

Local Adult and Older Adult Mental Health and Wellbeing Service

Service Framework



Department
of Health

August 2022

OFFICIAL

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In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people. 'Indigenous' or 'Koori/Koorie' is retained when part of the title of a report, program or quotation.

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Acknowledgement

The Department of Health proudly acknowledges Victoria's First Nations peoples and their ongoing strength in practising the world's oldest living culture. We acknowledge the Traditional Owners of the lands and waters on which we live and work and pay our respect to their Elders past and present.¹

The Department of Health acknowledges Aboriginal² ways of knowing, being and doing³ and prioritises Aboriginal culture, addressing trauma and supporting healing across mental health and social and emotional wellbeing services. We commit to improving the cultural safety of all services so that irrespective of where treatment, care and support is delivered, it is safe, inclusive, respectful and responsive for all Aboriginal people, families and communities.⁴

Furthermore, we acknowledge Aboriginal self-determination is a human right as enshrined in the United Nations Declaration on the Rights of Indigenous Peoples and we commit to supporting Aboriginal peoples' right to practice self-determination.⁵ Supporting Aboriginal self-determination means Aboriginal people will have the power to make decisions on matters that affect them and their communities, and this will help ensure they can achieve and sustain strong social and emotional wellbeing based on their own cultural values and way of life.⁶

The department also recognises all people with lived and living experience of trauma, neurodiversity, mental health challenges, psychological distress, suicide, substance use or addiction, and their families, carers, supporters, those experiencing bereavement, advocates and allies.

Language statement:

We recognise the diversity of Aboriginal people living throughout Victoria. Whilst the terms 'Koorie' or 'Koori' are commonly used to describe Aboriginal people of southeast Australia, we have used the term 'Aboriginal' to include all Aboriginal and/or Torres Strait Islander peoples, families and communities who are living in Victoria, unless stated or referenced otherwise.

The use of the word 'we' refers to the Department of Health.

¹ Victorian Government 2018, *Victorian Aboriginal Affairs Framework 2018-2023*, State Government of Victoria, Melbourne.

² The term 'Aboriginal' used in this document refers to Aboriginal and/or Torres Strait Islander individuals, families and communities unless stated or referenced otherwise.

³ Muller, L 2014, *A Theory for Indigenous Australian Health and Human Service Work – Connecting Indigenous knowledge and practice*. Allen & Unwin, New South Wales.

⁴ Armytage, P et al. 2021, 'Promoting inclusions and addressing inequities', *Royal Commission into Victoria's Mental Health System 2021*, Volume 3.

⁵ Victorian Aboriginal Affairs Framework 2018-2023

⁶ Victorian Aboriginal Affairs Framework 2018-2023

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Preamble

The purpose of this Service Framework is to guide the operation and service delivery of Local Adult and Older Adult Mental Health and Wellbeing Services across Victoria (hereafter referred to as 'Local Services').

This document outlines the objectives, key operational principles, service features and functions, components of the service model and the workforce, data reporting and operational requirements for Local Services.

The Department of Health (the department) expects that service providers funded to deliver Local Services will adhere to the service specification and operational requirements as set out in this document.

Service providers considering any substantive variation to the service model must consult with the department prior to implementation to ensure consistency in the service offer, equity of access and fidelity to the core functions and principles specified for Local Services.

Please note, this Service Framework is a working document and may be subject to adjustment and refinement as the service model matures. In addition, changes may be necessary to meet client needs or respond to any interrelated or interdependent mental health and wellbeing system reforms implemented by the department. This document is not intended to be a commissioning framework or a tender document.

Refer to **Appendix 1** for a Glossary of Terms.

1 Introduction

The final report of the Royal Commission into Victoria's Mental Health System (the Royal Commission) recommends the establishment of 50-60 Local Services across Victoria as an integral part of Victoria's reformed mental health and wellbeing system.

Local Services will ensure adults and older adults experiencing mental illness or psychological distress, including those with co-occurring substance use or addiction, can access integrated treatment, care and support in the community, and closer to their support networks.

Local Services will act as a welcoming front door to the public mental health and wellbeing system. Local Services, together with the expansion of, and reforms to Adult and Older Adult Area Mental Health and Wellbeing Services (hereafter referred to as 'Area Services') will close the service gap in the mental health and wellbeing system for Victorians experiencing mental illness and psychological distress.

Local Services will provide easy to access, high quality treatment, care and support for people aged 26 years and over experiencing mental illness or psychological distress, including those with co-occurring substance use or addiction, whose needs cannot be met by primary and secondary mental health care providers alone, but who do not require intensive episodic or ongoing care from tertiary area mental health and wellbeing services.

Consistent with the Royal Commission's recommendations, consumers, their families, carers and supporters will experience treatment, care and support that is:

- safe, accessible and non-judgmental, responsive to their individual needs and preferences, and based on a philosophy of *'how can we help?'* and a *'no wrong door'* approach
- respectful of their human rights and dignity every step of the way

- family inclusive – in culture and practice – to help family members, carers and supporters support the recovery of the person they care for and their own mental health and wellbeing
- recovery focussed
- trauma informed
- respectful and responsive to diverse needs
- equitable, accessible and culturally safe and responsive to Aboriginal and Torres Strait Islander people, LGBTIQ+ communities, members of culturally and linguistically diverse communities, people from refugee backgrounds, people seeking asylum, people with disability and the neurodiverse community
- integrated and holistic
- coordinated with the range of other health and social support services they may need.

The service model, delivered through an integrated multidisciplinary model of care, will offer the person, their family, carers and supporters (as a core response):

- **Engagement and initial discussions** with consumers, their families, carers and supporters in a safe, welcoming and non-judgemental manner with the focus on listening and understanding needs, delivered on a philosophy of *'how can we help?'* and a *'no wrong door'* approach.
- **Initial support** to address any immediate or pressing needs, if required.
- **Initial screening and comprehensive, biopsychosocial assessment** to identify what care or support a person is seeking, guided by the person's needs, preferences and circumstances.
- **Collaborative care planning** with the consumer, their family, carers and supporters to inform a co-designed care plan, undertaken by a multidisciplinary team (including peer workers).
- **Integrated treatment, care and support:**
 - **Wellbeing supports** to build the consumer's capacity to better manage their mental health and wellbeing and develop practical life skills for independent living, social connectedness and social relationships. These supports will help consumers optimise their wellbeing and address their psychosocial needs, such as safe stable housing, employment, financial security, safe and supportive relationships, cultural connection, responsible gambling, social connection and reduced harms associated with alcohol and other drug use.
 - **Education, peer support⁷ and self-help** to provide opportunities for consumers, their families, carers and supporters to share insights and mutual experiences to improve their mental health and wellbeing and support consumers with co-occurring substance use or addiction.
 - **Clinical treatment and therapies** including psychological and psychotherapeutic therapies, medication monitoring and review, inclusive of integrated treatment and care for those with co-occurring mental illness and substance use or addiction.
- **Consumer-led and family/carer inclusive care planning, care coordination and information** to help consumers, their families, carers and supporters to navigate, access and engage in the range of services they need. This includes supporting smooth transitions and referrals to and from other services, including Area Services, primary and secondary mental health and Alcohol and Other Drug (AOD) providers, and other local health and social support services.

⁷ The peer support workforce is inclusive of people with lived and living experience of mental ill-health.

- **Primary and secondary consultation to primary and secondary mental health care providers** to support improved treatment and care for shared consumers.

Diagram 1: Consumer, family, carer and supported driven treatment, care and support



2 Purpose of this framework

The purpose of this document is to provide a policy and operational framework to support the planning, delivery and monitoring of Local Services. This document is intended to:

- Provide a framework for the operation of the service model, including operational principles, core functions and features, funding model, workforce requirements, performance and reporting requirements.
- Promote an overall service philosophy of 'how can we help' that results in easy to access, timely and responsive treatment, care and support, based on the needs and preferences of the individual and their family, carers and supporters.
- Promote service provision that:
 - enables person-directed treatment, care and support
 - provides support to achieve individual goals for personal and relational recovery
 - prioritises resources to achieve services in line with the vision and principles.
- Promote a commitment to accessible high quality, safe, evidence-based or informed assessment, treatment, wellbeing, care coordination and peer supports.
- Establish clear guidance on the respective roles and responsibilities of Local Services and Area Services, with reference to areas of collaboration, interdependence, dual governance and shared responsibility.
- Establish clear principles for the development and implementation of referral pathways between mental health, AOD, health and social support providers and Local Services.
- Guide the implementation of the service in a way that complements the local service 'ecosystem' and is responsive to the mental health and wellbeing needs of the local community while delivering services within the integrity of this framework.

- Make sure the service complements but does not result in duplication, or cost shifting of services reasonably and more appropriately provided by Commonwealth-funded primary and secondary mental health care systems or other systems, such as the standalone AOD sector and the National Disability Insurance Scheme (with regard to psychosocial disability supports).

3 System context

The development and implementation of Local Services is guided by the Final Report of the Royal Commission.

3.1 Royal Commission into Victoria’s Mental Health System

The landmark final report of the Royal Commission into Victoria’s Mental Health System sets out a 10-year vision for a transformed, integrated mental health and wellbeing system which has the specialist expertise and capacity to support all Victorians, regardless of their specific mental health condition or personal circumstances.

The reforms aim to rebalance the system so that more services are delivered in community settings and extend beyond an acute mental health response to a more holistic approach to good mental health and wellbeing across the community. Local Services are an integral part of the reformed mental health and wellbeing system.

3.2 Six levels in a responsive and integrated system

The mental health and wellbeing system will be restructured around a community-based model of care, where people access treatment, care and support close to their homes and in their communities.

The reformed mental health and wellbeing system will consist of six levels, as shown in **Figure 1**, which people will access according to their strengths and needs. The levels progressively increase in the intensity of supports and services provided. Each level will engage with the next, with service providers working collaboratively together in the best interests of consumers who may need to move between these levels as their needs change over time. Local Services are the **fourth level** in this system, as outlined below.

Figure 1: Mental health and wellbeing system levels



Source: Royal Commission into Victoria’s Mental Health System, Final Report, Vol 1, p470

Level 3 relates to mental health treatment and care provided by primary (e.g. general practitioners) and secondary (e.g. private psychiatrists and psychologists) mental health care providers. Providers of Local Services and primary and secondary mental health care providers will need to work collaboratively to facilitate shared care arrangements, warm referrals and smooth transitions for consumers who may move between these service sectors.

Level 4 of the reformed mental health and wellbeing system will provide early intervention treatment, care and support for people across three age-based streams:

- Infants, children and families through new infant and child mental health and wellbeing multidisciplinary community-based hubs (0-11 years).
- Young people via headspace centres. Area Youth Mental Health and Wellbeing Services will have formal partnerships and step-up and step-down referral pathways with headspace centres, who will provide a 'local' mental health treatment and care response to young people aged 12-25 years. If a person is receiving treatment and care from a headspace service and turns 26 years of age, they may access treatment, care and support available at a Local Service if required.
- People 26 years and over through new Local Adult and Older Adult Mental Health and Wellbeing Services.

Level 5 of the reformed mental health and wellbeing system will be comprised of two aligned area mental health and wellbeing streams which will provide tertiary-level, high-intensity treatment, care and support services:

- infants and children (0-11 years) and young people (12-25 years)
- adults and older adults (26 years and over).

Level 5 Area Services will be delivered by public health services or public hospitals. Area Services will be funded to deliver wellbeing supports through collaborative partnerships with non-government mental health providers as part of an integrated model of care.

Access to an Area Service will be via their networked Local Service, direct referral by a medical practitioner, a psychiatric triage service or a crisis response (such as a presentation to an Emergency Department).

Local Services and Area Services will work collaboratively, and in line with consumers, their families, carers and supporters' choices and goals for their care and recovery. This collaboration will enable warm referrals and smooth transitions when a consumer's mental health needs change and movement between these levels of the mental health and wellbeing system is desirable.

Area Services will be funded to provide primary and secondary consultation to support the Local Service workforce to provide treatment and care to consumers with higher levels of clinical complexity (e.g. medication review and care planning and review).

Level 6 of the reformed mental health and wellbeing system comprises statewide specialist mental health and wellbeing services, such as the Victorian Personality Disorder Service (Spectrum), the Centre for Excellence in Eating Disorders, the statewide service for people living with mental illness and substance use or addiction and the Victorian Dual Disability Service. Statewide services will provide specialist primary and secondary consultation, education and professional development to Local Services and Area Services.

3.3 Consumer, family, carer and supporter partnership and leadership

Service providers must integrate lived experience perspectives throughout all aspects of governance and service delivery. Local Services must also respect and support the decision-making capacity of all consumers, consistent with departmental policies and guidance from national mental health standards and policies, and international human rights standards.

Service providers must ensure that people with lived and living experience of mental ill-health and substance use (consumers, families, carers and supporters, kin and community) are proactively encouraged and supported to participate in (as a minimum) service policy development, planning and design, quality improvement, program evaluation and research activities for the Local Service.

Consumer, family, carer and supporter participation and leadership are to be reflected in the service providers organisational governance structures and processes.

The Mental Health Lived Experience Engagement Framework⁸ provides guidance on how people experiencing mental ill-health, their family, carers and supporters are supported to participate in partnership with service providers on service co-design, co-production and service delivery, monitoring and review.

Service providers must also ensure that consumers and their families, carers and supporters are actively involved in the planning, coordination and decision making related to the consumer's treatment, care and support. Service providers are required to ensure organisational culture, practice and approaches support this requirement. This includes offering support to family members, carers and supporters in the context of their caring role and for their own wellbeing, in a way that does not impinge on consumer privacy and confidentiality. It also includes actively exploring with the consumer the benefit of inclusion of family, carers and supporters throughout the support pathway. Further guidance on involving families, carers and supporters in the treatment, care and support of individual consumers can be found in the [Working together with families and carers guideline](https://www.health.vic.gov.au/key-staff/working-together-with-families-and-carers) <<https://www.health.vic.gov.au/key-staff/working-together-with-families-and-carers>>.

3.4 Operational relationship between Local and Area Services

People with a mental illness (including those with co-occurring substance use or addiction) will get easy access to an Area Service, when required, via their networked Local Service, a direct referral by a medical practitioner, a psychiatric triage service or a crisis response.

Local Services must have effective strategic and operational partnerships with Area Services. Local Services and Area Services are required to work collaboratively to enable warm referrals and smooth transitions when a consumer's mental health needs change and they need to move between these levels of the mental health and wellbeing system.

Area Services will strengthen the capability of Local Services to support people with higher levels of need by providing timely access to primary and secondary consultation and shared care, as required.

Local Services are also required to establish and maintain an effective and collaborative operational interface with Area Youth Mental Health and Wellbeing Services and headspace services. This will support smooth, planned transitions for consumers who require further treatment, care and support available in the Local Service when they reach 26 years of age.

⁸ The Mental Health Lived Experience Engagement Framework was developed in response to a Victorian Government call for greater co-production with people with lived experience. While it was developed for a departmental context, the principles and approaches in the framework are transferable across the mental health system. See Appendix 6 for the link to this framework.

3.5 Interface with primary and secondary mental health care providers

Local Services are required to have a collaborative relationship with primary and secondary mental health care providers in the local community, to support effective shared care arrangements and smooth referral pathways for consumers to and from both service systems.

A person receiving care from a general practitioner (GP), or private psychiatrist or psychologist, or other mental health supports may also receive care from their Local Service (for example):

- A consultation for the purpose of diagnosis, care planning or medication review (for a person who is also a consumer of the Local Service).
- Shared care for the purpose of providing:
 - specialist medical or psychological treatment
 - concurrent wellbeing, peer and care coordination supports. For example, a Local Service may act on a referral from a GP to provide a person with support to address issues related to homelessness or social isolation.

Local Services will complement but not duplicate or replace mental health treatment provided by primary and secondary mental health care providers in the local community, subject to local availability and accessibility.

3.6 Collaboration in the local delivery environment

People who seek support from a Local Service may have multiple needs, such as co-occurring mental illness and substance use or addiction, physical health problems, co-existing disability and/or face significant social adversity or disadvantage including social isolation, poverty, unemployment and homelessness.

Service providers will require a contemporary understanding of local needs and the delivery environment in the geographical zone where the Local Service operates.

Service providers are required to work collaboratively with (but not limited to):

- Area Youth, Adult and Older Adult Mental Health and Wellbeing Services
- AOD services
- Community Health Services
- Commonwealth funded primary and secondary mental health and health care providers and local Primary Health Networks (PHNs)
- local community and social support services (e.g. Aboriginal health and community services, housing, homelessness, aged care, refugee and asylum seeker and disability services) and other key community services, to develop access and referral pathways and facilitate collaboration for seamless and coordinated care for mutual consumers.

4 Outcomes and benefits

Treatment, care and wellbeing supports delivered by the Local Services are expected to generate a range of benefits and outcomes for consumers, their families, carers and supporters, other health and human services, the broader mental health and wellbeing system and the community.

The expected benefits and outcomes are described in **Table 1**. Please note, the outcomes identified in Table 1 are illustrative only.

Providers of Local Services will be required to report on outcomes achieved for consumers, family, carers and supporters against measures identified in the *Mental Health and Wellbeing Outcomes Framework*, when this framework is finalised. This may involve the collection and reporting of additional outcome measures to the ones indicated in Table 1, and the use of associated outcome measurement instruments.

Table 1: Intended outcomes and benefits (indicative)

Strategic Goal	Intended Outcomes and Benefits
Best health outcomes	<ol style="list-style-type: none"> 1. Reduced psychological distress and mental ill-health 2. Reduced psychological crisis, self-harm and suicide 3. Improved physical health 4. Positive experience of treatment, care and support 5. Contribution to decreased drug and alcohol use, addiction or related harm
Improved quality of life outcomes and recovery	<ol style="list-style-type: none"> 6. Improved relationships and social connections 7. Improved capacity and opportunities to live a purposeful and contributing life 8. Improved daily living skills 9. Contribution to improved housing security 10. Contribution to improved economic participation and financial security 11. Contribution to decreased engagement with the justice system 12. Improved family, carer and supporter experiences and relationships with the consumer 13. Contribution to reduced family, carer and supporter stress 14. Reduced need for the service overtime
People are managing their own mental health and wellbeing better	<ol style="list-style-type: none"> 15. Improved capacity for self-management and self-care 16. Improved capacity for decision making about their own treatment, care and support 17. Improved sense of agency
Mental health and other system benefits	<ol style="list-style-type: none"> 18. Improved continuity of care 19. Reduction in need for more intensive acute mental health and wellbeing services 20. Reduction in Emergency Department presentations and emergency callouts 21. Improved consumer and supporter engagement with health, human services and other key social supports 22. Strengthened capability of primary mental health care providers 23. Strengthened capability of emerging workforces including the lived experience workforce 24. Improved support for and engagement of families, carers and supporters within the mental health and wellbeing system

5 Objectives

The objectives of Local Services are to:

- ensure people experiencing mental illness or psychological distress⁹, including people with co-occurring substance use or addiction – irrespective of their diagnosis or life circumstances – can access local high quality, evidence-based treatment, care and wellbeing supports when they need them.
- promote consumer choice and control.
- foster independent living, personal and relational recovery, and social, cultural and economic participation by consumers, their families, carers and supporters.
- reduce the risks associated with mental illness and trauma and harms associated with co-occurring substance use or addiction, particularly risk of suicide, self-harm or overdose by responding early, effectively and safely to the needs and preferences of consumers.
- intervene early to reduce the likelihood people experiencing a mental illness or psychological distress, including those with co-occurring substance use or addiction, will experience an acute psychological crisis, develop life-long impairments, face enduring social or economic disadvantage and/or stigma.
- improve outcomes for families, carers and supporters both in the context of their own mental health and wellbeing and their integral role in the consumers' support team.
- reduce Emergency Department presentations by people experiencing mental illness or psychological distress, including people with co-occurring substance use or addiction, and the need for more intensive acute (tertiary) mental health and wellbeing services by providing easy to access, responsive and integrated treatment, peer and wellbeing supports in the local community.
- provide seamless care through strong and sustainable collaborative relationships, shared care arrangements and clear referral pathways with primary and secondary mental health care providers, Area Services, AOD services and other local health, disability and social support services.

6 Service delivery principles

The following service delivery principles will guide and inform the way high quality, accessible and responsive Local Services are planned and delivered to consumers, their families, carers and supporters:

- **Partnership-driven and responsive** – providers will deliver services based on a philosophy of *'how can we help?'* and a *'no wrong door'* approach. Active listening to and understanding of the consumer and their family, carer and supporters' experiences, needs and aspirations will underpin engagement. The treatment, care and support plan will be co-designed by the consumer, their family, carers and supporters and their support team. Every interaction will be with the intention of providing a benefit to the consumer and the people close to them.

⁹ This is inclusive of family members, carers and supporters experiencing distress, both in their own right or in the context of their caring role.

- **Dignity, rights and responsibilities** – people with a mental illness or experiencing psychological distress, including those with co-occurring substance use or addiction, have the right and responsibility to make decisions regarding their lives and the support they need, and will be supported to do this. Their human rights and dignity will be respected and protected every step of the way. Organisational practices and culture will ensure the consumers' human rights are protected, promoted and fulfilled and dignity of risk respected. Power imbalances will be acknowledged, explored and actively addressed. Compassionate, respectful, hopeful, inclusive and non-judgemental approaches will be at the heart of service delivery. Services are voluntary, with no restrictive, coercive or involuntary practices in the provision of treatment, care and support.
- **Carer and family engagement and inclusion** – providers will demonstrate a family inclusive and culturally safe approach to service delivery and practice which enables family members, carers and supporters to support the sustainable recovery of the person they care for and their own mental health and wellbeing.
- **Right care in the right place, at the right time** – consumers will receive the treatment, care and support they need, when and where it is needed. Local Services will operate as a 'broad front door' for people who need treatment, care and support. Consumers of Local Services, their families, carers and supporters will experience seamless access to and from other services and will not fall between service gaps. Providers of Local Services will work with Area Services, local health, mental health, AOD, health and social support services to establish smooth referral pathways so that consumers will have reliable access to services in their local area and experience coordinated care.
- **Local, accessible and appropriate** – treatment, care and support will be free and provided in an equitable way that promotes ease of access. Support will be provided as close to the consumer's support networks as possible and will be appropriate to their needs. No referral will be required to access Local Services, and all consumers will be warmly supported to the most appropriate service (whether within the Local Service or via referral to other services) based on assessment of their needs and preferences. The type, intensity and duration of treatment and wellbeing supports will be based on each consumer's individual needs, preferences and aspirations.
- **Integrated treatment, care and support for people with co-occurring needs** – people with mental illness and co-occurring substance use or addiction and other co-existing health conditions or disability will receive an integrated, holistic and coordinated response to all of their treatment, care and support needs within the Local Service¹⁰. In respecting consumer choice, integrated mental health and AOD treatment, care and support will not be contingent on a consumer's commitment to reduce or cease the use of alcohol or other drugs. Integrated treatment, care and support must meet people where they are at across the stages of change, with a focus on reducing AOD-related harms and improving mental health and wellbeing. They will not experience barriers to access or be excluded based on their substance use or addiction, physical health and/or disability. They will be proactively supported, welcomed at every opportunity, made to feel safe, accepted and free to be themselves.
- **Recovery focused and person centred**¹¹ – the consumer's recovery (as they define it) is the central focus of the service. Consumers are empowered as decision makers in their own treatment, care and support. Staff will respect and respond to choices, needs, values and preferences of individuals. Person-centred support engages the consumer, their family, carers and supporters as key contributors to their clinical, personal and relational recovery.

¹⁰ Multiple workers or service provider organisations may be involved, but treatment, care and support should be experienced as a single service interface, prioritising simplicity and continuity.

¹¹ Further guidance on recovery orientated practice is provided in the [Victorian Government Framework for Recovery-oriented practice](https://www.health.vic.gov.au/publications/framework-for-recovery-oriented-practice) <<https://www.health.vic.gov.au/publications/framework-for-recovery-oriented-practice>>.

- **Co-designed and delivered in partnership with consumers, families, carers and supporters** – people with lived or living experience of mental illness, including those with co-occurring substance use or addiction, their family, carers and supporters are well resourced, engaged and supported partners in the planning, delivery and evaluation of treatment, care and support, at the individual and organisational levels.
- **Achieving best outcomes for consumers** – service delivery will maximise individual and public value and accountability by improving health and life outcomes, experiences and quality of life of the consumers, their families, carers and supporters who use Local Services.
- **Quality and safety** – Local Services will deliver safe and effective treatment, care and support. Treatment, care and support will be trauma informed; minimise the risk of harm to consumers, their families, carers and supporters (including dependent children), staff and visitors; and will be delivered in an environment that is safe, non-stigmatising, trusting and respectful. Local Services will use consumer and family, carer and supporter-led research, evaluation and innovation, to drive continuous improvement and service quality and remain responsive to community needs now and into the future, supported by robust data collection and reporting.
- **Respectful of and responsive** to cultural needs and diversity – all consumers, their families, carers and supporters will receive equity of access and culturally safe and responsive services that are free of stigma and discrimination, particularly Aboriginal and Torres Strait Islander people, LGBTIQ+ communities, members of culturally and linguistically diverse communities, people from refugee backgrounds, people seeking asylum, people with disability and people who are neurodiverse.
- **Collaborative and integrated** – providers of Local Services and Area Services and key interfacing service systems, including the AOD system, are responsible for developing and maintaining effective collaboration and communication protocols and processes. Partnership arrangements should leverage the strengths of each service provider, facilitate collaboration and drive a coordinated and integrated response to the needs of the consumers, their families, carers and supporters.
- **A high quality, skilled, diverse and multidisciplinary workforce** (including the lived experience workforce) – the commitment to high quality, evidence-based or innovative approaches to service delivery will be supported by an active learning culture, effective leadership to drive cultural and practice change, ongoing professional development and contribution to the evidence base. This includes opportunities for shared learning and collaboration between workers of different backgrounds and disciplines.
- **Privacy and confidentiality** – confidentiality between the consumer and service staff is fundamental to the relationship and permission must be obtained from the consumer to enable all staff involved in delivering supports to share relevant information about the consumer within the service and when a referral is made, in accordance with relevant privacy and information sharing legislation.

7 Target group

The following section describes the target group and consumer support streams for Local Services.

7.1 Target group

Local Services will provide treatment, care and wellbeing support for people 26 years and over, who are experiencing a mental illness or psychological distress (for whatever reason)¹², including people with co-occurring substance use or addiction, who:

- need more support than they can get from primary and secondary care providers (general practitioners, private psychologists and psychiatrists)
- do not need the type of specialist treatment, care and support available in Area Services.

Local Services will proactively provide a safe welcoming service for people with a mental illness (including those with co-occurring substance use and addiction), their families, carers and supporters. Priority will be given to people who experience barriers to access and/or vulnerability and disadvantage, particularly: Aboriginal and Torres Strait Islander people; people from culturally and linguistically diverse backgrounds; people from refugee backgrounds; people seeking asylum; LGBTIQ+ communities; people who are experiencing homelessness; neurodiverse people; and/or people who are engaged in the justice system.

7.1.1 Consumers who require more intensive treatment, care and support

Local Services will operate as a 'front door' to Area Services.

If a consumer presents to a Local Service and requires highly intensive and specialist treatment, care and support available from an Area Service, the Local Service will provide:

- initial engagement and support, including assistance to address any immediate or pressing needs
- an initial support discussion (that may include a screening assessment) to inform the referral decision
- supported referral to the Area Service for ongoing treatment, care and support and information and advice to the consumer, their family, carers and supporters throughout this process
- short term treatment, care and/or wellbeing support with a focus on reducing distress and/or achieving harm minimisation if access to supports in the Area Service are not immediately available.

The Local Service (with the consent of the consumer) will provide information on the consumer's needs to the Area Service to avoid multiple or duplicated screening assessments. In general, it is anticipated the Area Service will undertake a comprehensive biopsychosocial assessment (if required) to inform a co-designed treatment, care and support plan with the consumer, their family, carers and supporters when the consumer transitions to the Area Service for support.

Notwithstanding the above, a consumer may receive wellbeing and/or peer supports from a Local Service which are to be coordinated with treatment and care provided by the Area Service.

¹² This includes psychological distress related to situational crisis, natural or other disasters, trauma, grief and loss and social isolation.

7.1.2 Consumers under 26 years of age

In some circumstances, a Local Service may support a young person with a mental illness aged 16-25 years if:

- the young person presents to the Local Service seeking mental health and wellbeing support
- the young person is experiencing difficulty accessing a headspace service or Area Youth Mental Health and Wellbeing Service and needs assistance
- the young person is engaged in support being provided to their parents/care givers as part of family centred therapy provided by the Local Service¹³ and/or
- it is age and developmentally appropriate to provide treatment, care and support at the Local Service – this will be determined in consultation with the young person, their family, carers and supporters, local headspace provider or Area Youth Mental Health and Wellbeing Service.

If in any doubt, providers of Local Services will apply the principle of ‘how can we help?’ and a ‘no wrong door’ approach when deciding the need for appropriate and necessary supports at first contact.

7.1.3 High risk presentations

Local Services will not be a frontline emergency response for people experiencing very high risk of imminent harm to self or others.

To the extent that it is safe for the consumer, other service users at the Local Service and staff, the Local Service should provide immediate and intensive support to safely stabilise/de-escalate the person’s distress.

Suitably skilled and trained staff will be available to provide immediate, safe support to people who are experiencing high levels of psychological distress or crisis and need urgent help.

Peer support workers may provide support to the consumer, family, carers and supporters throughout this process but will not lead the response to people experiencing a psychological crisis (unless otherwise qualified to do so).

In circumstances where stabilisation/de-escalation of the distress cannot be safely achieved, with the consent of the consumer, staff of the Local Service are to immediately notify emergency services to transfer the consumer to an Emergency Department and provide follow up support.

This may include people who are (for example):

- experiencing acute suicidal ideation/attempting suicide
- expressing very high, imminent risk of harm to self or others with clear plans and means
- experiencing a drug overdose and/or are highly intoxicated¹⁴
- exhibiting very high-risk behaviour associated with perceptual or thought disturbance, delirium, dementia or impaired impulse control, which requires an immediate emergency response¹⁵.

¹³ This also applies to dependent children.

¹⁴ Local Services will provide first aid for people who present to the service highly intoxicated and require medical assistance. This includes the use of naloxone in the event of opioid overdose.

¹⁵ This includes people experiencing a suicidal crisis/urgent need who are consumers of a Local Service or have walked into a Local Service for the first time.

The Local Service should, as part of a consumer's individualised care plan, decide in advance with the consumer, their family, carers and supporters what action/support they would like to receive in the event of an episode of acute psychological distress.

The Local Service will also provide support to family, carers and supporters during and post the emergency. In addition, if the consumer is discharged back to the Local Service by the hospital, the Local Service will actively follow up with the consumer (post hospitalisation) to help the consumer address the factors causing the distress.

Appendix 2, Table 2 details the response to people experiencing extreme and very high risk and the related system responsibilities.

7.1.4 Family, Carers and Supporters

Local Services will support family members, carers and supporters in their caring role and for their own mental health and wellbeing. In line with the *Carers Recognition Act 2012*, Local Services are expected to be family inclusive in culture and practice.

More information about the *Carers Recognition Act 2012* can be found on [our Carer rights and recognition webpage](https://www.betterhealth.vic.gov.au/health/servicesandsupport/carers-rights-and-recognition) <<https://www.betterhealth.vic.gov.au/health/servicesandsupport/carers-rights-and-recognition>>.

Families, carers and supporters can also be referred to the new Family Carer-Led Centres once established.

7.2 Consumer support streams

The Royal Commission identified the following consumer support streams:

- communities and primary care
- primary care with extra support
- short-term treatment, care and support
- ongoing treatment, care and support
- ongoing intensive treatment, care and support.

The intensity, risk and complexity of a consumer's mental health needs (including the degree of impact on their daily life, work and wellbeing, any AOD use, and associated distress) and their preferences will determine which broad 'consumer support stream' they best align with at a given time. This will inform which part of the mental health and wellbeing system they should most appropriately receive treatment, care and support from, e.g. a Local Service or an Area Service, a standalone AOD provider, or a primary or secondary mental health care provider.

The 'typical' (indicative) presentations of people in each of the consumer support streams and (indicative) related system responsibilities are detailed in **Appendix 2, Table 1**.

The priority consumer support streams for Local Services are:

- primary care with extra support
- short-term treatment, care and support
- ongoing treatment, care and support (excluding consumers with complex and/or intensive ongoing needs that are better supported by an Area Service).

Area Services are responsible for providing integrated treatment, care and support to consumers in the following consumer support streams:

- short-term treatment, care and support
- ongoing treatment, care and support
- ongoing intensive treatment, care and support.

As a guide, consumers that require short-term or ongoing treatment, care and support may be the primary responsibility of Area Services if they have concerns associated with:

- very high risk associated with self-harm or suicide that requires a bed-based response
- diagnostic or clinical complexity
- complex co-morbidity (e.g. intellectual disability and schizophrenia)
- fluctuating need or risk the Local Service cannot manage safely, and/or
- unique needs which require specialist treatment and care.

7.3 Out of scope

A Local Service is not a designated health service and will not provide compulsory treatment to consumers.

Consumers who are under any legal status under *the Mental Health Act 2014*¹⁶, such as Compulsory Treatment Orders, must receive their treatment from an Area Service. Under the *Mental Health Act 2014*, only medical or mental health practitioners from designated mental health services have the power to provide compulsory mental health assessment or treatment services.

Any person in their capacity as a registered medical or mental health practitioner is able to determine if a person should be placed on an assessment order, however the actual assessment for the order and treatment must be provided by a designated mental health service.

This means that Local Services cannot provide compulsory mental health assessment or treatment services. A registered medical practitioner or mental health practitioner in a Local Service may however determine if a person should be placed on an assessment order and provide appropriate referral or recommendation.

A person on a Custodial Supervision Order or Non-Custodial Supervision Order under the *Crimes (Mental Impairment and Fitness to be Tried) Act 1997 (Vic)*(CMIA) must receive their treatment from a designated health service.

Should a consumer receiving compulsory treatment from an Area Service prefer to access wellbeing supports from the Local service, this will be facilitated.

Notwithstanding the above, a consumer under any legal status of the *Mental Health Act 2014* or the CMIA may receive wellbeing supports from a Local Service which are to be coordinated with treatment services provided by the Area Service.

¹⁶ Please note, the reformed mental health system and the broader vision of the Royal Commission will be enabled by a new *Mental Health and Wellbeing Act* which is under development.

8 Key features and service components

8.1 Service scope

The Local Service model has four core integrated service components, as described in **Figure 2**. Refer to Section 8.3 for detailed information on core service components.

Figure 2: Core service components



8.1.1 Out of scope services

Providers of a Local Service will not deliver the following service types:¹⁷

- A crisis outreach response for people with a mental illness experiencing a crisis/urgent need. When established, Area Services will deliver a 24 hour a day, seven day a week telephone/telehealth crisis response service which will provide crisis assessment and immediate support for people of all ages, complemented by a dedicated crisis outreach response, as part of the reformed mental health and wellbeing system.
- Residential and non-residential AOD withdrawal and rehabilitation services.¹⁸
- Disability support to a consumer that is a participant of the National Disability Insurance Scheme (NDIS) and is in receipt of an individualised funding package. Any support provided by a Local Service to a NDIS participant will complement but not duplicate disability supports funded by the NDIS.

8.2 Key Features

The key features of the Local Service model are:

- Easy to access, safe and welcoming service environment with no referral required – people can self-refer or (with their informed consent) be referred by their family, carers and supporters, a health professional or other provider.
- Free and delivered on a philosophy of ‘how can we help?’ and a ‘no wrong door’ approach.

¹⁷ Funding allocated to a provider for the delivery of the Local Service will not be used to fund the delivery of residential and non-residential AOD withdrawal and rehabilitation service types. A Local Service provider may deliver these services if they have been funded separately to do so.

¹⁸ Notwithstanding this, the Local Service will collaborate with providers of residential and non-residential AOD withdrawal services to provide coordinated mental health treatment, care and support when a consumer is concurrently receiving withdrawal and rehabilitation services.

- Voluntary, with no restrictive, coercive or involuntary practices in the provision of treatment, care and support.
- Recovery oriented – as defined by the consumer.
- Trauma informed treatment, care and support.
- Every interaction will provide a benefit and positive outcome for the consumer, their family, carers and supporters. All staff, from reception to peer workers, care coordinators, wellbeing staff and clinicians will work in a psychologically safe and healing way.
- Provided 52 weeks a year (including public holidays) with extended operating hours.
- Delivery modes: combination of site-based services, telehealth (phone or video call) and outreach (i.e. support provided in the consumer's home or other preferred location). On site access to computers for consumers, family, carers and supporters to access digital mental health information or self-help interventions.
- Engagement through active listening to, and understanding of, the consumer's experience, needs and social context (i.e. their 'story'). A safe environment is provided to empower the consumer to tell their story and make decisions about the treatment, care and support they need.
- Support is organised and delivered in a way that builds a trusting, safe relationship between the consumer, their family, carers and supporters and their support team; and facilitates continuity of the relationship.
- Consumer engagement and participation to co-formulate their initial needs which may occur over more than one session. Initial needs screening assessment questions are asked in the context of the consumer's story, needs and preferences.
- Proactive engagement and participation of the consumer's family, carers and supporters as an integral part of the consumer's support team (with the consent of the consumer), across the entire support pathway, including assessment of need.
- Support to family, carers and supporters, including brief assessment to identify their needs in the context of their caring role (including those of dependent children), as well as provision of psychosocial education, mutual support and self-help, advice and information, and supported referral to appropriate services (for example, Family Carer-led Centres when established).
- Provision of immediate, safe support for people who need urgent help to reduce any psychological distress they may be experiencing.
- People experiencing very high or imminent risk of suicide, self-harm or harm to others and require urgent medical attention will receive immediate warm transfer to emergency services with follow up engagement. The Local Service will provide support to stabilise/de-escalate the distress being experienced by the consumer while waiting for the emergency response.
- Multidisciplinary biopsychosocial assessment to better understand the consumer's mental health, wellbeing and other needs, including co-occurring substance use or addiction, physical health issues, disability and social adversity which may influence their needs.

- Co-design of an integrated treatment, care and support plan with the consumer, their family, carers and supporters (with consumer consent) and their multidisciplinary support team, that is regularly reviewed and adjusted in line with the needs and preferences of the consumer. The consumer determines what they want help with. Processes to support decision making and communication (e.g. for people who are non-verbal or deaf) are used to assist the consumer to express their needs and preferences and make decisions about their treatment, care and support. Family, carers and supporters are supported in the context of their caring role and for their own mental health and wellbeing while respecting the consumer's privacy and confidentiality.
- Evidence-based or informed integrated clinical treatment, care, healing and wellbeing support (including integrated AOD and physical health care as required), based on the care plan. May involve a brief intervention or extended sessions depending on the needs and preferences of the consumer.
- Provision of a 'package of wellbeing supports' tailored to the individual needs and aspirations of the consumer (based on their care plan). Key features include:
 - 1:1 wellbeing supports that build daily living skills, social and interpersonal skills, self-management, decision making and problem-solving skills
 - group based psychosocial education and skill development on self-management, self-care, social interaction, personal growth and problem solving for example Optimum Health, Hearing Voices programs, Flourish, mindfulness programs, art therapy, outdoor education programs, etc.
 - peer-led support and self-help programs for consumers, their families, carers and supporters (group and one-on-one) to promote and facilitate self-directed recovery and provide opportunities to socialise and learn from each other.
- Social prescribing to engage people in local community activities, with a focus on older adults to address social isolation and loneliness.
- Care coordination to assist the consumer, their family, carers and supporters to understand, navigate and remain connected to the Local Service and provide practical support e.g. assistance with making appointments and provision of information. As part of the care coordination function, the consumer will be supported to navigate and access local health, welfare and community services they may need through supported referral practices.
- Physical health care integrated into the service offer including (but not limited to) screening, preventative health care (e.g. smoking cessation), nutrition and diabetes education in partnership with the referring GP or a Community Health Service.
- Length of treatment, care and support to be based on assessment of the consumer's need, determined in discussion with the consumer, their family, carers and supporters and their support team, considering accessible and available primary and secondary mental health care in the local community. The length of treatment is likely to be short to medium term in duration but may be ongoing.
- Seamless referral pathways to and from Area Services and primary and secondary mental health care providers for ongoing treatment and care (if required), supported by shared care arrangements, supported referral practice and re-entry protocols to the Local Service.
- Proactive follow up response to check that consumers who have left the service are receiving the health, wellbeing and social supports they need.

8.3 Core functions

The core functions of the service model include:

- **Engagement** through active listening and responsiveness to the needs expressed by the consumer and their family, carers and supporters.
- **Initial needs screening discussion** at the initial point of access to understand the consumer's concerns and needs and those of their family, carers and supporters. Initial support discussions should consider a range of factors including: the consumer's social context; the intensity and nature of the consumer's mental health needs; experiences of trauma; the use of alcohol or other drugs; and/or unaddressed wellbeing needs. The initial screening assessment will involve the use of evidence-based tools and observation, as well as consumer subjectively reported distress, and/or their reported health related quality of life. For people with communication issues the assessment may involve discussions with, and the involvement of their formal or informal carers. This process may occur over more than one session.
- **Single or brief session therapy.** Providers may provide 1-3 support sessions after the initial screening discussion. These sessions may also inform the need for further treatment, care and support, including the need for a comprehensive biopsychosocial assessment.
- **Supported referral and smooth transition planning** to Area Services for consumers who (on initial assessment) have intensive (episodic or ongoing) treatment, care and support needs that are most appropriately responded to by an Area Service.
- **Multidisciplinary biopsychosocial assessment** using a skilled workforce (including consumer and carer peer workers) and evidence-based processes and tools. The identification of the consumer's needs will be co-formulated with the consumer, their family, carers and supporters (with the consumer's consent). This assessment will identify the consumer's mental health, physical health, substance use or addiction related needs and social factors that impact on their wellbeing. Family members, carers and supporters should have the opportunity to inform the assessment in a way that does not impinge on the consumer's privacy and confidentiality (should the consumer not consent to their participation in the assessment).
- **Integrated care plan** co-designed with the consumer, their family, carers and supporters (with the consumer's consent) and other key stakeholders, such as their GP, disability or aged care provider. Monitoring, regular review and adjustment of this plan will be undertaken with the consumer, their family, carers and supporters, support team, GP and/or other key support services the consumer may be receiving. It will also include relapse prevention planning for consumers experiencing episodic relapse, including consumers with a mental illness and co-occurring substance use or addiction. Family members, carers and supporters should have the opportunity to inform the care plan in a way that does not impinge on the consumer's privacy and confidentiality (should the consumer not consent to their participation in the development of the care plan).
- **Evidence-based or informed clinical treatment (including counselling, psychotherapeutic and structured psychological therapies) and mental health and AOD medication prescribing, monitoring and review,** integrated with AOD treatment and care (if required) and wellbeing supports to improve the consumer's recovery. This may include a brief or single session approach¹⁹, or multi-sessions, depending on the needs and preferences of the consumer.

¹⁹ Providers may provide 1-3 sessions after the initial screening assessment. These sessions will inform the need for further treatment (including the need for more comprehensive needs assessment) and referral decisions.

- **Evidence-based or informed wellbeing supports** co-designed with and tailored to the consumer's individual needs and preferences, to help them recover and/or address psychosocial stressors. This may include support to build community connections and social wellbeing. Social prescribing²⁰ may be used to support people to engage in local community activities to address social isolation and loneliness, with older adults being a priority group.
- **Psychoeducation and recovery support for consumers, family members, carers and supporters**, including supports tailored to consumers who are parents of dependent children, young carers and adult children of consumers.
- **Peer led self-help and mutual support groups** for consumers and their families, carers and supporters to provide opportunities to socialise, learn from each other and promote and facilitate self-directed recovery. The support groups may be tailored to the needs of particular groups such as people with eating disorders, perinatal depression or those with a mental illness and co-occurring substance use or addiction.
- **Care coordination, system navigation and linkages** including internal navigation and coordination of the Local Service offer and a consistent point of contact; supported referral and/or practical support to navigate and connect to Area Services and other local AOD, health and social support services the consumer may need; and the provision of information and advice to community and social support services, to build their capability to respond to the needs of people with a mental illness.
- **Integrated mental health and physical health** care such as healthy lifestyle coaching, healthy eating programs, group-based exercise programs, metabolic screening, preventative health care (e.g. smoking cessation), diabetes education and support to link to, for example, community health, general practitioners, dental, dietician and exercise services. Providers of Local Services may develop local arrangements with a Community Health Service, as well as bulk billed Medicare funded general practitioners and other medical services, to provide services on an in-house/in-reach basis, within the operational governance of the service.
- **Active support to understand and access the NDIS** for consumers living with ongoing, significant psychosocial disability and/or other disability who are likely to be eligible for the NDIS. This includes support and advocacy to support the consumer, their family, carers and supporters to prepare for their NDIS plan discussion and undertake a review or appeal of a NDIS access or plan decision (if required).
- **Information and advice** to consumers on local health, social support and community services, as well as mental health and AOD information and advice to family, carers and supporters to assist them in their role.
- **Comprehensive 'transition' planning as a consumer prepares to leave the service**, co-designed with the consumer, their family, carers and supporters and support team, with time limited follow up to ensure sustained engagement with health and social supports.
- **(Optional) Brokerage support** to help a consumer and/or family member, carer or supporter (in the context of their caring role) address an extraordinary or pressing need or prevent a critical emerging situation²¹.

²⁰ A social prescribing trial is being conducted in six Local Services.

²¹ Brokerage funding is to be used only when all alternative sources of support and negotiations have been exhausted or are not available or that the consumer cannot reasonably be expected to purchase themselves.

- **(Optional) vocational rehabilitation, financial counselling or legal services** on the basis that unemployment, debt and legal issues are associated with high levels of psychological distress. *It should be noted Local Services should not duplicate these services if available and accessible in the local community.*

The need for multidisciplinary care may vary, depending on the consumer's levels of distress or breadth of need. Providers will organise the workforce composition of a consumer's support team in response to their needs and those of their family, carers and supporters. For example, some consumers will require the support of a team comprising a clinical psychologist, AOD clinician, care coordinator and peer worker.

Other consumers may be experiencing stable symptoms (clinical recovery) but require coordinated wellbeing and peer supports to address psychosocial stressors that make it difficult for them to self-manage their mental illness or psychological distress.

The mix of co-located services a Local Service may provide may vary from location to location and will depend on arrangements negotiated with local service providers. Any services delivered on an in-reach basis by other providers should complement the Local Service treatment, care and support model and be included in the organisational and clinical governance model for the service.

9 Service Model

This section describes access and referral pathways, initial engagement and assessment processes and the core components of the service model.

9.1 Access and referral pathways

An easy to access, safe and welcoming service is a key feature of the Local Service model. **Figure 3** describes entry and referral pathways across primary and secondary health care services and Local and Area Services.

People experiencing mental illness or psychological distress, including those with co-occurring substance use or addiction, do not need a referral to seek and receive help from their Local Service.

Local Services may be directly accessed in person via walk-in (i.e. no appointment required), a phone discussion or an online booking. Local Services will also be delivered on an outreach basis to proactively identify people who would benefit from early intervention and/or to support consumers in a location of their choice.

A family member, carer or supporter may assist a person experiencing mental illness or psychological distress (including those with co-occurring substance use or addiction) to make contact with and access their Local Service. Referrals by a family member, carer or supporter must be made with the consent of the person they care for.

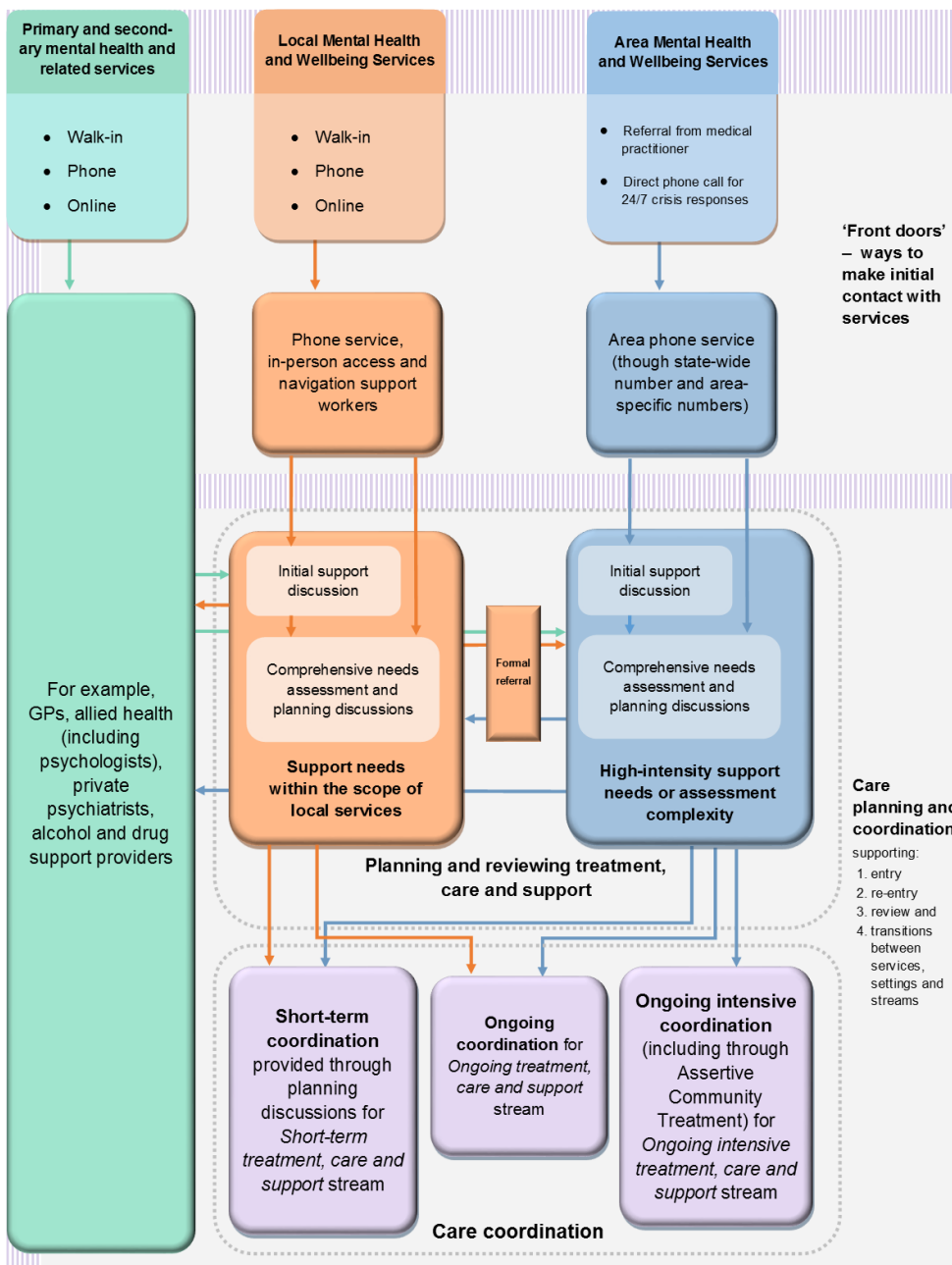
A family member, carer or supporter may seek advice and support from their Local Service on how to engage the person they care for in a discussion on why they may need support for their mental illness, psychological distress or co-occurring substance use or addiction and what supports are available at their Local Service.

Providers of Local Services will develop and maintain referral pathways with local health, social and community services that are supporting people experiencing mental illness, psychological distress or co-occurring substance use or addiction. Providers of a Local Service will actively promote the service to local providers and build their capability to make a supported referral to the service, complemented by referral protocols.

Local Services will provide consumers, family, carers and supporters with supported referral to the services and supports they need. Supported referral includes ensuring the consumer understands the referral process, reassuring them before the first appointment, accompanying the consumer to the first appointment, talking to them about the experience afterwards and providing follow up support as required. It also includes transfer of essential information about the consumer’s needs (with consent) before commencing the supported referral process.

All service providers making a referral on behalf of a person experiencing mental illness or psychological distress (including people with co-occurring substance use or addiction) must have the consent of the person to make a referral on their behalf. Service providers seeking to make a referral may request advice from their Local Service on how to engage and encourage the person they are supporting to seek help from the Local Service.

Figure 3: Entry and referral pathways across primary and secondary health care services and Local and Area Adult and Older Adult Mental Health and Wellbeing Services



Source: Royal Commission into Victoria’s Mental Health System, Final Report, Vol 1, page 472.

Referring service providers may include (but are not limited to):

- hospital Emergency Departments, for people who present to an Emergency Department experiencing psychological distress but do not require a hospital based medical intervention
- Area Services for consumers who are ready for discharge from tertiary care but would benefit from further treatment, care and/or support available in a Local Service (i.e. 'step down' response)
- phone-based psychiatric triage services managed by Area Services who may refer people who do not require intensive tertiary treatment, care and support
- Hospital Outreach Post-Suicidal Engagement (HOPE) service, for people who are not a consumer of an Area Service but require additional treatment, care and support when discharged from a HOPE service
- general hospitals/non-mental health outpatient clinics for consumers with comorbid physical and mental health needs
- general practitioners
- private psychiatrists, psychologists and mental health counsellors
- AOD service providers (for people with co-occurring mental illness and substance use or addiction)
- Community Health Services and Maternal and Child Health Services
- helplines, including crisis helplines such as Beyond Blue, Lifeline and Suicide Line Victoria
- Head to Health assessment phone service
- multiple and complex needs panels
- disability providers, including NDIS providers for participants who require mental health treatment and care
- Aboriginal (health and welfare) community-controlled organisations
- organisations supporting refugees and people seeking asylum
- community organisations supporting culturally and linguistically diverse and LGBTIQ+ communities
- aged care providers and residential aged care services
- homelessness providers
- The Orange Door (family violence and Child First services)
- public housing workforces and community-managed housing providers
- Police (for people experiencing psychological distress or signs of mental illness who come to their attention for whatever reason, including as witnesses or victims)
- custodial services (for people leaving custody) and community correction services
- family support services, including the new Family Carer-led Centres when established
- employment and education providers, including early childhood services, schools and tertiary education providers
- social support providers
- local government funded services.

9.1.1 Intra-referral pathways and navigation within a Local Service

Providers of Local Services will assist consumers, their families, carers and supporters to understand and navigate the range of supports provided within the Local Service. This function may be delivered by peer workers/care coordinators/navigators who will also support the consumer, their family, carers and supporters to make and keep appointments.

9.1.2 Inter-service referrals to other Local Adult and Older Mental Health and Wellbeing Services

Providers of Local Services will establish and maintain referral pathways with other Local Service to support consumers who move to another area or prefer to receive treatment, care and support from another Local Service of their choice.

The referring Local Service provider will proactively support the consumer to transfer to the 'receiving' Local Service provider, including information transfer, in accordance with privacy and consent requirements.

If a consumer wants to continue receiving treatment, care and support from their current Local Service when they move to a geographical area outside of the service zone for that Local Service, they may continue to do so, noting support may need to be delivered via telehealth if travel is prohibitive for the service provider.

9.1.3 Referral pathways between Local and Area Services

Local Services are required to be networked with the public health service/s funded to deliver Area Services in the service zone within which the Local Service operates. This will support smooth referral pathways and shared care arrangements for consumers who may need to:

- move between the levels of treatment, care and support available in Local Services and Area Services or would benefit from shared care,
- transition from headspace or a Youth Area Mental Health and Wellbeing Service to a Local Service when they turn 26 years of age.

People with intensive treatment, care and support needs can also access an Area Service directly via a medical practitioner referral, a direct call to a 24/7 crisis response or Area Service specific call lines.

Consumers of a Local Service who need intensive (episodic or ongoing) treatment, care and care support available in the networked Area Service will receive a supported referral, with follow up. A Local Service may need to develop an operational partnership with more than one Area Service, as consumers exercise choice and control over which Area Service they would prefer to receive their support from.

Supported referral includes ensuring the consumer understands the referral process, reassuring them before the first appointment, accompanying the consumer to the first appointment, talking to them about the experience afterwards and providing follow up support as required. It also includes transfer of essential information about the consumer's needs (with consent) before commencing the supported referral process, with the consent of the consumer.

The provider of the Local Service will maintain treatment, care and supports to the consumer until the consumer has transitioned to the Area Service.

All needs assessments undertaken by Local Services are to be designed in a way – including assessment instruments and documentation requirements – that ensures the decisions made across Local Services and Area Services are consistent and appropriate. This will eliminate the need for re-assessment of consumers that may need to transfer from a Local Service to an Area Service due to the intensity or complexity of their treatment, care and support needs.

An Area Service may 'step down' a consumer from their service to a Local Service, if a consumer no longer has intensive mental health needs but requires further treatment, care and/or wellbeing support. This will be determined on a case-by-case basis and may involve a period of shared care and dual clinical governance between the Local Service and the Area Service.

Referral pathways will be enabled by the establishment of formal communication, referral and information sharing protocols between Local Services and Area Services, including psychiatric triage services managed by Area Services. This will ensure referral decisions are based on agreed and consistent criteria for the transition of consumers to and from Local Services and Area Services. Area Services may provide primary or secondary consultation to a Local Service to inform a referral decision.

To facilitate the smooth transition and continuity of care of consumers between Local Services and Area Services, an agreed intake and triage classification scale and associated referral processes will be used.

The department will co-design the triage classification scale in collaboration with health services funded to deliver Area Services, providers funded to deliver Local Services, people with lived experience of mental illness, families, carers and supporters and other stakeholders.

Formal referral pathways and protocols will also be established and maintained with headspace services for young people who may need to transition to a Local Service when they turn 26 years of age.

9.1.4 Referral pathways with primary and secondary mental health care providers

Some individuals presenting to a Local Service may already be receiving Medicare Benefits Scheme (MBS) funded private mental health services. In situations where this is the case, providers of Local Services will establish and maintain robust communication, referral and information sharing protocols with local general practitioners and private MBS funded psychiatrists and psychologists, taking into account issues related to privacy, confidentiality and consent.

This will support smooth referral pathways for consumers who may:

- need to move between the levels of treatment and care available in Local Services and primary and secondary mental health care providers
- benefit from shared care arrangements for their treatment, including medication monitoring and review
- require wellbeing, care coordination and/or peer supports available in the Local Service.

Referral pathways from primary and secondary mental health care providers will be facilitated through the common use of the Initial Assessment and Referral tool (refer Section 9.2.2).

9.1.5 Referral pathway to and from AOD service providers

AOD services are responsible for supporting people with substance use or addiction, including people who experience low intensity mental health support needs. Local Services are responsible for supporting people with substance use or addiction concerns who are experiencing moderate to higher intensity mental health support needs.

Where a person presents to a Local Service with no or low intensity mental health support needs but has substance use or addiction needs, the Local Service will provide a supported referral to an AOD service who will provide integrated treatment and care. The provider of the Local Service will maintain treatment, care and supports to the consumer until the consumer has transitioned to the AOD service.

AOD services will be supported by Local Services²² and Area Services, via primary and secondary consultation, to ensure that the needs of the consumer can be met by their preferred AOD provider. This approach will build the capability of AOD services to deliver integrated treatment, care and support and ensure people receive continuity of care from their preferred AOD provider.

Where a person with moderate to higher intensity mental illness and co-occurring substance use or addiction presents to an AOD service, the AOD service will provide a supported referral to a Local Service for the provision of integrated treatment, care and support. If a consumer has moderate intensity mental illness and high intensity AOD needs, shared care arrangements²³ should be put in place between the Local Service and the AOD provider to support the consumer. This is particularly important for consumers receiving a concurrent mental health and residential/non-residential AOD withdrawal and rehabilitation service.

Providers of Local Services and AOD services will establish and maintain protocols for facilitating smooth referrals and shared care arrangements, including communication and information sharing protocols.

9.1.6 Referral pathways with Emergency Departments and Hospitals

Providers of Local Services will establish and maintain protocols for referrals, communication and information sharing with Emergency Departments to:

- support people who have presented to the Emergency Department experiencing psychological distress to be referred to their Local Service (excluding those experiencing acute psychological distress, suicidal crisis or overdose that requires an urgent medical response)
- urgently transfer people who have presented to a Local Service experiencing an acute psychological crisis, high risk suicidal crisis or overdose that requires Emergency Department attendance (with transport provided by emergency services if required).

Providers of Local Services will also establish and maintain protocols for referrals, communication and information sharing with hospitals in their service zone to facilitate planned discharge for people in hospital settings who require treatment and/or wellbeing supports available in the Local Service. This includes people discharged from HOPE and other programs managed by hospitals.

9.1.7 Referral pathways with other specialist mental health services, helplines and broader health system

Providers of Local Services will establish and maintain effective referral pathways with:

- mental health providers of specialist support programs for people with (for example) eating disorders, perinatal and postnatal depression and anxiety and obsessive-compulsive disorders,
- crisis helplines to ensure the smooth referral of callers who require support available in the Local Service
- the broader health system, to support people experiencing psychological distress or mental ill-health related to chronic health problems and illness, such as cancer.

²² Local Services will only provide primary or secondary consultation to AOD services when treatment, care and support is being provided to a common consumer i.e. when a consumer of a Local Service is in a shared care arrangement with an AOD service.

²³ Shared care is a structured approach between two or more services with each service taking responsibility for particular aspects of a consumer's care. This responsibility may relate to the particular expertise of each service. Shared care is supported by formal arrangements, including clear care pathways and responsibilities, dual clinical governance, coordinated care planning and the delivery, monitoring and review of an integrated care plan.

9.1.8 Transition of consumers from select mental health programs to Local Services

State funded Mental Health and Wellbeing Hubs and Commonwealth funded Head to Health²⁴ clinics operating in the service zone of a Local Service will be progressively decommissioned as Local Services are established.

The Local Service provider, with support from the department, will work with providers of Mental Health and Wellbeing Hubs and Head to Health clinics operating in the service zone of the Local Service to support the planned and coordinated transition of consumers, family, carers and supporters from these services to the Local Service. This will include working with the relevant PHN throughout the transition process, in the context of Head to Health clinics.

Further guidance on the transition process will be provided by the department.

9.1.9 Transition out of a Local Service and follow up

Supporting a consumer to leave a Local Service will be a collaborative activity with the consumer, their family, carers and supporters. Transition planning will be informed by:

- the consumer's progress towards their recovery
- progress in linking the consumer with other health and community support services they may need.

When a consumer begins the process of transitioning out of a Local Service, the following must be undertaken as a minimum:

- the consumer's care plan is reviewed and updated based on any outstanding needs and provided to the consumer
- with the consumer's consent, relevant information regarding their treatment, care and support needs is provided to a mental health professional of their choice, such as their GP (if relevant)
- the consumer, their family, carers and supporters are fully informed that they can come back to the Local Service at any time if needed
- collection of outcome data using specified outcome measurement tools (refer to Section 15)
- provide the opportunity to the consumer, family, carer and supporters to complete experience surveys.

When a consumer leaves the Local Service, regular follow up contact will be made for a period of up to three months with rapid support to re-enter the service provided as required.

In some cases, a consumer may choose to withdraw from the service spontaneously and/or contact with a consumer may be lost over the course of the support period. In these situations, a minimum of three contact attempts (by phone, in person or by messaging) must be made over a two-week period. Attempts at contact may also be made through the consumer's support person if one has been nominated.

²⁴ Excluding the Corio based Head to Health service.

9.2 Initial engagement and initial screening assessment

9.2.1 Initial engagement

Local Service staff will engage people on a philosophy of **'how can we help?'** and a **'no wrong door'** approach.

Suitably skilled and trained staff will be available to provide immediate safe support to people who are experiencing high levels of psychological distress or crisis and need urgent help. See Section 7.1.3 high risk presentations.

Suitably skilled and trained staff will undertake the initial screening assessment to identify the consumer's initial needs when they first access the service. Peer support workers will provide support to the consumer, family, carers and supporters throughout this process but will not undertake initial screening assessment themselves (unless otherwise qualified to do so).

All staff will use active listening to understand the consumer's experience, the cause of their distress and what help they need. Consumers, families, carers and supporters will be supported to feel safe and empowered to tell their 'story' and make decisions about their treatment, care and support.

The initial engagement/initial support discussion/s should result in a shared understanding of the consumer's individual circumstances, support networks, social impacts, needs and preferences and those of their family, carers and supporters. A whole of person approach will be taken, focused on what the consumer values in life, consistent with recovery-oriented practices. Providers must ensure all staff receive training in interpersonal and relationship building skills to support effective engagement of consumers, their family, carers and supporters.

The domains in the initial assessment tool will be used to support this discussion with the consumer, their family, carers and supporters (See Section 9.2.2). The identification of a consumer's initial needs may occur over more than one session during which time the consumer, their family, carers and supporters can be provided with support.

The key focus should be on safe and supportive engagement with the consumer, their family, carers and supporters and the identification of their initial issues, needs and aspirations (as determined by the consumer). Approaches such as open dialogue could be used to facilitate these discussions.

The information gathered through the initial support discussion will be used to:

- co-formulate the consumer's initial support needs, including any urgent needs
- co-design a next steps plan with the consumer, their family, carers and supporters
- inform internal (to the Local Service), external referral decisions (including the need for a rapid supported referral to an Area Service for consumers with intensive treatment and care needs), or the need for secondary consultation from an Area Service (to inform the referral decision).

The initial support discussion approach should consider the consumer's readiness to disclose their personal experiences and history (particularly adverse childhood events and experiences of trauma), to ensure safe appropriate engagement and care.

Staff undertaking engagement and initial needs discussions (and comprehensive biopsychosocial assessment and subsequent treatment, care and support) will use the consumer's preferred communication methods, particularly for people who do not use speech to communicate (e.g. Augmentative and Alternative Communication). If additional information is required for people with communication difficulties, a person who knows the consumer well, such as a carer or family member, disability or aged care provider, should be involved in the discussion to support gathering of information about the consumer's likes, dislikes, preferences, and so on.

9.2.2 Initial screening tool

Providers of Local Services will use the [Initial Assessment and Referral Decision Support Tool](https://iar-dst.online/#/) <https://iar-dst.online/#/> or equivalent to screen for a consumer's initial needs during the initial discussion. The IAR tool has been developed by the Australian Department of Health and is designed to be used by general practitioners, Primary Health Networks (PHN) and PHN commissioned providers for initial assessment and referral for people presenting with a mental health condition in these service settings. Use of the IAR tool may also facilitate referral from primary mental health care providers to Local Services.

The domains in the IAR tool may be used or adapted to determine and contextualise the questions against each domain to the consumer's situation, social context and carer/family supports; provide a greater recovery focus; and/or capture the needs of specific groups. Additional evidence-based screening tools may be used as required.

Local Service providers must ensure all staff delivering initial assessments receive appropriate training in the IAR tool in alignment with the Australian Department of Health guidance.²⁵

Table 2 describes the IAR tool's four primary assessment domains and four contextual domains and the scope of each domain. An overview of the IAR tool is provided in **Appendix 3** of this document.

Table 2: Initial assessment domains and scope

Domains	Description
Primary assessment domains	
Domain 1 Symptom severity and distress	Current symptoms and duration, level of distress, experience of mental illness, symptom trajectory
Domain 2 Risk of harm	Past or current suicidal ideation or attempts, past or current self-harm, symptoms posing a risk to self or others, risk arising from self-neglect
Domain 3 Impact on functioning	Ability to fulfill usual roles/responsibilities, impact on or disruption to areas of life, capacity for self-care
Domain 4 Impact of co-existing conditions	Substance use/misuse, physical health condition, intellectual disability/cognitive impairment
Contextual Domains	
Domain 5 Treatment and recovery history	Previous mental health and AOD treatment (including specialist or mental health inpatient treatment), current engagement in treatment, response to past or current treatment
Domain 6 Social and environmental stressors	Life circumstances such as significant transitions, trauma, harm from others, interpersonal or social difficulties, performance related pressure, difficulty having basic needs met, illness, legal issues
Domain 7 Family and other supports	Presence of informal supports and their potential to contribute to recovery
Domain 8 Engagement and motivation	The individual's understanding of the symptoms, condition, and its impact. The person's ability and capacity to manage the condition and motivation to access the necessary support

²⁵ Primary Health Networks (PHN) mental health care guidance – initial assessment and referral for mental health care. Australian Government Department of Health and Aged Care

9.2.3 Wait list management

Providers of Local Services will ensure prompt initial engagement for people who walk into the service, with priority given to those experiencing high levels of distress. This will require appropriate resourcing of 'front-end' service components so that consumers and referrers do not face long waits for an initial support discussion and connection to treatment, care and support. Notwithstanding, Local Services will make appropriate care decisions based on their available resources which may necessitate prioritisation.

People experiencing the highest intensity of need or risk will be prioritised to ensure they receive appropriate care at the earliest time possible.

Local Services will put in place a process to support consumers who may need to wait for specific treatment, care or support available at the Local Service. This includes:

- actively engaging with people to make and keep appointments
- offering wellbeing or peer supports if the consumer is required to wait for an appointment
- undertaking wellbeing checks if there are concerns about a consumer who has to wait for an appointment
- proactively managing a wait list to reduce long waits.

Local Services are encouraged to use telehealth interventions to provide people with immediate access to support while they wait for a face-to-face session.

9.3 Multidisciplinary biopsychosocial assessment

An evidence-based comprehensive biopsychosocial assessment will be offered to consumers to understand the psychological, biological and social factors – and the interaction between these factors – that are impacting on their mental health and wellbeing. It will assess for the full range of mental health conditions and psychosocial wellbeing needs common in adults and older adults and may occur over more than one session.

As per the initial screening needs assessment, the comprehensive assessment tool(s) should be populated from the outcomes of discussions. The key focus should be on engagement with the consumer, and an assessment of issues identified by the consumer. If further information is required, additional questions can be asked at a later time.

Family members, carers and supporters should be engaged and supported to participate in the assessment. They should have the opportunity to inform the assessment in a way that does not impinge on the consumer's right to privacy and confidentiality, should the consumer not consent to their participation in the assessment.

Staff undertaking the comprehensive assessment will use the consumer's preferred method of communication, particularly for people who do not use speech to communicate. If additional information is required, a person who knows the person well, such as a carer or family member, should be involved in the discussion to better capture information about a person's likes, dislikes, preferences etc.

The comprehensive assessment will be undertaken in a way that engages the consumer and builds rapport and trust and may occur over more than one session. The assessment questions should be framed in a positive manner, in line with recovery-oriented practices.

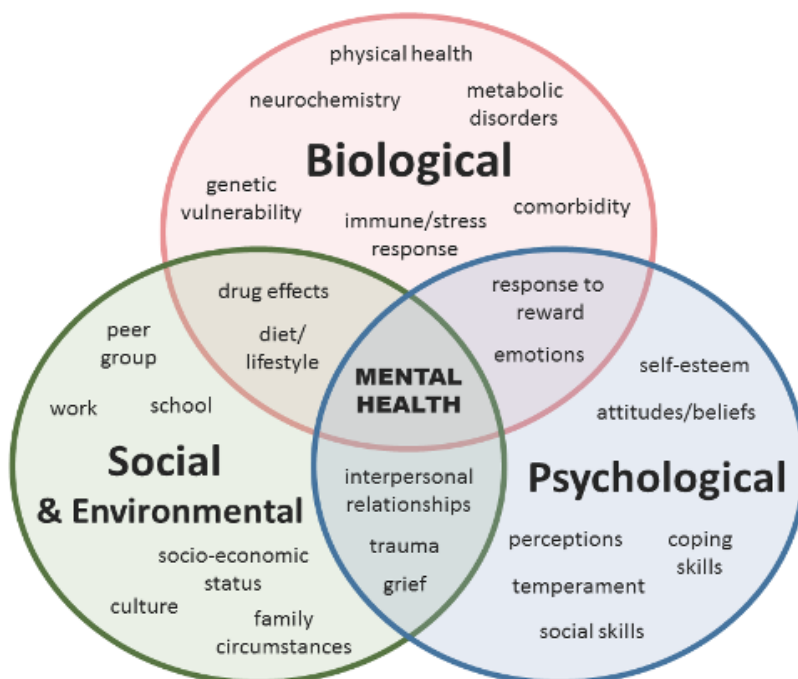
Providers will use evidence-based or evidence-informed biopsychosocial assessment tools and processes to assess for presence of:

- mental illness, psychological distress and trauma
- co-occurring mental illness and substance use or addiction
- disability (psychosocial disability and developmental disability)
- other physical, cognitive, emotional, behavioural factors, sociocultural and environmental factors and influences that contribute to the consumer’s distress. This includes non-health factors that contribute to or are causing the distress, such as lack of adequate, stable safe housing, domestic and family violence, unemployment, a history of trauma, and past experiences of discrimination and stigma.

Biopsychosocial assessments will be undertaken by professionals with the requisite level of expertise. Peer support workers may provide support to the consumer, family, carers and supporters throughout this process but will not undertake biopsychosocial assessment themselves (unless otherwise qualified to do so).

The information collected through the comprehensive biopsychosocial assessment will be used to co-design a care plan with the consumer, their family, carers and supporters and their support team.

Figure 4: The bio-psycho-socio-environmental model for mental health



Source: *The bio-psycho-socio-environmental model for mental health., The Open University.*

Where people present with co-occurring mental illness and substance use or addiction, professionals with competency in assessing substance use or addiction within the Local Service, or if necessary, through secondary consultation, should be involved in the assessment and the subsequent co-design of an integrated care plan with the consumer, their family, carers and supporters (as appropriate).

Where physical health needs are prominent (e.g. people with co-occurring chronic illness), this will form part of the assessment and subsequent integrated care plan. The assessment and care plan will be developed with the consumer, their family, carers and supporters (as appropriate), their general practitioner and/or other health professionals.

Where a person has a co-existing disability (e.g. people living with a mental illness and co-existing Intellectual Disability, Acquired Brain Injury, Autism and other developmental disabilities), this will be considered as part of the assessment and subsequent development of the integrated care plan. Professionals with competency in assessing the needs of people living with a mental illness and co-existing disability should be involved or consulted in the assessment process and subsequent co-design of an integrated care plan. The assessment and care plan will be developed with the consumer, their family, carers and supporters (as appropriate), formal carers/disability support staff, their general practitioner and/or other health professionals.

Providers of Local Services are able to access primary and secondary consultation services provided by Area Services and state-wide specialist mental health and wellbeing services to support the assessment and care planning process.

The Local Service will support and facilitate the consumers' access to specialist assessments as required, such as neuropsychological assessment for people with Acquired Brain Injury.

9.4 Lived and living experience and peer support

Several different terms are used to describe lived and living experience roles. They include 'peer support', 'peer work', 'peer support work' and 'lived experience work'.

The Mental Health Foundation²⁶ (UK) defines consumer peer support as follows:

Peer Support may be defined as the help and support that people with lived experience of a mental illness, or a learning disability are able to give to one another. It may be social, emotional or practical support but importantly this support is mutually offered and reciprocal, allowing peers to benefit from the support whether they are giving or receiving it.

The term 'peer work' is a collective term for a broad range of roles where lived experience is an essential requirement. This includes people with lived or living experience of mental illness and families, carers and supporters with lived or living experience of supporting a family member or friend.

No matter what their role is called or the function they carry out, the principle of their work is the same: workers with lived experience use their real-life experience, coupled with skills learned through education and training, to support and represent people impacted by mental illness, psychological distress and substance use or addiction.

Lived experience roles are not only informed by an individual's experience with challenge, support or even 'recovery'. They are also informed by how those experiences are contextualised in relation to the wider lived experience movement and universal issues of marginalisation and loss of identity, human rights and citizenship.²⁷

The lived and living experience workforce complements other disciplines through unique functions and qualities that instil hope through positive self-disclosure and positive role modelling, offering practical ways of overcoming day-to-day barriers and by challenging each other to try new things.

While the peer support workforce will not deliver treatment related supports, they may support consumers, family, carers and supporters throughout the entire Local Service journey including treatment aspects of the care plan.

²⁶ Mental Health Foundation 2018, viewed 26 July 2022, <<https://www.mentalhealth.org.uk/a-to-z/p/peer-support>>.

²⁷ National Mental Health Commission 2022, Australian Government, Canberra, viewed 26 July 2022, <[https://www.mentalhealthcommission.gov.au/lived-experience/lived-experience-workforces/peer-experience-workforce-guidelines/national-lived-experience-\(peer\)-workforce-develop](https://www.mentalhealthcommission.gov.au/lived-experience/lived-experience-workforces/peer-experience-workforce-guidelines/national-lived-experience-(peer)-workforce-develop)>.

It has long been recognised that lived and living experience makes a valuable contribution to the planning, implementation, and evaluation of health services. Embedding a lived and living experience workforce in Local Services will create better opportunities for service improvement, cultural change and consumer, family and carer engagement, co-design and co-delivery.

If a person with lived experience is employed in generic support roles or business roles within a Local Service and does not use their lived experience as the primary approach in the delivery of these roles, they are not practicing as a lived experience worker.

Lived and living experience work is effective when it:

- is values-based and authentically lived and living experience informed, person-directed and aligned with recovery and family inclusive principles
- is undertaken by people with lived or living experience of mental illness and/or substance use or addiction and family members, carers and supporters who have a significant understanding and ability to use their personal story effectively and appropriately for the benefit of the consumer, their family, carers and supporters
- conveys or inspires hope by providing a living example of hope
- creates a bridge between organisations and people accessing services
- is trauma-informed
- responds compassionately and sensitively
- is strengths-based, focused on the relationship/person
- helps a service to be more flexible and responsive to the consumer, their family, carers and supporters.

It is expected that providers of Local Services will employ people with lived or living experience of mental health concerns (consumers and carers) and substance use or addiction as an integral part of the multidisciplinary team.

This may include:

- **Mental health peer workers** who will use their personal lived or living experience of mental illness and recovery to support consumers with a mental illness, including those with co-occurring substance use and addiction, to support and challenge each other to try new things and new ways of seeing, thinking and doing. This workforce will focus on building mutual and reciprocal relationships where understanding and emotional, social, spiritual and physical wellbeing and recovery are possible. This is skilled and specialised work which requires training and ongoing supervision from experienced peer support workers, as well as regular opportunities for co-reflection.
- **AOD peer workers** who will use their lived or living experience of substance use or addiction plus skills learnt through training to deliver treatment, care and support. AOD peer workers can offer recovery-focused support as well as harm reduction education, in line with a consumer's needs and preferences.
- **Family/ carer peer workers** who will use their personal lived or living experience of supporting a person with a mental illness, including people with co-occurring substance use or addiction, to support family members, carers and supporters.
- **Peer advocates** who will support consumers to have a voice and be a party to issues which affect them. Peer advocates support consumers to speak on their own behalf and in their own interests, or they may speak for and/or on behalf of a consumer under instruction.
- **Consumer and carer consultants** who will provide system advocacy, consultation and participate in service design and policy development etc.

Providers of Local Services should endeavour to have diversity in their peer workforce to meet the needs of consumers, their families, carers and supporters. This may include: LGBTIQ+ communities; older people; people who are neurodivergent; people with disability; members of culturally and linguistically diverse communities; and Aboriginal and Torres Strait Islander peoples.

9.5 Wellbeing supports

Wellbeing supports aim to help consumers return, or progress to, independent living and good quality of life by working with them and their family, carers or supporters to (at a minimum):

- improve their capacity to better self-manage their mental illness
- develop practical life skills for independent living and the development of meaningful social relationships
- develop or strengthen family and social networks, social connectedness and economic participation
- develop the knowledge and confidence they need to make decisions and choices about their health and wellbeing support needs
- adopt a healthy lifestyle and minimise/reduce behaviours that are, or likely to be, harmful
- help them optimise their wellbeing by working together to address psychosocial stressors such as family breakdown, family violence, unaddressed disability needs, housing instability, unemployment, financial difficulties and poor physical health.

The nature and intensity of wellbeing supports to be provided will depend on the degree of disruption in social, home and work life and/or the distress a consumer is experiencing as a result of their psychological distress, co-occurring substance use and addiction and life circumstances.

Some consumers may experience minor impacts on their wellbeing and need minimal, short-term support to return to good levels of psychosocial functioning and wellbeing, whereas others may be experiencing significant distress because their mental health condition and co-occurring substance use and addiction impacts their social, home and work life and quality of life.

The need for wellbeing supports will also be impacted by (for example): personal characteristics; social context, such as informal social supports (family and carer supports) and cultural and social expectations; life and living circumstances such as employment, housing stability and food security; and issues related to engagement with, for example, justice and child protection systems.

Wellbeing supports will be flexible and tailored around the consumer's individual changing needs with the aim of helping the consumer return to good or reasonable psychosocial functioning. They will also help the consumer to address situational circumstances that may be impacting on their recovery and quality of life.

The provision of wellbeing supports will be based on the consumer's individual needs and preferences identified in their co-designed care plan.

This may include needs related to one or more of the following life domains:

- daily living and self-care
- self-management of their own recovery and wellbeing
- relationships (including family and carer relationships)
- meaningful life (including social connections and participation, creative expression and spiritual and cultural needs)
- management of physical health, including chronic disease
- substance use or addiction

- functional impairment and disability (e.g. psychosocial disability and disability related to Autism, Acquired Brain Injury, Intellectual Disability, physical disability and age-related frailty)
- housing and living arrangements
- education and employment
- parenting and carer/family support needs, including needs of dependent children
- involvement with the aged care system
- involvement with the justice system.

Wellbeing supports will include (as a minimum):

- One-on-one individualised wellbeing supports that build:
 - daily living (for example, how to keep house, clothes and belongings clean, managing money, how to use public transport, etc.)
 - social and interpersonal skills (for example, social skills training covering goal setting, developing of routines, role modelling, behavioural rehearsal, positive reinforcement and emotional regulation)
 - self-management, decision making and problem-solving skills.
- Group based psychosocial/recovery education and skill development on self-management, self-care, social interaction, personal growth and problem solving for example, Optimum Health, Hearing Voices programs, Flourish, mindfulness programs, arts and music therapy, etc.
- Peer led support and self-help programs for consumers, families, carers and supporters (group and one-on-one) to provide opportunities to socialise, learn from each other and promote and facilitate self-directed recovery (See Section 9.4 Lived and living experience and peer support).
- Care coordination and supported referral to support the consumer to navigate the mental health service system and access and engage with local health, social and community services (see section 9.8 Care coordination and care planning).
- Active support to complete the NDIS access process and become a NDIS participant (if required).

Wellbeing supports will be organised around three indicative levels of intensity of support, as detailed in **Table 3**.

Table 3: Indicative levels of wellbeing supports

Low level	Moderate level	Intensive level
Short term	Medium term	Longer term
<p>Duration 4 to 6 weeks</p> <ul style="list-style-type: none"> wellness recovery programs and mutual support self-help programs psychosocial education and information time limited wellbeing coaching to develop coping strategies to manage life stressors group based, recovery orientated programs time limited wellbeing checks support to link to mainstream community groups and services one off support to address a pressing need 	<p>Duration: up to 6 months</p> <ul style="list-style-type: none"> one on one tailored wellbeing supports group based, recovery orientated programs mutual support and self-help programs. <p>Level of wellbeing support reduced over time as the consumer recovers.</p>	<p>Duration: up to 12 months</p> <ul style="list-style-type: none"> intensive one on one, tailored wellbeing supports e.g. daily/weekly support group based, recovery orientated programs mutual support and self-help programs focused effort on: <ul style="list-style-type: none"> addressing persistent psychosocial stressors and unaddressed needs impacting on their mental health and wellbeing difficulties with social engagement and connection and economic participation. <p>Level of wellbeing support reduced over time as the consumer returns to a good level of psychosocial functioning and wellbeing.</p> <p>People with significant, enduring psychosocial disability will be supported to access the NDIS.</p>

Optional wellbeing supports delivered as part of a Local Service may also include:

- financial counselling and legal services (noting these functions should be provided through referral arrangements with local financial counselling and pro-bono or funded legal services if available)
- vocational rehabilitation to support employment outcomes (noting this function should be provided through referral arrangements with local employment services if available)
- brokerage funding to address urgent, pressing needs or high-risk circumstances (see Section 9.11 Brokerage funding).

9.6 Clinical treatment

Local Services will provide evidence-based or informed medical and clinical treatment, including counselling, psychological therapies, psychotherapeutic interventions, pharmacological treatment, including prescribing, medication monitoring and review.²⁸ Providers are required to have the clinical governance, clinical supervision and workforce capability to provide safe and effective treatment and care to all consumers.

²⁸ This includes working with the consumer, their families, carers and supporters to come off prescribed medications (if required) in a supportive manner with regular monitoring.

As part of the service offer, integrated treatment and care will be provided to consumers with co-occurring mental illness and substance use or addiction. In addition, this consumer group will also receive wellbeing supports, care coordination and peer supports in a manner that addresses their needs, as part of the core service offer. See Section 9.7 for further information on the provision of integrated treatment, care and support for people with a co-occurring mental illness and substance use or addiction

The treatment and care provided to the consumer will be based on the consumer's care plan and any subsequent changes to the care plan as a result of plan review processes conducted in partnership with the consumer.

The department will not specify types of psychological therapies and psychotherapeutic interventions to be provided.

Providers are required to deliver evidence-based or informed clinical therapies and interventions that are indicated for the range of mental health conditions common in adults and older adults. This is inclusive of (but not limited to) condition specific psychological therapies for people living with a personality disorder, Post-Traumatic Stress Disorder, eating disorders, obsessive compulsive disorders and post-natal mental illness.

The psychological therapies used may be varied and include techniques that address ways of thinking, and/or apply a range of behavioural techniques (such as Cognitive Behavioural Therapy, Dialectical Behaviour Therapy and Cognitive Processing Therapy); or address issues pertaining to self and/or interpersonal relationships (e.g. including brief dynamic therapies such as interpersonal therapy and family-based therapies; and approaches such as self-compassion therapies, acceptance and commitment therapy, mentalization-based therapy, etc.)

Treatment and care will be provided in a manner that engages the consumer through a trusting, safe therapeutic relationship. It will be voluntary, and no coercive or restrictive practices will be used. Consumers are to be supported to make informed choices about treatment, care and support and will have the right to decline services offered or seek a second opinion.

A tiered approach to treatment is encouraged. This includes single session approaches, brief condition specific interventions (e.g. 1-6 sessions) and extended sessions, depending on the therapeutic needs and preferences of the consumer. Family support will be considered for all consumers, including those with dependent children and adult children of older adult consumers.

Use of common factors or transdiagnostic approaches to treatment is encouraged. This approach identifies common elements that are not particular to any specific condition or mental health problem but can produce benefits across a range of presentations. The common factors approach includes:

- A therapeutic alliance/treatment relationship with the consumer which includes agreement on goals and expectations of the therapy.
- Core psychotherapy skills and clinical attributes in the workforce such as: validating, non-judgmental approach; capacity for self-reflection; holding hope; consistent; and reliable.
- Treatment and care that has been co-designed with the consumer and is based on a clear structured treatment approach involving shared monitoring of progress.
- A treatment approach that:
 - is consistent and reliable
 - is trauma-informed and sensitive
 - encourages self-agency and recovery
 - has compassionate boundaries and flexible limits

- o includes strategies to manage crisis, self-injury and suicidal behaviours
- o is able to help the consumer connect their emotions with thoughts and behaviours and develop skills to manage painful thoughts and emotions, self-sabotage, suicidal and self-harming behaviours, and interpersonal challenges
- o provides education and support to families, carers and supporters.

Clinical interventions will be integrated with and complemented by wellbeing supports, peer and mutual self-help supports and care coordination.

The consumer's informal supports (family members, carers and supporters) will be actively involved and supported to understand the treatment, care and support being provided, its benefits and risks and will be supported to assist the consumer to engage in the treatment offer (with the consumer's consent).

Providers are required to use an appropriate assessment tool on the completion of each session to enable the consumer to rate the value of the session and promote responsiveness and trust (for example, Outcome Rating Scale or a Session Rating Scale).

While the peer support workforce will not deliver treatment related supports, they may support consumers, families, carers and supports throughout the entire Local Service journey, including with treatment aspects of the care plan.

9.7 Integrated mental health and AOD treatment, care and support

Local Services will provide integrated treatment, care and support for people with co-occurring mental illness and substance use or addiction based on a 'how can we help?' and 'no wrong door' approach.²⁹

Further guidance for Local Services in relation to integrated mental health and AOD service provision is set out in the *Integrated treatment, care and support for people with co-occurring mental illness and substance use or addiction: Guidance for Victorian mental health and wellbeing and alcohol and other drug services* available at <https://www.health.vic.gov.au/mental-health-reform/recommendation-35>.

The needs of consumers with a co-occurring mental illness and substance use or addiction will be fully integrated into all service components and the overall delivery model for a Local Service. As for all other consumers who present to a Local Service, the focus will be on understanding and responding to the distress being experienced and the consumer's needs and preferences.

Local Services are expected to approach substance use from a health and wellbeing perspective. This includes recognising that not all consumers with co-occurring mental illness and substance use or addiction may wish to reduce or cease use of alcohol or other drugs. This does not reduce their entitlement to treatment, care and support. Local Services must meet people where they are at across the stages of change, providing practical strategies to improve mental health and wellbeing and reduce associated risks, especially where a person continues to use substances.

²⁹Armytage AM, P et al. 2021, 'Promoting inclusions and addressing inequities', Royal Commission into Victoria's Mental Health System (2021), Volume 3.

The integrated model of care for people with co-occurring mental illness and substance use or addiction will have the following critical features:

- Initial screening to identify and respond to initial needs, which considers the complex interactions between mental illness and substance use, and the impacts this may have on a person’s health and wellbeing.
- Comprehensive biopsychosocial needs assessment, including diagnosis of symptoms.
- Range of evidence-based, clinically indicated and trauma informed psychological therapies (such as therapeutic counselling, motivational interviewing and Cognitive Behaviour Therapy), integrated with wellbeing supports.
- Pharmacotherapy prescribing and management for people experiencing dependency to opioids and/or alcohol if they³⁰:
 - are receiving active clinical treatment of a mental illness from the Local Service and
 - do not have access to pharmacotherapy prescribing from a local general practitioner or other health professional.
- Psychoeducation regarding co-occurring mental illness and substance use or addiction, including:
 - education, information and practical strategies to reduce the harms associated with the use of alcohol or other drugs, for example safe consumption practices
 - programs that explore the relationship between trauma, mental health and substance use or addiction
 - psychoeducation for families, carers and supporters.
- Overdose prevention and response training that focuses on building awareness about how to prevent overdoses for consumers who may be at risk of, or likely to witness, an overdose. This can include training on how to safely use naloxone to reverse the effects of an opioid overdose.
- Peer workers with experience of mental illness and/or substance use or addiction and families, carers and supporters who utilise their lived and living experience expertise (alongside skills learnt in formal training) to deliver support.
- Inclusive models of integrated treatment, care and support that assist families, carers and supporters to carry out their caring role as well as address their own wellbeing needs.
- Care coordination to ensure continuity of care and coordinate effective referrals, information transfer and communication between Local Services and the AOD sector, as well as assist the consumer to access the range of health and social support services they need in the local community.

Local Services will have on-site availability of naloxone for administration by qualified staff to a person that presents on site and requires an immediate response to rapidly reverse an opioid overdose. Outside of this circumstance, Local Services are not expected to distribute naloxone to a person presenting to a Local Service. If a person requires a prescription for naloxone, the Local Service may provide this directly if it is an approved provider or make a supported referral to a locally approved organisation that can prescribe naloxone.

³⁰ If a provider of a Local Services is funded separately (from a funding source other than for delivery of the Local Service) to provide pharmacotherapy and management, they can provide this service to consumers of the Local Service.

Local Services are to ensure that consumers with co-occurring mental illness and substance use or addiction have access to a Needle and Syringe Program (NSP). This may be delivered by the Local Service, or via a referral pathway to a local NSP.

The Local Service will also provide support for people with substance use or addiction who seek help from a Local Service because they are experiencing psychological distress that resolves rapidly. In supporting this cohort, Local Services may provide interventions including:

- initial engagement and initial support, including crisis stabilisation if required
- screening assessment to determine initial needs and inform referral decisions if required
- brief interventions to reduce the harms associated with substance use, including:
 - single session therapy
 - harm reduction measures
 - overdose prevention and response training
 - education and support to consumers who continue to use substances, to promote wellbeing and reduce associated risks.
- support to address any psychosocial stressors that are causing distress
- supported referral to AOD services for the provision of specialist AOD counselling, treatment and ongoing support. If required, the Local Service will continue to support the consumer while they wait for access to a specialist AOD service.

Providers of Local Services are required to build effective referral pathways and work collaboratively with local AOD services to assist consumers to access specialist AOD treatment, care and support if required.

Providers are required to ensure the workforce has:

- Core competencies to effectively provide integrated, treatment, care and support for people with co-occurring mental illness and substance use or addiction. This includes providing integrated treatment, care and support that upholds the inherent rights and dignity of consumers, and is delivered in a respectful, non-judgemental manner, free from stigma and discrimination.
- Capability to support people who may present to the Local Service under the influence of alcohol or other drugs and require an immediate and safe stabilisation response.
- Hierarchy of knowledge and skills levels – ranging from a core ‘baseline’ capability to advanced practice in delivering integrated mental health and AOD treatment, care and support.
- Qualified staff that can safely administer naloxone to reverse the side effects on an opioid overdose.

Providers may propose further innovations to improve outcomes for people with co-occurring mental illness and substance use and addiction in addition to the core requirements above.

The new statewide service for people living with mental illness and substance use or addiction will provide support to both Local Services and AOD services, including timely access to primary and secondary consultation as required.

9.8 Care coordination and care planning

The aim of care coordination is to:

- act as a single point of contact to help the consumer, their family, carers and supporters to navigate the Local service, stay engaged and manage any transitions
- build the consumer's individual capability for self-determination and self-advocacy and ability to coordinate their own needs
- actively support the consumer to participate in planning and case conferencing processes and make decisions about their own needs
- ensure care is well planned and coordinated across multiple providers by facilitating case conferencing and shared care arrangements, at the direction of the consumer
- help the consumer access the range of health, aged care, disability, community supports, social activities and social care services they need and address barriers to access through supported referral and advocacy (at the consumer's direction)
- act as a contact point to facilitate rapid re-entry to the service, if required.

Guided by the consumer and their individual care needs, care coordinators will have the following core functions:

- **Individual capacity building** – build the consumer's capacity and capability for genuine self-determination, self-advocacy and exercise of choice and control in decision making (e.g. prepare the consumer to lead their care plan development and case management meetings) and coordinate their own supports.
- **Consistent point of contact** – assist the consumer, their family, carers and supporters to engage/remain engaged in and navigate the Local service and facilitate rapid re-entry if required.
- **Facilitate care planning** – with, or at the direction of the consumer, facilitate and participate in joint planning/case conferencing to ensure a coordinated response between the consumer's health, wellbeing, disability supports and other needs. This may involve development and monitoring of a shared care plan with the consumers mental health team and other services external to the Local service.
- **Joint care planning** in a safe, nonjudgmental environment where the consumer and their family, carers and supporters can participate and explore service solution/s for their needs. This is particularly important when the consumer is unwell or overwhelmed and requires support to make decisions and have their views and preferences heard.
- **System and service navigation** - provide practical support to assist the consumer and their family, carers and supporters to understand and navigate multiple service systems and services, including services internal to the Local Service, key interfacing tertiary, primary and secondary mental health services and community supports and activities. This also includes support and advocacy to make an access request to the NDIS and/or prepare for a first plan discussion or plan review, if required.
- **Key coordination point** - act as a key coordination point for multiple services (on behalf of the consumer) who are involved with the consumer, such as general practitioners, disability, aged care, corrections, education, homelessness, housing, child protection, legal, and family violence services etc.
- **Linkages, engagement, and individual advocacy** - proactively help the consumer to identify, engage and remain engaged with the range of health and social support services they need, as well as access local social and community activities.

Care coordinators will work across the interface between mental health, social support and welfare services and NDIS funded disability support to help the consumer get the right supports at the right time and address barriers to access.

9.9 Social prescribing

A social prescribing trial will be undertaken in select Local Services³¹ to support consumers, particularly older adults, to engage in local social and community activities and online communities.

Many people with a mental illness face stigma, discrimination and social exclusion which impacts on their sense of self and belonging, and directly affects their health and wellbeing. Meaningful social connections and relationships are critical to the health and wellbeing of all people, particularly those living with a co-occurring mental illness and substance use and addiction, who may experience compounded forms of stigma.

The social prescribing trials will test how consumers, their families, carers and supporters can be linked to, and remain engaged in local community activities as part of their co-designed care plan, particularly those experiencing loneliness, social isolation and marginalisation.

Social prescribing activities to be delivered by Local Services include:

- developing extensive knowledge of, and pathways to local community activities and providers
- proactively supporting consumers, families, carers and supporters to engage in a range of local community groups and social activities, such as walking groups, Men's Sheds and Neighbourhood Houses, sport and art classes, group-based exercise, intergenerational programs, recreation activities, volunteering, University of the Third Age, TAFE courses etc.
- building the capability of local community providers to ensure their activities and services are welcoming, safe and inclusive for people with a mental illness (including those experiencing substance use and addiction), their families, carers and supporters.

The social prescribing trial will run for three years in select Local Services and will be evaluated using a framework that is sensitive to local contexts. The evaluation will assess the benefits and outcomes to consumers and determine whether the continued roll out of social prescribing services are warranted as part of the Local Service model.

9.10 Shared care

Providers of Local Services are required to support effective shared care arrangements for consumers receiving concurrent treatment and support from other service providers, such as (but not limited to) private primary and secondary mental health care providers (including general practitioners), Area Services, AOD services and other local health, disability and social support services.

Shared care arrangements (and associated processes and protocols) should at a minimum: facilitate clear and consistently applied understanding of each provider's respective role and responsibilities; information sharing; integrated care planning and review; dual clinical governance arrangements; and service coordination.

³¹ The social prescribing trial will be conducted in the following Local Services: Benalla, Wangaratta and Mansfield; Brimbank; Frankston; Geelong and Queenscliffe; Latrobe; and Whittlesea. High level guidelines for service providers delivering the social prescribing trials will form an annex to this framework when finalised.

9.11 Brokerage funding

The use of brokerage funding is at the discretion of the service provider. Use of brokerage funding should be recorded and align with the consumer's care plan.

Brokerage funding is to be used to address an urgent, pressing need or high-risk circumstance such as (but not limited to): rent arrears to avoid eviction; methadone arrears; food vouchers; urgent clothing; urgent health needs such as wound management, dental service; mobile data for service engagement and material goods.

Brokerage funding is not to be used to purchase activities, goods or services that:

- duplicate, replace or supplement supports that form part of the consumer's support package delivered by the Local Service, including sub-contracted services funded by the provider of the Local Service
- are reasonably accessible and available from alternative sources (for example crisis accommodation, housing establishment fund, public dental, bulk billing general practitioners, respite services, employment services, subsidised education and vocational training)
- should reasonably be expected to be purchased by the consumer themselves (for example ongoing costs associated with rent, household expenses and travel costs)
- provide family or carer support, unless other support services (such as the Carer Support Fund) are unable to provide the requested support, and the support will address a pressing or urgent need that is impacting on their ability to provide care
- require an ongoing funding source (for example subsidisation of public or private rent, gym membership).

In addition, brokerage funding cannot be used to:

- support people that are not consumers of the Local Service
- provide a financial loan to a consumer or their family members, carers and supporters
- reimburse a consumer or family member, carer or supporter for goods or services purchased for the benefit of either or both parties
- purchase illicit drugs for a consumer.

10 Workforce composition

10.1 Workforce disciplines

The core functions of the Local Service will be delivered by a multidisciplinary workforce supported by appropriate clinical governance structures and processes to ensure responsiveness, quality and safety within the service and shared care arrangements with external partners and providers.

The provider of the Local Service will ensure each consumer of the service is allocated to a senior staff member(s) with the relevant skills, experience and competency to monitor a consumer's entire pathway through the Local Service and who will provide oversight throughout the episode of care.

The Local Service operations manager is expected to have operational expertise and experience in the delivery of a mental health service.

The model of care requires a range of professional disciplines and expertise matched to workforce roles and functions. Providers are required to configure, manage and sustain a competent and capable workforce, including the lived and living experience workforce, with the necessary knowledge and skills across the range of services, roles and functions required for the delivery of all aspects of the Local Service model.

Local Services should, where possible, embed pre-qualification and trainee positions into their workforce model (with supervision, and training support to attract staff to the specialty of mental health).

Staff will utilise their particular skill sets and expertise to deliver clearly defined role functions while working as an integrated team with shared clinical review, clinical/practice supervision, peer-to-peer reflection and team supports. This approach will drive inter-professional teamwork.

As some people may present at a Local Service experiencing significant distress (including walk-ins), staff providing the initial engagement response, support discussion and assessment are required to have the requisite skills, competency and experience needed to respond safely and appropriately. This includes the ability to identify those who require urgent/emergency care and provide crisis stabilisation and harm minimisation.

Biopsychosocial assessment and clinical treatment will need to be undertaken by staff skilled in biopsychosocial formulation, including diagnostic assessment and care planning and the provision of condition specific clinical interventions, respectively.

The Local Service workforce will need to have the requisite skills and competencies to provide (at a minimum):

- assessment, diagnosis and care planning
- crisis stabilisation and harm minimisation
- consumer-directed, family-inclusive and recovery-oriented treatment, care and support across a broad range of diagnoses as well as medication review and monitoring
- trauma informed practice
- family practice, including family-based treatment, care and support
- integrated treatment, care and support for people with co-occurring mental illness and substance use or addiction
- integrated treatment, care and support for people living with mental illness and co-existing disability (intellectual disability, Acquired Brain Injury, Autism and physical disability),

- clinical/practice governance
- supervision, including peer supervisors
- support that is cultural safety and responsive to diversity.

Table 4 shows the expected staff skills for each of the functions of the service model, and suggested discipline type.

Note:

- *Multiple functions may be found in the same position.*
- *Where possible, embed pre-qualification and trainee positions in the workforce model.*
- *The disciplines identified for each function do not preclude other staff supporting the consumer in the delivery of the function e.g. a peer support worker supporting the consumer during initial screening or biopsychosocial assessments.*

Table 4: Multidisciplinary Team Functions and disciplines (Indicative)

Function	Key knowledge and skills	Multidisciplinary team members (guide only) ³²
Operations manager	<ul style="list-style-type: none"> • Operational management experience and expertise in mental health service delivery. • Clinical mental health experience and expertise. • Risk management expertise and experience. 	<ul style="list-style-type: none"> • Psychiatrist • Mental health nurse / mental health nurse practitioner • Mental Health Allied Health³³
Clinical director	<ul style="list-style-type: none"> • Clinical mental health experience and expertise. • Clinical governance expertise and experience. • Leadership experience. 	<ul style="list-style-type: none"> • Psychiatrist • Mental health nurse / mental health nurse practitioner • Mental Health Allied Health
Lived experience directors/ senior leaders (consumer and carer)	<ul style="list-style-type: none"> • Lived experience of mental illness. • Peer supervision experience. • Leadership experience. 	<ul style="list-style-type: none"> • Appropriately qualified
Initial engagement	<ul style="list-style-type: none"> • Interpersonal, communication and engagement skills. • Knowledge, skills and values in mental health and AOD recovery. 	<ul style="list-style-type: none"> • Mental health support workers (Diploma in Mental Health, Certificate IV in Mental Health) • Peer workers – mental health (Certificate IV in Mental Health Peer Work) • AOD Peer worker – Self Help Addiction Recovery Centre (SHARC) Peer Worker Training
Initial screening assessment	<ul style="list-style-type: none"> • Skills in client-centred practice. • Experience and capability in identifying and providing reassurance to individuals in distress, including crisis stabilisation and or de-escalation. • Skills and experience in initial assessment, use of mental health screening tools and risk assessment. • Skills and experience to assess for physical health, AOD and disability needs and risks. 	<ul style="list-style-type: none"> • Mental Health Nurses • Psychologists • Social workers • Occupational Therapists • Medical trainees (psychiatry) • AOD qualified clinicians. (Certificate IV in Alcohol and Other Drugs)

³² This includes use of prequalification and graduate/training positions across the disciplines.

³³ Allied health includes but is not limited to: clinical psychologists, general psychologists, occupational therapists and social workers.

Function	Key knowledge and skills	Multidisciplinary team members (guide only) ³²
<p>Biopsychosocial assessment and care planning discussions</p> <p>(Noting a single professional would be likely to undertake an individual assessment, but may seek support and advice from other team members)</p>	<ul style="list-style-type: none"> • Skills in client-centred practice. • Skills and experience in mental health and AOD diagnosis, assessment and treatment planning, including dual disability, and use of evidence-based assessment tools and practices. • Skills and experience in risk assessment. • Skills and experience to assess for physical health needs and risks. • Skills and experience in assessment of social and occupational functioning and risks, including psychosocial disability and other disability. 	<ul style="list-style-type: none"> • Psychiatrists and Registrars (medical staff) • Addiction specialists – psychiatric and addiction medical • Psychology registrars • Clinical psychologist • Psychologist • Occupational Therapists, Social Workers • Mental health nurse / mental health nurse practitioner • Mental health support workers (Diploma in Mental Health, Certificate IV in mental health) • Physical health – nurse practitioner (Bachelor or Masters).
<p>Wellbeing supports</p>	<ul style="list-style-type: none"> • Skills in client-centred practice. • Skills, competency and experience in the delivery of interventions for people experiencing poor social and occupational functioning and risks, including psychosocial disability, in a social model of health framework. • Skills, competency and experience in building individual’s capability for self-care and self-management. • Experience and capability in identifying and providing reassurance to individuals in distress, including crisis stabilisation and or de-escalation. • Skills, competency and experience in identifying early signs of risk and engaging consumers to reduce psychosocial stressors/risks. • Skills, competency and experience in providing psychoeducation and support for consumers, carers, family members and supporters. 	<ul style="list-style-type: none"> • Occupational Therapists • Social Workers • Mental health nurse • Mental health support workers (e.g. Diploma in Mental Health, Certificate IV in Mental Health, Graduate Diploma of Counselling) • Peer workers – mental health (Certificate IV in Mental Health Peer Work) • AOD Peer worker • Training Art and music therapists • Vocational Support Workers • Aboriginal Health Workers • Multidisciplinary Aboriginal Social and Emotional Wellbeing Workers • Transcultural Health Workers.
<p>Peer work</p>	<ul style="list-style-type: none"> • Knowledge, skills and values in mental health recovery and the promotion of wellbeing within an intentional peer model. • Knowledge, skills and values in AOD recovery and the promotion of wellbeing within an intentional peer model. • Communication and wellbeing coaching skills. • Skills and experience in providing psychoeducation and support for consumers, carers, family members and supporters. 	<ul style="list-style-type: none"> • Peer worker – mental health (Certificate IV in Mental Health Peer Work) • AOD Peer worker – Self Help Addiction Recovery Centre (SHARC) Peer Worker Training • Peer Cadets (targeted to individuals undertaking VET studies in Mental Health Peer Work or equivalent).

Function	Key knowledge and skills	Multidisciplinary team members (guide only) ³²
<p>Clinical treatment, including structured psychological therapies and medication prescribing and review</p> <p>Integrated mental health and AOD treatment and care interventions</p>	<ul style="list-style-type: none"> • Skills in client-centred practice. • Skills and experience in the provision of a broad range of evidence-based clinical treatment and structured therapies and harm reduction for people living with a mental illness and co-occurring substance use and addiction. • Skills and experience in medication prescribing, monitoring and review (medical staff). • Skills and experience in care planning. • Experience and capability in identifying and providing reassurance to individuals in distress, including crisis stabilisation and or de-escalation. • Understanding and knowledge of complementary therapies e.g. exercise and wellbeing interventions. 	<ul style="list-style-type: none"> • Psychiatrists and Registrars (medical staff) • Addiction specialists – psychiatric and addiction medical • Clinical psychologists • Psychologists • Psychology registrar • Mental health nurse / mental health nurse practitioner • Occupational Therapists • Social Workers • Mental Health Counsellor (Graduate Diploma of Counselling) • AOD counsellor (Diploma, Bachelor of Counselling, Social Work, psychologists) • AOD nurse (Bachelor or Masters) • Multidisciplinary Aboriginal Social and Emotional Wellbeing Workers.
<p>Care coordination</p>	<ul style="list-style-type: none"> • Skills in client-centred practice. • Skills in service navigation, referral and advocacy. • Skills in coordinating care across multiple systems/services. • Knowledge of mental health system, including primary and secondary mental health care systems. • Knowledge of local health, community and social supports services. • Skills in building the capability of local health, social and community service providers to engage and support people with a mental illness and co-occurring substance use and addiction to address barriers to access. • Knowledge of digital mental health services. 	<ul style="list-style-type: none"> • Occupational Therapists • Social workers • Mental health nurses • Mental health support workers (Diploma in Mental Health, Certificate IV in Mental Health, Graduate Diploma of Counselling) • Peer workers – mental health (Certificate IV in Mental Health Peer Work) • AOD Peer worker • Multidisciplinary Aboriginal Social and Emotional Wellbeing Workers.
<p>Physical health care</p>	<ul style="list-style-type: none"> • Skills in client-centred practice. • Skills and experience in delivery of integrated mental health and physical health. • Skills and experience in preventative health and physical wellbeing coaching/health education. 	<ul style="list-style-type: none"> • General practitioners – trainee • Nurse practitioners and Nurses (including enrolled nurses) • Exercise/physical health practitioners • Diabetes educators • Dietitian • Aboriginal Health Workers • Transcultural Health Workers.
<p>Administrative staff (e.g. receptionist, data management staff)</p>	<ul style="list-style-type: none"> • Well-developed interpersonal skills • Knowledge of mental illness and substance use and addiction its impacts. • Skills relevant to functions. 	<ul style="list-style-type: none"> • Appropriately qualified.

Providers of Local Services may share employment arrangements with a public health service delivering Area Services, including (for example) secondments, staff rotations and sessional in-reach services, to enhance the skill and expertise within the team.

10.2 Training and development

Providers of Local Services are required to have effective strategies in place to recruit and retain suitably qualified and experienced staff.

Providers are also required to ensure their workforce development plan and related activities facilitate delivery of person-centred, outcome focused models in ways that respond to contemporary practice, as defined in the *National Mental Health Practice Standards 2013*.

Consistent with the requirements of the service model, the workforce will practice in a recovery-focused, trauma-informed, person-centred and family inclusive manner.

All staff who provide 'front of house' functions (such as reception staff) should be trained to respond to all consumers appropriately and safely, including those experiencing psychological distress. This includes culturally safe practices.

Providers must ensure their workforce receives the training, professional development and clinical supervision needed to deliver safe, high quality clinical treatment and care. This includes the provision of staff training in (but not limited to):

- interpersonal and relationship building skills to support the effective engagement of consumers, their families, carers and supporters
- skills in early intervention to effectively identify and support consumers who may be displaying early warning signs/symptoms of mental illness before their condition worsens
- the provision of high-quality integrated treatment, care and support to consumers with co-occurring mental illness and substance use or addiction
- understanding of, and capability to respond to the signs of a range of mental health conditions experienced by adult and older adults, inclusive of: eating disorders or concerns around eating, weight and shape; early signs of post-natal depression; obsessive compulsive disorders; and Post Traumatic Stress Disorder
- responding to behavioural and psychological distress and mental illness in consumers with intellectual and pervasive developmental disorders, regardless of whether the disorder has been previously diagnosed.

Providers are responsible for:

- identifying the ongoing training and development needs of their workforce, including the unique needs of the peer workforce
- providing a program of structured learning, training and professional development for staff which reflects the requirements of the Local Service model
- ensuring graduate and entry programs are structured, evidence-based (accredited where necessary) and supported
- providing clinical/practice supervision to the workforce and facilitating peer to peer reflection
- embedding pre-qualification, training and career progression roles into the workforce to support workforce recruitment and sustainability.

11 Roles and responsibilities

11.1 Role of the Department of Health

The Department of Health will:

- Fund and provide policy and strategic oversight of Local Services.
- In collaboration with providers of Local Services and other key stakeholders:
 - lead changes in the operational requirements as required, including: outcome measurement, data collection, reporting requirements and any other data collection enhancements; workforce competency requirements; and the funding model
 - develop guidelines³⁴ to support the implementation of the service model.
- Oversee the implementation of the Service Framework and make any necessary amendments as the service model matures, or in response to the implementation of interrelated or interdependent mental health and wellbeing system reforms.
- Analyse data submitted by providers of Local Services and collate reports.
- Monitor and manage the performance of providers delivering Local Services.
- Evaluate the Local Service model to drive continuous improvement and inform future directions for the service model.

11.2 Role of lead service provider and funded partners

The department will enter into an agreement with a single organisation or consortium for the delivery of a Local Service. In the case of a consortium, the department will allocate funding to the consortium lead (defined as the lead service provider).

The lead service provider will allocate funding to consortium partner/s through a:

- Formal operational collaborative agreement or equivalent, which focuses on operational governance.
- Sub-contract agreement which focuses on the delivery of agreed services by contracted partner/s and the timely payment for those services by the lead service provider. It should also clearly define what each party must deliver under the agreement.

Refer to Sections 14.1.4 and 14.1.5 of this document for guidance on operational collaborative agreements and sub-contract agreements respectively.

The lead service provider will be responsible for:

- implementation of the service model, in accordance with this Service Framework and any future refinement of this framework
- performance of any consortium partner/s and/or sub-contractor/s and for addressing any identified underperformance
- efficient and effective organisational governance structures and processes, ensuring consumers, family, carers and supporters are actively involved in the monitoring and delivery of the service

³⁴ Guidelines will form an Annex to this Service Framework.

- maintaining and managing a collaborative relationship with networked health service/s and other collaborative partnerships and networks with local health and social support services required for the efficient and effective delivery of the service
- monitoring broader environmental issues relevant to the Local Service that may impact on performance and demand for the support delivered by the Local Service
- collecting and reporting agreed data as per the specified requirements.

11.3 Working with a networked health service

Each Local Service will be networked to the public health service funded to deliver Area Services in the geographical zone of operation for the Local Service.

The role of the networked health service is to provide tertiary-level, high intensity mental health treatment, care and support, via multidisciplinary teams, in both community and bed-based settings for infants, children, young people, adults and older adults.

The success of Local Services will be dependent on an effective strategic and operational partnership between Local Services and Area Services. Providers of Local Services and Area Services have a mutual obligation to work collaboratively to ensure smooth transitions and continuity of care for consumers who may need to move between these levels of the mental health and wellbeing system.

Local and Area Services will develop and implement agreed protocols to facilitate seamless referral pathways, shared care arrangements, information sharing and the timely provision of primary and secondary consultation.

11.3.1 Secondary consultation

Providers of Local Services will be able to access primary and secondary consultation services provided by Area Services and Statewide Mental Health and Wellbeing Services to support assessment, care planning, medication review and the provision of treatment, care and support, particularly for consumers with clinical complexity.

Area Services will:

- Provide secondary consultation to Local Services to confirm diagnosis and/or a decision to refer the consumer to the Area Service.
- Strengthen the capability of the Local Service workforce to support people with higher levels of need by providing timely access to primary consultation and shared care, as required.
- Provide secondary consultation to Local Services to support the workforce to manage higher levels of clinical complexity (e.g. diagnosis, care planning and medication review).

Statewide Mental Health and Wellbeing Services will strengthen the capability of Local Services to support people with higher levels of need and ensure quality care through the provision of training and professional development.

11.4 Interface with local primary and secondary mental health care providers

Providers of Local Services will be required to work collaboratively with local primary and secondary mental health care providers to facilitate warm referrals, shared care arrangements and support smooth transitions for consumers who may move between a Local Service and these service sectors.

Local Services may provide the following to local primary and secondary mental health care providers:

- Primary consultation to a patient for the purposes of diagnosis, care planning and/or medication review.
- Secondary consultation to review/inform a patient's diagnosis, care plan or medication and (as a result of this support) strengthen the capability of these providers to support patients with higher levels of need and/or provide improved quality of care.

Please note, the above only applies to registered consumers of a Local Service who are in a shared care arrangement with a primary or secondary mental health care provider.

Providers of Local Services may facilitate a referral for a primary and secondary mental health care provider to an Area Service for the provision of primary and secondary consultation for patients with intensive and/or complex needs.

11.5 Role of the Office of the Chief Psychiatrist

The Chief Psychiatrist provides clinical leadership and advice to mental health and wellbeing service providers, promotes continuous improvement in the quality and safety of mental health services and promotes the rights of people receiving these services.

The Chief Psychiatrist is appointed under the *Public Administration Act 2004 (Vic)* and is given various functions and powers under the *Mental Health Act 2014*³⁵. Under the *Mental Health Act 2014*, the Chief Psychiatrist's role is to:

- support continuous improvement in mental health services and promote the rights of people receiving these services
- provide advice to services informed by clinical audits and reviews
- provide clinical leadership through clinical guidelines and specialist clinical information, training and education
- investigate mental health services if they believe any person's health, safety or wellbeing is at risk of harm.

Under the *Mental Health Act 2014*, the Office of the Chief Psychiatrist has the jurisdiction to investigate and conduct clinical reviews of public mental health services.

Section 122 of the *Mental Health Act 2014* outlines investigations by the Chief Psychiatrist. The Chief Psychiatrist can conduct investigations into the provision of mental health services by a mental health service provider as per the definition below.

³⁵ Please note, the reformed mental health system and the broader vision of the Royal Commission will be enabled by a new *Mental Health and Wellbeing Act* which is under development. The department will keep providers abreast of the development of the new Act. Further information can be found here: [A new Mental Health and Wellbeing Act for Victoria](https://www.health.vic.gov.au/mental-health-reform/a-new-mental-health-and-wellbeing-act-for-victoria) <<https://www.health.vic.gov.au/mental-health-reform/a-new-mental-health-and-wellbeing-act-for-victoria>>.

mental health service provider means:

- (a) a designated mental health service; or
- (b) a publicly funded mental health community support service - to the extent it provides services not funded by the National Disability Insurance Scheme within the meaning of the NDIS Act.

Local Services are considered mental health service providers in the context of the above definition and as such fall under the Powers of the Office of the Chief Psychiatrist.

11.6 Safer Care Victoria

Safer Care Victoria (SCV) is the administrative office established as Safer Care Victoria: The Office for Safety and Quality Improvement under section 11(a) of the *Public Administration Act 2004*.

SCV is the state's lead agency for monitoring and improving quality and safety in Victorian healthcare. SCV supports health services and clinicians to identify and respond to areas for improvement.

SCV works closely with consumers, clinicians and health service managers to support the continuous improvement of healthcare to deliver better, safer health outcomes through:

- prevention and learning from consumer/patient harm
- identifying and delivering service improvements
- engaging with consumers.

12 Service operations

12.1 Service zones

Service providers are funded to deliver a minimum of one (or in some cases multiple) physical Local Service premises within the specified geographical service zone for that Local Service. Funding is based on the adult and older adult population within the service zone specified for each Local Service. Service zone boundaries for Local Services are based on Local Government Areas.

Priority of access will be given to people who live in the service zone of a given Local Service or in neighbouring suburbs. Service providers are to prioritise access for ongoing support based on greatest need. This action is being taken to ensure the sustainability of individual Local Services until the majority of Local Services are operational across Victoria. As Local Services are established across Victoria, consumers may access any Local Service of their choice.

Centre based, telehealth and outreach services provided by the service provider are to be delivered within the specified geographical service zone for the Local Service.

The department will monitor 'out of zone' demand with individual service providers.

12.2 Service operating hours

It is expected that a Local Service will operate during business hours weekdays, after business hours weekdays and on the weekend throughout the entire year.

The department will negotiate operating hours with individual service providers taking into account local service usage trends and referral patterns, to ensure opening hours best meet the needs of consumers, their family, carers and supporters and referrers in the local community.

Providers of Local Services are required to report opening hours quarterly to the department, as part of the activity-based data collection.

12.3 Branding

Providers of Local Services are required to abide by the branding and naming convention requirements for Local Services, as specified by the department.

12.4 Funding model

Local Services will be funded on a block funding model with service targets.

After an appropriate establishment period for each Local Service, the department may implement funding recall processes associated with target attainment in line with departmental recall policies, if required.

As per Recommendation 48 of the Royal Commission's final report, an Activity Based Funding (ABF) model is intended to be trialled and implemented for both bed-based and community-based mental health and wellbeing services.

As the ABF model (including extensions to ABF options such as capitated funding and bundled payments) is further developed, the department will work with service providers to determine how best to align with the ABF model and consider if any components of a Local Service need to remain block funded.

Funding provided for the delivery of Local Services will be indexed consistent with the Victorian Government's annual determination for health services and NGO community service organisations.

Details are available on the [Funded Agency Channel](https://fac.dhhs.vic.gov.au/)³⁶ <<https://fac.dhhs.vic.gov.au/>>.

12.4.1 Hours of service – community clinical and community non-clinical

The funding split between community clinical and community non-clinical output is 60 per cent clinical and 40 per cent non-clinical. Providers may increase quantum of community clinical output delivered in response to local demand in consultation with the department.

For the purposes of this calculation, community non-clinical activity is defined as:

- wellbeing supports
- care coordination
- peer led supports
- brokerage funding (optional)
- social prescribing (select Local Services only).

³⁶ Funded Agency Channel is a shared service between Department of Families, Fairness and Housing and Department of Health, Department of Education and organisations funded through Service Agreements.

Service providers will be funded for a specified total volume of community clinical service hours and community non-clinical service hours at a specified service hour rate.

12.4.2 Community Clinical service rate

Each Local Service will be funded for a specified volume of community clinical service hours. The department will set targets for all domains of clinical mental health activity delivered by a Local Service based on service hours. The use of this duration measure enables activity to be readily related to funding levels.

The price of an hour of community clinical service is inclusive of all costs associated with the delivery of that hour of service, including staff, management, corporate, training and professional development and operating costs.

The clinical output includes:

- Consumer-facing activities - consumer support provided in a client-facing environment either on a one-on-one basis or in all types of group-based settings, including face-to-face and telehealth modes of service delivery. This includes support to and engagement with family, carers and supporters.
- Consumer non-facing activities - consumer related support provided in a non-consumer facing environment that relates directly to and benefits an individual consumer or group of consumers or their family, carer or supporters, such as case conferences, shared care planning and secondary consultation/liaison with the consumer's GP etc.
- System-related activities - system related activities that are not specific to an individual consumer or family/carer/supporter but support the overall consumer and family/carer/supporter cohorts.

Service hours for group-based sessions for consumers are to be measured and reported from a clinician perspective (i.e. clinical hours). One hour of community clinical service in a group setting equates to one hour of service time regardless of the number of consumers in the group. For example, if a clinician delivers a one-hour group session, only one service hour is recorded and reported irrespective of whether there were five clients at the session. If two clinicians are involved in delivering a group session of one hour in duration, this would equal two service hours (irrespective of the number of consumers in the group session).

12.4.3 Client Support Unit (CSU)

The Client Support Unit (CSU) provides a standard single price unit/currency for provider reporting to ensure that resources allocated by the department are being utilised efficiently and effectively.

At its simplest construction, a CSU is the average, efficient total cost of providing one service hour of consumer related (non-clinical) wellbeing support.

The following community non-clinical service components will be funded on a CSU:

- wellbeing supports
- care coordination
- peer led supports
- brokerage funding (optional)
- social prescribing (selected Local Services only).

A service provider will be funded for a specified total volume of CSUs for the Local Service. The department will set targets for wellbeing supports based on service hours. For example, if a provider is allocated 1,000 CSUs, this will equate to 1000 service hours.

It should be noted that within the specified activities that funding for wellbeing supports can be used, the department will not prescribe any particular configuration, ratio or activities for an individual consumer. Service providers are required to use the funding provided in a way that delivers the agreed total volume of activity to acceptable standards of quality, efficiency and value for money.

The price of the CSU:

- is inclusive of all costs associated with the delivery of the hour of service, including staff, management, corporate, training and professional development and operating costs.
- does not include a weighting for individual consumer complexity. Variations in consumer need will be accommodated by varying the number of CSUs allocated to a consumer (together with the mix of activities provided within the consumer’s wellbeing ‘support package’).

The number of CSUs allocated to each consumer’s wellbeing ‘support package’ is to be:

- Determined by the service provider following the initial engagement with the consumer, their family, carers and supporters and subsequent co-design of a care plan with the consumer.
- Based on the intensity, frequency and duration of the individual’s wellbeing support needs, supports provided to their family, carer and supporters and mix/type of supports provided. This approach provides the responsiveness and flexibility needed to respond to a consumer’s changing support needs.

The CSU covers three broad classifications:

- consumer-facing activities
- consumer non-facing activities
- system related activities.

Table 5 describes activities that are covered by the CSU across these classifications. Please note the examples of activities provided are not intended as an exhaustive list.

Table 5: Application of Client Support Unit

Application of CSU	Description	Examples of activities
<p>Consumer-facing activities</p>	<p>Consumer support provided in a client-facing environment either on a one-on-one basis or in all types of group-based settings, including face to face and telehealth modes of service delivery.</p> <p><i>Please note an hour of active consumer engagement in a group setting delivered by a worker equates to one hour of support time regardless of the number of consumers in the group e.g. if one worker delivered a one-hour group session, only one community non-clinical hour/one CSU is recorded and funded irrespective of whether there were five consumers in the session.</i></p> <p><i>If two workers are involved in delivering an hour-long group session this would equal two CSUs (i.e. two hours of service will be reported) irrespective of the number of consumers in the session.</i></p>	<ul style="list-style-type: none"> • Initial engagement and initial support (consumer, family, carers and supporters) • Engagement with the consumer’s family, carer and supporters, including support provided to a carer to assist them to engage the person they care for in a discussion on the benefit of receiving support from a Local Service. • Participation in initial assessment with the consumer. • Participation in comprehensive assessment with the consumer. • Participation in the development of a consumer-directed care plan. • Monitoring and review of the consumer’s wellbeing supports with the consumer (as part of the care plan) at regular intervals. • Provision of direct: <ul style="list-style-type: none"> ○ wellbeing supports (on an individual basis or in a group-based setting), ○ care coordination, including consumer facing support related to supported referral to other local health, community and social services, and ○ peer led supports (on an individual basis or in a group-based setting).

Application of CSU	Description	Examples of activities
		<ul style="list-style-type: none"> • Assistance to family, carer and supporters, including a carer brief assessment, carer peer led supports/groups and supported referral to link to Family-Carer Centres or equivalent. • Consumer facing support associated with the supported referral and transition of the consumer to Area Services or other health services. • Program/activity related costs related to the provision of direct supports, including interpreter services. <p>CSUs may be used to broker support to address pressing needs and are to be reported as consumer-facing support.</p>
Consumer non-facing activities	Consumer related support provided in a non-consumer facing environment that relates directly to and benefits an individual consumer or group of consumers or their family, carer or supporters.	<ul style="list-style-type: none"> • Travel time to and from a consumer to provide direct supports. • Time spent documenting case notes or other consumer related information. • Liaison, collaboration and coordination with relevant support providers on behalf of the consumer including facilitation of, or participation in, for example case conferencing (e.g. as part of the consumer's multidisciplinary support team), liaison with the consumer's GP, aged care or other support providers. • Time spent organising activities or providing other support functions on behalf of consumers (e.g. organising appointments, follow-up on referrals). • Administration of group activities for consumers, family members, carers and supporters.
System related activities	System related activities that are not specific to an individual consumer or family/carer/supporter but support the overall consumer and family/carer/supporter cohorts.	<p>Support to the overall consumer group of the service:</p> <ul style="list-style-type: none"> • Planning and co-design activities. • Quality assurance activities. • Data collection and reporting. • Promotion of the service. • Staff training, professional development and peer to peer reflection. • Cross sector collaboration and service coordination activities e.g. building support networks and referral pathways with Area Services, primary mental health care providers, and other local community and social support services; involvement in local governance structures and processes to advance consumer outcomes at the local system level; and capability building of local community and social services to improve their accessibility and responsiveness to people with a mental illness etc. • Community engagement activities e.g. working with community groups to facilitate their engagement with the service (e.g. ATSI, Culturally and linguistically diverse, older people and people who are homeless).

12.5 Targets and outputs

12.5.1 Targets

The performance of service providers will be monitored against a small initial set of core targets that will be specified in the contract/agreement with the provider.

The following initial targets and requirements must be met as a condition of funding by the service provider:

- expenditure targets (98 per cent expenditure) over a 12-month period
- number of community clinical and community non-clinical hours to be delivered and proportional split between community clinical and community non-clinical hours of service
- mandatory compliance with data reporting requirements
- maintenance of accreditation against an accepted accreditation standard
- compliance with Incident Reporting and Complaints Reporting requirements.

12.5.2 Establishment of new targets

If changes to, or additional targets are deemed necessary, output and activity data from the first 12-month period of the operation of the Local Service will be analysed to understand the drivers and restraints of performance.

Engagement will occur between the service provider and the department and other key stakeholders during this time to develop a shared understanding of performance data, data relationships and drivers of service performance.

Should new performance targets be established, the service provider and the department will consider the relationship between outputs, outcomes and experience of service data to ensure that any new targets do not create distortion in service delivery or other unintended consequences that may impact negatively on the consumer group, families, carers and supporters.

12.6 Workforce requirements

The core functions of the Local Service are to be delivered by a multi-disciplinary workforce, supported by appropriate clinical governance structures and processes, to ensure responsiveness, quality and safety within the service, and shared care arrangements with external partners and providers.

The [Victorian Mental Health and Wellbeing Workforce Capability Framework](https://www.health.vic.gov.au/strategy-and-planning/mental-health-workforce-strategy) <<https://www.health.vic.gov.au/strategy-and-planning/mental-health-workforce-strategy>> sets out the skills, knowledge and ways of working that the workforce will require in the new integrated and responsive mental health and wellbeing system.

The model of care will require a range of professional disciplines and expertise matched to workforce roles and functions. This includes peer and other lived and living experience workers; mental health support workers; AOD clinicians; mental health nurses, allied health staff (clinical and general psychologists, social workers and mental health occupational therapists); and medical staff (psychiatrists and registrars). The operations manager/clinical director is required to have both operational and clinical mental health expertise and experience.

Service providers are required to configure, manage and sustain a competent, well supported and capable workforce, including a peer workforce, inclusive of peer supervisors/managers, with the necessary knowledge and skill across the range of services, roles and functions required for the delivery of all aspects of the Local Service model.

Service providers are required to have systems in place to support and protect a skilled, competent and proactive workforce. This requires comprehensive strategies and plans for recruiting, allocating, developing, engaging and retaining high-performing staff. These strategies will ensure the Local Service has the right people with the right skills to provide optimal care.

Staff will utilise their skill sets and expertise to deliver the functions of the service model, while working as an integrated team with shared clinical review, clinical/practice supervision and team supports. This approach will drive interprofessional teamwork.

Service providers are expected to:

- Have in place effective strategies to recruit, develop and retain suitably qualified staff.
- Develop and maintain a training, education, supervision and development pathway for the employment of graduates, pre-qualification and trainee positions (across all disciplines) to address workforce supply issues and ensure current and future workforce requirements can be met.
- Ensure their workforce development plan and related activities facilitate delivery of consumer-centred, and outcome-focused models, in ways that respond to contemporary practice, as defined in the [National practice standards for the mental health workforce 2013](https://www.health.gov.au/resources/publications/national-practice-standards-for-the-mental-health-workforce-2013) <<https://www.health.gov.au/resources/publications/national-practice-standards-for-the-mental-health-workforce-2013>>.
- Be responsible for identifying the ongoing training and development needs of their workforce and provide a program of learning and professional development for staff which reflects the requirements of the Local Service model.
- Provide clinical/practice supervision to the workforce and facilitate peer-to-peer reflection and capability uplift.

Local Services providers may also share employment arrangements with, for example, health services delivering Area Services, Community Health Centres and bulk billing general practitioners and MBS funded secondary mental health care providers, to enhance a multi-disciplinary team approach.

12.7 Clinical governance

Providers of Local Services must have in place robust clinical governance, including clinical supervision, systems and processes to be accountable for, and assure the provision of, evidence-based treatment that is effective and safe, and delivers high-quality care to all service users, at all times.

Clinical governance refers to the systems and practices organisations implement to:

- ensure organisational and individual accountability for the safety and quality of care
- maintain high standards of care to all service users
- ensure care is evidence-based, effective and safe
- continuously improve the quality of service delivery.

Strong clinical governance and robust system processes will also drive continuous improvement, consumer-centred and family inclusive care, and the management of risk.

Shared accountability for clinical governance and system processes will apply to any consortium partner(s) and/or subcontractor(s) of the Local Service.

Service providers are required to align with the requirements of the [Victorian Clinical Governance Framework](#).

12.8 Risk Management

To ensure quality, safety and risk management in the operation of the service in accordance with the Australian/New Zealand Risk Management Standard³⁷, service providers are expected to have structures and processes in place that support best practice standards of organisational and clinical governance. Risk management is expected to be embedded in all levels of operations, activities and business processes of the Local Service.

12.9 Quality assurance

Service providers are required to consistently deliver high quality and safe services, that are compliant with an accredited standard(s).

12.9.1 Compliance and accreditation against standards

To assure quality care, the service provider, including any consortium partner(s) and/or sub-contractor(s), must comply with the requirements of relevant industry accreditations and standards.

Standards include but are not limited to:

- National Standards for Mental Health Services 2010
- National Safety and Quality Health Service Standards
- Victorian Human Services Standards
- Quality Improvement Council Health and Community Services Standards.

Service providers must achieve and maintain accreditation against an acceptable standard by an independent body that is certified by the:

- International Society for Quality Health Care or
- Joint Accreditation System of Australia and New Zealand.

Service providers are required to retain this accreditation throughout the contract term as a condition of funding. Compliance with this requirement is a condition of funding. These requirements also apply to any consortium partner(s) or sub-contractor(s).

Service providers will be expected to implement the National Standards for Mental Health Services 2010, however, while preferred, there is no formal accreditation requirement against these standards.

12.9.2 Safety and quality frameworks

Providers of Local Services are required to have a comprehensive safety and quality framework to support all aspects of the delivery of the service model. This includes ensuring the risks of supporting individuals who may be experiencing high distress, suicidal risk and/or are intoxication or the like are effectively managed.

³⁷ The Australian New Zealand Risk Management Standard (AS/NZ 4360:2004)

The safety and quality frameworks should include the following (at a minimum):

- compliance with one or more of the specified safety and quality standards
- implementation of appropriate confidentiality and privacy arrangements in accordance with relevant legislation, whilst ensuring appropriate information sharing is in place between services involved in a care pathway, to support quality care and continuity of care
- systems and practices in accordance with the *Privacy Act 1988* and the Australian Privacy Principles, for the sharing of information by practitioners, as part of effective collaboration with consumers, carers and other professionals involved in the consumers' care
- robust clinical governance frameworks and associated procedures and processes, to ensure staff are appropriately credentialled, well supported and trained in the delivery of high quality and safe care
- protocols that guide the review of the care provided and the response to critical incidents and complaints
- clear lines of accountability within the service, including responsibilities of sub-contractors and partners
- protocols and procedures to ensure the safety of staff, consumers and visitors in the event a consumer presents a risk to themselves or others
- protocols with networked Area Services to ensure the smooth transition of consumers who need to move between both service streams and to facilitate information transfer
- after hours arrangements that include provisions to ensure staff, consumers and other visitors are not at risk, and staff are resourced to manage the care of individuals who are intoxicated, exhibiting anti-social behaviour associated with drug use, or are at risk of suicide or self-harm (e.g. arrangements in place with police, minimum after hours staffing levels etc)
- cultural safety considerations to ensure that Aboriginal and Torres Strait Islander people receive quality responses and equality of care
- overall physical building and amenity design is safe and inclusive, and considers, for example, safe physical spaces, multiple egresses, ligature assessments etc.

12.10 Incident management and reporting

12.10.1 Incident reporting

Service providers and any consortium partner/s and/or subcontractor/s are:

- responsible for the safety of their consumers and for managing risks that may affect service delivery. Consistent with this responsibility, all parties involved in the delivery of a Local Service must have systems and processes to identify, report and respond to incidents.
- (In the case of consortium partnership or subcontracting arrangements) required to have shared agreements regarding policies and processes to respond to critical incidents, including incident review and reporting. Agreements should include mutual contribution to incident review.

The service providers (and any consortium partner/s and/or subcontractor/s) are required to report consumer related incidents as outlined in **Table 6**. Incident reporting is a condition of funding and is a mandatory requirement.

Submitting an incident report in accordance with departmental processes and requirements will be the responsibility of the lead service provider. The lead service provider's organisational type will determine which incident reporting system they will report to.

This will either be the Victorian Health Incident Management System (VHIMS), including the new VHIMS Minimum Dataset (MDS) or the Client Incident Management System (CIMS).

Table 6: Overview of incident reporting requirements based on provider/organisation type

Service Provider type	Incident reporting requirements
Health services Hospitals Integrated Community Health Services Stand-alone Community Health Services	Victorian Health Incident Management System (VHIMS) including the new VHIMS Minimum Dataset (MDS) Service providers must record all adverse events in their chosen VHIMS solution (VHIMS Central Solution or VHIMS Local Solution) and submit the VHIMS MDS to VAHI as required. Further details available on the Victorian Health Incident Management System (VHIMS) page < https://www.bettersafecare.vic.gov.au/notify-us/vhims >; the Adverse Patient Safety Events Policy and the VHIMS Minimum Dataset (MDS) .
Non-government or community service organisations	Client Incident Management System (CIMS) All 'major impact' and 'non-major impact' incidents must be reported to the department within 3 business days of the service provider becoming aware of the incident. Further details including definitions of major and non-major incidents, and categorisation types are outlined in the CIMS and CIMS Summary guides available on the Client incident management system page < https://providers.dffh.vic.gov.au/cims >.
Private health providers	Client Incident Management System (CIMS) – submitted directly to the Department of Health. All 'major impact' and 'non-major impact' incidents must be reported directly to the department of Health, Mental Health and Wellbeing Division <u>within 3 business days</u> of the Service provider becoming aware of the incident. The incident reporting protocol will be consistent CIMS. Further details including definitions of major and non-major incidents, and categorisation types are outlined in the CIMS and CIMS Summary guides available on the Client incident management system page < https://providers.dffh.vic.gov.au/cims >. <p>As per Section 48 of the <i>Health Service Act 1988</i> requirements: The proprietor of a health service establishment must ensure the following information is recorded in writing and reviewed at least every 3 months:</p> <ul style="list-style-type: none"> (a) information in relation to the decisions and actions taken for the purposes of improving the quality and safety of health services provided; (b) if applicable, information in relation to: <ul style="list-style-type: none"> (i) all adverse events occurring at the health service establishment; and (ii) all sentinel events occurring at the health service establishment; and (iii) mortality and morbidity occurring at the health service establishment; and (iv) compliance with the health service establishment's protocols; and (v) results from surveys about patient experience and about staff safety culture.

Service providers are required to submit a bi-annual report to the department that thematically analyses the volume and type of incidents that have occurred in the previous six-month period and details actions taken by the service provider to mitigate or reduce risks of future incidents.

Note: As per Section 46A of the *Health Services Regulations 2013*, all health services are required to notify Safer Care Victoria of sentinel events within 3 business days of becoming aware of the incidents: See the [Victorian sentinel events guide](https://www.bettersafecare.vic.gov.au/publications/sentinel-events-guide) <<https://www.bettersafecare.vic.gov.au/publications/sentinel-events-guide>> for further details.

Sentinel events are broadly defined as wholly preventable adverse patient safety events that result in serious harm or death to individuals. All health services are required to report adverse patient safety events in accordance with the Australian national sentinel event list.

12.10.1 Reportable deaths

Under the *Mental Health Act 2014*, the Chief Psychiatrist must be notified of all reportable deaths within the meaning of the *Coroners Act 2008*.

The Reportable Death guidelines define the reportable death and the reporting process for designated mental health services and mental health community support services to follow in the event of a death of a person who was receiving, had received or sought mental health services.

The Reportable Death notification process allows the Chief Psychiatrist to monitor adverse outcomes for consumers of mental health services. Section 348 of the *Mental Health Act 2014* outlines requirements of deaths that must be reported.

For community patients the Chief Psychiatrist must be notified in writing by the service provider of all unexpected, unnatural, or violent deaths (including suspected suicides) of persons who were registered as mental health consumers within the previous three months or who had sought service from a mental health provider within that period and were not provided with service. The MHA.125 Notice of death form must be completed and sent to the Chief Psychiatrist within three business days of the person in charge becoming aware of the death.

More information can be found in the [Reportable deaths guideline](#)

<<https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/reportable-deaths>>.

12.11 Feedback and Complaints

12.11.1 Internal complaints mechanisms

Service providers and any consortium partner(s) and/or subcontractor(s) are required to develop and maintain internal policies and processes to incorporate feedback as part of continuous improvement, and to respond to complaints.

Service providers and any consortium partner(s) and/or subcontractor(s) must:

- have a feedback and complaints management system in place, with a clear process to receive and respond to feedback, and to receive and resolve complaints about their services and supports
- ensure that consumers, family members, carers and supporters who are using their services know how to provide feedback and make a complaint to the service provider and to the Mental Health Complaints Commissioner
- take all reasonable steps to ensure that no person is adversely affected because a complaint has been made by them, or on their behalf
- report every six months to the Mental Health Complaints Commissioner about the number of complaints received and their outcomes.

Service providers are required to record, collect and report all complaints and compliments and how each complaint was resolved. In the case of consortium partner(s) and/or sub-contractor(s), shared policies and processes must be established to collect, collate and report data on complaints, as well as manage and resolve complaints if the complaint relates to more than one party.

Complainants will be supported to resolve complaints at the Local Service/provider level where possible.

Complainants should always be advised of their option to take their complaint to the Mental Health Complaints Commissioner at any stage of the complaints process.

Service providers are required to submit a bi-annual report to the department that thematically analyses the volume and type of complaints that have occurred in the previous six-month period and details action taken by the service provider to mitigate or reduce complaints. This includes de-identified information concerning any formal complaints against their service being investigated by the Mental Health Complaints Commissioner and the outcome of the investigation, including any compliance notices.

12.11.2 Mental Health Complaints Commissioner

The Mental Health Complaints Commissioner is an independent, specialist body established under the *Mental Health Act 2014* to safeguard rights, resolve complaints about Victorian public mental health services and recommend improvements.

People receiving public mental health services, families, carers, advocates, mental health workers and friends or any person who is genuinely concerned about someone's experience with a public mental health service in Victoria can make a complaint.

The Mental Health Complaints Commissioner (the Commissioner) can receive complaints about mental health services, including access to services. Complaints are accepted from people receiving or trying to access mental health services, a person acting on their behalf or who has a genuine interest in their well-being. This includes carers, family members, friends and advocates.

The Commissioner may resolve complaints informally, receive and monitor undertakings from providers, conciliate matters, conduct investigations, provide recommendations to providers and issue a compliance notice to the service.

Detailed information about the role of the Mental Health Complaints Commissioner can be found on the [Mental Health Complaints Commissioner \(MHCC\) website](https://www.mhcc.vic.gov.au) <<https://www.mhcc.vic.gov.au>>.

12.12 Insurance obligations

Service providers and any consortium partners and/or subcontractors are required to have appropriate insurance to cover their operational and business risks. The insurance cover must be maintained for the period of the service agreement.

In accordance with the standard Service Agreement terms and conditions, all service providers are required to indemnify the department against a claim, by any person, for loss of or damage to property, death or personal injury or other financial loss caused by the negligence of or breach of statutory duty by the service provider.

A significant majority of service providers that enter into a departmental Service Agreement are covered under the Community Service Organisations Insurance arranged and funded by the department's insurance programs. The insurer is the Victorian Managed Insurance Authority (VMIA).

Details of the insurance cover provided, including the respective insurance manuals, can be accessed via the department's Funded Agency Channel website or [VMIA Community Services Organisation program](https://www.vmia.vic.gov.au/insurance/policies-and-cover/community-service-organisations-program) <<https://www.vmia.vic.gov.au/insurance/policies-and-cover/community-service-organisations-program>>.

Service providers that are not eligible for cover under departmental insurance programs are required to arrange appropriate insurance.

12.13 Information management

12.13.1 Information management and information technology systems

Service providers must have established and tested processes and systems to collect, securely store and report consumer and service delivery data, at both individual consumer and aggregate levels.

Service providers will be accountable for the appropriate use of funding and for the delivery of services specified in the Service Agreement. To ensure accountability, service providers will be required to regularly report on the services they are funded to deliver through data collections and other reporting. See **Appendix 4** for indicative aggregate data and individual service user data that will be reported by service providers to the department.

This will allow the service provider and the department to periodically review the progress and achievement of agreed targets and performance measures and ensure accountability.

The department will analyse consumer data received from service providers to assess performance (including assessing service provider performance against benchmarks); produce reports to inform performance monitoring, service planning and policy development; and meet national reporting requirements. Data will be de-identified where necessary, to comply with privacy and other considerations.

Service providers are required to have the following information communication technology (ICT) system capabilities:

- A consumer record/information system that can collect consumer, service provision and outcome measurement information, to support case management, coordination of care, service planning, performance monitoring and resource allocation. Service providers must commit to working with the department to report data to the department's data reporting system(s) and any new system the department may develop over the course of the Service Agreement.
- An information system with the capacity to share consumer information between Local Services and Area Services to facilitate referral and case coordination.

These capabilities may be met through the service provider's existing IM/ICT systems, planned enhancements to these systems and/or supplementary collection tools.

All service providers will be required to work with the department as longer-term integrated information and reporting and feedback solutions are developed, as per Recommendation 62 of the Royal Commission's final report relating to contemporary information architecture.

12.13.2 Communication and information sharing mechanisms

Effective and efficient communication and timely, appropriate information sharing between Local Services, partner organisations, Area Services and other health and social support providers (including AOD services) for mutual consumers is vital in supporting the consumers' recovery and wellbeing.

Providers of Local Services are required to have the system capability and protocols in place to facilitate effective communication and information sharing with relevant parties.

Consumers must be informed about information sharing protocols and must provide consent for their information to be shared across and outside of the service. Sharing of consumer information must adhere to legislative requirements.

12.13.2 Health Records Act

Service providers will be bound by the *Health Records Act 2001* or equivalent disclosure provisions in any new mental health legislation. The *Health Records Act 2001* creates a framework to protect the privacy of individuals' health information and regulates the collection and handling of health information.

The *Health Records Act 2001* applies to the health, disability and aged care information handled by a wide range of public and private sector organisations.

This includes, for example:

- bodies such as companies, incorporated associations, unincorporated associations, Local Government, Victorian Government agencies and Departments, public hospitals and other public bodies (such as Victoria Police)
- sole practitioners, partnerships, Members of Parliament, and trustees.

The Health Privacy Principles (HPPs) in the *Health Records Act 2001* apply to health information that is handled in Victoria.

13 Legislative requirements

13.1 Mental Health Act

Victoria's *Mental Health Act 2014*³⁸ places people with a mental illness at the centre of decision making about their treatment and care.

The *Mental Health Act 2014* encourages psychiatrists and other mental health practitioners to develop strong relationships with consumers using mental health services, and to provide them with information and support to make informed choices about their care.

Consumers are defined in the *Mental Health Act 2014* as a person who:

- has received mental health services from a mental health service provider
- is receiving mental health services from a mental health service provider
- was assessed by an authorised psychiatrist and was not provided with treatment, or
- sought or is seeking mental health services from a mental health service provider and was, or is not, provided with mental health services.

People are considered mental health consumers until their case is 'closed' on discharge from the service and they have been notified of this closure (or the service has made all reasonable efforts to do so).

The *Mental Health Act 2014* has a number of core principles and objectives, including:

- assessment and treatment are provided in the least intrusive and restrictive way
- people are supported to make and participate in decisions about their assessment, treatment and recovery
- individuals' rights, dignity and autonomy are protected and promoted at all times

³⁸ Please note, the reformed mental health system and the broader vision of the Royal Commission will be enabled by a new *Mental Health and Wellbeing Act* which is under development – see [A new Mental Health and Wellbeing Act for Victoria](https://www.health.vic.gov.au/mental-health-reform/a-new-mental-health-and-wellbeing-act-for-victoria) <<https://www.health.vic.gov.au/mental-health-reform/a-new-mental-health-and-wellbeing-act-for-victoria>> .

- priority is given to holistic care and support options that are responsive to individual needs
- the wellbeing and safety of children and young people are protected and prioritised
- carers are recognised and supported in decisions about treatment and care.

Under the *Mental Health Act 2014*, only medical or mental health practitioners from a Designated Mental Health Service have the power to provide compulsory mental health assessment or treatment services. As Local Services are not a Designated Mental Health Service under the meaning of the *Mental Health Act 2014*, they cannot provide compulsory mental health assessment or treatment services.

Any person in their capacity as a registered medical practitioner can determine if a person should be placed on an assessment order, however the actual assessment for the order and treatment must be provided by a Designated Mental Health Service. Once an Assessment Order is made, the examination under the Assessment Order must be made by the authorised psychiatrist of a Designated Mental Health Service or their delegate.

Under the *Mental Health Act 2014*, the Office of the Chief Psychiatrist has the jurisdiction to investigate and conduct clinical reviews of public mental health services. Local Services are considered mental health service providers in the context of the above definition and as such fall under the Powers of the Office of the Chief Psychiatrist.

As of July 2022, a new Mental Health and Wellbeing Act is being developed in response to a recommendation made by the Royal Commission into Victoria's Mental Health System. The new Act will replace the current *Mental Health Act 2014*. Pending passage through the Victorian Parliament, the new Act will come into effect in mid-2023.

13.2 Other legislative requirements

Service providers and any consortium partners and/or sub-contractors are required to adhere to and have in place mechanisms and processes to ensure compliance with all applicable legislation, including but not limited to:

- *Charter of Human Rights and Responsibilities Act 2006 (Victoria)*
- *Carers Recognition Act 2012 (Vic)*
- *Health Legislation Amendment (Quality and Safety) Bill 2021*
- *Children, Youth and Families Act 2005 (Vic)*
- *Drugs, Poisons and Controlled Substances Act 1981*
- *Family Violence Protection Act 2008 (Vic)*
- *Gender Equality Act 2020 (Vic)*
- *Health Records Act 2001(Vic).*
- *Multicultural Victoria Act 2011 (Vic)*
- *Occupational Health and Safety Act 2004 (Vic)*
- *Privacy and Data Protection Act 2014 (Vic)*

Service providers are required to consider in general, safety and quality priorities outlined in the *Fifth National Mental Health and Suicide Prevention Plan*.

13.3 Additional policies and procedures

All Victorian organisations that provide services or facilities to children are required by law to comply with the Child Safe Standards. The standards are a compulsory framework that supports organisations to promote the safety of children by requiring them to implement policies to prevent, respond to and report allegations of child abuse. The legislation that creates the standards is the *Child Wellbeing and Safety Act 2005*.

The standards are designed to drive cultural change and embed a focus on child safety by placing children's rights and wellbeing at the forefront of the organisation's mind.

13.3.1 Aboriginal and Torres Strait Islander cultural safety framework

Mainstream health and community services are required to provide culturally safe workplaces and services through the development of strategies, policies, practices and workplace cultures that address unconscious bias, discrimination and racism.

Further information is available at [Aboriginal and Torres Strait Islander cultural safety framework](https://www.dhhs.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework) <<https://www.dhhs.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework>>.

13.3.2 Aboriginal cultural safety fixed grant guidelines - Cultural safety planning and reporting 2021-22

The Aboriginal cultural safety fixed grant guidelines - Cultural safety planning and reporting 2021-22 outline the funding requirements for health services in receipt of the Aboriginal cultural safety fixed grant and offer guidance to all health services in meeting the 2021-2022 Statement of Priorities (SOP), Part A. Further information is available at [Aboriginal cultural safety fixed grant guidelines - Cultural safety planning and reporting 2021-22](https://www.health.vic.gov.au/publications/aboriginal-cultural-safety-fixed-grant-guidelines-cultural-safety-planning-and-reporting-2021-22) <<https://www.health.vic.gov.au/publications/aboriginal-cultural-safety-fixed-grant-guidelines-cultural-safety-planning-and-reporting-2021-22>>.

13.3.3 Balit Murrup: Aboriginal social emotional wellbeing framework 2017-2027

Balit Murrup is a broader policy framework which aims to reduce the health gap attributed to suicide, mental illness and psychological distress between Aboriginal Victorians and the general population.

Further information is available at [Balit Murrup: Aboriginal social emotional wellbeing framework 2017-2027](https://www2.health.vic.gov.au/about/publications/policiesandguidelines/balit-murrup-aboriginal-social-emotional-wellbeing-framework-2017-2027) <<https://www2.health.vic.gov.au/about/publications/policiesandguidelines/balit-murrup-aboriginal-social-emotional-wellbeing-framework-2017-2027>>.

13.3.4 Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027

Korin Balit-Djak is the Aboriginal health, wellbeing and safety strategic plan which is designed to realise the Victorian Government's vision for 'Self-determining, healthy and safe Aboriginal people and communities' in Victoria.

Further information is available at [Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027](https://www.health.vic.gov.au/health-strategies/korin-korin-balit-djak-aboriginal-health-wellbeing-and-safety-strategic-plan-2017) <<https://www.health.vic.gov.au/health-strategies/korin-korin-balit-djak-aboriginal-health-wellbeing-and-safety-strategic-plan-2017>>.

13.3.5 Family Violence and Multi-Agency Risk Assessment and management Framework

Service providers of Local Services are prescribed providers under the Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM)³⁹.

³⁹ The MARAM has been established in law under a Part 11 of the *Family Violence Protection Act 2008*.

The MARAM has been designed to increase the safety and wellbeing of Victorians by supporting relevant services to identify, assess and manage family violence risk effectively. The MARAM sets out key principles and elements that should be embedded into policies, procedures, service delivery and practice, and identifies the responsibilities of various organisations and staff across the system. Service providers are required to align their policies, procedures, practice guidance and tools to the MARAM.

An Organisational Embedding guide and supporting resources are available on the [MARAM practice guides and resources page](https://www.vic.gov.au/maram-practice-guides-and-resources) <<https://www.vic.gov.au/maram-practice-guides-and-resources>> under Organisational focussed resources.

Additional resources including the [Guidance for professionals working with adults using family violence](https://www.vic.gov.au/maram-practice-guides-professionals-working-adults-using-family-violence) <<https://www.vic.gov.au/maram-practice-guides-professionals-working-adults-using-family-violence>> are also available.

13.3.6 Mandatory Reporting to Child Protection

Mandatory reporting refers to the legal requirement of certain groups of people to report a reasonable belief of child physical or sexual abuse to child protection authorities. Mandatory reporters include registered medical practitioners, nurses and registered psychologists.

In Victoria, under the *Children, Youth and Families Act 2005*, mandatory reporters must make a report to child protection, if in the course of practising their profession or carrying out duties of their office, position or employment they form a belief on reasonable grounds that a child is in need of protection from physical injury or sexual abuse.

Providers of Local Services must have systems and processes in place to ensure:

- Mandatory reporters understand and fulfil their obligations under the *Children, Youth and Families Act 2005*, including compliance with Child Safe Standards under the Act. Organisations are responsible, regarding children who use their services or facilities or who are engaged to assist in providing their services or facilities, for continuously improving their operations to ensure that the safety of children is promoted, child abuse is prevented, and allegations of child abuse are properly responded to.⁴⁰
- Staff that are worried about a child's wellbeing but do not believe they are in need of protection, know how to make a referral to Child FIRST or The Orange Door who can provided assistance to families with the care and wellbeing of children, including those experiencing family violence.

13.3.7 Language Services Policy

The Multicultural Victoria Act 2011 (the Act) states that all individuals in Victoria are equally entitled to access opportunities and participate in and contribute to the social, cultural, economic and political life of the state. Interpreting and translation services are crucial to ensuring this is achieved.

Department funded organisations and services are encouraged to develop local language services policies and procedures that:

- are consistent with these guidelines
- take into account relevant legal requirements
- require interpreters and translators they engage to have appropriate National Accreditation Authority for Translators and Interpreters (NAATI) credentials
- address the language needs of clients with limited English

⁴⁰ *Child Wellbeing and Safety Act 2005*, s. 5A(1)(a).

- define when interpreters must be engaged
- are reviewed and updated regularly in consultation with relevant community stakeholders
- reflect the needs of their particular client groups.

More information can be found on [our Language Services policy page](https://www.health.vic.gov.au/publications/language-services-policy) <<https://www.health.vic.gov.au/publications/language-services-policy>>.

14 Governance and Accountability

14.1 Organisational requirements

A Local Service may be operated by a:

- hospital
- public health service, including an integrated Community Health Service
- non-government organisation (NGO) with expertise and experience in the delivery of mental health services or the like, inclusive of Community Health Services
- private entity with expertise and experience in the delivery of mental health services or the like.

14.1.1 Incorporated legal entity

To enter into a service agreement with the department, an organisation must be an incorporated legal entity established under either an Act of Parliament or another relevant legislative framework.

The department will only enter into a legal agreement/contract with an organisation with legal capacity established under one of the following:

- *Associations Incorporation Reform Act 2012 (Vic)*
- *Co-operatives National Law Application Act 2013 (Vic)*
- *Corporations Act 2001 (Cth)*
- *Health Services Act 1988 (Vic)*
- *Trustee Act 1958 (Vic)*
- an individual Act of Parliament.

Organisations are required to maintain their legal status and must advise the department within five business days should their status change.

14.1.2 Consortium partners and subcontractors

The following consortium, partnership or sub-contracting arrangements are acceptable to the department:

- incorporated as a single body
- each member signs as part of a non-incorporated consortium, or
- consortium partners and/or sub-contractors are sub-contracted by a lead service provider.

The department recognises that partnerships may be formed within the service sector, with the objective of promoting integration to better meet the needs of the community.

Service providers must consult with the department regarding any proposed changes to consortia or subcontracting arrangements during the period of the service agreement.

14.1.2 Service Agreement

The basis for funding between the department and a service provider funded to deliver a Local Service is:

- Public health services and public hospitals – funding and accountability for Public Health Services and Public Hospitals is managed through a combination of funding, service frameworks, guidelines and specifications and the Statement of Priorities.
- All other legal entities – standard Department of Health Service Agreement.

14.1.3 Organisational governance and accountability

Organisational governance encompasses the processes by which organisations are directed, controlled and held to account. It enables organisations to perform efficiently, effectively and safely and to respond strategically to changing demands.

Service providers are required to have sound organisational governance structures, processes and controls that:

- comply with relevant legislative requirements that govern how the organisation is constituted and functions
- ensure robust financial management for the efficient administration and utilisation of resources
- ensure the delivery of effective high-quality safe services, including compliance with relevant accreditation, standards and other regulatory and quality requirements
- ensure privacy and confidentiality of consumer information and the collection and reporting of robust data
- ensure people with lived experience of mental illness and those with lived or living experience of supporting someone with a mental illness are involved in the governance of the Local Service
- create value through innovation, development and exploration
- ensure safe and effective management of risk, commensurate with the delivery of the Local Service.

Providers delivering Local Services with consortium partner(s) and/or subcontractor(s) must have and maintain efficient and integrated organisational governance structures and processes, including consumer information management and reporting systems.

14.1.4 Operational collaborative agreement

For the purpose of this framework, operational governance can be defined as the system by which clinicians and staff of any sub-contracted partner organisations share responsibility and are held accountable for:

- the quality of care provided to consumers, their family, carers and supporters
- the continuous improvement of the service
- the minimisation of risks
- fostering of a safe environment for consumers, their family, carers and supporters and the workforce.

At a minimum, the operational collaboration agreement, or equivalent, between the lead service provider and any consortium partners and/or sub-contracted partner organisations should address:

- purpose, context and rationale for the partnership arrangement

- principles of collaboration, for example, commitment to collaborative and transparent work and recognition of the value of each party to the operational relationship
- requirements of the initiative, including;
 - operational goals and objectives
 - service delivery model and key service features
 - referral arrangements, including prioritisation of need
 - clarity of the role of all parties, including staffing roles, accountabilities, ongoing staff orientation, training and development, clinical/practice supervision, and separate and mutual accountabilities of all parties in the consortium with regards to the Local Service
- operational organisational structure and governance model
- operational decision-making guidelines and process
- dispute resolution policy and process
- communication mechanisms
- policies, procedures and protocols required to meet the requirements of the service framework for the Local Service
- budget/resource management and allocation
- performance monitoring: agreement regarding performance monitoring, management and review to ensure efficient, effective, responsive, safe and high-quality service provision
- reporting: agreement regarding departmental reporting and accountability requirements and locally determined performance measures designed to support high quality service provision and continuous improvement
- quality standards
- risk management approach
- insurance requirements
- maintenance and ownership of records
- external communication and media.

Note: The above is intended as a guide only and is not intended to be comprehensive or exhaustive. Operational collaborative agreements will be specific to each lead service provider and their consortium partners/sub-contractors.

14.1.5 Sub-contract agreement

The sub-contract agreement must effectively allow the lead service provider to fulfil its obligations to the department.

The sub-contract agreement should clearly describe and detail the specific services that the contracted provider will provide, and the payment terms for those services. It should also clearly define what each party must deliver under the agreement and the obligations of each party.

It should address (at a minimum):

- articulation of lead organisation agency and contractor(s)
- articulation of lead organisation and contractor/s responsibilities

- articulation of output delivery obligations by the lead organisation and its contractor(s)
- contract dispute resolution
- legal obligations
- reporting obligations of each party (the agreement should also set out the purpose for which this information will be used, including who will be provided with the information)
- financial arrangements, including:
 - budget allocation
 - audit responsibilities
 - process for negotiation of changes to budget allocation
 - payment terms, processes and default processes
- quality assurance requirements
- qualifications and experience of staff employed by the sub-contracted provider/s and training of staff
- risk management, insurance and indemnity
- confidentiality and privacy: the agreement should define which information is confidential, recognise that confidentiality survives the termination of the contract; reference should be made to compliance with the departmental information privacy principles and any relevant legislative provisions
- maintenance of records
- ownership of intellectual property
- assets, including asset disposal at the conclusion of the contract
- specification of the term for which the arrangement is operative/review of agreement at agreed intervals
- compliance with the departmental funding agreement and requirements
- termination/variation of agreement process.

Note: The above is intended as a guide only and is not intended to be comprehensive or exhaustive. Contractual requirements will be specific to each lead service provider.

15 Data reporting requirements

Data collection requirements for performance monitoring are outlined in the following section. Local Services data will enable the department to monitor performance and ensure accountability for delivering tangible outcomes for consumers, family, carer and supporters using Local Services. Data reporting is a requirement of funding and is mandatory.

Please note, as set out in the final report of the Royal Commission, a new Mental Health and Wellbeing Outcomes and Performance Framework is to be developed. This framework may impact on the data reporting requirements of Local Services once finalised.

15.1 Data reporting

The measurement of the achievement of consumer, family, carer and supporters and system activity, outcomes and experience will involve the use of multiple data sources including:

- **activity-based data** – indicators of effectiveness, efficiency, sustainability, responsiveness, accessibility and appropriateness derived from activity delivered by the service
- **outcome data** – indicators of effectiveness and appropriateness derived from consumer outcome measures, using agreed outcome measurement instruments
- **consumer and carer experience of service data** – indicators of effectiveness, responsiveness, accessibility, continuity, safety and appropriateness derived from client experience of service measures, using the consumer Your Experience of Service (YES) and the Carer Experience Survey (CES) instruments
- **incidents⁴¹ and complaints⁴²** – indicators of effectiveness, responsiveness, accessibility, continuity, safety and appropriateness collected through incident reporting and formal complaint mechanisms
- **other data⁴³** – indicators of sustainability, capability and continuity derived from review and core monitoring processes and other sources, including accreditation status.

Providers are required to submit de-identified consumer data, aggregate consumer data and outcome data quarterly to the department as part of their reporting requirements. The frequency of data collection for experience of service data will be at least annually.

Please refer **Appendix 4** for the indicative data reporting requirements.

15.2 Performance Domains

A total of six performance domains apply to Local Services, as described in **Table 7**.

The performance domains are consistent with those used in other health performance frameworks. Service provider performance will be monitored against these domains.

⁴¹ Service providers are required to submit a bi-annual report to the department that thematically analyses the volume and type of incidents that have occurred in the previous six-month period and details action taken by the service provider to mitigate or reduce risks of future incidents.

⁴² Service providers are required to submit a bi-annual report to the department that thematically analyses the volume and type of complaints that have occurred in the previous six-month period and details action taken by the service provider to mitigate or reduce complaints and related incidents and circumstances that gave rise to the complaint.

⁴³ Other type of indicators refers to information that providers are required to submit to the Department of Health. They include the providers and any sub-contractor's accreditation status and financial viability.

Table 7: Performance monitoring and accountability domains

Performance Domain	Domain Definitions
1. Appropriate	Treatment, care and support is person-centred, rights-based, trauma informed, and recovery orientated, respecting the human rights and dignity of consumers, families, carers and supporters. Consumers are encouraged and supported to make decisions about their treatment, care and support.
2. Effective	Treatment, care and support is based in evidence and meets the desired outcomes and evolving needs and preferences of consumers, families, carers and supporters.
3. Connected	Services work together to achieve shared goals and ensure that consumers, families, carers and supporters experience treatment, care and support that is integrated, coordinated and responsive over time.
4. Safe	Treatment, care and supports respect the human rights of consumers, avoids preventable harms, and the safety and wellbeing of those who provide, and access treatment, care and support is maintained.
5. Accessible	Treatment, care and support is provided at the right time and place, taking account of different population needs.
6. Value	Treatment, care and support is cost efficient and sustainable, representing good value for money.

Source: Royal Commission into Victoria’s Mental Health System, Final Report, Volume 4, page 148

15.3 Performance Indicators

Service providers are required to use agreed indicators to enable the department, the service provider and any consortium partner(s) or sub-contractor(s) to monitor and manage performance across the six performance domains.

The performance indicators for Local Service-related activity will be derived from multiple sources. These include activities, outputs, outcomes, experience of service data and other types of data that will be reported by the service provider to the department. **Table 8** maps the data collection to the performance domains. Performance indicators for Local Services will be co-designed with people with lived experience, service providers and departmental staff. The department will facilitate this process.

Table 8: Data collection mapped to performance domains (indicative)

Performance Domains	Data collection mapped to performance domains				
	Activity and Output data	Outcome data	Experience of service data	Incidents and complaints	Other
1. Appropriate	✓	✓	✓	✓	✓
2. Effective	✓	✓	✓	✓	
3. Connected	✓		✓	✓	✓
4. Safe			✓	✓	✓
5. Accessible	✓		✓	✓	
6. Value	✓				✓

16 Performance monitoring and management

16.1 Performance monitoring and management process

Understanding what Local Services are achieving against the desired outcomes will inform future planning, investment and implementation.

The department will manage service performance monitoring. Service requirements will be monitored through the collation of performance indicators and supported by an analysis of issues impacting on the performance achieved.

The department may conduct regular performance and operational reviews, which may include but are not limited to:

- assessment of service delivery that is at variance to the requirements of this Service Framework
- evidence of ongoing workforce development activity
- quality of submitted activity and outcome data
- safety issues and progress in addressing identified issues (in collaboration with the Office of the Chief Psychiatrist)
- quality improvement activity, including actions being undertaken to address incidents and complaints
- policy and procedure development and reporting.

Departmental staff will identify areas of underperformance and work with the service provider to identify and discuss strategies and solutions that the service provider will implement to address the area(s) of concern. The service provider should also proactively report areas of underperformance and alert departmental staff.

The lead service provider will be responsible for the performance of any consortium partner(s) and/or sub-contractor(s), and for addressing any underperformance identified by the department.

The performance monitoring and management of service providers funded to deliver the Local Service comprise three steps:

1. An ongoing, routine, core monitoring process of service delivery performance built around the review of output and outcome data, as it is received on a quarterly basis, and the review of incident and complaints data.
2. In situations where unsatisfactory performance requires remedial action, core monitoring with actions will be undertaken. This will involve increased frequency and intensity of performance monitoring processes and the development and implementation of agreed actions by the service provider, to address identified performance issues and improve service quality.
3. Escalation to performance review in response to persistent, significant unaddressed performance issues. This process may result in funding recall or other agreed actions.

The performance monitoring process will:

- adopt a consistent approach to monitoring service provider performance to identify areas of underperformance
- identify actions required to improve the service performance of the service provider (where performance is within their control).

A quarterly monitoring process will be used that:

- aligns the monitoring process to the quarterly outcome and output data submission timetable
- facilitates early identification of emerging drifts in performance results and timely intervention.

16.2 Accountabilities and requirements

The service provider will be accountable for using funding to deliver services, as specified in the service agreement. This includes funding allocated to any consortium partner(s) and/or sub-contractor(s). As part of this accountability, the service provider will be required to comply with funding expenditure, data collection and other reporting requirements.

In addition, the department undertakes monitoring of service providers funded through service agreements, in accordance with the service agreement terms and conditions and the Service Agreement Requirements. Information about Service Agreement Requirements can be obtained through the department's Funded Agency Channel.

The department undertakes monitoring of health services funded through the Statement of Priorities in accordance with the Victorian health service Performance Monitoring Framework. Information about this framework can be found on our [Performance monitoring framework page](https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/performance-monitoring) <<https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/performance-monitoring>>.

To assist service providers in the delivery of the service, the department will undertake to provide:

- an ongoing commitment to developing collaborative relationships
- formal support via regular meetings with the service provider
- regular updates on relevant policy directions, initiatives, strategic documents and training opportunities
- consultancy where appropriate
- formal and informal contact as required.

The department will undertake to distribute funding in a timely manner and to address any issues requiring clarification or discussion at the earliest opportunity to reach a resolution.

The frequency of formal liaison meetings will be determined in consultation with the service provider. A departmental representative will be nominated to act as the point of contact for the service provider.

17 Evaluation

The department will evaluate the impacts and outcomes of the Local Service. The department has an evaluation strategy for mental health that sets out the parameters for evaluation. This will be used to guide the development of an evaluation framework.

The evaluation will determine whether the service has been effectively implemented and achieved the intended consumer, family, carer and supporter and system benefits and outcomes. It may also identify areas for continuous improvement and inform future service configuration and scale.

Funded providers and their partner agencies (as relevant) will be required to participate in the evaluation as a condition of funding. This will include the acceptance of any approvals of a certified Human Research Ethics Committee of the department's choosing.

18 Knowledge sharing and learning

As Local Services are progressively implemented, a range of broader mental health and wellbeing system reforms will also be undertaken. Providers of Local Services will be required to work closely with the department to refine and evolve the service model in response to these reforms.

The department will convene a community of practice to support knowledge sharing, learning and best practice across providers of Local Services, and work with providers in response to the impact of broader system reforms on the delivery of Local Services.

Appendix 1: Glossary of Terms

Term	Meaning
ABN (Australian Business Number)	An ABN is a number that identifies your business. It is required for tax, payment, GST and other business activities.
Aboriginal people	We recognise the diversity of Aboriginal people living throughout Victoria. While the terms 'Koorie' or 'Koori' are commonly used to describe Aboriginal people of south-east Australia, we have used the term 'Aboriginal' in this document to include all people of Aboriginal and Torres Strait Islander descent who are living in Victoria. This approach is consistent with the language conventions of key Victorian frameworks such as the Aboriginal Affairs Framework 2018–2023.
Accessible mental health and wellbeing treatment, care and support	Treatment, care and support provided at the right time and place, taking account of different population needs.
Activity-based Funding (ABF)	ABF is a funding method that is based on the number of services provided to a consumer and the price to be paid to the service provider for delivering those services.
Addiction	A medical term used to describe a condition where someone continues to engage in a behaviour despite experiencing negative consequences. Similarly, gambling addiction is the uncontrollable urge to continue gambling despite the toll it takes on one's life. It is classed as an impulse control disorder as it stimulates the brain's reward system much like drugs or alcohol can.
Area Adult and Older Adult Mental Health and Wellbeing Services	State funded services which provide tertiary-level treatment, care and support for people aged 26 years or over experiencing a mental illness or psychological distress. This includes treatment, care and support provided in community and bed-based settings.
Appropriate mental health and wellbeing treatment, care and support	Treatment, care and support that are person-centred, trauma-informed and recovery orientated while respecting the rights and dignity of consumers, families, carers and supporters. Consumers are encouraged and supported to make decisions about their treatment, care and support.
Approved Service Provider	An organisation which has been approved by the Minister for Mental Health to deliver a Local Adult and Older Adult Mental Health and Wellbeing Service.
Area Mental Health and Wellbeing Service	State funded services that provide tertiary-level, high intensity mental health treatment, care and support, via multidisciplinary teams, in both community and bed-based settings for infants, children, young people, adults and older adults.
Assessment Order	An order made under the <i>Mental Health Act 2014</i> (Vic) that authorises a person to be compulsorily examined by an authorised psychiatrist to determine whether the treatment criteria, specified in the <i>Mental Health Act</i> , apply to the person. The order can either be an Inpatient Assessment Order or a Community Assessment Order, which reflects the location of where the examination is to occur.
Authorised psychiatrist	A psychiatrist appointed by a designated mental health service to exercise the functions, powers and duties conferred on this position under the <i>Mental Health Act 2014</i> (Vic), the <i>Crimes (Mental Impairment and Unfitness to be Tried) Act 1997</i> (Vic) or any other Act.
Brokerage	The flexible use of designated funds to enable an eligible consumer to access appropriate support services, essential goods or material aid.
Care	The provision of support, assistance or personal care to another person.

Term	Meaning
Care Coordination	Care coordination helps to achieve quality and consistency of care and allows treatment to be coordinated around each consumer. It does this through clear communication, linkages and collaborative integrated care planning between acute and community-based services in order to reduce the need for emergency department presentations or hospitalisation. ⁴⁴
Care/Support Team	A group of individuals responsible for the treatment, care and wellbeing of a consumer.
Carer	A person caring for a person with a mental illness. This may be a family member, partner, dependent child, friend or other person who has a significant role in the life of the person. The role of a carer may not necessarily be a static or permanent one but may vary over time according to the needs of the person and the carer. Paid carers, such as professional staff in services, disability support carers or residential workers are not included in this definition.
Case Management	The coordination of services by a professional for the assessment, planning and implementation of care to meet an individual's needs. The underlying tasks of case management include assessment of need; care planning; care plan implementation; monitoring; and regular review.
Catchment	A geographical area with defined geographical boundaries.
Client Support Unit (CSU)	A standard, single-price unit. A CSU is based on the average efficient overall cost of providing one hour of consumer related support.
Clinical governance	Systems and processes that services need to have in place to be accountable to service users and the community for ensuring treatment and care is safe, effective, consumer-centred and continuously improving.
Clinical leadership	The leading of activities that ensure high-quality and safe clinical treatment and care is delivered and improved.
Clinical treatment	In accordance with the <i>Mental Health Act 2014 (Vic)</i> , a person receives clinical treatment for mental illness if things are done in the course of the exercise of professional skills to remedy the person's mental illness; or to alleviate the symptoms and reduce the ill effects of the person's mental illness.
Co-design	Co-design refers to a collaborative process bringing people with lived or living experience of mental illness, family, carers and supporters and the staff together to design the service offer and policies.
Commissioning	A cycle that involves planning the service system, designing services, selecting, overseeing and engaging with providers, managing contracts and undertaking ongoing monitoring, evaluation and improvement.
Consortium	A group made up of two or more organisations that work cooperatively together as partners to achieve a common objective or deliver a joint service.
Consumer	People who identify as having a living or lived experience of mental illness or psychological distress, irrespective of whether they have a formal diagnosis, who have used mental health services and/or received treatment, care or support.
Consumer-facing activities	Support provided directly to a consumer or family members, carers and supporters either on a one-on-one basis or in a group setting.
Consumer non-facing activities	Consumer-related support provided in a non-consumer facing environment that relates directly to and benefits an individual consumer or group of consumers or family members, carers and supporters.

⁴⁴ Department of Health 2020, *Care coordination*, State Government of Victoria, Melbourne.

Term	Meaning
Culturally and linguistically diverse (CALD)	Culturally and linguistically diverse communities. The Australian Bureau of Statistics (ABS) defines the Culturally and linguistically diverse population mainly by country of birth, language spoken at home, English proficiency, or other characteristics (including year of arrival in Australia), parents' country of birth and religious affiliation (ABS 1999).
Division	The Mental Health and Wellbeing Division of the Victorian Department of Health.
Family	Family of origin and/or family of choice.
Good mental health	A state of wellbeing in which a person realises their own abilities, can cope with the normal stresses of life, can work productively and is able to contribute to their community.
Harm reduction	Harm reduction empowers people to reduce the harms associated with substance use without necessarily requiring a reduction in use. Harm reduction strategies support safer decision making about the use of substances, modify risk factors that can lead to AOD-related harm, and contribute to better health and wellbeing outcomes for individuals and the community. Harm reduction strategies may include (for example) safer consumption practices and overdose prevention and response and can be used by people with co-occurring mental illness and substance use or addiction, as well as their families, carers and supporters.
Incident	An event or accident that occurs during the delivery of treatment, care and support and harms a consumer or member of staff. This can include a 'near-miss' where no harm occurs from the event or accident.
Incident Reporting	Reporting of incidents and adverse events that may occur in the delivery of a Local Adult and Older Adult Mental Health and Wellbeing Service. A range of incident reporting requirements are in place across the department. These reporting requirements vary depending on the type of incident and the services involved.
Informal supports	Unpaid supports a person receives from people around them, for example family, carers, friends and neighbours.
Information Management (IM)	The collection, storage and use of information from one or more sources and the distribution of that information to one or more audiences. It includes both electronic and physical information.
Information System	The technical infrastructure and human resources that support the collection, storage, processing, transmission and dissemination of information required by all or some part of an agency to support the delivery of services.
Initial discussion	A discussion at first point of contact to determine initial support requirements and any risks that require immediate action.
Intentional peer support	A way of thinking about and inviting transformative relationships. Practitioners learn to use relationships to see things from new angles, develop greater awareness of personal and relational patterns, and support and challenge each other in trying new things.
Lead service provider	The nominated lead of a consortium or partnership funded by the department to deliver the service.
Legal entity (incorporated)	An organisation with legal capacity established under the: <ul style="list-style-type: none"> • <i>Associations Incorporation Reform Act 2012</i> (Vic) • <i>Co-operatives National Law Application Act 2013</i> (Vic) • <i>Corporations Act 2001</i> (Cth) • <i>Health Services Act 1988</i> (Vic) • <i>Trustee Act 1958</i> (Vic), or • an individual Act of Parliament.

Term	Meaning
Local Adult and Older Adult Mental Health and Wellbeing Services	State funded services which provide treatment, care and support in the local community for people aged 26 years and over experiencing a mental illness or psychological distress.
LGA	Local Government Area
LGBTIQ+	People who identify themselves as lesbian, gay, bisexual, transgender, intersex, or questioning.
Lived/living experience	People with lived/living experience who identify either as someone who is living with (or has lived with) mental illness or psychological distress, or someone who is caring for or otherwise supporting (or has cared for or otherwise supported) a person who is living with (or has lived with) mental illness or psychological distress. People with lived experience are sometimes referred to as 'consumers' or 'carers'.
Measures	A defined collectable unit which enables organisations to track and assess progress against indicators.
Mental health and wellbeing	Mental health and wellbeing does not refer simply to the absence of mental illness but to creating the conditions in which people are supported to achieve their potential.
Mental Health and Wellbeing System	<p>The Royal Commission into Victoria's Mental Health System has taken a broad view of what comprises the mental health and wellbeing system. The six levels of the mental health and wellbeing system described by the Royal Commission are:</p> <ol style="list-style-type: none"> 1. Families, carers and supporters, informal supports, virtual communities and communities of place, identity and interest. 2. Broad range of government and community services. 3. Primary and secondary mental health and related services. 4. Local Mental Health and Wellbeing Services. 5. Area Mental Health and Wellbeing Services. 6. Statewide services. <p>A mental health and wellbeing system focuses on the strengths and needs that contribute to people's wellbeing. The addition of the concept of 'wellbeing' represents a fundamental shift in the role and structure of the system.</p>
Mental illness	The <i>Mental Health Act 2014 (Vic)</i> defines mental illness as a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory. However, it is recognised that people with lived experience can have varying ways of understanding the experiences that are often called 'mental illness'. Mental illness can be described using terms such as 'neurodiversity', 'emotional distress', 'trauma' and 'mental health challenges'.
Multidisciplinary care	A multidisciplinary care team comprises the consumer, their family, carer and supporters and multiple support workers from different disciplines. The consumer and their informal supports and the multidisciplinary staff work together to support the recovery of the consumer.
National Disability Insurance Agency (NDIA)	The independent statutory agency that is responsible for implementing the NDIS.
National Disability Insurance Scheme (NDIS)	Established under the <i>National Disability Insurance Scheme Act 2013</i> , the NDIS provides disability support to eligible people with intellectual, physical, sensory, cognitive and psychosocial disability.
Networked health service	The health service and Local Adult and Older Mental Health and Wellbeing Service will work collaboratively to optimise outcome for common consumers.

Term	Meaning
Neurodiversity	Neurodiversity describes the idea that people experience and interact with the world around them in many different ways; there is no one "right" way of thinking, learning, and behaving, and differences are not viewed as deficits.
Non-government organisation (NGO)	A non-profit organisation that provides services to the community and does not operate to make a profit for its members (or shareholders, if applicable).
Peer support	<p>Help and support that people with lived experience of a mental health challenges, including those with experience of substance use or addiction, are able to give to one another. It may be social, emotional or practical support but importantly this support is mutually offered and reciprocal, allowing peers to benefit from the support whether they are giving or receiving it.</p> <p>Peer support workers use their personal lived experience to support other people who are facing similar challenges. Peer support work focusses on building mutual and reciprocal relationships where understanding and emotional, social, spiritual and physical wellbeing and recovery are possible.</p> <p>Peer advocates support people to have a voice and be a party to issues which affect them. Advocates support an individual or group to speak on their own behalf and in their own interests, or they may speak for and/or on behalf of an individual or group under instruction.</p> <p>Family or carer peer support workers use their personal lived experience of assisting someone with mental health challenges to support families or carers who are assisting someone with mental health challenges.</p>
Power imbalance	Power imbalance occurs when society provides advantage to one group over another. Mental health consumers are one such group. Consumers can be treated against their will, restrained against their will, have decisions made against their will and consequently the wealth of knowledge that consumers have is often ignored. The outcome of a power imbalance is tokenism, where consumers are only given limited capacity to contribute. It is important to address this imbalance by resourcing consumers to have productive participation.
Preferred Provider	A service provider formally selected by the Department of Health with whom the Department may finalise a Service Agreement.
Primary and secondary consultation	<p>Primary Consultation refers to a consultation between a mental health clinician or multidisciplinary mental health team and a consumer that may be conducted in person or through teleconferencing or phone. A primary consultation can occur following a referral—for example, where a GP makes a referral for a consumer to have a primary consultation with a psychiatrist.</p> <p>Secondary Consultation refers to a discussion between mental health clinicians about a particular consumer. This can enable different care providers to work collaboratively to discuss issues related to the consumer's care. This model focuses on sharing knowledge and expertise between different care providers.</p>
Primary and secondary mental health care providers	<p><u>Primary mental health care</u></p> <p>The World Health Organisation defines primary mental health care as 'mental health services that are integrated into general health care at a primary care level'. All diagnosable mental health disorders are included. This is the first level of care within the formal health system.</p> <p><u>Secondary mental health care</u></p> <p>Mental health services that require a referral from a primary care provider (usually a GP). A common example is a referral from a GP to a private psychologist under the Better Access scheme.</p>

Term	Meaning
Psychological distress	A measure of poor mental health, which can be described as feelings of tiredness, anxiety, nervousness, hopelessness, depression and sadness. This is consistent with the definition accepted by the National Mental Health Commission.
Psychosocial functioning	A person's ability to perform the activities of daily living, work roles and relationships with other people in ways that are gratifying, and that meets the demands of the community in which the individual lives. Psychosocial health encompasses the mental, emotional, social and spiritual dimensions of what it means to be healthy.
Psychosocial stressors	A life situation or circumstance that creates an unusual or intense level of distress.
Psychological therapies	Various forms of treatment and psychoeducation—including psychotherapy and behaviour modification, among others—aimed at increasing an individual's adaptive and independent mental and behavioural functioning. Psychological treatment is the specific purview of trained mental health professionals and incorporates diverse theories and techniques for producing healthy and adaptive change in an individual's actions, thoughts, and feelings. It stands in contrast to treatment with medication, although medication is sometimes used as an adjunct to various forms of psychological treatment.
Quality assurance	A range of strategies, including regulation, used to provide assurance that services are meeting minimum quality or safety standards or expectations.
Recovery	<p>Clinical recovery is an idea that has emerged from the expertise of mental health professionals and involves reducing or eliminating symptoms and restoring social functioning.</p> <p>Personal recovery is an idea that has emerged from the expertise of people with lived experience of mental illness. It is being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues.</p> <p>Relational recovery is a way of conceiving recovery based on the idea that human beings are interdependent creatures and that people's lives, and experiences cannot be separated from the social contexts in which they are embedded.</p> <p>Recovery is different for everyone. However, central to all recovery paradigms are hope, self-determination, self-management, empowerment and advocacy. Also, key is a person's right to full inclusion and to a meaningful life of their own choosing, free of stigma and discrimination.</p> <p>Some characteristics of recovery commonly cited are that it is:</p> <ul style="list-style-type: none"> • a unique and personal journey • a normal human process • an ongoing experience and not the same as an end point or cure • a journey rarely taken alone • nonlinear, frequently interspersed with both achievement and setbacks.
Recovery oriented support	Support that is provided for people to build and maintain a meaningful and satisfying life, regardless of whether or not there are ongoing symptoms of mental illness, with an emphasis on hope, social inclusion, community participation, self-management, personal goal setting, and improvements in a person's quality of life.
Referral	The act of directing a person to a service by ensuring they fully understand the referral process (including any access criteria that may apply to the service they are being referred to) and by transmission of personal and/or health information relating to the individual (with their consent), for the purposes of further assessment and/or support by the service they are being referred to.
Safety	A state in which risk has been reduced to an acceptable level.
Self-refer	A person is able to refer themselves to a service without requiring assistance.

Term	Meaning
Service provider	An entity funded by the department to deliver services.
Shared care	A structured approach between two or more health services that each take responsibility for particular aspects of a consumer's care. This responsibility may relate to the particular expertise of the health service. Shared care is supported by formal arrangements, including clear care pathways and clinical governance, and all health services involved share a joint and coordinated approach to the health and wellbeing of the consumer. Shared care approaches can also benefit health providers— for example, by providing them with access to expert advice, which can increase their capabilities over time.
Social and emotional wellbeing	Being resilient, being and feeling culturally safe and connected, having and realising aspirations, and being satisfied with life. This is consistent with Balit Murrup, Victoria's Aboriginal social and emotional wellbeing framework.
Social prescribing	Social prescribing, also known as community referral, is a means of enabling health professionals to link people to a range of local, non-clinical services. Social prescribing is designed to support people with a wide range of social, emotional or practical needs, and many schemes are focused on improving mental health and wellbeing. Schemes delivering social prescribing can involve a range of activities including volunteering, arts activities, group learning, gardening, cooking, healthy eating advice and a range of sports.
Stakeholder	Any individual, group, organisation or political entity with an interest or stake in the outcome of a decision. Stakeholders can be consumers, family members or carers, other community members, policymakers, service providers or other organisations involved with an interest, motivation or need to participate.
Standards	General statements against which organisations can audit their performance. The Australian Council of Healthcare Standards (ACHS) defines standards as "a statement of the level of performance to be achieved" (ACHS 2006).
State	The Crown in right of the State of Victoria (and includes the Department of Health).
Stigma	<p>The World Health Organisation defines stigma as a 'mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society'. Stigma is a fundamentally social process - different characteristics or traits are not inherently negative, 'rather, through a complex social process, they become defined and treated as such'. This process leads to social exclusion.</p> <p>Self-stigma - the process whereby someone begins to agree with stigmatised views and then applies these views themselves.</p> <p>Interpersonal stigma (or public stigma) – attitudes and behaviours towards people living with a mental illness.</p> <p>Structural stigma – discriminatory or exclusionary policies, laws and systems.</p> <p>Stigma by association – stigma experienced by someone on the basis of their association with someone with lived experience of mental illness.</p>
Submission	The submission made by a service provider in response to this Advertised Call for Submission.
Substance use	Substance use refers to the use of alcohol or other drugs. In some cases, substance use may become harmful to a person's health and wellbeing or can have other impacts on someone's life and/or that of their family and broader social network.
Supported decision making	The process that supports a person to make and communicate decisions with respect to personal matters. This may be achieved by offering consumers access to a variety of tools and resources such as advocates and peer workers.

Term	Meaning
Supported referral	A process that ensures the person understands the referral process, reassuring them before the first appointment, accompanying the person to the first appointment, talking to them about the experience afterwards and providing follow up support as required.
System related activities	System related activities that are not specific to an individual consumer or carer/family member/supporter but support the overall consumer and carer/family member/supporter cohorts.
Telehealth	Use of online software, phone-conferencing or videoconferencing to deliver services and supports directly to a consumer.
Tertiary mental health services	Highly specialised treatment, care and support usually over an extended period of time that involves advanced and complex procedures and treatments provided by specialist staff. Also known as specialist public mental health and wellbeing services.
Trauma	<p>A deeply distressing or disturbing experience.</p> <p>Historical trauma describes events that significantly disrupt, or erode, the culture or heritage of a community. Communities that have experienced historical trauma are often affected by further trauma and/or adversity. Examples of historical trauma in Victoria include experiences of invasion and displacement of Aboriginal Victorians and the experiences of humanitarian migrants.</p> <p>Complex trauma refers to severe trauma experiences that are repetitive, prolonged and cumulative. Complex trauma is often interpersonal, intentional, extreme, ongoing and can be particularly damaging when it occurs in childhood. Examples of complex trauma include physical abuse, sexual or emotional abuse, neglect, witnessing family violence or community violence, as well as medical trauma.</p> <p>Adverse childhood experiences typically refer to trauma or enduring adversity experienced during childhood. Examples of adverse childhood experiences include physical, sexual, and emotional abuse, physical and emotional neglect or witnessing family violence as a child. Some definitions of early adversity are broader and include sibling and peer victimisation (for example, bullying) or the death of a parent when young.</p> <p>Vicarious trauma describes the cumulative effects of exposure to information about traumatic events and experiences, potentially leading to distress, dissatisfaction, hopelessness and serious mental and physical health problems.</p>
Treatment, care and support	Treatment, care and support as fully integrated, equal parts of the way people will be supported by the mental health and wellbeing system.
Value	Treatment, care and support is cost efficient and sustainable, representing good value for money.
Value based care	Care whose goal is to create more value for consumers by focusing on the outcomes that matter to them, rather than just focusing on cost efficiency.
Wellbeing supports (Previously known as 'psychosocial supports')	Supports that focus on a person's overall wellbeing, mental health recovery, rehabilitation and community participation (social and economic). Wellbeing is about: being resilient; being and feeling culturally safe and connected; having and realising aspirations; and being satisfied with life.
Zone/service zone	A geographical catchment with a discrete adult and older adult population that a Local Service will operate and have physical premise(s) within, defined by Local Government Area (LGA) boundaries. A service zone may have one or more physical Local Service premises or cover one or more LGAs.

Appendix 2: Consumer support streams

Table 1: Indicative consumer support streams and service system responsibilities

Consumer Support Stream	Typical presentation of an individual	Local Adult and Older Adult Mental Health and Wellbeing Service	Area Adult and Older Adult Mental Health and Wellbeing Service	Primary and secondary consultation – Area Adult and Older Adult Mental Health and Wellbeing Service
<p>Community and primary care stream (self-management to low intensity)</p>	<p>Typically, no or minimal risk of harm or other risk factors.</p> <p>Low intensity mental health needs – experiencing mild needs and/or low levels of psychological distress, which may be in response to recent psychosocial stressors or stressful life circumstances.</p> <p>Mental health issues may have typically been present for a short period of time (less than six months but may vary).</p> <p>Generally, the person is managing social relationships, activities of daily living and work reasonably well and may have no to some problems with motivation and engagement.</p>	<p>n/a</p> <p>Responsibility of primary care providers (e.g. general practitioner, private psychologists, counselling provided by Community Health)</p>	<p>n/a</p>	<p>n/a</p>
<p>Primary care with extra support stream</p>	<p>Moderate intensity psychological distress.</p> <p>May present with a range of issues such as anger (e.g. related to the early aftermath of a traumatic event), social withdrawal and anxiety and would benefit from a specialist early intervention response.</p> <p>Likely responsive to and readily engages with treatment, care and support but may need encouragement to engage with treatment, care and support. Will likely recover with access to treatment, care and support.</p> <p>No significant risk factors – where present likely in response to a stressful environment. Presents with minimal or no risk of suicide or self-harm but may require postvention support.</p> <p>May experience co-occurring mental illness and substance use or addiction requiring integrated treatment, care and support.</p>	<p>Provision of treatment, care and support.</p> <p>May have shared care arrangement with the consumer's treating primary/secondary care clinician. In these circumstances, the Local Service may provide:</p> <ul style="list-style-type: none"> • Wellbeing supports, care coordination and/or peer supports • Time limited treatment for the purpose of confirming the diagnosis and GP led care plan (e.g. up to six sessions). <p>If a consumer's mental health needs cease/reduce to low or self-manageable levels and they are experiencing co-occurring substance use or addiction,</p>	<p>n/a</p>	<p>Area Services will provide secondary consultation to Local Services to support the workforce to manage higher levels of need (e.g. diagnosis, care planning and medication review).</p>

Consumer Support Stream	Typical presentation of an individual	Local Adult and Older Adult Mental Health and Wellbeing Service	Area Adult and Older Adult Mental Health and Wellbeing Service	Primary and secondary consultation – Area Adult and Older Adult Mental Health and Wellbeing Service
	<p>May be experiencing significant psychological distress due to situational issues or unaddressed psychosocial stressors.</p> <p>Mental health issues may moderately impact on social relationships, activities of daily living and work. Likely return to good/reasonable psychosocial functioning with treatment, care and or wellbeing supports.</p> <p>May need assistance to address significant life stressors such as homelessness, social isolation, relationship concerns and financial difficulties.</p>	<p>they will receive brief intervention supports and supported referral to an AOD service. The Local Service will continue to provide support to that person until the referral has been accepted and the person has transitioned over to the AOD service.</p>		
<p>Short-term treatment, care and support stream</p>	<p>Moderate and severe intensity psychological distress. Requires specialist assessment, treatment, care and wellbeing support.</p> <p>May experience episodic relapse but can achieve stable mental health and wellbeing with access to treatment, care and support.</p> <p>Likely responsive to and readily engages with treatment, care and support but may need encouragement to engage with treatment, care and support.</p> <p>May experience moderate to high risk of suicide risk or self-harm or rapidly increasing psychological distress. May require postvention support.</p> <p>May be experiencing significant psychological distress due to situational issues or unaddressed psychosocial stressors.</p> <p>May experience co-occurring mental illness and substance use or addiction requiring integrated treatment, care and support.</p> <p>May have complexity regarding risk, anger or aggression.</p> <p>May have complexity associated with co-existing mental illness and disability and associated behaviours (such as Intellectual Disability, Autism and Acquired Brain Injury).</p>	<p>Comprehensive biopsychosocial assessment.</p> <p>Provision of treatment, care and support for consumers with needs and psychological distress for consumers with moderate risk and complexity, including consumers with co-occurring substance use or addiction.</p> <p>Supported referral to an Area Service, for consumers experiencing a significant, unstable and/or rapidly increasing mental health needs or complexity that and requires specialist clinical treatment. Support to family, carers and supporters throughout this referral process.</p> <p>If a consumer’s mental health needs reduce to low or self-manageable levels and they are experiencing co-occurring substance use or addiction, they will receive brief intervention supports and a supported referral to an AOD service. The Local Service will continue to provide support to that person until the referral</p>	<p>Comprehensive biopsychosocial assessment.</p> <p>Provision of treatment, care and support to consumers with issues associated with higher risk; diagnostic or clinical complexity/complex co-morbidity; fluctuating need or risk the Local Service cannot manage safely; or unique features which requires specialist capacity.</p> <p>An Area Service may ‘step down’ a consumer from their service if they have reached a level of clinical stability/recovery that is best supported by the Local Service. This may involve a period of shared care.</p> <p><i>Note: Consumers subject to a Compulsory Treatment</i></p>	<p>Area Service will provide secondary consultation to Local Services to support the workforce to manage higher levels of clinical complexity (e.g. diagnosis, care planning and medication review).</p>

Consumer Support Stream	Typical presentation of an individual	Local Adult and Older Adult Mental Health and Wellbeing Service	Area Adult and Older Adult Mental Health and Wellbeing Service	Primary and secondary consultation – Area Adult and Older Adult Mental Health and Wellbeing Service
	<p>Mental health moderately to significantly impacts social relationships, activities of daily living and work. While activities of daily living and work is impacted by their mental health condition or co-occurring substance use or addiction and is distressing, they will likely return to good/reasonable psychosocial functioning with treatment, care and/or wellbeing supports.</p> <p>Known consumers who requires review, adjustment of treatment/medication or follow up support over time due to episodic nature of their mental health condition.</p>	<p>has been accepted and the person has transitioned over to the AOD service.</p>	<p><i>Order cannot receive treatment, care and support from a Local Service.</i></p>	
<p>Ongoing treatment, care and support stream</p> <p>Ongoing intensive treatment, care and support stream</p> <p>Ongoing mental health need (severe, episodic, persistent and complex needs requiring specialist tertiary mental health treatment and care)</p> <p>Significant impairments associated with mental health condition or co-occurring substance use or addiction which markedly interferes with social relationships, activities of daily living and work.</p>	<p>Ongoing, significant, unstable and/or rapidly increasing mental health needs.</p> <p>High-risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control.</p> <p>Significant, persistent risk of suicide, self-harm, self-neglect and vulnerability and/or harm to others.</p> <p>Significant, ongoing psychological distress associated with mental health condition with potential negative consequence.</p> <p>May need encouragement to engage with treatment, care and support.</p> <p>High degree of clinical complexity, including dual disability, unstable mental health condition and/or high frequency of relapse.</p> <p>May experience co-occurring mental illness and substance use or addiction.</p> <p>Multiple previous presentations to Area Services. Previous history of unsuccessful treatments.</p> <p>Intensity of need is seriously distressing and unmanageable for the consumer. Distress markedly interferes with their social relationships, activities of daily living and work. Significant risk of ongoing psychosocial disability.</p>	<p>Initial engagement, immediate support and discussion on needs (to inform initial screening assessment and subsequent referral decision).</p> <p>Comprehensive biopsychosocial assessment (note: may be undertaken by the Area Service for consumers who will receive a supported referral to the Area Service).</p> <p>Provision of treatment, care and support for consumers with ongoing but relatively low intensity/complexity needs.</p> <p>Supported referral to Area Service for the provision of treatment, care and support for consumers with ongoing and intensive/complex ongoing treatment, care and support needs. Support to family, carers and supporters throughout this referral process. Provision of support until the referral is accepted and the consumer has transitioned to the Area Service.</p>	<p>Comprehensive biopsychosocial assessment (note, will accept the assessment undertaken by the Local Service).</p> <p>Ongoing provision of treatment, care and wellbeing supports for consumers with:</p> <ul style="list-style-type: none"> • ongoing mental health needs that require specialist treatment and care, or • intensive, ongoing treatment care and support needs. <p>Engagement with and support to families, carers and supporters.</p>	<p>May provide secondary consultation to Local Services to confirm diagnosis and/or decision to refer the consumer to the Area Service.</p>

Table 2: Response to people experiencing extreme and very high risk

Description	Response type	Typical presentation	Action/response by Local Adult and Older Adult Mental Health and Wellbeing Service	Action/response by Area Adult and Older Adult Mental Health and Wellbeing Service
Current actions endangering self or others	Emergency services response IMMEDIATE REFERRAL	Current actions presenting immediate danger to self or others. Overdose. Suicide attempt/self-harm in progress. Violence/threats of violence and possession of a weapon/high lethality self-harm.	Immediate referral. Local Service to <u>immediately notify</u> ambulance, police or fire brigade. <u>Additional actions to be considered:</u> <ul style="list-style-type: none"> • Crisis stabilisation/de-escalation support and care advice (to consumer/carers) while waiting for emergency services to arrive. • Notification of other relevant services (e.g. child protection). • Support to family, carers and supporters during and post emergency. • Active follow up engagement with the consumer (post hospitalisation) to co-design and implement a response to address factors causing the distress (if consumer is discharged to the Local Service). • In event of an opioid overdose, administration of naloxone. 	Urgent medical assessment in acute inpatient setting under the <i>Mental Health Act</i> . Hospitalisation and intensive clinical treatment and care for stabilisation. Supported referral to state-wide specialist service, if required for direct care e.g. Spectrum.
Very high risk of imminent harm to self or others	Very urgent mental health response WITHIN TWO HOURS	Acute suicidal ideation/self-harm and risk of harm to others with clear plans and means and/or history of self-harm or aggression. Very high-risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control. Unprovoked aggression. Urgent assessment requested by Police under Section 351 of the <i>Mental Health Act 2014</i> .	Immediate referral Local mental health service clinician to <u>immediately notify</u> ambulance, police or fire brigade. OR Transport to hospital emergency department (if safe to do so). <u>Additional actions to be considered:</u> <ul style="list-style-type: none"> • Crisis stabilisation/specific harm minimisation and care advice (to consumer/carers) while waiting for emergency services to arrive. • Notification of other relevant services (e.g. child protection) • Support to family, carers and supporters during and post emergency. • Active follow up engagement with the consumer (post hospitalisation) to co-design and implement a response to 	Mental health crisis assessment team to do face to face assessment or triage clinician to advice attendance at Emergency Department (when medical assessment/treatment is required). Urgent assessment under the <i>Mental Health Act</i> . Hospitalisation and intensive clinical treatment and care for stabilisation if required. Supported referral to state-wide specialist service, if required for direct care e.g. Spectrum.

Description	Response type	Typical presentation	Action/response by Local Adult and Older Adult Mental Health and Wellbeing Service	Action/response by Area Adult and Older Adult Mental Health and Wellbeing Service
			<p>address factors causing the distress (if consumer is discharged to the Local Service).</p> <ul style="list-style-type: none"> In event of an opioid overdose, administration of naloxone. 	
<p>Moderate risk of harm and/or significant distress</p>	<p>Semi-urgent mental health response.</p>	<p>Significant consumer distress associated with mental health condition but not suicidal.</p> <p>Early symptoms of psychosis.</p> <p>Requires face to face engagement to understand issue driving distress and formulate response.</p>	<p>Immediate crisis stabilisation and de-escalation support to keep the consumer safe.</p> <p>Provide specific harm minimisation and care advice.</p> <p>Follow up engagement to understand issues causing distress and co-design and implementation of a response to address factors causing the distress.</p> <p>Monitor the situation for signs of deterioration with the consumer and family, carers and supporters.</p> <p>Support to family, carers and supporters during and post the urgent episode of need.</p> <p>Supported referral to Area Services for consumers with issues that have higher risk and clinical complexity requiring more specialist treatment and care.</p>	<p>Provisions of treatment, care and support for consumers with issues that have higher risk and clinical complexity requiring more specialist treatment and care.</p>

Source: Adapted from Statewide mental health triage scale guidelines, Department of Health, 2010

Appendix 3: Initial Assessment and Referral Tool

1 Introduction

People seeking mental health support may present with a range of interrelated factors that can make it challenging to determine the most appropriate level of stepped care. The Initial Assessment and Referral Support Tool (IAR) provides a standardised, evidence-based and objective approach to assist with mental health care recommendations.

The IAR is a tool to assist general practitioners and clinicians to recommend the most appropriate level of care for a person seeking mental health support. The IAR is an initiative of the Australian Department of Health and brings together information from a range of sources including Australian and international evidence and advice from a range of leading experts.

The IAR is designed to assist the various parties involved in the assessment and referral process, including:

- General Practitioners (GP) and other clinicians seeking to determine the most appropriate care type and intensity for individuals.
- Commissioned providers, intake teams and PHNs responsible for undertaking initial assessments which may involve making recommendations on the level of care required.

Local Services may adapt the IAR within the context of their local circumstances and service systems.

2 Assessment domains

The IAR guidance identifies eight domains that should be considered when determining the next steps in the referral and treatment process for a person seeking mental health support. There are 4 primary assessment domains and 4 contextual domains. Specific criteria are outlined in the guidance for assessing severity across each domain.

Domains	Description
Domain 1 Symptom severity and distress	Current symptoms and duration, level of distress, experience of mental illness, symptom trajectory.
Domain 2 Risk of harm	Past or current suicidal ideation or attempts, past or current self-harm, symptoms posing a risk to self or others, risk arising from self-neglect.
Domain 3 Impact on functioning	Ability to fulfill usual roles/responsibilities, impact on or disruption to areas of life, capacity for self-care.
Domain 4 Impact of co-existing conditions	Substance use/misuse, physical health condition, intellectual disability/cognitive impairment.
Domain 5 Treatment and recovery history	Previous treatment (including specialist or mental health inpatient treatment), current engagement in treatment, response to past or current treatment.
Domain 6 Social and environmental stressors	Life circumstances such as significant transitions, trauma, harm from others, interpersonal or social difficulties, performance related pressure, difficulty having basic needs met, illness, legal issues.
Domain 7 Family and other supports	Presence of informal supports and their potential to contribute to recovery.
Domain 8 Engagement and motivation	The individual's understanding of the symptoms, condition, and its impact. The person's ability and capacity to manage the condition and motivation to access the necessary support.

3 Levels of Care

The information gathered through the initial assessment domains is used to recommend a service type and intensity (level of care) and inform a referral decision. This process is based on a clinically informed algorithm and is calculated automatically using the [digital Decision Support Tool \(DST\)](https://iar-dst.online/#/). The levels are differentiated by the amount and scope of resources available in each region. An individual may use some or all interventions described at that level and move between levels of care as required.

Level of Care 1	Level of Care 2	Level of Care 3	Level of Care 4	Level of Care 5
Self-Management	Low intensity	Moderate Intensity	High Intensity	Acute & Specialist
<p>Typically, no risk of harm, experiencing mild symptoms and/ or no/low levels of distress – which may be in response to recent psychosocial stressors.</p> <p>Symptoms have typically been present for a short period of time.</p> <p>The individual is generally functioning well and should have high levels of motivation and engagement.</p>	<p>Typically, minimal or no risk factors, mild symptoms/low levels of distress, and where present, this is likely to be in response to a stressful environment.</p> <p>Symptoms have typically been present for a short period of time (less than 6 months but this may vary).</p> <p>Generally functioning well but may have problems with motivation or engagement.</p> <p>Moderate or better recovery from previous treatment.</p>	<p>Likely mild to moderate symptoms/distress (meeting criteria for a diagnosis).</p> <p>Symptoms have typically been present for 6 months or more (but this may vary).</p> <p>Likely complexity of risk, functioning or co-existing conditions but not at very severe levels.</p> <p>Suitable for people experiencing severe symptoms with mild or no problems associated with Risk, Functioning and Co-existing Conditions.</p>	<p>Usually, a person requiring this level of care has a diagnosed mental health condition with significant symptoms and/or significant problems with functioning.</p> <p>A person with a severe presentation is likely to be experiencing moderate or higher problems associated with Risk, Functioning and Co-existing Conditions.</p>	<p>Usually, a person requiring this level of care has significant symptoms and problems with functioning independently across multiple or most everyday roles and/or is experiencing:</p> <ul style="list-style-type: none"> • Significant risk of suicide; self-harm, self-neglect or vulnerability • Significant risk of harm to others • A high level of distress with potential for debilitating consequence.
Evidence-based digital interventions and other forms of self-help.	Services that can be accessed quickly and easily and include group work, phone/online interventions and involve few or short sessions.	Moderate intensity, structured and reasonably frequent interventions (e.g. psychological interventions).	Periods of intensive intervention, typically: multidisciplinary support, psychological interventions, psychiatric interventions, and care coordination.	Specialist assessment and intensive interventions (Typically, state/territory mental health services) with involvement from a range of mental health professionals.

Appendix 4: Data reporting requirement

1 Introduction

Providers of Local Adult and Older Adult Mental Health and Wellbeing Services (Local Services) will be required to collect and report operational data and de-identified aggregate and individual client data to the Department of Health (the department) on a quarterly basis. A small set of data items may be required to be submitted monthly to the department.

Data is to be submitted in the prescribed format within 14 days of the end of each financial quarter. Data specifications will be provided to assist service providers to understand the data requirements and definitions for each item.

The submission of data is a requirement of funding.

Data specifications have been specifically developed to assist provider to understand the data requirements and definitions for each item. The data collection and specifications will be finalised in discussion with providers of Local Services and other key stakeholders.

The data items are indicative only and the department reserves the right to change this collection at its absolute discretion.

The following reporting requirements will apply to all Local Services:

1. **Aggregate client, service usage and operational data items:** detailed requirements outlined in section 2.1.
2. **Individual client data items:** detailed requirements outlined in section 2.2.
3. **Outcome data** (as part of individual client data reporting).
4. **Bi-annual Incidents Report:** service providers are required to submit a bi-annual report to the department that thematically analyses the volume and type of incidents that have occurred in the previous six-month period, and that details actions taken by the service provider to mitigate or reduce risks of future incidents.
5. **Bi-Annual Complaints Report:** service providers are required to submit a bi-annual report to the department that thematically analyses the volume and type of complaints that have occurred in the previous six-month period, and that details actions taken by the service provider to mitigate or reduce complaints and related incidents and circumstances that gave arise to the complaint.

2 Data reporting requirements

Providers of Local Services will be required to collect and report de-identified aggregate and individual client data to the Department of Health on a quarterly basis. A small set of data items will be required to be submitted monthly to the Department of Health as part of dashboard report.

Data is to be submitted within 14 days of the end of each financial quarter.

Quarter 1	Quarter 2	Quarter 3	Quarter 4
July - Sept	Oct - Dec	Jan - March	April - June
All data is due to be submitted 14 days from the last day of the reporting period of each quarter.			

The submission of aggregate and de-identified individual client data is a requirement of funding.

The department will use the data to produce a state-wide quarterly service stream report, to inform policy and service-level improvement and monitor provider performance and trends.

This dictionary has been specifically developed to assist provider to understand the data requirements and definitions for each item.

Aggregate data will be reported to the department through the Local Adult and Older Adult Mental Health and Wellbeing Services data collection webform using the HealthCollect portal.

The data reported falls into two categories:

1. aggregate client, service usage and operational data items
2. individual Client data items.

2.1 Aggregate client, service usage and operational items

Providers of Local Services will be required to collect and report the aggregate data items outlined in **Table 1** to the Department of Health on a quarterly basis.

Providers of Local Services will be able to report the aggregate data through the Local Adult and Older Adult Mental Health and Wellbeing Services data collection webform using the HealthCollect portal.

The aggregate data covers:

- service data
- operational data (operating patterns and wait list)
- referrals in and out
- level of care at referral
- shared care arrangements
- client demographics
- client life circumstances.

Each service type outlet must provide information relating to its operation for the purposes of:

- a better understanding of the patterns of:
 - service delivery including capacity to meet demand
 - accessibility of the service to consumers particularly in individuals from diverse communities
- monitoring implementation of this new model including development of performance measures to:
 - support service improvement activities
 - understand the impact of the service on consumer outcomes
 - underpin any future evaluation activities
- an analysis of staffing input and other operational activities.

2.1.1 Aggregate client, service usage and operational data items

Table 1: Aggregate client and service usage

Service data	
Client Status	
1.	Total number of registered clients
2.	Total number of non-registered clients
3.	Total number of new clients
4.	Total number of registered clients discharged from the service
5.	Total number of family carers and supporters that received support
6.	Total number of clients who received a single session treatment intervention
Clinical Hours	
7.	Total number of clinical hours (sum of all client facing, client non-facing and system related activities)
Wellbeing CSU	
8.	Total number of Wellbeing CSU ⁴⁵ (sum of all client facing, client non-facing and system related activity)
Social Prescribing CSU	
9.	Total number of social prescribing CSU ⁴⁶ (sum of all client facing, client non-facing and system related activity)
Brokerage CSU	
10.	Total number of brokerage CSU
Family, Carer and /or supporter CSU	
11.	Total number of CSU ⁴⁷ (hours) for family, carers and/or supporters activity
Service Modality	
12.	Total number of centre-based service hours
13.	Total number of tele-health service hours
14.	Total number of outreach service hours.
Operational data	
15.	Weeks per quarter of operations
16.	Days per week of operations
17.	Hours per day of operation during business hours
18.	Hours per day of operation after business hours
19.	Total number of clients for the service type outlet who are on a waiting list to receive services
20.	Total number of days spent on the waiting lists for all clients

⁴⁵ Wellbeing includes: wellbeing supports, peer supports, care coordination and social prescribing. Brokerage CSU are reported separately. CSU means Client Support Unit – CSU covers activity related to wellbeing supports, peer supports, care coordination, brokerage and social prescribing

⁴⁶ Measure 9 is sub-set of measure 8

⁴⁷ Measure 11 is sub-set of measure 8

Referrals in and out
21. Number of new clients who self-referred
22. Number of new clients referred by family/carer/supporter
23. Number of new clients referred from a primary or secondary mental health care provider
24. Number of new clients referred from an Area Mental Health and Wellbeing Service
25. Number of clients referred from a specialist AOD services
26. Number of clients referred from other referral sources
27. Number of clients referred to a primary mental health care provider for mental health treatment
28. Number of clients referred to Area Mental Health and Wellbeing Services for treatment, care and/or support
29. Number of clients referred to state-wide specialist mental health and wellbeing services
30. Number of clients referred to AOD service
31. Number of clients supported to access the NDIS
32. Number of clients referred to local organisations for wellbeing and other support (social prescribing)
Level of Care at Referral (based on IAR)
33. Number of clients assessed as Level of Care 1 (self-management) on referral
34. Number of clients assessed as Level of Care 2 (low intensity) on referral
35. Number of clients assessed as Level of Care 3 (moderate intensity) on referral
36. Number of clients assessed as Level of Care 4 (high intensity) on referral
37. Number of clients assessed as Level of Care 5 (acute and specialist) on referral
Shared care arrangements
38. Number of clients in shared care arrangement with a primary or secondary mental health care provider
39. Number of clients in shared care arrangement with an Area Mental Health and Wellbeing Service
40. Number of clients in shared care arrangement with AOD services
41. Number of clients in receipt of NDIS disability supports
Client demographics
42. Number of clients presenting aged 16-25
43. Number of clients aged 26-64
44. Number of clients aged 65-79
45. Number of clients aged 80 and over
46. Number of clients identifying as female
47. Number of clients identifying as male
48. Number of clients identifying as other
49. Number of registered clients who identify as Indigenous People I (either Aboriginal, Torres Strait Islander, or both)

50. Number of registered clients who identify as culturally and linguistically diverse (CALD)
51. Number of registered clients who are refugee ⁴⁸ or asylum seekers ⁴⁹
52. Number of registered clients who identify as from LGBTIQ+ community
Client life circumstances
53. Number of registered clients with dual diagnosis (mental health and AOD)
54. Number of registered clients with a co-existing disability
55. Number of registered clients reporting experiencing homelessness
56. Number of registered clients reporting experiencing family violence
57. Number of registered clients reporting engagement in the justice system
58. Number of registered clients who received interpreter services

**These data items will be reported on an aggregate basis via Local Adult and Older Adult Mental Health and Wellbeing Services data collection webform).*

2.2 Individual client data

Providers are required to provide information about all service users receiving support through activities funded through the Local Service. Service providers will collect and report de-identified individual service user data as detailed in **Table 3**. This data is to be submitted within 7 days of the end of each financial quarter.

Data items relating to clients will be identifiable using a unique number (Statistical Linkage Key) derived from:

- selected letters of family name
- selected letters of formal given name
- date of birth
- birth date estimate flag
- identified gender.

⁴⁸ A refugee is a person who is outside their country of origin (or habitual residence in the case of stateless persons) and who, owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion, is unable or unwilling to avail themselves of the protection to which they are entitled.

⁴⁹ An asylum seeker is deemed to be any person who has a current request for protection which is being assessed by the Commonwealth Government or being deemed by the Commonwealth not to be a person owed protection, is seeking either a judicial review (through the courts) or is making a humanitarian claim (to Commonwealth minister) for residence.

Table 2: Individual Client data (indicative)

Data Item	Measure
Demographic data	Age Identified gender Suburb (name and postcode)
Culture and communication	Indigenous status (identifies as Aboriginal and/or Torres Strait Islander) Country of Birth Main language Cultural background and ethnicity Interpreter services required, offered, requested or fulfilled Communication method (including sign language)
Suicidal Crisis and follow up	Client suicide risk assessment outcome Client suicide risk assessment Date Suicidal crisis follow-up action time
Family violence	Family violence reported
Diagnosis and disability	Diagnosis: Primary (mental health) Diagnosis: Other Diagnosis: Disability
Housing	Living arrangements – usual Residential setting – usual Dependent children
Income/Work	Labour force status Main source of income
Support need	Returning client
Source of clinical treatment / contact	Source of clinical treatment Contact with clinical support provider
Services received	Initial screening assessment Comprehensive biopsychosocial assessment Care plan development Care plan review Care plan goals met Clinical treatment and care Wellbeing supports (psychosocial) Care Coordination Peer supports Social prescribing Shared care Brokerage support
Amount of service	Clinical service hours to registered client (total) Clinical service hours – client facing Clinical service hours – client non-facing Clinical service hours – system related activities CSU - wellbeing supports to registered client (total) CSU - one-on-one client facing activities for client CSU - group-based – client facing

	CSU - client non-facing activities CSU - system level activities CSU - care coordination CSU - peer support
Discharge	Discharge date Discharge within mental health service system Reason for discharge
Outcome Measures (indicative only)	Health of the Nation Outcome (HONOS) scale K10 (TBC) Life Skills Profile 16 (TBC) BASIS 32 (TBC)

3 Privacy

3.1 Privacy Practices

The department and funded providers are obligated to comply with Victorian privacy legislation.

Service users must be made aware that their information, which does not identify them specifically, is being transmitted to the department, and the Australian Institute for Health and Welfare (AIHW), and that it will only be used for statistical and performance monitoring and management purposes.

3.2 Informing service users about data collection

Each funded service provider is responsible for informing service users about: the information being gathered about them; the purposes for which the information will be used; how their information is managed; who within the organisation will routinely see their records, and for what purpose; other organisations (such as the department and AIHW) with whom information is routinely shared and why; their right to access their information and amend it if necessary.

3.3 Privacy information

The Department of Health and Department of Families and Fairness and Housing currently operate under the [DHHS Privacy Policy](https://www.dhhs.vic.gov.au/publications/privacy-policy) <https://www.dhhs.vic.gov.au/publications/privacy-policy> which outlines key responsibilities under the:

- *Privacy and Data Protection Act 2014*
- *Health Records Act 2001*
- *Charter of Human Rights and Responsibilities Act 2006*
- *Freedom of Information Act 1982.*

The Department of Health and Department of Families Fairness and Housing will publish separate policies in the near future.

3.4 Consent to data collection

Health Privacy Principle (HPP) 1.1 provides that an organisation may only collect health information if it is necessary for one or more of its functions or activities, and the individual has consented to the collection.

Where consent is **not** given, HPP 1.1 allows certain exceptions for which this data is exempted: namely, that data can be collected **without consent** if it is de-identified or is used for the purpose of funding, planning, monitoring and evaluation of health services. Because both exceptions apply to the reporting of data related to the delivery of Local Services, funded service providers can legitimately provide data to the department under the terms specified by this data collection.

Data reported to the department by service providers of Local Services will not identify specific individuals and is used for funding, planning, and monitoring and evaluation only.

Appendix 5: Royal Commission into Victoria's Mental Health System Guiding Principles

Guiding principles for Victoria's mental health system

The Royal Commission acknowledges that mental health is shaped by the social, cultural, economic and physical environments in which people live and is a shared responsibility of society.

It envisages a mental health system in which:

1. The inherent dignity of people living with mental illness is respected, and necessary holistic support is provided to ensure their full and effective participation in society.
2. Family members and carers of people living with mental illness have their contributions recognised and supported.
3. Comprehensive mental health treatment, care and support services are provided on an equitable basis to those who need them and as close as possible to people's own communities - including in rural areas.
4. Collaboration and communication occur between services within and beyond the mental health system and at all levels of government.
5. Responsive, high-quality, mental health services attract a skilled and diverse workforce.
6. People living with mental illness, their family members and carers, as well as local communities, are central to the planning and delivery of mental health treatment, care and support services.
7. Mental health services use continuing research, evaluation and innovation to respond to community needs now and into the future.

These principles are in large part based on the many contributions made to the Commission to date, as well as relevant international documents such as the UN Convention on the Rights of Persons with Disabilities, the World Health Organization's publications on mental health (including its 2014 report with the Calouste Gulbenkian Foundation on the social determinants of mental health) and legislation such as the Commonwealth's *Carers Recognition Act 2010*.

Source: [Royal Commission into Victoria's Mental Health System Interim Report](http://rcvmhs.archive.royalcommission.vic.gov.au/interim-report.html)
<<http://rcvmhs.archive.royalcommission.vic.gov.au/interim-report.html>>

Appendix 6: Useful resources

Mental Health Complaints Commissioner

Website	https://www.mhcc.vic.gov.au
Online	https://www.mhcc.vic.gov.au/contact-us
Contact via phone	1800 246 054 (free call from landlines) or 03 9032 3328
Email:	help@mhcc.vic.gov.au
Post:	MHCC, Level 26, 570 Bourke Street, Melbourne, 3000
Fax:	03 9949 1506

Safer Care Victoria

Website	https://www.bettersafecare.vic.gov.au/
Victorian Agency for Health Information	Safer Care Victoria
Email: vahi@vahi.vic.gov.au	Email: info@safecare.vic.gov.au
Address: 50 Lonsdale Street, Melbourne VIC 3000	

Office of the Chief Psychiatrist

Website	https://www.health.vic.gov.au/practice-and-service-quality/chief-psychiatrist
Phone	03 9096 7571
Email	ocp@health.vic.gov.au

About Victoria's Mental Health services

<https://www.health.vic.gov.au/mental-health/about-victorias-mental-health-services>

Local Adult and Older Adult Mental Health and Wellbeing Services

<https://www.health.vic.gov.au/mental-health-reform/local-adult-and-older-adult-mental-health-and-wellbeing-services>

Current *Mental Health Act 2014*

<https://www.health.vic.gov.au/practice-and-service-quality/mental-health-act-2014>

Reform in progress - A new *Mental Health and Wellbeing Act*

<https://www.health.vic.gov.au/mental-health-reform/a-new-mental-health-and-wellbeing-act-for-victoria>

Mental Health Lived Experience Engagement Framework

<https://www.health.vic.gov.au/publications/mental-health-lived-experience-engagement-framework>

Framework for recovery-oriented practice

<https://www.health.vic.gov.au/practice-and-service-quality/recovery-oriented-practice-in-mental-health>

Integrated treatment, care and support for people with co-occurring mental illness and substance use or addiction needs: Guidance for Victorian mental health and wellbeing and alcohol and drug services (the Guidance)

<https://www.health.vic.gov.au/mental-health-reform/recommendation-35>

MARAM Practice Guides and Resources

<https://www.vic.gov.au/maram-practice-guides-and-resources>

Funded Agency Channel

<https://fac.dffh.vic.gov.au/>