies are using them for, and to address any gaps or ambiguities that may emerge in the assessment.

An impact assessment is also required to ensure these standards align with the various funding scheme requirements such as Medicare, NDIS and DVA, within the mental health care system. A misalignment between these schemes and the standards can give rise to complexities that can potentially overburden mental health providers.

The cost of accreditation and audits should also be assessed, particularly for small to medium practices such as sole traders, to ensure that the implementation costs are clearly articulated, and to help identify areas for cost-reduction. These measures will help to support the governance and longer-term sustainability of mental health practice.

- **Ensure longer-term viability.** The current mental health reforms are impacting the mental health workforce, the structure of practices, and the type of services that will be available. There is a need to consider how the NSQPHS will remain viable, as mental health system reforms are being implemented, workforce roles are clarified, and different mental health service types emerge.

- **Establishes evidence to inform implementation and continuous improvement.** Identifying the costs and benefits associated with these standards will facilitate better uptake and support continuous improvement. The Productivity Commission Inquiry into Mental Health highlights the need to embed measurement, evaluation and continuous improvement throughout the mental health system, including for funding and governance process, such as those associated with these standards. A well-developed change management process, and proactive identification of the costs and benefits of implementing the standards will best support the implementation.

- **Leverages technology to streamline processes.** Substantial savings could be made, for both the government and individual practices, by leveraging technology to streamline processes. The APS recommends developing an online portal to simplify the underlying processes, facilitate the uptake of and adherence to the standard, and reduce the regulatory and cost burden (including compliance and audits) for the Government and mental health practices. Technology could also assist decision-making, establish processes and task-lists etc. to aid practice and collect data.

- **Provides profession-specific education and training.** The ACSQ should develop an education and training package to facilitate the uptake of the standards by mental health services, tailored to meet the differing needs of mental health professionals and practices.

Develop a robust change management process

The APS recommends that the ACSQ, in collaboration with the National Mental Health Commission develop a change management process that:

- Adjusts the language
- Assesses flow on impacts
- Ensures viability of the standards through mental health reforms
- Establishes evidence to inform implementation and continuous improvement
- Leverages technology to streamline processes, and
- Provides profession-specific education and training

APS Response to the Consultation Questions

Please find below the APS response to the questions raised in the Consultation Paper.

Introduction

Does the Introduction aid your understanding of the context of the NSQPH Standards and how they are to be applied? If not, please outline what further information is required to support your understanding.

Yes the introduction is clear.

Appropriateness

Do the actions cover the key safety and quality issues for primary healthcare services? If no, please provide details.

The high-level nature of the document does not lend itself to quick implementation, potentially compromising the ability of mental health practices to interpret the standards, and appropriately apply the recommended actions.

Further work is needed to ensure that the standards can be implemented across all contexts, in particular across the wide range of mental health professions and practice. In their current form the standards do not recognise the heterogeneous nature and differing scope of practice across the mental health system, with differing professional, ethical, legal and practice requirements. A set of profession-specific examples will need to be developed, to facilitate uptake and support the implementation of these standards.

Actions

Do the actions make sense to you? Is it clear how they will be applied in your primary healthcare service?

Many of the actions apply to the psychology profession, however as outlined above, profession-specific guidance will also be needed for some actions. More work needs to be undertaken, for these standards to apply across the broad range of mental health settings and professions, so that they can be appropriately

interpreted and applied. Several actions should be amended to better suit the mental health profession, specifically psychological practices, including the following:

1.06 The primary healthcare service uses the Australian Open Disclosure Framework when a patient is harmed through the delivery of care. The APS do not support the requirement for mental health services to adhere to the Australian Open Disclosure Framework (AODF), as it is not fit for purpose for mental health. The AODF was formally endorsed in 2013 by professional organisations for medicine and pharmacy, but not by allied or mental health organisations. The literature referenced in this framework and the review conducted in 2012[a] that led to the revised AODF (2013) is predominantly grounded in medical care, not mental healthcare services or professionals. Requiring mental health professionals to adapt to a medically-oriented framework that provides examples of medical interventions and adverse events, does not appropriately support strengthening governance within the mental health system.

There are substantial differences between the form and type of adverse events, and the medico-legal frameworks that occur in medical settings, as compared with mental health settings. As outlined in Box 1 of the AODF (page 11) mental health practices are encouraged to adapt the framework to suit their particular context, yet there are insufficient details and examples provided, about its applicability to mental health services. The AODF also clearly emphasises medical-related adverse events - for example, Table 1 (page 44 of the AODF) does not include any examples relating to mental health incidents.

The requirement for mental health services to use a framework that has not been developed for, nor reviewed to ensure it can apply to, mental health settings is problematic. There has also been a lack of consultation and endorsement of these standards, by mental health or allied health professionals. This can significantly compromise the safety and quality of mental health services delivered across practices. The requirement for mental health and allied health services to fit a predominantly medically-oriented framework, is also unlikely to work in practice.

The APS also recommends removing the requirement for adherence to the Australian Open Disclosure Framework, until such time as it has been sufficiently reviewed and revised to apply to mental health services. The framework should be reviewed based on literature and broad consultation with experts associated with mental and allied health, mental health professionals and regulatory bodies etc. It should also review the applicability to the diverse range of mental health services and professionals, and their varying regulatory and ethical standards. This is particularly relevant for psychological services, as the psychology profession and AHPRA require psychologists to continue to practice in line the APS Code of Ethics. It would be useful to consider how this framework can better align with the ethical and practice requirements for the psychology profession in Australia.

3.02 Hand hygiene. There is a potential for ambiguity between the requirement that processes should be consistent with the National Hand Hygiene Initiative developed by ASQC, and the guidelines and audit needs outlined for non-acute care, including office-based services. The minimum standards for mental are unclear, as hand hygiene training is not recommended for these settings. There are also no clear standards that outline the requirements for mental health services in community or primary care.

[a] Open Disclosure Standard: Review Report June 2012

3.12 & 3.13 Documentation, provision and access to medicines related information. The NSQPHS do not provide sufficient detail to delineate the extent to which each mental health practice and profession is required to undertake the action. This should be revised to ensure it appropriate for the variety of mental health practices, for example it will not be the role of some mental health professions to undertake actions related to documenting patient's medicines.

3.18 & 3.19 Planning and delivering comprehensive care. Standard **3.18** does not fit some services in mental health care or allied healthcare - for example, family therapy will not involve diagnosis. Also some mental health professionals such as lived experience mental health support workers, will not conduct risk screening or clinical assessment.

With regards to standard **3.19,** there is a need to ensure that specific cultural groups including those from Aboriginal and Torres Strait Islander or culturally and linguistically diverse backgrounds, are engaged to ensure that the care, safety and quality standards are culturally-informed. Multicultural nuances could be strengthened in these standards, to support broader inclusiveness and diversity.

3.21. Predicting, preventing and managing aggression and violence. The standards could better acknowledge that these behaviours occur along a spectrum, and responses would differ across professional groups. For example in some forensic practices, managing these behaviours would need to be conducted quite differently to managing a person with dementia who may behave aggressively at times. The standards need to be flexible, and/or provide more guidance to ensure they are able to be appropriately implemented for different professional service types.

Other standards, such as **3.22** which requires all allied health professionals to assess the risk for suicide, can be inappropriate or even outside the scope of practice for some allied health professionals. Many professionals are also not trained to competently undertake these assessments and/or manage the risks. Standard **3.23** is also inappropriate for many of the listed professions, as they may not be trained to identify, assess and remediate deterioration in mental health.

Standard **3.23** also implies that it is appropriate for people without sufficient skills to manage a mental health care crisis, yet could lead to problems with a person's mental health, and subsequent care pathways. If the goal of this standard is to improve the response to mental health crises, then there needs to be a discernment about the various roles and scope for each of the different professions, particularly for those who are not trained in crisis mental healthcare.

While these examples do not represent all the areas of mismatch between the NSQPHS and the range of professional services listed, they do highlight the need for more nuanced mental health standards.

Language

Is the language and terminology used in the document easy to understand and appropriate for the primary healthcare sector? How could it be improved?

The language in the document is medical-oriented and needs to be revised, to ensure it is interpretable and applicable to mental health practices.

Not applicable actions

Is the summary table of not applicable actions at Appendix 1 clear? What other 'not applicable actions' need to be added for your service? What other primary healthcare services should be included in this table?

The summary table in Appendix 1 is not clear and should be simplified for use. Practitioners trying to work through the standards must manually cross-check items for applicability, which is time-consuming, increases the margin for error, and complicates the process. The APS suggests simplifying the way 'not applicable actions' are identified by including the notation into the main standards, rather than in Appendix 1. This can be in the form of a notation for the applicable standards as follows:

- **All professions listed.** For 'not applicable actions' that apply to all professions then a notation can be made within the standard, such as a footnote. For example,
    - Standards 1.12 and 1.13 could contain a notation to stating that this standards only applies when evidence is provided that the My Health Record System (MHR) is not in use. It should also be noted that this would require practitioner to provide evidence of not using MHR.
    - Standard 1.24 could contain a notation that this action is not applicable when evidence is provided that the risk of harm to Aboriginal and Torres Strait Islander patients is the same as for the primary healthcare service's general population.
- **Selected professions.** For 'not applicable actions' that apply to only some professional services these can be noted as above but with applicability to only those professions. For example, standard **3.04** can be noted with the exception of Chinese medicine, dental services, optometry services, this action item is applicable to all other categories unless evidence is provided that procedures where sterility needs to be maintained does not occur. However, again this would require the service to provide evidence of something that they do not do.

Embedding the 'not applicable items' into the standards will make it simpler and easier for services to work through, and apply the standards in practice. It will also help them to gather evidence, where requested, for certain items.