Mental Health and Wellbeing Locals

Service Framework

Version 2.0

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Except where otherwise indicated, the images in this document show models and illustrative settings only, and do not necessarily depict actual services, facilities or recipients of services. This document may contain images of deceased Aboriginal and Torres Strait Islander peoples.

In this document, 'Aboriginal', 'Indigenous' or 'Koori/Koorie' is retained when part of the title of a report, program or quotation.

ISBN 978-1-76131-705-7 **(Print)**

ISBN 978-1-76131-706-4 **(pdf/online/MS Word)**

Available at Mental Health and Wellbeing Locals | health.vic.gov.au <https://www.health.vic.gov.au/mental-health-services/mental-health-and-wellbeing-locals>

Printed by Department of Health.

Acknowledgements

The Department of Health proudly acknowledges Aboriginal and Torres Strait Islander peoples as Australia's First Peoples and the Traditional Owners and custodians of the lands and waters on which we learn, work and play. We pay our respects to Elders and leaders, past and present. We recognise the ongoing enrichment Aboriginal and Torres Strait Islander peoples, culture and communities bring to the cultural landscape of this state. We acknowledge that sovereignty has never been ceded.

Since time immemorial, Aboriginal and Torres Strait Islander peoples have practised their lores, customs and languages and nurtured Country through spiritual, material and economic connections to land, water and resources. These connections are central to Aboriginal and Torres Strait Islander social and emotional wellbeing.

We know we achieve better outcomes when Aboriginal and Torres Strait Islander peoples are making the decisions that affect First Nations communities. Victoria's Treaty process gives us a pathway to give First Peoples a say on the policies that impact First Peoples' lives. We commit to working proactively to support this work in line with the aspirations of Traditional Owners and Aboriginal and Torres Strait Islander peoples living in Victoria.

We look forward to a time where, through the Treaty process, we have recognised the wrongs of the past, made peace, and can walk together with greater respect, understanding and connection, and fully celebrate the strength, resilience and diversity of First Nations people living in Victoria.

Lived and living experience recognition

We recognise the individual and collective expertise and knowledge of those with lived and living experience and thank them for their invaluable contributions in the development of this Framework.

This document uses language to describe and discuss themes and concepts relating to mental health, but it is recognised that others might use different words to communicate their experience which are also valid. Given this, all endeavours have been taken to match the expectations of people with lived and living experience in the language used.

Language statement

We recognise the diversity of *Aboriginal and Torres Strait Islander peoples* 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 and Torres Strait Islander peoples*' 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.

Version history

Version	Date	Notes
1.0	May 2022	First published edition.
2.0	January 2026	Revised edition containing structural, technical and administrative updates.

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1 Introduction

Mental Health and Wellbeing Locals (hereafter referred to as 'Local Services')[1] are state funded community-based services for adults and older adults, experiencing mental ill-health or psychological distress, including people with co-occurring substance use and/or dependence, requiring moderate to high intensity care.[2] They provide holistic integrated mental health clinical and wellbeing treatment, care and supports, delivered by a multidisciplinary team.

Local Services provide support for people whose needs are too complex for primary mental health care alone, but do not require acute care from tertiary Area Mental Health and Wellbeing Services (hereafter referred to as 'Area Services'). This includes people who may experience difficulties accessing specialist care through the private system.

Local Services provide additional and alternative support to primary mental health services, Area Services and/or other mental health services including services offered through both public and private systems. The Royal Commission into Victoria's Mental Health System (the Royal Commission) recommended the establishment of Local Services across Victoria to make it possible for people to access community-based support that aligns with their needs and preferences.

Local Service operate as a network, with some linked as Hubs and Spokes. The Service Framework applies to all Local Services, with **Appendix A** outlining the operational requirements for Hubs and Spokes.

For a glossary of terms, please refer to **Appendix B**.

The Department of Health (Victoria) (the department) is progressively commissioning service providers to deliver Local Services. The department expects that service providers funded to deliver Local Services will adhere to the service expectations, operational requirements and principles set out in this document. Service providers considering any substantive variation to the Service Framework must consult with the department prior to implementation to ensure consistency in the service offer, equity of access and fidelity to the Local Services model.

This Service Framework is a living document and may be updated over time to respond to evolving consumer needs, implementation experience or broader mental health and wellbeing system reforms led by the department.

2 Purpose of this framework

The purpose of this document is to provide clear policy and operational parameters to guide the planning, delivery and monitoring of Local Services. This Service Framework aims to:

[1] Originally referred to as Adult and Older Adult Local Mental Health and Wellbeing Services in the final report of the Royal Commission, the Local Services underwent a branding process in 2022 to ensure they are more accessible and relatable to the Victorian community

[2] The Commonwealth Government's Initial Assessment and Referral Decision Support Tool (IAR-DST), which Local Services are to use, provides a standardised, evidence-based and objective approach to assist with mental health care recommendations. The IAR-DST sets five levels of care, moderate intensity is level 3 and high-intensity is level 4.

- Describe the minimum expectations for Local Services in Victoria.
- Provide clear guidance about who Local Services are to support, services to be provided and operational 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.
- Enable consistency in models of care to support consumers, carers, families and supporters to receive equitable mental health and wellbeing support in the community, closer to home.
- Support and enable integration of Local Services with other parts of the mental health and wellbeing system, and other service providers.

Expectations set out in the Service Framework should inform the development of localised models of care and operational guidelines. Guidelines provide the next layer of operational detail for service providers and frontline staff, which will include standards, protocols and service delivery requirements specific to Local Services.

2.1 Out of scope

This document is not a commissioning framework or a tender document for Local Services.

2.2 Obligations under Mental Health and Wellbeing Act 2022

Under the *Mental Health and Wellbeing Act 2022 (the Act),* service providers of Local Services' are mental health and wellbeing service providers and are required to:

1. **Apply the principles**:
    a. Make all reasonable efforts to comply with the mental health and wellbeing principles when exercising any function under *the Act*.
    b. Give proper consideration to the principles when making decisions under *the Act*.
2. **Deliver safe, person-centred care** and continuously improve quality and safety.
3. **Comply with other key Act requirements**, including:
    a. Sharing health information lawfully and appropriately.
    b. Seeking informed consent before treatment.
    c. Supporting consumers, families, carers, guardians, nominated support persons and complainants to understand information when required under *the Act*.
4. **Establish complaint-handling procedures** that meet standards set by the Mental Health and Wellbeing Commission.

For more information on obligations under *the Act* please refer to the Mental Health and Wellbeing Act fact sheet for mental health and wellbeing providers <https://www.health.vic.gov.au/mental-health-and-wellbeing-act>.

2.3 Alignment to other policies and frameworks

This framework should be read in conjunction with other interrelated statewide mental health and wellbeing policy and legislative documents, including but not limited to:

- Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework 2017-27
- Diverse communities mental health and wellbeing 10-year framework and Blueprint for Action 2025-28
- Victorian Mental Health and Wellbeing Workforce Capability Framework ('Our Workforce, Our Future')
- Victorian Statewide Mental Health and Wellbeing Service and Capital Plan
- Victorian Suicide Prevention and Response Strategy 2024-34.
- Wellbeing in Victoria: A Strategy to Promote Good Mental Health 2025 – 2035

Refer to **Appendix C** for Legislative and Policy Requirements.

3 System context

The mental health and wellbeing system is being 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 consists 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.

All six levels of the system will work collaboratively together and in the best interests of consumers who may need to move between these levels as their needs change over time. Local Services are in the **fourth level** of this system.

Figure 1: Mental health and wellbeing system levels

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

Broad descriptions of each of the levels is below:

- **Levels 1** and **2** focus on promotion, prevention and early intervention to support good mental health and wellbeing, reducing the need for people to access other levels of the system.

- **Level 3** provides primary and secondary care to people experiencing mild to moderate mental health needs, including navigation support and warm referrals to Local and Area Services.
- **Level 4** provides easy-to-access, high-quality treatment, care and support to people experiencing mental ill-health and/or psychological distress who require moderate to high-intensity care, whose needs cannot be met by primary and secondary mental health care providers alone.
- **Level 5** provides higher intensity, acute and/or specialist treatment, care and support to people with moderate to severe mental ill health and/or psychological distress, compared to Level 4 services, for people of all ages.
- **Level 6** provides highly specialised care for consumers with the most complex and intensive needs, where Area Services do not have the scale or available workforce to do so safely and efficiently.

3.1 Local Health Service Networks

From 1 July 2025, Victoria's Local Health Service Networks (Networks) were officially established. The Networks group health services within a geographical region and are responsible for supporting collaborative care for their community, as close to home as possible.

There are 12 Networks across Victoria. Each Network is responsible for:

- meeting their communities' care needs as close to home as possible
- supporting more equitable and consistent care for patients
- increasing consistency of quality and safety of care
- strengthening workforce attraction, retention and support
- delivering support services at scale.

Networks are intended to improve integration with other parts of the health system, including primary health, Aboriginal health, community health, non-acute mental health, alcohol and other drugs, home and community care providers, aged care and private health.

Local Services are to engage and collaborate with Networks. This may occur at an individual Local Service level, or it could occur collectively where there are multiple Local Services within the same Network region.

4 Service overview, features and enablers

Specific service objectives and principles underpin the delivery of Local Services, supporting the achievement of intended outcomes.

4.1 Service partnerships

Local Services are delivered by partnerships which can include:

- Non-government organisations (NGOs) with expertise and experience in the delivery of mental health services or the like, inclusive of Aboriginal Community Controlled Health Organisations (ACCHOs)

- Community Health Services
- Public health services, including an integrated Community Health Service
- Hospitals
- Private entities with expertise and experience in the delivery of mental health services or the like.

All Local Services must have defined pathways with the relevant Area Service to enable warm referrals and smooth transitions in response to a consumer's mental health needs and are strongly encouraged to establish a joint escalation of care agreement with the relevant Area Service.

All **new Local Services** with funding commencing from 2025 are to include the relevant Area Service in the partnership (as either a partner or lead provider) to deliver the service.[3]

When determining partnership arrangements, **all new Local Services** are to consider including the following organisations as partners (in addition to the Area Services or any others deemed appropriate by the Local Services):

a. an Aboriginal Community Controlled Organisation (ACCO) and/or ACCHO, with experience working with community in the Service Zone

b. an organisation with relevant experience working with local culturally and linguistically diverse communities in the Service Zone.

All service partnership arrangements must be:

- Supported by clear governance structures, formal agreements and shared protocols to enable timely and effective decision-making across the service system.
- Person-centred and family-inclusive, ensuring consumers, families, carers and supporters receive integrated services that are responsive to their diverse needs, strengths, recovery goals and circumstances.
- Built on mutual respect, shared accountability and transparent communication, fostering trust and active collaboration across settings and services.
- Grounded in two-way dialogue and respect, recognising that public health services, NGOs and other community partners each bring unique perspectives, expertise and strengths to service delivery.
- Enabled through clear communication channels, including operational and leadership forums, joint planning processes and information sharing to support collaboration at all levels.
- Underpinned by effective coordination between services, to facilitate clear 'step-up' (escalation) and 'step-down' pathways and transfers of care for consumers as their needs evolve.

4.2 Service objectives

The objectives of Local Services are to:

[3] Relevant Area Services refers to the Area Service/s operating in the Service Zone of a Local Service.

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- Provide people experiencing mental ill-health or psychological distress[4] including people with co-occurring substance use and/or dependence– irrespective of their diagnosis or life circumstances – access to local high quality, holistic, integrated mental health clinical and wellbeing treatment, care and 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.
- Address the risks associated with mental ill-health or psychological distress, trauma and harms associated with co-occurring substance use and/or dependence, particularly risk of suicide, self-harm or overdose. Risks are managed by responding early, effectively and safely to the needs and preferences of consumers.
- Intervene early to reduce the likelihood of people experiencing mental ill-health or psychological distress, including co-occurring substance use and/or dependence.
- Offer clinical treatments as required to treat mental illness, including clinical assessments, psychological therapy, psychiatry and pharmacological treatment.
- Improve outcomes for families, carers and supporters both in the context of their own mental health and wellbeing and their integral role in supporting the consumer.
- 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 and opportunities.

A longer-term objective of Local Services is to reduce Emergency Department presentations by people experiencing mental ill-health or psychological distress, including people with co-occurring substance use and/or dependence, and the need for more intensive acute (tertiary) mental health and wellbeing services by providing easy to access, local high quality, holistic, integrated evidence-based treatment, care and wellbeing supports when they need them.

4.3 Service principles

The principles from *the Act* will guide and inform the way Local Services are planned and delivered to consumers, their families, carers and supporters.[5] As mental health and wellbeing service providers, all Local Services are expected to make all reasonable efforts to comply with the principles.[6] A summary of the principles are below:

- Promote and protect rights, dignity and autonomy of people living with mental ill health or psychological distress.
- Provide access to a diverse mix of care and support services.
- Promote recovery and full participation in community life.
- Support shared decision-making in assessment, treatment and recovery.

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

[5] *Mental Health and Wellbeing Act 2022* part 1.5.

[6] *Mental Health and Wellbeing Act 2022* section 29.

- Support and involve families, carers and supporters (including children).
- Recognise and value lived experience of mental ill health or psychological distress (for individuals, as well as their families, carers and supporters).
- Identify and respond to medical and other health needs.
- Respect the right of people receiving services to take reasonable risks to achieve personal growth, self-esteem and overall quality of life.
- Actively consider diverse needs and experiences, and provide safe, sensitive and responsive services.
- Provide culturally safe and responsive services.
- Promote and protect the health, wellbeing, safety and autonomy of children, young people and other dependents.

Furthermore, in line with the direction set by the Royal Commission, Local Services are expected to provide:

- **Person-centred and responsive services** – providers will deliver services based on a philosophy of 'how can we help?' and a 'broad front door' approach, enabling consumers, their families, carers and supporters seamless access to services, both inside and outside of a Local Service.
- **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, accessible and appropriate treatment, care and support** – that is free and provided in an equitable way that promotes ease of access. No referral will be required to access Local Services, and all consumers will be warmly supported to access the most appropriate service based on assessment of their needs and preferences.
- **Integrated treatment, care and support for people with co-occurring needs** – people with mental illness and co-occurring substance use and/or dependence 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 Service.[7]
- **Recovery focused services**[8] – 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.
- **Services that are co-designed and delivered in partnership with consumers, their families, carers and supporters** – people with lived or living experience of mental illness, including those with co-occurring substance use and/or dependence, 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.

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[7] 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.

[8] 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>.

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- **Quality and safe services** – Local Services will deliver safe and effective treatment, care and support. Treatment, care and support will be:
  - Trauma informed.
  - Designed to minimise the risk of harm to consumers, their families, carers and supporters (including dependent children), staff and visitors.
  - Delivered in an environment that is safe, non-stigmatising, trusting and respectful.
- **Respectful of and responsive to cultural needs and diversity** – all consumers, their families, carers and supporters will receive culturally safe and responsive services that are free of stigma and discrimination, particularly Aboriginal and Torres Strait Islander peoples, LGBTIQA+ communities, members of culturally and linguistically diverse communities, multicultural communities, disability communities and people who are neurodiverse.

Key features and functions underpin Local Services, enabling consistency across service delivery. These key features outline how services will operate in practice, guiding providers to deliver holistic, culturally safe and responsive care. Refer to **Appendix D** for a description of service features.

4.4 Target group

Local Services support adults and older adults (people 26 years and over) experiencing mental ill-health or psychological distress, including people with co-occurring substance use and/or dependence, requiring **moderate to high intensity care**.[9]

In some circumstances, young people aged 18–25 years may also be supported, depending on their needs and access to other services (see further details at Section 5.1.5).

People requiring moderate to high intensity care usually:

- Experience:
  - moderate to high symptoms associated with functioning, co-existing conditions and risk and/or
  - a diagnosed mental health condition with moderate to severe symptoms.
- Need more support than they can get from primary and secondary care providers (general practitioners, private psychologists and psychiatrists or are unable to access support from private providers). This may include support to consider alternative diagnoses, medication reviews and manage co-morbidities and/or dual diagnoses.
- Do not need treatment, care and support from Area Services.

The intensity, risk and complexity of a consumer's mental health needs and their preferences and goals will determine how and what supports a Local Service will provide.

Local Services are to actively consider the barriers to care for Aboriginal and Torres Strait Islander communities, diverse communities and other groups and understand their needs and preferences. Providers may address barriers through defined pathways. These communities include:

[9] The Commonwealth Government's Initial Assessment and Referral Decision support Tool (IAR-DST), which Local Services are to use, provides a standardised, evidence-based and objective approach to assist with mental health care recommendations. The IAR-DST sets five levels of care (refer to **Appendix E**), moderate intensity is level 3 and high-intensity is level 4.

- Aboriginal and Torres Strait Islander people
- people from culturally and linguistically diverse communities, including refugees and people seeking asylum
- Lesbian, gay, bisexual, trans and gender diverse, intersex, queer and asexual (LGBTIQA+) people
- people with disability
- people with co-occurring substance use and/or dependence
- people experiencing homelessness
- Neurodiverse people
- people who are engaged or have engaged with the justice system.

4.5 Intended outcomes

Treatment, care and wellbeing support delivered by 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 outcomes and benefits are being updated to align with the new *Mental Health and Wellbeing Outcomes and Performance Framework* (MHW OPF).

The MHW OPF is underpinned by four main domains, which together describe what success looks like in Victoria's reformed mental health and wellbeing system. The four domains contain a series of outcomes, each with respective indicators and measures, which together define how success will be measured. Refer to the Mental Health and Wellbeing Outcomes and Performance Framework <https://www.health.vic.gov.au/mental-health/research-and-reporting/mental-health-and-wellbeing-outcomes-and-performance-framework> for detailed information about outcomes, measures and indicators.

The Department is taking a strategic approach to measuring and reporting mental health and wellbeing outcomes. Providers of Local Services will be required to report on outcomes achieved against measures identified in the MHW OPF. The transition to new measurement instruments and MHW OPF aligned reporting (including service level reporting) will ensure strong governance and alignment with broader mental health and wellbeing sector reform. Over time and in consultation with consumers, families, carers and supporters, this will involve the collection and reporting of additional outcome measures.

4.6 Cultural safety and responsiveness

Local Services will prioritise the cultural safety of all consumers and staff, including fostering inclusion and support for Aboriginal and Torres Strait Islander staff within Local Services. Aboriginal and Torres Strait Islander cultural safety is when Aboriginal and Torres Strait Islander people experience safety in their environment - there is no assault, challenge, or denial of their identity and experience. It is important Local Services establish a relationship of trust and respect with Aboriginal and Torres Strait Islander staff, consumers and local ACCHOs and ACCOs. For guidance please refer to the Aboriginal and Torres Strait Islander cultural safety framework

<https://www.health.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework>.

Local Services will identify and respond to the mental health and the social and emotional wellbeing needs of Aboriginal and Torres Strait Islander peoples in line with the Department's Balit Murrup: Aboriginal social emotional wellbeing framework 2017–2027 <https://www.health.vic.gov.au/publications/balit-murrup-aboriginal-social-emotional-wellbeing-framework-2017-2027>.

Local Services will provide access to language and cultural support, including interpreters, translation tools, cultural brokerage and tailored communication, to improve access and service quality for people from diverse cultural, linguistic and faith communities.

Local Services must also ensure culturally safe and inclusive environments for all consumers, families, carers and supporters, including Aboriginal and Torres Strait Islander peoples, LGBTIQA+ communities, multicultural communities, people with disability and neurodiverse communities.

4.7 Embedding lived and living experience

Service providers must integrate lived and living experience perspectives throughout all aspects of governance, service delivery and organisational improvement. This includes ensuring that people with lived and living experience of mental illness, substance use and/or dependence including consumers, their families, carers, supporters, kin and community, are 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.

4.7.1 Supporting engagement through governance and workforce

The Mental Health Lived Experience Engagement Framework provides guidance on how people experiencing mental illness, 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.[10]

Consumer, family, carer and supporter participation and leadership are to be reflected in the service provider's organisational governance structures and processes. Service providers are also required to foster an organisational culture, practices and approaches that support these requirements.

4.8 Family, carers, and supporters

Most consumers have relationships of care and support, and these relationships play an important role in wellbeing and recovery. Local Services will support family members, carers and supporters in their caring role for people with mental ill-health or psychological distress, as well as for their own mental health and wellbeing when their needs are within the scope of Local Services target group. Otherwise, the Local Services will support family

[10] 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 K** for the link to this framework.

members, carers and supporters in warm referrals to services that meet their mental health and wellbeing needs.

In line with the *Carers Recognition Act 2012* (Vic) and the families and carers principle in *the Act*, Local Services are expected to be family inclusive in culture and practice.[11]

Services must ensure that consumers are empowered and encouraged to involve their families, carers, and supporters in treatment, care, and planning processes. This includes actively discussing with consumers the potential benefits of engaging carers throughout their care journey, while upholding the principles of privacy, autonomy, and informed consent. When involved, families, carers, and supporters must be supported in their caring role - either within the service itself or through flexible and responsive referral pathways to other appropriate services.

Local Services will acknowledge the substantial contribution of families, carers, and supporters to the wellbeing of the people they support, and the significant role they play in the mental health and wellbeing system. Local Services should proactively identify families, carers and supporters, including young carers. Services should seek to understand the needs of families, carers and supporters as early as possible in their engagement in the consumer's care. Services should assist families, carers and supporters to access appropriate support to sustain them in their caring role.

Accordingly, services are required to employ suitably qualified staff, under the appropriate EBA, with the expertise to assess the needs of, and provide support to, families, carers and supporters and to guide individuals to the most suitable services whilst respecting preferences.

Local Services must offer informed choice to families, carers, and supporters, considering service demand, local accessibility, and the appropriateness of available services. Support options should be tailored to individual needs, ensuring that carers receive the most suitable assistance. Where carers also have mental health and wellbeing needs, they will be referred to appropriate services, with individuals requiring low-intensity support being referred to primary care providers or other community services. If their needs are moderate to higher intensity, they can also be supported by the Local Service as a consumer and participate in the assessment and intake process.

Services should ensure that families, carers, and supporters are informed about the specific roles and services provided by Local Services and Mental Health and Wellbeing Connect centres (**Connect centres**), utilising established referral pathways to support families, carers and supporters to make informed choices that match with their needs with service practicalities.

Connect centres are free to access and don't have a referral requirement, enabling individuals to access the service via walk-ins or through phone or online bookings. They provide a range of dedicated support services including peer worker support, psychological and wellbeing support, assistance with navigating the mental health and wellbeing system, access to the Carer Support Fund, and education and practical support.

Local Services must establish clear referral pathways with Connect centres (if not already in place). This includes:

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[11] Refer to the following guideline for additional guidance: Victorian Government 2018, *Working together with families and carers: Chief Psychiatrist's guideline*, State Government of Victoria, Melbourne, p. 5.

- ensuring clear collaboration to provide coordinated and non-duplicative support
- sharing information (with consent)
- aligning care plans, and
- communicating referral processes clearly and compassionately to families, carers, and supporters.

Local Services retain flexibility to step in and provide direct support when Connect centres cannot meet specific needs or when preferences dictate.

More information about the Connect Centres can be found on Mental Health and Wellbeing Connect webpage <https://www.betterhealth.vic.gov.au/mental-health-and-wellbeing-connect>.

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/chief-psychiatrist/working-together-with-families-and-carers>, as well as in the Client Centred Framework for Involving Families <https://www.latrobe.edu.au/__data/assets/pdf_file/0006/1153923/From-Individual-to-Families-A-client-centred-framework-for-involving-families.pdf>.

4.9 Co-design

Co-design is a foundational principle of Local Services, ensuring that consumers, their families, carers, and support networks, service staff and community representatives are actively involved in shaping the services that impact their lives. Co-design is not a one-off activity; rather it is an ongoing commitment to partnership, innovation, and accountability in mental health care.

Guidance on co-design minimum requirements are set out in **Appendix F**.

5 Access and intake

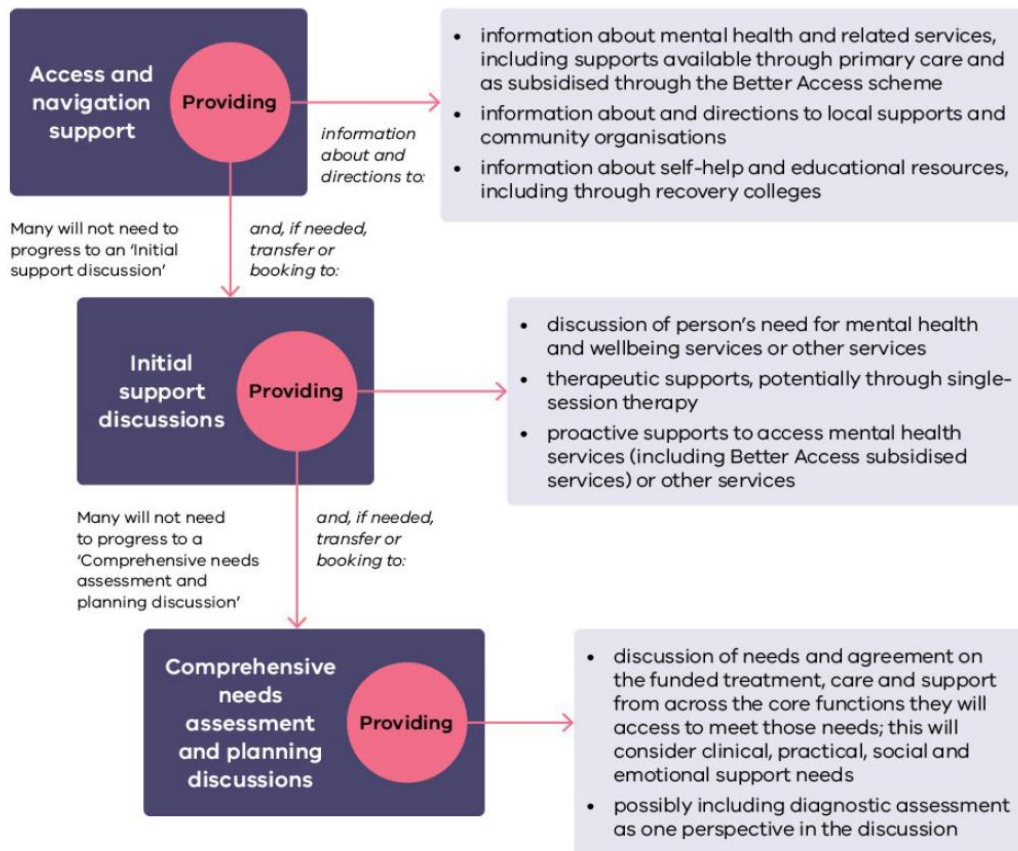
5.1 Access, initial supports and needs assessment

The three front-end components of the mental health and wellbeing system include:

- Access and navigation support.
- Initial support discussions.
- Comprehensive needs assessments and planning discussions.

These functions help determine the type, intensity and level of treatment, care and support a consumer needs, as set out in **Figure 2**.

Figure 2: Three front-end components of the mental health and wellbeing system



Source: Royal Commission into Victoria's Mental Health System, Final Report, Vol 1, p481

Local Services are designed to provide holistic, integrated mental health clinical and wellbeing treatment, care and support for people who require **moderate to high intensity care** (refer to Section 4.4 regarding Target group and **Appendix E** for information on the Initial Assessment and Referral – Decision Support Tool (IAR-DST) levels of care).

Access and intake procedures should be guided by the clinical governance protocols established by Local Services. The IAR-DST is intended to complement—not replace—a personalised assessment approach established by localised clinical governance arrangements.

If, during the intake process, a clinician identifies that an individual is at significant risk and requires urgent intervention, they should follow the Local Service's escalation protocols.

5.1.1 Access and navigation support

This service component offers a warm welcome, compassionate listening and information about services and pathways. This function will primarily be facilitated by trained and supported peer workers who encourage access and support navigation. Volunteers can also support service access by warmly welcoming service users. Consumers will be able to speak with access and navigation support workers without requiring a referral.

The role of trained peer workers may include:

- Greeting people who come to the service.
- Providing information about mental health and related services.

- Connecting people to local supports and community organisations.
- Helping people organise an appointment if they are looking for treatment, care or support from mental health and wellbeing services.
- In pressing cases, collecting basic information—such as contact details and information about what the consumer is asking for—and transferring the person to an initial support discussion.

The role of volunteers may include:

- Welcoming individuals who arrive at the service.
- Fostering a warm, inviting atmosphere while they wait to connect with a trained peer worker for service navigation support.

5.1.2 Initial support discussions

Local Service staff will engage people on a philosophy of 'how can we help?'.

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 5.1.6 High risk presentations
- 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, their 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 IAR-DST will be used to support this discussion with the consumer, their family, carers and supporters (see Section 5.1.3 Initial Assessment and Referral Decision Support Tool). 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 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:

- Identify the consumer's initial support needs, including any urgent needs, and the most appropriate level of care required.
- Co-design a next steps plan with the consumer, their family, carers and supporters.
- Inform internal (to the Local Service) and 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 and appropriate engagement and care.

Single or brief session therapy may be provided for 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.

5.1.3 Initial assessment tool

Providers of Local Services are required to use the IAR-DST <https://iar-dst.online/#/> as part of the screening process to assess initial consumer needs.

The IAR-DST is intended to assist health professionals to decide the most appropriate level of care a consumer will need across the five levels of care in a stepped care model and to match them with appropriate treatment, care and wellbeing support. Guided by the person's needs, consent and preferences, the service will either provide direct mental health treatment, care and support, or assist in navigating and connecting them with the most appropriate service, such as a GP or community-based support for low-intensity needs. The IAR-DST is not mandatory for all consumers, such as when someone presents seeking support to access low-intensity supports or social services.

The IAR-DST assessment must be undertaken prior to commencement of integrated treatment, care, support to ensure service delivery is prioritised for consumers with moderate and high intensity needs (as per the target group). The IAR-DST assessment may be undertaken in-person, via telehealth or by telephone, depending on individual circumstances and service availability.

The domains in the IAR-DST 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-DST in alignment with the Australian Department of Health, Disability and Aging guidance.[12]

Clinicians and peer workers may work collaboratively with consumers to complete the IAR-DST, with the clinician leading the process. This may take place over several sessions with the consumer, depending on the consumer's readiness to engage and share information.

Where the IAR process already incorporates biopsychosocial domains and meets clinical requirements, a separate comprehensive assessment may not be required. A

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[12] Primary Health Networks (PHN) mental health care guidance – initial assessment and referral for mental health care, Australian Government Department of Health and Aged Care

comprehensive assessment may be completed by a clinician as part of ongoing treatment planning and service delivery.

An overview of the IAR-DST including the assessment domains is provided in **Appendix E** of this document.

5.1.4 Consumers who require more intensive treatment, care and support

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

If a consumer presents to a Local Service with treatment needs that cannot be adequately addressed, the Local Service will promptly and appropriately implement its escalation response. To support the consumer and a seamless transition, the Local Service will provide:

- Initial engagement and support.
- 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 if access to supports in the Area Service are not immediately available.

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.

5.1.5 Consumers under 26 years of age

In the first instance, Local Services will refer a young person to the most appropriate service (including headspace) considering the person's presenting needs.

In some circumstances, a Local Service may support a young person aged 18-25 who is experiencing mental ill-health or psychological distress. This occurs only by exception and is subject to service capacity, and where one or more of the following apply:

- 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 Service[13], 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.

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[13] This also applies to dependent children.

If in any doubt, providers of Local Services will apply the principle of *'how can we help?'* when deciding the need for appropriate and necessary supports at first contact.

5.1.6 High risk presentations

Local services are not intended to provide crisis responses. Referrals or requests for urgent mental health care will be redirected.

In circumstances where a person presents in crisis, Local Services will take all necessary steps to maintain safety and coordinate a crisis response in line with established clinical governance and internal protocols.

If a registered consumer is admitted to an emergency department or Area Service, and subsequently discharged, the Local Service is expected to proactively follow up with the consumer and support them in addressing the underlaying factors contributing to their distress.

The Local Service will also provide support to family, carers and supporters during and post the event.

5.1.7 Assessment and planning

An evidence-based comprehensive biopsychosocial assessment, illustrated in **Figure 3**, 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. Where the IAR assessment already incorporates the biopsychosocial domains and meets clinical requirements, a separate comprehensive assessment may not be required.

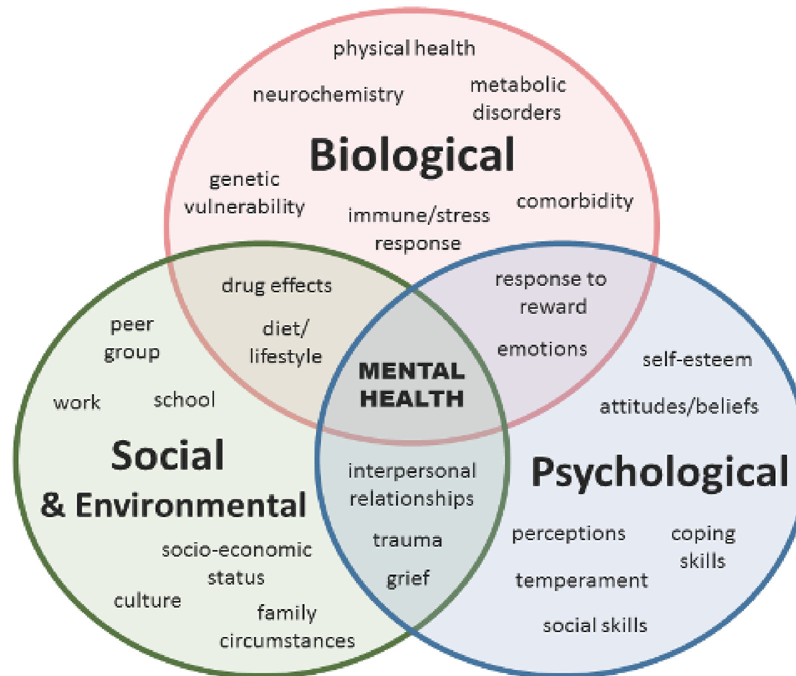
As per the initial needs assessment, the comprehensive assessment tool(s) should be populated from the outcomes of discussions.

The comprehensive assessment is designed for people with more complex support needs and 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. The comprehensive assessment will include consumer needs across multiple life domains and may include diagnostic assessment, medication initiation or review.

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 3: 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 and/or dependence, professionals with competency in assessing substance use and/or dependence 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 needed).

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 needed), formal carers/disability support staff, their general practitioner and/or other health professionals.

Providers of Local Services can 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.

5.2 Entry pathways to Local Services

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

People experiencing mental ill-health or psychological distress, including those with co-occurring substance use and/or dependence, 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 ill-health or psychological distress (including those with co-occurring substance use and/or dependence) to contact and access their Local Service. 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 ill-health, psychological distress or co-occurring substance use or and/or dependence 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 ill-health, psychological distress or co-occurring substance use or and/or dependence.

5.2.1 Referrals to and from Local Services

Local Services will provide consumers, family, carers and supporters with supported referrals 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 ill-health or psychological distress (including people with co-occurring substance use and/or dependence) must have the informed 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.

Refer to **Appendix G** for further information.

5.2.2 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.

5.2.3 Inter-service referrals to other Local Services

Providers of Local Services will establish and maintain referral pathways with other Local Services 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 either the consumer or the service provider.

5.2.4 Referral pathways between Local Services 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 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. Any Area Service can refer to any Local Service, in accordance with a consumer's needs and preferences and with their consent.

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 are to 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.

5.2.5 Referral pathways with primary and secondary mental health care providers

Local Services are expected to enable referral pathways between primary and secondary providers for consumers requiring such assistance. 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, considering 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 to Section 5.1.3).

All Local Services will proactively engage with local general practitioners on the direct referral process, including providing the direct referral email address and phoneline (as applicable), and outlining services available.

5.2.6 Referral pathway to and from AOD service providers

AOD services are responsible for supporting people with substance use and/or dependence, including people who experience low intensity mental health support needs. Local Services are responsible for supporting people with substance use and/or dependence 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 and/or dependence 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 Services and Area Services, via primary and secondary consultation, to ensure that the needs of the consumer can be met by their

preferred AOD provider.[14] 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 and/or dependence presents to an AOD service, the AOD service will make 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 arrangements should be put in place between the Local Service and the AOD provider to support the consumer.[15] 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.

5.2.7 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.

5.2.8 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.

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[14] 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.

[15] 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.

- 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 illness related to chronic health problems and illness, such as cancer.

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.

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

Time limited, state funded Mental Health and Wellbeing Hubs and Commonwealth funded Head to Health (H2H) clinics operating in the service zone of a Local Service will be progressively decommissioned as Local Services are established.[16]

As of April 2025, as part of National Mental Health reform the Commonwealth government is implementing a national network of 61 Medicare Mental Health Centres (MMHC). The new MMHCs are replacing and expanding upon some of the existing H2H clinics in Victoria, while others will be decommissioned. For more information about the above programs refer to the following links:

- **Mental Health and Wellbeing Hubs** < https://www.betterhealth.vic.gov.au/mental-health-and-wellbeing-hubs>
- **Medicare Mental Health Centres** < https://www.health.gov.au/our-work/medicare-mental-health-centres>

The Local Service provider, with support from the department, will work with providers of Mental Health and Wellbeing Hubs and the remaining H2H 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 the remaining H2H clinics.

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

5.3 Demand 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:

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[16] Excluding the Geelong Head to Health Clinic, as of January 2025 referred to as Geelong Medicare Mental Health Centre.

- Actively engaging with people to make and keep appointments.
- Offering wellbeing supports or peer supports if the consumer is required to wait for an appointment for clinical services.
- 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.

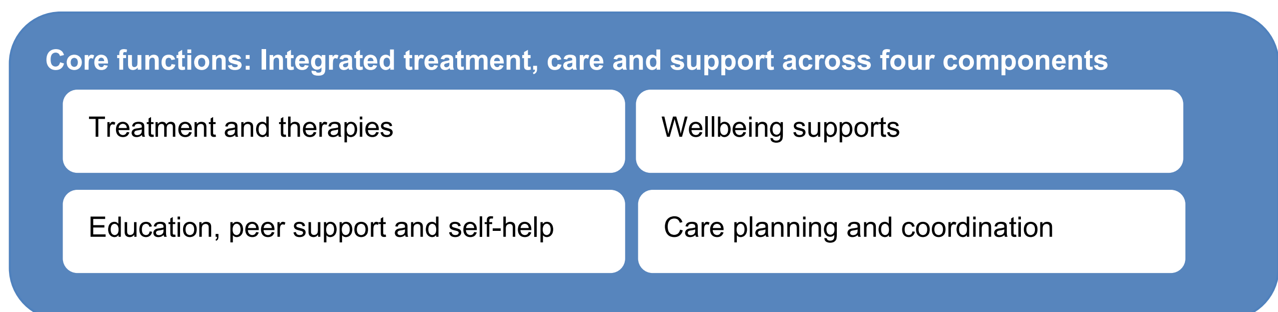
Local Services are encouraged to use telehealth interventions to provide people with immediate access to support while they wait for a face-to-face session.

To support the management of wait lists, the department may request providers of Local Services to develop a targeted action plan and provide regular progress reports on the actions undertaken to address the wait list.

6 Service delivery

This section outlines the core components of the Local Service model, focusing on wellbeing supports, treatment and therapies, care planning and care coordination, shared care, social prescribing, and transition of care (see **Figure 4**). The goal (where possible) is to address holistically the persons mental health treatment, care and support needs to stabilise their mental health and prevent further deterioration, and to establish or improve ongoing quality supports.

Figure 4: Core service components



6.1 Wellbeing supports

Wellbeing supports are non-clinical services that support people experiencing mental ill-health and/or psychological distress to achieve good quality of life through recovery-oriented, family-inclusive care tailored to individual needs. Wellbeing supports aim to support people to (at a minimum):

- Improve their capacity to better self-manage their mental ill-health or psychological distress.
- Develop practical life skills for independent living and the development of meaningful social relationships.
- Develop or strengthen family and social networks, social connectedness or participation in work or education.[17]

[17] Work refers to any effort or activity aimed at achieving a goal or producing value, whether paid (e.g., employment) or unpaid (e.g., volunteering).

- Develop the knowledge and confidence they need to make decisions and choices about their health and wellbeing support needs.
- Improve their capacity to optimise physical health and wellbeing.
- 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/or dependence and life circumstances, based on consumer preference. These supports form part of a continuum of care that may occur concurrently with clinical treatment and other interventions, recognising that wellbeing and treatment are interrelated components of holistic, person-centred care.

Wellbeing supports will be flexible and tailored around the consumer's individual needs with the aim of supporting the consumer to meet their wellbeing needs and goals. 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.

Wellbeing supports offered by the Local Service will include (as a minimum):

- Goal based one-on-one individualised wellbeing supports.
- Individual or 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, their 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 6.1 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 6.4 Care planning and care coordination).
- Support to understand the NDIS and navigate access pathways through referrals to relevant NDIS services and partners. Local Services are not responsible for completing functional assessments or NDIS access applications.

Optional wellbeing supports delivered as part of a Local Service 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 10.8 Brokerage funding).

6.2 Treatment and therapies

6.2.1 Psychological therapies

Local Services will provide evidence-based or informed medical and therapeutic treatment, including counselling, psychological therapies, psychotherapeutic interventions, pharmacological treatment, including prescribing, medication monitoring and review.[18] Providers are required to have the clinical governance, clinical supervision and workforce capability to provide safe and effective treatment and care to all consumers.

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 collaboration with the consumer, their family, carers and supporters and any other relevant support providers.

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. It is expected that a broad range of therapies will be available and delivered by appropriate qualified staff. 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.

Treatment and care will be provided in a manner that engages the consumer through a trusting, safe and 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.

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.

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

[18] 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.

6.2.2 Integrated mental health and physical health treatment, care and support

Integrated mental health and physical health care is a core function of the Local Services model. This includes, but isn't limited to:

- 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 Community Health Services, 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. Noting the Local Services funding model does not include consideration of Medicare Benefit Schedule (MBS) funds to deliver required components of the Local Service model. Local Services are to remain a free service to the community with no requirement for a Medicare card.

6.2.3 Integrated mental health and AOD treatment, care and support

Given the high prevalence of comorbidity, AOD care is a core service function of Local Services, not an optional element. Support for consumers with co-occurring mental ill-health or psychological distress and substance use and/or dependence will be fully integrated into all service components and the overall delivery model for a Local Service.

As with all consumers who access a Local Service, the focus will be on understanding and responding to their distress, needs and preferences. Consumers with co-occurring needs may receive wellbeing supports, care coordination and peer supports, in addition to coordinated support to ensure clear pathways, referrals, and collaboration with AOD providers where needed.

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 and/or dependence 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.

The integrated model of care for people with co-occurring mental illness and substance use and/or dependence 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, single session therapy, motivational interviewing and Cognitive Behaviour Therapy), integrated with wellbeing supports.
- Pharmacotherapy prescribing and management for people experiencing dependency to opioids and/or alcohol if they:[19]
  - Are receiving active clinical treatment of a mental illness from the Local Service.
  - 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 and/or dependence, 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 and/or dependence.
  - Psychoeducation for families, carers and supporters.
- Peer workers with experience of mental ill-health or psychological distress and/or substance use and/or dependence 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.
- 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 administer naloxone to reverse the effects of an opioid overdose.
- 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.

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

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 and/or dependence. 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.

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[19] 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.

- 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.

The Statewide and specialist mental health services for people living with mental illness and substance use and/or dependence will provide support to both Local Services and AOD services, including timely access to primary and secondary consultation as required. For more information about **Statewide and specialist mental health services** refer to <https://www.health.vic.gov.au/mental-health-services/statewide-and-specialist-mental-health-services>.

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*. The guidance is available at department's Recommendation 35 webpage <https://www.health.vic.gov.au/mental-health-reform/recommendation-35>.

6.2.3.1 Provision of Naloxone and access to the Needle and Syringe Program

In accordance with amendments to the *Drugs, Poisons and Controlled Substances Regulations 2017* (specifically sections 161D and 161E), organisations delivering Local Services are eligible to participate in Victoria's Take Home Naloxone (THN) Program as approved alternative providers of naloxone, effective from **7 August 2025**.

Approved organisations may opt in to the program and supply naloxone to individuals who are at risk of, or may witness, an opioid overdose. Participation is subject to compliance with the conditions outlined in the Victorian Government Gazette and the Victorian Take Home Naloxone Program Operating Policy and Guidelines.

Local Services will maintain 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 as per Australian and New Zealand Committee on Resuscitation First Aid Management of Suspected Opioid Overdose available from: <https://www.anzcor.org/assets/anzcor-guidelines/guideline-9-5-2-first-aid-management-of-opioid-overdose-289.pdf>.

Local Services are to enable consumers with co-occurring mental illness and substance use and/or dependence to access a Needle and Syringe Program (NSP). This may be delivered by the Local Service, or via a referral pathway to a local NSP. There are different types of NSP service delivery in Victoria. The location of NSPs is available at Needle and syringe program website <https://www.health.vic.gov.au/aod-treatment-services/needle-and-syringe-program>.

Local Services participating in NSP services can supply free naloxone to consumers, their families, carers and supporters as part of Victoria's Take-Home Naloxone Program, in accordance with the program's operating policy and guidelines.

Information about the Victorian THN and the Victorian Take Home Naloxone Operating Policy and Guidelines is available from: <https://www.health.vic.gov.au/aod-treatment-services/victorias-take-home-naloxone-program>.

6.3 Care planning and care coordination

The requirement for integrated, multidisciplinary care may vary, depending on the consumer's levels of distress or 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 ill-health or psychological distress.

Care planning will be facilitated via an 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 and/or dependence. 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).

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, 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 and care.
- 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 support 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.

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.

6.4 Social prescribing

Local Connections – a social prescribing initiative – aims to reduce social isolation and loneliness and to improve social connection and wellbeing. Select Local Services are participating in the Local Connections trial.[20] The trial is concluding in the 2025-26

[20] The social prescribing trial is being conducted in the following Local Services: Benalla, Wangaratta and Mansfield; Brimbank; Frankston; Geelong and Queenscliffe; Latrobe; and Whittlesea. Social Prescribing Guidelines are available to support the social prescribing trial.

financial year and is undergoing program evaluation. The evaluation will assess the benefits and outcomes to consumers and provide learnings for the department to explore opportunities for social connection supports within the Local Service model. Further advice will be provided to all Local Services when the evaluation is finalised.

Service providers delivering the trial are to adhere to the Social Prescribing Guidelines.[21]

6.5 Transition of care

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

- The consumer's progress towards achieving their recovery goals.
- The consumer's preferences and goals.
- Progress in linking the consumer with other health and community support services they may want or 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, updated based on any outstanding needs in collaboration with the consumer, their family, carers and supporters and shared with all parties.
- 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 informed that they can come back to the Local Service at any time if needed, with rapid support to re-enter the service provided as required.
- Collection of outcome data using specified outcome measurement tools (refer to Section 12 Data, monitoring and evaluation).
- Provide the opportunity to the consumer, family, carer and supporters to complete experience surveys.

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 identified.

6.6 Out of scope functions

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

- A crisis outreach response for people with mental ill-health or psychological distress experiencing a crisis/urgent need.

[21] For information about the initiative visit: Local Connections – a social prescribing initiative | health.vic.gov.au <https://www.health.vic.gov.au/mental-health-wellbeing-reform/local-connections-social-prescribing-initiative>. For a copy of the guidelines please email: MHWPO@health.vic.gov.au

- Residential and non-residential AOD withdrawal and rehabilitation services.[22]
- Disability support to a consumer that is a participant of the 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.
- Compulsory treatment to consumers. Obligations for assessment and treatment orders are set out in *the Act*. Refer to this legislation when developing clinical governance arrangements to meet these obligations.[23]

7 Workforce

The Local Services workforce needs to be diverse, highly skilled, and supported by strong governance structures to deliver safe, integrated, and person-centred care. Multidisciplinary teams, along with comprehensive training and management strategies, are essential to meeting the varied needs of consumers effectively.

7.1 Workforce disciplines

The core functions of the Local Service are to be delivered by a multi-disciplinary workforce, supported by appropriate clinical governance structures and processes.

Our workforce, our future (previously known as the Mental Health and Wellbeing Workforce Capability Framework) <https://www.health.vic.gov.au/our-workforce-our-future/introduction> sets out the essential skills, knowledge, and collaborative practices needed to support a workforce that is effective within an integrated and responsive mental health and wellbeing system.

The model of care requires a diverse range of professional disciplines and areas of expertise aligned with specific workforce roles, functions and requirements. 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, occupational therapists, and expanded allied health disciplines); and medical staff (psychiatrists and registrars).

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.
- 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-inclusive practice, including family-based treatment, care and support for the whole family including children.

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[22] 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.

[23] The Department will provide guidance on assessment and treatment orders in the context of Local Services.

- Family violence identification, screening, risk assessment and management
- Integrated treatment, care and support for people with co-occurring mental illness and substance use and/or dependence.
- Integrated treatment, care and support for people living with mental ill-health or psychological distress and co-existing disability (intellectual disability, Acquired Brain Injury, Autism and physical disability).
- Clinical/practice governance.
- Supervision, including discipline-specific supervision.
- Support that is culturally safe and responsive to diversity.

See **Appendix H** for more information on multidisciplinary team functions.

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.

Local Services should, where possible, embed pre-qualification student placements and trainee positions into their workforce model. Service providers must ensure that discipline-specific support and supervision are available onsite for every shift.

7.2 Lived and living experience and peer support

Workers with lived and living experience use their real-life experience, coupled with skills learned through education and training, discipline knowledge, values and principles, to support and represent people impacted by mental ill-health, psychological distress and substance use and/or dependence and their family, carers and supporters. 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.

Discipline frameworks articulate the knowledge, skills and scope of practice for each lived and living experience workforce (LLEW) discipline. They guide LLEW training and development and support staff within mental health and AOD organisations to better understand, support and work alongside the LLEW. Five frameworks have been developed for the following LLEW disciplines in Victoria:

- The Alcohol and Other Drug (AOD) Lived Experience Workforce <https://www.sharc.org.au/about-sharc/sharc-publications/>
- The Alcohol and Other Drug (AOD) Family Lived and Living Experience Workforce <https://www.sharc.org.au/about-sharc/sharc-publications/>
- The Harm Reduction Lived & Living Experience Peer Workforce <https://www.hrvic.org.au/fuse>
- The Mental Health Consumer Lived Experience Workforce <https://healthsciences.unimelb.edu.au/departments/nursing/about-us/centreformentalhealthnursing/news-and-events/the-launch-of-the-mental-health-consumer-lived-experience-workforce-discipline-framework>
- The Mental Health Family Carer Lived and Living Experience Workforce <https://tandemcarers.org.au/discipline-framework>

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 and/or dependence as an integral part of the multidisciplinary team. This may include:

- **Consumer peer workers** who will use their personal lived or living experience of mental ill-health or psychological distress and recovery to support consumers with mental ill-health or psychological distress, including those with co-occurring substance use and/or dependence, 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, support and ongoing supervision from experienced and suitably qualified senior peer support workers or discipline-specific supervisors, as well as regular opportunities for co-reflection.
- **AOD peer workers** who will use their lived or living experience of substance use and/or dependence 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 someone with mental ill-health or psychological distress, including people with co-occurring substance use and/or dependence, as well as carer discipline knowledge, values and principles, to support family members, carers and supporters.
- **Peer advocates** who will support consumers, family members, carers and supporters to have a voice and be a party to issues which affect them. Peer advocates support consumers, family members, carers or supporters to speak on their own behalf and in their own interests, or they may speak for and/or on behalf of a consumer, family member, carer or supporter 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 in their community.

7.3 Workforce governance

The core functions of the Local Services are to be delivered by a multidisciplinary workforce, underpinned by robust workforce and clinical governance frameworks. These structures ensure that roles and responsibilities are clearly defined, care is responsive and safe, and quality standards are consistently met. Effective governance also supports integrated service delivery and shared care arrangements with external partners and providers.

7.3.1 Workforce oversight

The provider of the Local Service will ensure each consumer of the service is allocated to a 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. Workforce oversight will be guided by clearly defined governance structures to ensure accountability, safety, and quality of care.

If the workforce composition includes:

- An **operations manager** role, they will require comprehensive operational management experience and expertise in mental health service delivery, as well as a demonstrated ability to manage multidisciplinary teams. They will be accountable for ensuring the smooth and effective administration of programs and resources across the Local Service to meet strategic and operational goals.
- A **clinical services manager** role, they will hold overarching accountability for clinical governance within the Local Service. The clinical services manager must have clinical mental health expertise, including significant experience in clinical governance, ensuring that clinical services meet safety, quality, legislative, and professional standards and requirements.

Proposed workforce composition must clearly demonstrate clinical governance roles and responsibilities, providing evidence of appropriate oversight mechanisms. For more information refer to Section 11.2 Clinical Governance. Depending on the organisational structure and partnership arrangement for delivery of a Local Service, expertise and skills may be combined, and role titles may differ.

Local Service providers are expected to establish and sustain a workforce that is both capable and well-supported. This includes maintaining a competent multidisciplinary team and integrating a peer workforce, inclusive of trained peer supervisors and managers across all aspects of service delivery. Workforce governance strategies must ensure alignment with its core focus areas, including workforce supply, skills development, and retention of talent, emphasising training in person-centred, trauma-informed, and recovery-oriented approaches.

7.3.2 Responsibility for appropriate workforce

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, appointing, developing, engaging and retaining high-performing, appropriately qualified and registered staff (where applicable). These strategies will ensure the Local Service has the right people with the right skills to provide optimal care.

Depending on the organisational structure and partnership arrangement for delivery of a Local Service, roles may be combined, and the required expertise and skills delivered under different role titles.

Staff will utilise their particular skill sets and expertise to deliver clearly defined role functions of the service model, while working as an integrated team with shared clinical review, clinical/practice supervision, peer to peer reflection and team supports. This approach will drive interprofessional teamwork. Staff are supported by an organisational structure which has clear roles and responsibilities and articulates the process for escalating clinical and operational issues.

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 consumers who require urgent/emergency care and provide crisis stabilisation and harm reduction. Staff must have appropriate support and processes for timely clinical escalation.

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.

Service providers are expected to:

- Have in place effective strategies to recruit, develop and retain appropriately qualified and, where applicable, registered, staff.
- Be responsible for identifying the ongoing training and development needs of their workforce, including the unique needs of the peer workforce and provide a program of learning and professional development for staff which reflects the requirements of the Local Service model.
- Promote a culture of workforce wellbeing through implementing policies and programs designed to promote mental health, physical wellbeing, and resilience within the workforce.
- Confirm and record all staff credentials to practice on an annual basis.
- Support structured postgraduate (mental health nurses), graduate and early career programs that are evidence based (accredited where necessary). Further it is noted that service providers must ensure that the early career workforce have discipline-specific support providing both operational and clinical supervision onsite for their shifts and that applicable EBA requirements are 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>.
- Make certain that the workforce practices in a recovery focused, trauma informed, person-centred and family/carer/supporter inclusive manner, consistent with the requirements of the service model.
- Nurture effective leadership practices within frontline, mid-level, and senior management roles, ensuring staff are provided with structured pathways for leadership development through training, mentoring, and succession planning.

7.3.3 Leadership of integrated teams

To drive interprofessional teamwork, Local Service staff must have clearly defined role functions aligned with the Local Service model while operating as part of an integrated team. Team supports should include:

- Shared consumer review processes.
- Clinical and practice supervision.
- Peer-to-peer reflection opportunities.

Local Services providers may also share employment arrangements with, for example, health services delivering Area Services, including possible secondments and sessional in-reach services, Community Health Centres and bulk billing general practitioners and MBS funded secondary mental health care providers, to enhance the skill and expertise within the team.

To ensure alignment with state-wide reform priorities, workforce governance strategies must demonstrate consistency with the principles and objectives outlined in the Victoria Mental Health Workforce Strategy <https://www.health.vic.gov.au/our-workforce-our-future/introduction> , emphasising safe, responsive, equitable, and high-quality care.

These strategies must also articulate structured approaches to workforce sustainability and succession planning, addressing the challenges of workforce supply and demand while fostering a culture of continuous improvement.

7.3.4 Victorian Fair Jobs Code for the community services sector

The Community Services Fair Jobs Code (CS Code) came into effect on the 1 August 2024.

The CS Code is a series of standards relating to compliance with applicable workplace obligations; promoting secure employment and job security; fostering cooperative relationships between employers, employees and their representatives; and promoting workplace equity and diversity.

Complying with the CS Code will be a condition of Victorian Government funding. It will form part of the organisations' requirements under their Service Agreements.

Further information is available at Department of Families Fairness and Housing Victoria | The Victorian Fair Jobs Code for the Community Services Sector (dffh.vic.gov.au) <https://www.dffh.vic.gov.au/victorian-fair-jobs-code-community-services-sector>.

7.4 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*.

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.

The Victorian Collaborative Centre for Mental Health and Wellbeing can also provide support for workforce training and development, including access to education resources, evidence-informed best practice, and opportunities for knowledge sharing.

The Victorian Collaborative Centre leads the statewide workforce development function for Victoria's mental health and wellbeing sector. Providers and workforce are encouraged to engage with the Collaborative Centre to access to high quality continuing education and professional development opportunities.

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):

- Mental health legislative frameworks which cover principles of supported decision-making, recovery-oriented practice, and cultural safety, focusing on the dignity and autonomy of consumers. Training must address how these principles apply to clinical care, including the compulsory treatment process and the role of Local Services – noting that Locals do not initiate compulsory treatment but must be able to explain the process, support consumers to understand their rights, and facilitate referrals. It must also cover information sharing and emphasise reducing restrictive interventions.

- Identification of and how to respond to family violence as described in the Family Violence Multi Agency Risk Assessment and Management Framework (MARAM), MARAM practice guides and resources.
- 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 and/or dependence.
- 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.
- Comprehensive training on addressing AOD stigma, implementing harm reduction strategies, and the safe and effective administration of Naloxone (to reverse opioid overdoses).
- Providers are further 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 early career programs are structured, evidence-based (accredited where necessary) and supported.
- Ensuring staff training is conducted regularly, supporting recurrency and remaining relevant to current practices.
- Providing clinical/practice supervision to the workforce and facilitating peer to peer reflection.
- Providing suitably experienced discipline-specific (consumer and/or carer) supervision for lived and living experience workforce.
- Embedding pre-qualification, training and career progression roles into the workforce to support workforce recruitment and sustainability.

8 Roles and responsibilities

The roles and responsibilities for delivering Local Services are designed to ensure effective oversight, governance, and collaboration. The department, lead service providers, networked health services, and key agencies work together to implement and improve the mental health and wellbeing system, delivering integrated, high-quality care for consumers.

8.1 Role of the Department of Health

The department will perform the functions detailed below to support effective oversight, delivery, and continuous improvement of Local Services.

Stewardship functions

The department will perform the following stewardship functions:

- Providing policy leadership and strategic oversight for the Local Services.
- Overseeing the implementation of the Service Framework, making amendments as needed to support a maturing service model or in response to interrelated and interdependent reforms within the mental health and wellbeing system.
- Developing outcome-reporting processes to monitor system performance, ensuring alignment with state and sector-wide mental health and wellbeing objectives.

Commissioning functions

The department will perform the following commissioning functions:

- Funding Local Services and allocating resources based on strategic priorities.
- Monitoring and managing the performance of providers delivering Local Services to ensure accountability, quality, and value for investment.
- Developing and implementing changes to operational requirements in collaboration with providers and stakeholders, including:
  - Enhancing outcome measurement, data collection, and reporting requirements.
  - Establishing workforce competency standards.
  - Refining the funding model over time.
- Implementing strategies to monitor and manage demand through planning, coordination and service delivery to ensure timely, equitable and efficient access to treatment care and support.

Support functions

The department will perform the following support functions:

- Collaborating with Local Service providers and stakeholders to develop guidelines and resources to support the implementation of the service model.
- Analysing data submitted by Local Service providers, collating reports, and providing insights to drive service improvement.
- Evaluating the Local Services model to promote continuous learning and inform future directions for the service model.

8.1.1 Role of the Office of the Chief Psychiatrist

The Chief Psychiatrist provides clinical leadership and expert clinical advice to clinical mental health service providers, promotes the highest standards of clinical practice and care and promotes the rights of people receiving these services.

The Chief Psychiatrist is an independent statutory officer. They hold powers and responsibilities conferred by *the Act* to uphold quality and safety of clinical services in Victoria's mental health and wellbeing system. This applies to clinical mental health service providers. A clinical mental health service provider is:

- A designated mental health service.
- A mental health and wellbeing service provider providing services in custodial settings.
- Any other prescribed entity or prescribed class of entity.

Local Services are not currently prescribed entities under this section of *the Act* and are therefore not currently under the jurisdiction of the Chief Psychiatrist. However, if employees of a designated mental health service are working at a Local Services and providing clinical governance, their clinical governance is to that designated mental health service, which sits under the jurisdiction of the Chief Psychiatrist.[24] If employees of a designated mental health service are working at a Local Services but not providing clinical governance, this does not sit under the jurisdiction of the Chief Psychiatrist. As part of their oversight and leadership role, the Chief Psychiatrist:

- Monitors clinical mental health service providers to ensure compliance with *the Act*.
- Investigates incidents when the safety or wellbeing of a person was endangered while receiving a mental health and wellbeing service at a clinical mental health service provider.
- Reviews and audits service provision of clinical mental health service providers to find and resolve quality and safety issues.
- Publishes guidelines on clinical best practice and supports services to embed them; and
- Promotes the rights of people receiving a mental health and wellbeing service.

8.2 Safer Care Victoria

Safer Care Victoria (SCV) is the state's healthcare quality and safety improvement agency. As the peak State authority for quality and safety improvements across the Victorian health system.

SCV works in partnership with the department, health services, consumers, clinicians, and the wider community to monitor and improve the quality and safety of healthcare within Victoria. SCV is an administrative office of the department under Section 11 of the *Public Administration Act 2004* (Vic).

SCV is focused on delivering an impact in four strategic priority areas to improve the quality and safety of healthcare and patient outcomes:

- Leadership and reform.
- Strengthening clinical governance.
- Proactive monitoring.
- Effective intervention and improvement.

8.3 Role of lead service provider and 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).

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[24] In this scenario they report to their line of governance as an employee of that service.

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 **Appendix I** of this document for guidance on consortium partners and subtractors requirements, 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.
- 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.

9 System integration and pathways

People who seek support from a Local Service may have multiple needs, such as co-occurring mental illness and substance use and/or dependence, 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 service 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.
- Emergency departments and emergency services.
- Alcohol and other drugs (AOD) services.
- Community Health Services.
- Commonwealth funded primary and secondary mental health and health care providers, GPs and local Primary Health Networks (PHNs).

- Aboriginal Community Controlled Health Organisations (ACCHOs – focused on health services) and Aboriginal Community Controlled Organisations (ACCOs – community based non-profit Aboriginal led organisations).
- Local community and social support services (e.g. diverse communities support 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.

It is expected that Local Services have a deep understanding of the local needs and issues, and proactively engage with partners and communities to identify and respond to these needs to support seamless and coordinated service delivery

9.1 Relationship with Area Services

Local Service and Area Service partnership expectations are outlined in Section 4.1.

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.

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.

9.2 Relationship 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), 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.

Local Services will complement, not duplicate or replace, mental health treatment provided by primary and secondary mental health care providers. Primary and secondary consultation activities by Local Services will occur only in shared care arrangements and for consumers registered with the Local Service.

Local Services may provide the following to local primary and secondary mental health care providers for consumers already registered with the Local Service:

- Primary consultation to support diagnosis, care planning and/or medication review as part of shared care arrangements.
- Secondary consultation to review or inform a patient's diagnosis, care plan or medication, strengthening the capability of these providers to support people with higher levels of need.
- 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.

9.3 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.

9.4 System interfaces and integration

Local Services operate as part of a broader mental health and wellbeing ecosystem. Their effectiveness relies on clear and well-defined interfaces with other parts of the system to support coordinated, safe, and responsive care. This includes:

- Vertical integration: Local Services work in close partnership with Area Services (Level 5), with clear roles and responsibilities regarding service delivery, referral pathways, collaboration, shared governance, and accountability. These principles also apply to Level 3 services where relevant. Vertical integration ensures seamless transitions for consumers with higher or lower acuity needs and supports shared clinical and operational responsibility between service levels.
- Horizontal integration: Local Services establish structured and collaborative relationships with other relevant providers across the mental health, alcohol and other drug (AOD), health and social support sectors.
- System alignment and efficiency: System interfaces are designed to avoid duplication and cost-shifting of services more appropriately provided through Commonwealth-funded primary and secondary mental health care, standalone AOD services, or the NDIS for psychosocial disability supports. Local Services are expected to proactively collaborate with these providers to ensure services are well coordinated and resources are used effectively.
- Shared ecosystem approach: Effective integration allows Local Services to facilitate warm referrals, step-up and step-down pathways, and shared care arrangements. This ensures consumers receive the right support, at the right time, from the right part of the

system. Strong integration also promotes a culture of partnership and collaboration between services to support recovery-oriented, person-centred care.

This integrated approach ensures that Local Services are not operating in isolation, but as an integral part of the mental health and wellbeing service system, delivering a connected and coordinated response to community needs.

10 Service operations

Local Services operate within defined service zones, delivering accessible care through site-based, telehealth, and outreach services. Providers must meet governance, safety, and quality standards, ensure data privacy, and support statewide integration and reporting requirements.

10.1 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.

Effective demand management is increasingly important in supporting Local Services to remain responsive, accessible, and aligned with community needs. As coverage grows, the department may consider strategies to balance timely access with sustainable service delivery. At this time, the department will continue to monitor 'out of zone' demand with individual service providers.

10.2 Accommodation requirements

Consistent with the Royal Commission's recommendations, providers of Local Services will work in partnership with consumers, their family, carers and supporters in the local community to identify suitable sites for Local Services.

Property selection must be undertaken in consultation with the department, with the physical site/s for each Local Service agreed upon and approved by the department. The service provider will be responsible for the management of all leasing requirements. Prior to executing any premises' lease, the service provider must provide details of any proposed premises lease to the department for review.

The fit-out of Local Services' permanent sites will be undertaken based on design principles co-designed with people who have lived and living experience, including consumers and their family, carers and supporters in the local community, and Local Services staff.

The service provider will consult and work with the department on plans for any building works, the initial fit- out of the premises and related costs. Service providers will be

responsible for organising and managing the required building works and initial fit- out. They will work with the department to verify access and safety compliance of buildings identified as potentially suitable sites for Local Services.

10.3 Service operating hours

It is expected that a Local Service will operate 52 weeks a year, during business hours weekdays, after business hours weekdays and on the weekend throughout the entire year (inclusive of public holidays).

The department will negotiate operating hours with individual service providers considering 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.

After hours arrangements need to include provisions to ensure staff, consumers and other visitors are not at risk and staff are resourced to safely manage the care of individuals (for example) who are intoxicated, exhibiting anti-social behaviour associated with drug use or at risk of self-harm (e.g. arrangements in place with police, minimum after hours staffing levels). This includes processes for clinical escalation.

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

10.4 Mode and frequency of engagement

Local Services are flexible and can provide short, medium or long-term treatment, care and support depending on the individual's needs.

Service providers are expected to deliver the following service modalities:

1. site-based services, including services for walk-ins and face-to-face services
2. telehealth, including phone or video call
3. outreach support, i.e. support provided in the consumer's home or other preferred location within the specified geographical service zone for the Local Service.

While telehealth offers flexibility and reduces access barriers, it must be balanced with face-to-face service delivery. For people with higher-complexity needs, in-person care should be the default, with telehealth used to complement, not replace, direct service delivery. Providers must ensure service models reflect both consumer preferences and clinical needs.

Local Services should also provide on-site access to computers for consumers, family, carers and supporters to access digital mental health information or self-help interventions.

10.5 Branding

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

The department will provide brand guidelines which outline correct branding usage and application of government endorsement requirements. Providers will have access to a Brand Hub and can email LocalServices@health.vic.gov.au with questions to ensure they adhere to the branding requirements.

Providers must also consult with the department before undertaking any paid or unpaid promotional marketing activity.

10.6 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[25] <https://fac.dffh.vic.gov.au/>.

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

The funding split between community clinical and community non-clinical output is 60 per cent of funding toward clinical and 40 per cent of funding toward 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).

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.

10.6.2 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.

[25] 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.

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 provided 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 their family/carer/supporters.

Refer to Data specifications and a reporting guideline for information about clinical output and counting service hours.

10.6.3 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.

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- 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 activity (one-on-one and group based, including social prescribing).
- Non-consumer facing activity (e.g. case conferencing, planning and secondary consultation and social prescribing support activity).
- System related activities (activities that the Local Service provider undertakes to advance the system level responses for the target cohort).

Refer to Data specifications and a reporting guideline provided separately for information about clinical output and counting service hours.

See **Appendix J** for more information on the CSU.

10.7 Targets and outputs

10.7.1 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. Annual output hours will be confirmed at the start of each new financial year.
- Number of consumers.
- Mandatory compliance with data reporting requirements.
- Maintenance of accreditation against an accepted accreditation standard.
- Compliance with incident reporting and complaints reporting requirements.

10.7.2 Establishment of new targets

If changes to, or additional targets are deemed necessary, output and activity data from the previous 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 unintended consequences that may impact negatively on the consumer group, families, carers and supporters.

10.8 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.

Brokage 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.

10.9 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 or persons, for loss of or damage to property, for death or personal injury, or for any other

financial loss caused by the negligence of or breach of statutory duty by the service provider.

A significant majority of service providers funded by the department are covered under the Community Service Organisations Insurance or Medical Indemnity Insurance which is arranged and funded by the department's insurance programs. The insurer is the Victorian Managed Insurance Authority (VMIA).

The VMIA also provides various insurance coverages for hospitals in Victoria, including medical indemnity, public and products liability, and professional indemnity. These policies cover potential claims arising from healthcare incidents, such as negligence in diagnosis or treatment, leading to personal injury or death. VMIA also insures other aspects of the public health system, including community health centres and hospitals.

Details of the insurance cover provided, including the respective insurance manuals, can be accessed via the Funded Agency Channel or VMIA Community Services Organisations and VMIA Medical Indemnity. Refer to the following links for more information:

- **Funded Agency Channel**: <https://providers.dffh.vic.gov.au/funded-agency-channel>
- **VMIA**: <https://www.vmia.vic.gov.au/insurance/policies-and-cover>.

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

10.10 Information management and technology

10.10.1 Information management

Information management is the way in which an organisation plans, identifies, creates, receives, collects, organises, governs, secures, uses, controls, disseminates, exchanges, maintains, preserves and disposes of its information.

Service providers must develop and implement appropriate technologies, systems and processes to ensure effective management of the information and data they collect and must comply with departmental policies, state and Commonwealth legislative requirements.

10.10.2 Technology

The department is currently in the process of implementing Recommendation 62 of the Royal Commission. Recommendation 62 involves the development of a contemporary information architecture for the mental health system; seeking to improve care delivery by supporting Victorian public health services and Local Services to access and contribute to a single, shared view of a consumer's health information.

The establishment of a new statewide electronic Mental Health and Wellbeing Record to replace the current Client Management Interface/Operational Data Store (CMI/ODS) will include a new Client Management System (CMS) for Mental Health and Wellbeing Service Providers. Local Services are in scope for the new record system and will be expected to use it when established.

Until the statewide electronic Mental Health and Wellbeing Record is fully operational, service providers must maintain their existing consumer record / information systems and information sharing capabilities.

At minimum, service providers must adhere to the following:

- Legacy operations (until statewide system go live):
  - Maintain a consumer record/information system capable of capturing consumer details, service provision and outcome measurements, in order to support case management, coordination of care, service planning, performance monitoring and resource allocation.
  - Operate secure information-sharing interfaces between Local Services and Area Services to facilitate referrals and case coordination
- Statewide transition:
  - Local Services are expected to participate in the rollout of the new statewide electronic Mental Health and Wellbeing Record (replacing CMI/ODS), including its embedded Client Management System (CMS). Early engagement will support readiness and alignment with statewide service delivery reforms.
  - Following full deployment of the statewide record and the transition of existing consumer records from legacy systems, services are encouraged to decommission legacy consumer record systems and associated information-sharing interfaces to support consistency, data quality, and streamlined operations.

10.10.3 Privacy

Entities (service providers) within the public health sector have privileged access to personal, health and sensitive information about Victorians. This access is provided based on trust. It is critical for all entities to protect the privacy of this information.

All service providers are required to have appropriate systems and processes to protect the privacy and confidentiality of people accessing their services. This includes the collection, storage and sharing of consumer's personal and health information and/or data.

The department may conduct regular reviews, or initiate audits, of privacy and confidentiality processes related to the management and handling of consumer information, and/or data, by the organisation. The department may require the service provider to make changes at the department's request in order to comply with applicable privacy regulations to the extent this relates to funded activities performed by the Local Services which are a function/activity of department.

The proportion of costs payable to the service provider by the department for the service provider to implement any changes needed to comply with such privacy regulations remains the sole discretion of the department and will be determined by the department on a case-by-case basis.

10.10.4 Information sharing and consent

The *Act* includes information sharing principles to give mental health and wellbeing providers clarity of the purpose and expectations around information sharing.

The Act adopts a consent-driven approach to information sharing. As a general rule, Local Services must obtain explicit written consent from the consumer before sharing their health or personal information. Consent must be specific, time-bound, and can be withdrawn at any time. Consumers must be clearly informed what information may be shared, with whom, and for what purpose.

Information can only be shared without consent in clearly defined legal circumstances – for example, to ensure immediate safety, to support integrated care where legally authorised, or to meet statutory obligations.

For more detailed guidance about the information sharing principles and information sharing with consumer consent refer to *the Act* Handbook published by the department at: <https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/information-sharing>.

10.10.5 Cybersecurity

The department conducts assurance on all digital health initiatives in accordance with department-defined standard frameworks that are applied across the health sector. All Mental Health NGOs will be subjected to such assurance activities.

The department will conduct ongoing assessments of the organisation's cybersecurity maturity, ensuring essential security controls have been implemented and all major security vulnerabilities have been resolved or are being resolved in accordance with an action plan as agreed with the department.

11 Governance and accountability

Requirements for Local Services include establishing legal and organisational governance, forming approved consortium or subcontracting arrangements, and adhering to Service Agreement terms. Emphasis is placed on accountability, collaborative frameworks, and maintaining high-quality, integrated service delivery.

11.1 Organisational requirements

11.1.1 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.

11.1.2 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
- Sub-contractors are sub-contracted by a lead funded service provider.

Service providers must consult with the department, take part in any required departmental due diligence assessments and obtain the department's written approval prior to implementing any proposed changes to consortia or subcontracting arrangements during the period of the Service Agreement.

Refer to **Appendix I** for guidance on criteria and relevant evidence requirements for new partners and sub-contractors.

11.1.3 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.

In this document the term "service agreement" will be used to refer to either the Statement of Priorities or Department of Health Service Agreement (as service agreement) recognising both as contractual obligations depending on the legal entity involved.

11.1.4 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.
- Enable the delivery of effective high-quality safe services, including compliance with relevant accreditation, standards and other regulatory and quality requirements.
- Maintain the privacy and confidentiality of consumer information and the collection and reporting of robust data.
- Allow people with lived and living experience of mental ill-health or psychological distress and those with lived or living experience of supporting someone with mental ill-health or psychological distress to be involved in the governance of the Local Service.
- Create value through innovation, development and exploration.

- Facilitate 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.

11.2 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 is underpinned by the Victorian Government Clinical Governance Framework and refers to the systems and practices that 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.

Clinical governance is also inclusive of having systems and protocols in place for:

- The selection and use of evidence-based, developmentally, and contextually appropriate assessment and care plan instruments, protocols and procedures to support a personalised approach to a consumer's care needs and preferences.
- Clinical escalation to account for people attending a Local Service in psychological distress or whose health deteriorates after engagement with the service.
- Staff to have a clear understanding of their scope of practice and when they should refer a consumer to a more senior clinician or escalate their treatment and/or care to someone who is more experienced or better qualified and equipped to manage the consumers' needs and circumstances.
- Staff to escalate through clear and established internal structures.
- Review of any (serious) clinical incident(s) and implementation of recommendations as part of quality improvement. The system of review and escalation should also include lived and living experience membership as part of a multidisciplinary team who reviews incidents.
- Shared accountability for clinical governance and system processes will apply to any consortium partner(s) and/or subcontractor(s) of the Local Service. However, clinical governance structures must clearly define role and responsibilities and clinical accountability.

Service providers are required to align with the requirements of the Victorian Clinical Governance Framework <https://www.safercare.vic.gov.au/publications/victorian-clinical-governance-framework>.

11.3 Risk management

To ensure quality, safety and risk management in the operation of the service in accordance with the Australian/New Zealand Risk Management Standard, service providers are expected to have structures and processes in place that support best practice standards of organisational and clinical governance.[26] Risk management is expected to be embedded in all levels of operations, activities and business processes of the Local Service.

11.4 Quality assurance

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

11.4.1 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. 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.

11.4.2 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.

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

- Compliance with one or more of the specified safety and quality standards.

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[26] The Australian New Zealand Risk Management Standard (AS/NZ 4360:2004)

- 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). This includes processes for clinical escalation.
- Cultural safety considerations to ensure that Aboriginal and Torres Strait Islander peoples receive high quality care that is safe and responsive to their needs.
- Overall physical building and amenity design is safe and inclusive, and considers, for example, safe physical spaces, multiple egresses, ligature assessments etc.

11.5 Incident management and reporting

11.5.1 Incident reporting

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

- Responsible for the safety of 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 1.** 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 1: 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://vahi.vic.gov.au/ourwork/analysis-and-insights/safety-and-surveillance-reporting>; the Adverse Patient Safety Events Policy <https://www.bettersafercare.vic.gov.au/sites/default/files/2019-08/Policy%20-%20Adverse%20Patient%20Safety%20Events.pdf> and the VHIMS Minimum Dataset (MDS) <https://www.bettersafercare.vic.gov.au/sites/default/files/2020-08/200820-1%20VHIMS_Minimum%20dataset%20%28003%29.pdf>.
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, categorisation types, and policy updates for 2024 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 within 3 business days 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>. As per Section 48 of the *Health Service Act 1988* requirements: The proprietor of a health service establishment must ensure the following information is recorded in writing and reviewed at least every 3 months: (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: (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.safercare.vic.gov.au/best-practice-improvement/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 <https://www.bettersafercare.vic.gov.au/notify-us/sentinel-events/notify-and-review-a-sentinel-event> in accordance with the Australian national sentinel event list.

11.5.2 Reportable deaths

Under the Act, the Chief Psychiatrist must be notified of all reportable deaths within the meaning of the *Coroners Act 2008*. A reportable death is defined as violent, unnatural, or unexpected deaths, including homicide, suicide and drug, alcohol and poison-related deaths. The Reportable Death notification process allows the Chief Psychiatrist to monitor and review adverse outcomes for consumers of mental health services.

The Reportable Death directive applies to clinical mental health service providers, including any services who are prescribed in the future.[27] It outlines the procedure to follow in the event of a death of a person who was receiving, had received or sought mental health services.

Local Services are not required to submit MHWA125 Notice of Death to the Chief Psychiatrist unless they are operated by a designated mental health service.[28] Where a Local Service is operated in partnership with a designated service, the designated service retains responsibility for submitting the MHWA125 Notice of Death form and fulfilling reporting obligations.

For community patients (supported through designated mental health service) the Chief Psychiatrist must be notified in writing by the service provider of reportable deaths of persons who are either registered as a current mental health consumer or were registered as mental health consumers within the previous three months or who had either sought service from or been assessed by a mental health service provider within that period and were not provided with service. The MHWA 125 Notice of Death form must be completed and sent to the Chief Psychiatrist within three business days of the person in charge of the designated service becoming aware of the death.

[27] Services will not be required to report retrospectively.

[28] https://www.health.vic.gov.au/chief-psychiatrist/reportable-deaths-mental-health-and-wellbeing-act-2022

More information can be found in the Reportable deaths <https://www.health.vic.gov.au/chief-psychiatrist/reportable-deaths-mental-health-and-wellbeing-act-2022>.

11.5.3 Notifying the Department of Health

In the event of the death of a consumer in receipt of support from a Local Service, or in the event of a serious incident, the respective Local Service is additionally required to formally notify the department's Program Area within 24 hours of becoming aware of the incident. Notifications are to be made by email to the department at <LocalServices@health.vic.gov.au>.

This departmental notification is separate and distinct from any MHWA125 Notice of Death obligations described in Section 11.5.2, which apply to designated clinical mental health service providers under *the Act.* The notification to the department should, at minimum, include:

- Whether the incident involves a death or another serious incident.
- The type of incident, cause of death (if known) and the date of occurrence.
- Details about the support provided (i.e. length of care with the Local Service, referral type, IAR level of care, services provided and staff disciplines involved, any clinical risks identified and last contact with the Local Service).
- A short description of any immediate actions or escalations undertaken.
- Whether an MHWA125 Notice of Death is being submitted by a designated service (if applicable).

For clarity, the term 'serious incident' is not separately defined in the Chief Psychiatrist's guidelines but, for the purposes of this framework, refers to incidents that result in significant harm, risk to safety, or where further review or escalation is warranted.

11.6 Feedback and complaints

11.6.1 Local Services 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 and Wellbeing Commission.
- 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 and Wellbeing Commission 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 and Wellbeing Commission 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 and Wellbeing Commission and the outcome of the investigation, including any compliance notices.

11.6.2 Mental Health and Wellbeing Commission

The Mental Health and Wellbeing Commission (MHWC) is established under *the Act*. It is an independent statutory body.

Detailed information about the role of the Mental Health and Wellbeing Commission can be found on the Mental Health and Wellbeing Commission (MHWC) website <https://www.mhwc.vic.gov.au/>.

11.7 Performance monitoring and management process

Understanding whether Local Services are delivering on their intended outcomes is essential for guiding future planning, investment and implementation. This insight helps ensure that services remain responsive, effective and aligned with community need.

To support this, the department will oversee ongoing service performance monitoring. This will include the collection and analysis of performance indicators alongside a review of contextual factors that may influence service delivery and outcomes.

To ensure accountability and continuous improvement of services, the department may also 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.

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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 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.

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.[29]

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

[29] Service Agreement requirements: https://fac.dffh.vic.gov.au/service-agreement-requirements.

monitoring framework page <https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework>.

To assist service providers in the delivery of the service, the department undertakes 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.

12 Data, monitoring and evaluation

Providers of Local Services are expected to actively engage with consumers, their families, carers and supporters to gather feedback and insights. This approach ensures services are monitored, adjusted, and improved to meet changing needs and maintain quality. It applies the principle of continuous improvement, positioning Local Services as a learning system that uses data, evaluation, and lived experience to guide service and quality improvements.

In addition, providers are required to consistently collect and report operational data and de-identified aggregate and individual consumer data to the Department of Health (the department) on a regular basis.

The reported data will enable service providers and the department to regularly assess progress toward meeting agreed targets and performance measures, ensuring accountability and continuous improvement.

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.

Current data items and reporting requirements may be subject to adjustment and refinement in line with broader mental health and wellbeing system reforms.

12.1 Performance monitoring data requirements

Data reporting is a mandatory funding requirement. The section outlines reporting requirements applicable to all Local Services.

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 deliver by the service is reported monthly. More information provided in Section 12.2 Aggregate data submission requirements (inclusive of aggregate consumer, service usage and operational data).
- **Individual consumer data collection:** providers are required to collect unit record data at the individual consumer level; however, it is not currently mandatory to submit this data to the department. In alignment with Recommendation 62 of the Royal Commission, a new Mental Health and Wellbeing Client Management System (MHWCMS) is under development. Upon the implementation of the MHWCMS, all providers will be required to submit unit record data to the department which will also be further detailed in future iterations of this Service Framework.
- **Outcome data**: providers are required to collect and submit outcome data to the department, specifically relating to patient-reported experience measures (PREMs) and patient-reported outcome measures (PROMs). The PROMs include the Kessler Psychological Distress Scale (K10), while the PREMs encompass the Your Experience of Service (YES) survey (Primary Health Network version) and the Carer Experience of Service (CES) survey. Data submissions will be made monthly, with the data collected for a given month due by the 15th of the following month. For example, data collected in August must be submitted by September 15th.

  Outcomes data should be collected at relevant stages of the consumers care pathway, depending on the specific the outcome measure. It is essential that options are made available to every consumer and their carer. This data collection process should be seamlessly integrated into standard service delivery.
- **Feedback and complaints**:[30] indicators of effectiveness, responsiveness, accessibility, continuity, safety and appropriateness collected through incident reporting and formal complaint mechanisms. The frequency of this data collection is bi-annual from operational commencement.
- **Financial data**: Providers are required to report quarterly financial expenditure, ensuring that both total direct and indirect costs of service delivery are accurately captured and reported. This data will enable the department to monitor and evaluate the efficiency of Local Services and support continuous improvement in resource allocation and service delivery.
- **Other data**:[31] indicators of sustainability, capability and continuity derived from review and core monitoring processes and other sources, including accreditation status.

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[30] Service providers are required to submit a bi-annual report to the department that thematically analyses the volume and type of feedback and 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 arise to the feedback or complaint.

[31] 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.

12.2 Aggregate data submission requirements

At present providers of Local Services are required to collect and report de-identified aggregate data, submitted to the Department of Health using the HealthCollect online platform.

Data is to be submitted by the 10th day of each new month. For example, data collected for the month of October, is due on 10 November.

Data specifications and a reporting guideline (including the detailed list of individual data items) are provided separately to assist service providers in understanding current aggregate data requirements and definitions for each item. Providers can obtain copy of the Data specifications and reporting guideline by submitting request to LocalServices@health.vic.gov.au.

12.3 Privacy and data protection

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.

12.3.1 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.

12.3.2 Privacy policy requirements

The Department of Health currently operates under the Department of Health Privacy Policy <https://www.health.vic.gov.au/department-of-health-privacy-policy> which outlines key responsibilities under applicable legislation.

12.4 Evaluation

The department is progressing a phased evaluation to understand the overall impact and effectiveness of the services being delivered.

The evaluation will assess whether services are being implemented as intended and whether they are achieving meaningful outcomes for consumers, family, carers and supporters and wider system. It will also help identify areas for improvement and inform future service configuration and scale.

As a condition of funding, all funded organisations and relevant partners are required to participate in the evaluation. This includes adhering to ethical standards, including obtaining approval from a certified Human Research Ethics Committee nominated by the department.

Appendix A: Requirements for Hub and Spoke Services

Mental Health and Wellbeing Locals

Service Framework Appendix: Service requirements for Hub and Spoke Services

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Version 2.0

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A.1 Introduction

A.1.1 Purpose of this appendix

This appendix complements the Service Framework and provides additional guidance for Hub and Spoke Mental Health and Wellbeing Locals (Local Services). It supports clarity in the expectations for Spoke services (Spokes), emphasising their role relative to Hub services (Hubs). A full list of Hub and Spoke services are provided in Section A.7.

The Service Framework applies to both Hubs and Spokes, with this document defining the adjusted operational requirements for Spokes.

The appendix aims to:

- Set out the service delivery functions of Hub and Spoke services.
- Outline minimum requirements for workforce, service operations and partnerships for Spokes.

A.1.2 Scope and application

This appendix applies to all Local Services operating under the Hub and Spoke model. It presumes that the existing guidance within the Service Framework remains applicable unless this appendix provides otherwise.

Should a linked Hub and Spoke wish to establish a different approach that still meets minimum requirements set out in this document, they may propose an alternative to the Department of Health (the department) for consideration and approval.

A.1.3 Overview of the Hub and Spoke model

The Hub and Spoke model is designed to expand access to mental health and wellbeing services for people aged 26 years and above across the state.

Each Hub and each Spoke is funded to support distinct geographic Local Government Areas (LGAs) and their respective populations (also known as service zones). All Spokes are funded equally, providing greater consistency across services. It is acknowledged that service delivery approaches may vary between Hubs and Spokes, including differences in scale, structure and resourcing. The model may be adapted to local contexts while meeting minimum service requirements.

A.1.3.1 Key expectations of Hubs

Hubs are expected to deliver services as set out in the Service Framework, with additional responsibilities with respect to the linked Spoke. Hubs are expected to establish and lead the following shared arrangements with the linked Spoke:

- corporate service functions
- workforce development practices
- technology and data systems.

These shared arrangements are further explained in Section A.2.1.

A.1.3.2 Key expectations of Spokes

Spokes independently manage their service offerings, operational decisions, demand management, and community partnerships to ensure their services are tailored effectively to their respective communities, within the overarching framework of the Hub and Spoke model.

At a minimum, Spokes are expected to:

- Deliver the three front-end components including access and navigation support, initial support discussions, needs assessment and planning discussions. This includes the usage of the Initial Assessment and Referral Decision Support Tool (IAR-DST) for all consumers.
- Deliver integrated treatment, care, and support including:
  - care planning and coordination
  - treatments and therapies
  - wellbeing support
  - education, peer support and self-help.
- Operate Monday to Friday, from 9 am to 5 pm 52 weeks a year.[32] There is no requirement or expectation for a Spoke to be open on a public holiday.
- Provide in person on-site services, as well as telehealth and outreach services, via appointment. Walk-ins may be provided by the Spoke if service model capacity allows. Outreach services must be conducted in line with OHS requirements.
- Set up a physical premises within the service zone. It is expected that Spokes will typically utilise multifunctional/shared or co-located facilities within existing facilities.

A.2 Core service components of Hubs and Spokes

This section sets out the core service components of Hub and Spoke services, where they differ from the functions for Local Services as set out in the Service Framework.

A.2.1 Core service components of Hubs

Further to the requirements detailed in the Service Framework, Hubs must assume delivery for additional key support functions to effectively support a linked Spoke.

A.2.1.1 Corporate service functions

Hubs provide corporate service functions to Spokes, including:

- human resources
- legal and compliance
- marketing, promotion and communications
- regulatory compliance
- finance and payroll.

[32] Equivalent alternative opening hours may be provided subject to approval by the department.

These shared services support the administration of the Spokes, streamline operations, and support consistent and effective service delivery.

Spoke administrative staff handle daily administrative tasks such as appointment scheduling, consumer communications, maintaining accurate records, and meeting reporting requirements for performance and accountability purposes.

A.2.1.2 Workforce development practices

Hubs are expected to support the professional development of Spoke staff to align with Our workforce, our future <https://www.health.vic.gov.au/our-workforce-our-future>. Hubs must also facilitate the following for Hub and Spoke staff to promote professional growth and consistency across the linked services:

- reflective practice (e.g. peer or group supervision focused on shared learning and professional growth)
- clinical supervision (where relevant to clinical roles)
- discipline specific supervision (tailored to the professional scope of practice)
- multidisciplinary learning sessions
- peer workers at Spokes also require role-specific training and capability-building programs.

These activities are intended to support a safe and skilled workforce. Protected time should be allocated to enable participation.

A.2.1.3 Technology and data systems

Hubs are responsible for implementing and managing technology and data systems across both Hub and Spoke services. Shared systems may include:

- consumer records management
- case management databases
- telehealth platforms
- administrative systems
- clinical and non-clinical reporting systems (if applicable).

Hubs and Spokes should agree on appropriate privacy and data protection protocols to support the secure management of consumer information. Hubs should also support all relevant Spoke staff to be trained in the use of these systems, including relevant protocols, with ongoing technical support available as needed.

A.2.2 Core service components of Spokes

Spokes are expected to deliver the same suite of core services as Hubs and other Local Services, consistent with the Service Framework. **Table 1** below sets out the minimum core functions expected to be delivered by Spokes.

Table 1: Minimum core functions delivered by Spokes

Core service components	Description
Access and intake	Acting as an entry point into the mental health and wellbeing system, the Local Service provides the three front-end components including access and navigation support, initial support discussions, needs assessment and planning discussions. This includes, at a minimum, conducting an assessment using the IAR-DST for all consumers prior to commencement of treatment, care and support. Should a linked Hub and Spoke wish to implement a centralised intake process that is managed by the Hub and supports the Spoke (e.g. a shared phone line), they may propose an alternative model to the department for consideration and approval.
Treatment and therapies	Treatment and therapies include the delivery of integrated, high quality, evidence-based clinical treatment, care and support to consumers with co-occurring mental ill health or psychological distress and substance use or addiction. Spokes are required to maintain clearly documented clinical pathways, clinical governance, clinical supervision and workforce capability to provide safe and effective treatment and care to all consumers.
Wellbeing supports	Wellbeing services support people experiencing mental ill-health and/or psychological distress to achieve good quality of life through recovery-oriented, families, carers and supporters-inclusive care tailored to individual needs. Wellbeing supports will be flexible and tailored around the consumer's individual needs with the aim of supporting the consumer to meet their wellbeing needs and goals. These supports form part of a continuum of care that may occur concurrently with clinical treatment and other interventions, recognising that wellbeing and treatment are interrelated components of holistic, person-centred care. The provision of wellbeing supports will be based on the consumer's individual needs and preferences identified in their co-designed care plan.
Education, peer support and self-help	Spokes are required to provide education to build mental health awareness, deliver peer support through connections with those with lived experience, and offer self-help resources to support independent mental health management. This may also include education and support for families, carers and supporters where appropriate.
Care planning and coordination	Care planning will be facilitated via an 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 and/or Area Mental Health and Wellbeing Services (Area Services). Monitoring, regular review and adjustment of this plan will be undertaken with all parties. Care coordination will include service and system navigation and linkages, ensuring care is well planned and coordinated across multiple services and providers.

All services will be tailored to the local community and designed to meet specific geographic and demographic needs, while being responsive to cultural and community priorities.

A.3 Workforce

While delivering the same suite of core services, Hubs and Spokes will have different staffing profiles.

This section sets out the key workforce requirements for Spokes.

A.3.1 Workforce composition

Both Hubs and Spokes are expected to maintain multidisciplinary teams capable of delivering their core functions with appropriate leadership. Additionally, Spokes are required to establish key leadership roles to support their operations.

The specific roles, number of full-time equivalent roles, and other employment arrangements are to be determined by service providers, in consultation with the department.

Providers of Spokes 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.

A.3.2 Key leadership roles for Spokes

A3.2.1 Operational leadership

Spokes require strong on-site leadership to manage day-to-day operations and represent Local Service needs. An operational lead should be appointed to oversee service delivery and workforce management at Spokes. Responsibilities include:

- Acting as the primary operational liaison between the Spoke and the Hub, ensuring alignment with systems and processes as required.
- Line management to all Spoke staff (across all work streams) providing mentorship, guidance, and support.
- Reviewing and escalating operational issues, including risks, to the Spoke senior governance committee.
- Supporting the escalation of clinical issues through the appropriate clinical governance mechanisms.
- Facilitating regular team meetings to discuss performance, troubleshoot challenges, and promote shared learning.

A.3.2.2 Clinical leadership

Clinical leadership at Spoke services is expected to be in line with clinical governance, as detailed in Section A.4.2. Clinical governance arrangements at Spokes must include a clinical lead who is available to provide:

- Clinical oversight of access and intake, care coordination and multidisciplinary case review meetings.
- Clinical advice and decision-making.
- Clinical escalation support during operating hours.
- Clinical supervision of staff.

Spokes must ensure the availability of a suitably qualified and experienced clinical lead during operating hours. Should the availability of the clinical lead be through a partner or the linked Hub offsite, the Spoke service will need to identify processes and procedures for contacting and accessing the clinical lead for advice, decision-making and clinical escalation.

The clinical lead is required to have the necessary skills, qualifications and experience, as detailed in the Service Framework.

A.3.2.3 LLE leadership

Spokes must make arrangements to facilitate LLE leadership and supervision for LLE staff working at the Spoke. Depending on the workforce model adopted by the Spoke, these leadership and supervision requirements may be provided via the linked Hub.

A.4 Service operations

This section outlines expectations relating to governance arrangements, accommodation requirements, service operating hours, service modalities, service branding and reporting for Spokes.

A.4.1 Operational governance

Spokes are expected to establish clear and effective operational governance arrangements that support the proper functioning of the service. This should include a senior governance committee comprising representation from each partner service that is responsible for planning, performance and service activity monitoring, risk management and other operational oversight functions.

A.4.2 Clinical governance

Spokes are expected to establish clinical governance arrangements. These arrangements must align with broader Service Framework requirements and maintain high standards of quality, safety and accountability. It is expected that clinical governance will at a minimum include representation from the relevant Area Service.

Final governance arrangements should be developed in consultation with the department.

It is also expected that processes will be established for review of incidents, and include all partners involved.

As noted in the Service Framework, service providers are required to align with the requirements of the Victorian Clinical Governance Framework <https://www.safercare.vic.gov.au/publications/victorian-clinical-governance-framework>.

A.4.3 Accommodation requirements

It is expected that Spokes will typically utilise multifunctional/shared or co-located facilities, with priority given to ready-to-use spaces that require minimal or no refurbishment. Underpinning all accommodation choices is the expectation that they adhere to foundational service delivery principles and meet basic physical infrastructure standards.

Service providers are expected to work in partnership with staff and people with LLE to ensure the location, facilities and amenities meet the needs of consumers and their family, carers and supporters.

A.4.4 Service operating hours

Spokes are required to, at minimum, operate Monday to Friday, from 9 am to 5 pm[33], 52 weeks a year. There is no requirement or expectation for a Spoke to be open on a public holiday.

Additional after-hours and weekend services may be provided if there is sufficient consumer demand and service model capacity allows. Additional funding is not provided for overperformance.

A.4.5 Service modalities

As a minimum, Spokes are expected to deliver services as set out in the table below.

Table 2: Spoke service modality expectations

Modality	Description
On-site services	On-site support is provided at least three days per week to ensure consistent access for consumers attending face-to-face appointments. Walk-ins may be provided by the Spoke if service model capacity allows.
Telehealth services	Telehealth services must be provided on the days when on-site services are not provided (i.e. a minimum of two days per week). These services address barriers faced by consumers in remote areas or those unable to travel.
Outreach services	Outreach services must be offered to accommodate consumers facing isolation, mobility challenges, or geographic barriers. They must be conducted in line with OHS requirements. These services enable staff to engage directly with consumers within their communities.

A.4.6 Service branding

When engaging externally or with consumers, both Hubs and Spokes are to be referred to and recognised as Mental Health and Wellbeing Locals.

This unified branding approach promotes a cohesive and consistent service identity for consumers, supporting a seamless experience across locations.

A.4.7 Reporting

Spokes are subject to reporting obligations as set out in the Service Framework and in line with clinical governance arrangements.

In the event that a consumer receives services from both a Hub and Spoke, the service zone in which the consumer lives will determine which Local Service is responsible for the relationship, and for consumer-based reporting.

[33] Equivalent alternative opening hours may be provided subject to approval by the department.

Data specifications and a reporting guideline (including the detailed list of individual data items) are provided separately. Providers can obtain a copy of the Data specifications and reporting guideline by submitting request to LocalServices@health.vic.gov.au.

A.5 Partnerships

Hubs and Spokes are expected to align with partnership requirements set out in the Service Framework. This section sets out any departures from the Service Framework.

A.5.1 Spoke partnership requirements

Spokes are expected to form a documented partnership or other legal or contractual arrangement acceptable to the department for the effective operation of new Local Services. The following information articulates the minimum partnership requirements for a Spoke:

- Each Spoke will be linked to a Hub. As such, the lead provider of the Spoke will be the same as the Hub lead provider.
- The lead provider is responsible for the establishment of the partnership and required legal or contractual arrangements. They are also expected to coordinate service delivery among partners.
- Area Services must be included in the Spoke partnership.
- Other organisations may also be included in the partnership, with the department's approval. This could include, for example:
  - appropriately experienced and skilled local service providers
  - An Aboriginal Community Controlled Organisation or Aboriginal Community Controlled Health Organisation with experience working with community in the service zone.
  - Organisations with experience working with culturally and linguistically diverse communities in the service zone.

A.5.2 Partnership with an Area Service

A Spoke is required to maintain a documented partnership or other legal or contractual arrangement with the relevant Area Service, outlining roles and responsibilities. It is expected that arrangements to support the partnership will be detailed further in agreed documentation, for example agreed shared policies, protocols and operational manuals.

A.6 Summary of features of Hub and Spoke services

The table below summarises the key features of Hubs and Spokes.

Table 3: Key features of Hubs and Spokes

Hub	Spoke
Core service components	

Hub	Spoke
Conducts intake and assessment processes via walk-ins, phone calls and online platforms.	Conducts intake and assessment processes via phone calls and online platforms. Walk-ins are provided if service model capacity allows.
Service offering: • Treatment and therapies • Wellbeing supports • Education, peer support and self-help • Care planning and coordination	Service offering: • Treatment and therapies • Wellbeing supports • Education, peer support and self-help • Care planning and coordination
Provides shared integrated support functions to the Spoke, including corporate service functions, workforce development, and technology and data systems.	Leverages shared arrangement with Hub for integrated support functions, including corporate service functions, workforce development, and technology and data systems.
Workforce	
A larger workforce comprising a multidisciplinary team of leadership, operational, clinical, wellbeing and peer worker roles, as well as corporate function roles.	A smaller workforce comprising a multidisciplinary team of leadership, operational, clinical, wellbeing and peer worker roles.
Service operations	
Maintain operational governance arrangements that support the proper function of their Local Service.	Maintain operational governance arrangements that support the proper function of their Local Service.
Establish clinical governance arrangements to ensure quality and safety of service delivery at the Hub. Based on the nature of the agreement with Spokes, Hubs may also be required to support Spoke clinical governance arrangements.	Establish clinical governance arrangements to ensure quality and safety of service delivery at the Spoke.
Contractual relationship between the lead provider and the department, with sub-contractual relationship with Hub partner organisations.	Contractual relationship between the lead provider and the department, with sub-contractual relationship with Spoke partner organisations.
The service operates 9 am to 5 pm on weekdays, with extended operating hours on the weekends and after-hours support (operating 52 weeks a year, including public holidays).	Spokes are required to, at minimum, operate Monday to Friday, from 9 am to 5 pm, 52 weeks a year. There is no requirement or expectation for a Spoke to be open on a public holiday. Equivalent alternative and additional opening hours may be provided subject to approval by the department.
The service will operate from a dedicated and intentionally designed premises.	The service will typically utilise multifunctional/shared or co-located facilities during on-site days.

A.7 Locations of services operating under the Hub and Spoke model

The table below outlines the locations of services operating under the Hub and Spoke model.

Table 4: Locations of services operating under the Hub and Spoke model

Spoke service zone (LGAs)	Linked Hub service zone
Cardinia Shire	Dandenong, servicing Greater Dandenong
City of Darebin	Whittlesea
Maribyrnong City	Brimbank
Wyndham City	Brimbank
City of Maroondah	Lilydale, servicing Yarra Ranges
Mount Alexander Shire, servicing Central Goldfields Shire and Macedon Ranges Shire	Bendigo and Echuca, servicing Greater Bendigo, Loddon and Campaspe
City of Port Phillip	Frankston

Appendix B: Glossary of terms

Table 2: 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 and Torres Strait Islander peoples	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 and Torres Strait Islander peoples in this document to include all people of Aboriginal and Torres Strait Islander descent who are living in Victoria.
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 (or dependence)	A medical term used to describe a condition where someone continues to engage in a behaviour despite experiencing negative consequences. 'Dependence' is a term used interchangeably with 'addiction'. Similarly, gambling addiction or dependence 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.
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, their 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 Service.
Area Adult and Older Adult Mental Health and Wellbeing Services (Area Services)	State funded services which provide tertiary-level treatment, care and support for people aged 26 years or over experiencing mental ill-health or psychological distress. This includes treatment, care and support provided in community and bed-based settings.
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.

Term	Meaning
Assessment Order	An order made under *the Mental Health and Wellbeing Act 2022* (Vic) that authorises a person to be compulsorily examined by an authorised psychiatrist to determine whether the treatment criteria, specified in the *Mental Health and Wellbeing Act*, 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 mental health practitioner	An authorised mental health practitioner is a person who is employed or engaged by a designated mental health service as a registered psychologist, registered nurse, social worker, registered occupational therapist, or a member of a prescribed class of person.
Authorised psychiatrist	A psychiatrist appointed by a designated mental health service to exercise the functions, powers and duties conferred on this position under the *Mental Health and Wellbeing* Act 2022 (Vic), the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (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 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.[34]
Care/support	The provision of support, assistance or personal care to another person. This phrase is used to present treatment, care and support as fully integrated, equal parts of the way people will be supported in the future mental health and wellbeing system. In particular, wellbeing supports (previously known as 'psychosocial supports') that focus on rehabilitation, wellbeing and community participation will sit within the core functions of the future system.
Care/Support Team	A group of individuals responsible for the treatment, care and wellbeing of a consumer.
Carer	Carer is legally defined in the *Carers Recognition Act 2012 as; a person, including a person under the age of 18 years, who provides care to another person with whom he or she is in a care relationship.* Care relationship is further defined in the *Carers Recognition Act 2012,* which can be found on our carer rights and recognition webpage <https://www.betterhealth.vic.gov.au/health/servicesandsupport/carer-rights-and-recognition>. Paid carers such as professional staff in services, disability support carers or residential workers are not included in this definition., such as professional staff in services, disability support carers or residential workers are not included in this definition.

[34] Department of Health 2020, *Care coordination*, State Government of Victoria, Melbourne.

Term	Meaning
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.
Chief Officer	The Chief Officer, as defined in the *Mental Health and Wellbeing Act 2022* (Vic), is the person responsible for overseeing and managing the mental health and wellbeing system, and the functions within the system. They further oversee non-legal advocacy services and promote awareness and equitable access across the community.
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 services	A service being delivered by a clinician providing medical and clinical treatment, including assessments, counselling, psychological therapies, psychotherapeutic interventions, pharmacological treatment, including prescribing, medication monitoring and review.
Clinical treatment	In accordance with the *Mental Health Act 2014* (Vic), a person receives clinical treatment for mental ill-health or psychological distress if things are done in the course of the exercise of professional skills to remedy the person's mental ill-health or psychological distress; or to alleviate the symptoms and reduce the ill effects of the person's mental ill-health or psychological distress.
Co-design	Co-design refers to a collaborative process bringing people with lived or living experience of mental ill-health or psychological distress, family, carers and supporters and the staff together to design the service offer and policies.
Co-develop	Co-develop refers to a collaborative process where people with lived or living experience of mental ill-health or psychological distress, family, carers, supporters, service providers, and other stakeholders work together to jointly create, refine, and implement services, programs, or 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.

Term	Meaning
Consumer	People who identify as having a lived or living experience of mental ill-health or psychological distress, irrespective of whether they have a formal diagnosis, who have accessed mental health services and/or received treatment.
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.
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).
Designated mental health service	A designated mental health service is a public hospital, public health service, denominational hospital, privately operated hospital or a private hospital within the meaning of section 3(1) of the Health Services Act 1998 that has been prescribed to be a designated mental health service in the Mental Health and Wellbeing Regulations 2023, or the Victorian Institute of Forensic Mental Health; a service that is temporarily declared to be a designated mental health service under the Act, or a declared operator of Youth Mental Health and Wellbeing Victoria.
Disability communities	In line with the *Disability Discrimination Act 1992* (Cth), the definition of disability includes physical, intellectual, psychiatric, sensory, neurological and learning disabilities and chronic health conditions.
Division	The Mental Health and Wellbeing Division of the Victorian Department of Health.
Family	May refer to family of origin and/or family of choice. Family is broadly defined and inclusive of family of choice and origin, and broader kin. The *Chief Psychiatrist's Guideline: Working together with families and carers* 2018 <https://www.health.vic.gov.au/chief-psychiatrist/working-together-with-families-and-carers> defines family as: *Family includes the consumer and those with a significant personal relationship with the consumer. This includes biological relatives and non-biological relatives, intimate partners, ex-partners, people in co-habitation, friends, those with kinship responsibilities, and others who play a significant role in the consumer's life. Some family members may identify themselves as a 'carer' in a consumer's life, others will identify more so with the characteristic of their relationship (for example, parent, child, partner, sibling).*
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.

Term	Meaning
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 ill-health or psychological distress 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 Mental Health and Wellbeing Local. 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: • 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), or • an individual Act of Parliament.
LGA	Local Government Area

Term	Meaning
LGBTIQA+	The term 'LGBTIQA+' refers to people who are lesbian, gay, bisexual, trans and gender diverse, intersex, queer and asexual. We use variations of the term throughout this strategy depending on the language originally used. We use other terms like 'TGD' (trans and gender diverse) or 'LGBT' depending on specific communities referenced. We also note that some Aboriginal communities use the terms 'sistergirls' and 'brotherboys'.
Lived/living experience	People with lived/living experience identify either as someone who is living with (or has lived with) mental ill-health 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 ill-health or psychological distress. People with lived and living experience are sometimes referred to as 'consumers' or 'carers', acknowledging that the experiences of consumers and carers are different.
Lived and living experience workforce	The lived experience workforce is a broad term used to represent two distinct professional groups in roles focused on their lived expertise: • people with personal lived experience of mental illness ('consumers') • families and carers with lived experience of supporting a family member or friend who has experienced or is experiencing mental illness. There are various paid roles among each discipline. This includes workers who provide support directly to consumers, their families and carers through peer support or advocacy, or indirectly through leadership, consultation, system advocacy, education, training or research.
Local Adult and Older Adult Mental Health and Wellbeing Service	Royal Commission recommendation name, now referred to as **Mental Health and Wellbeing Locals and abbreviated to Local Services.**
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 ill-health or psychological distress but to creating the conditions in which people are supported to achieve their potential. The addition of the concept of 'wellbeing' represents a fundamental shift in the role and structure of the future system. In the future mental health and wellbeing system for Victoria, mental health and wellbeing refers to the absence of mental health challenges or psychological distress and to creating the conditions in which people are supported to achieve their potential.

Term	Meaning
Mental Health and Wellbeing Local	A service funded by the state as a Mental Health and Wellbeing Local (also referred to as a Local Service), based in community that supports adults and older adults experiencing mental ill-health or psychological distress, including people with co-occurring substance use and/or dependence, requiring moderate to high intensity care.[35] Local Services provide holistic integrated mental health clinical and wellbeing treatment, care and supports delivered by a multidisciplinary team.
Mental Health and Wellbeing System	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: 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. 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.
Mental ill-health or mental illness	Mental ill-health is a term encompassing overall emotional, psychological and social well-being. The term is broadly used to describe experiences that include mental health challenges, psychological distress, 'neurodiversity', 'emotional distress', and 'trauma'. Mental ill-health and mental illness are related concepts. The *Mental Health Act 2014 (Vic)* 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 and living experience can have varying ways of understanding the experiences that are often called 'mental illness'.
Multicultural communities	The term 'multicultural communities' describes the vast number of diverse cultural, racial and ethnic groups who live in Victoria. We chose this word because it is succinct and broadly inclusive and recognises the different lived experiences of: • migrants from new and emerging communities who have recently arrived in Victoria • people from refugee backgrounds and people seeking asylum • people who speak languages other than English or who speak English with an accent • people who follow a broad range of religious and spiritual practices.

[35] The Commonwealth Government's Initial Assessment and Referral Decision support Tool (IAR-DST), which Local Services are to use, provides a standardised, evidence-based and objective approach to assist with mental health care recommendations. The IAR-DST sets five levels of care (refer to **Appendix E**), moderate intensity is level 3 and high-intensity is level 4.

Term	Meaning
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 *National Disability Insurance Scheme Act 2013*, the NDIS provides disability support to eligible people with intellectual, physical, sensory, cognitive and psychosocial disability.
Networked health service	A networked health service is the publicly funded health service responsible for delivering Area Mental Health and Wellbeing Services (Area Services) in the Service Zone of the Local Service. These services work in collaboration with Local Services to ensure optimal outcomes for shared consumers through effective operational partnerships. For further details, refer to Section 3.1. Note this is not the same as Local Health Service Networks.
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).
Outcomes	In the mental health system, 'outcomes' often refers to the changes in an individual's mental health as a result of accessing a service.
Peer support	Help and support that people with lived and living experience of a mental health challenges or psychological distress, including those with experience of substance use and/or dependence, 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. Peer support workers use their personal lived and living 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. 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. Family or carer peer support workers use their personal lived and living experience of assisting someone with mental health challenges or psychological distress (including those with experience of substance use and/or dependence), to support families or carers who are assisting someone with mental health challenges or psychological distress.

Term	Meaning
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	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. 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.
Primary and secondary mental health care providers	Primary mental health care 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. Secondary mental health care 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.
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.
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.

Term	Meaning
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.
Quality assurance	A range of strategies, including regulation, used to provide assurance that services are meeting minimum quality or safety standards or expectations.
Recommendation	A suggestion or proposal as to the best course of action. Royal Commissions make recommendations to government about what should change. The Victorian Government has committed to implementing all recommendations from the Royal Commission into Victoria's Mental Health System.
Royal Commission	A Royal Commission is an investigation, independent of government, into a matter of great importance. Royal Commissions have broad powers to hold public hearings, call witnesses under oath and compel evidence. Each Royal Commission has terms of reference, which define the issues it will investigate. The Royal Commission into Victoria's Mental Health System was established on 22nd February 2019 and provided its final report on 3rd February 2021.

Term	Meaning
Recovery	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. Personal recovery is an idea that has emerged from the expertise of people with lived and living experience of mental ill-health or psychological distress. 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. 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. 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. Some characteristics of recovery commonly cited are that it is: • 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 ill-health or psychological distress, 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.
Service provider	An entity funded by the department to deliver services.

Term	Meaning
Service Agreement	A Service Agreement is a legal contract between a government department and a funded organisation for delivery of services in the community on behalf of the Department of Families, Fairness and Housing, Department of Health, Department of Education and Adult Community and Further Education Board. For more information refer to the following: **Service Agreement:** <https://fac.dffh.vic.gov.au/service-agreement> **Service Agreement requirements:** <https://fac.dffh.vic.gov.au/service-agreement-requirements>
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).

Term	Meaning
Stigma	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. Self-stigma - the process whereby someone begins to agree with stigmatised views and then applies these views themselves. Interpersonal stigma (or public stigma) – attitudes and behaviours towards people living with mental ill-health or psychological distress. Structural stigma – discriminatory or exclusionary policies, laws and systems. Stigma by association – stigma experienced by someone on the basis of their association with someone with lived and living experience of mental ill-health or psychological distress.
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.
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.
Statement of Priorities	Statement of Priorities (SoPs) are annual accountability agreements between Victorian public healthcare services and the Minister for Health. They outline the key performance expectations, targets and funding for the year as well as government service priorities. SoPs are a requirement for public healthcare services under the *Health Services Act 1988* and represent the service agreement requirements for public hospitals under the Act. For more information about SoPs refer to <https://www.health.vic.gov.au/funding-performance-accountability/statements-of-priorities>
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.

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Term	Meaning
Telehealth	Use of online software, phone-conferencing or videoconferencing to deliver services and supports directly to a consumer.[36]
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	A deeply distressing or disturbing experience. 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 and Torres Strait Islander peoples of Victoria and the experiences of humanitarian migrants. 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. 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. 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.
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.

[36] Ibid, p.533

Term	Meaning
Wellbeing supports (Previously known as 'psychosocial supports')	Non-clinical and recovery-oriented services, delivered in the community and tailored to individual needs, which support people experiencing mental ill-health to live independently and safely in the community They include services that assist people with mental ill-health to: • manage daily living skills • obtain and maintain housing • identify client needs for other services (such as the NDIS, alcohol and other drug treatment services, clinical care), connect with and maintain engagement with these services • socialise, build and maintain relationships • engage, and maintain engagement, with appropriate education (including vocational skills) and employment opportunities.
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 C: Legislative and policy requirements

This section outlines the legislative, safety, and quality requirements for service providers, including relevant laws, child safety standards, and cultural safety frameworks, along with mandated reporting and information-sharing obligations.

C.1 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 (in alphabetical order):

- *Carers Recognition Act 2012* (Vic).
- *Charter of Human Rights and Responsibilities Act 2006* (Vic).
- *Children, Youth and Families Act 2005* (Vic).
- *Disability Act 2006* (Vic).
- *Drugs, Poisons and Controlled Substances Act 1981* (Vic).
- *Family Violence Protection Act 2008* (Vic).
- *Gender Equality Act 2020* (Vic).
- *Health Records Act 2001* (Vic).
- *Health Services Act 1988* (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*.

C.2 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.

C.2.1 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.health.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework>.

C.2.2 Aboriginal cultural safety fixed grant guidelines – Cultural planning and reporting

The Aboriginal cultural safety fixed grant guidelines - Cultural safety planning and reporting 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 Statement of Priorities (SOP), Part A. Further information is available at Aboriginal cultural safety fixed grant guidelines - Cultural safety planning and reporting <https://www.health.vic.gov.au/publications/aboriginal-cultural-safety-fixed-grant-guidelines-cultural-safety-planning-and>.

C.2.3 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 ill-health 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://www.health.vic.gov.au/ publications/ balit-murrup-aboriginal-social-emotional-wellbeing-framework-2017-2027>.

C.2.4 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.dffh.vic.gov.au/publications/korin-korin-balit-djak>.

C.2.5 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).[37] Organisations and services prescribed under MARAM (which includes mental health services and their workforces) are required to align their policies, procedures, practice guidance and tools to the framework. This is a legal obligation as recommended by the Royal Commission into Family Violence.

The MARAM framework has been designed to increase the safety and wellbeing of Victorians by supporting relevant services to identify, assess, manage and respond to

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

family violence risk effectively. The MARAM framework 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.

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

C.2.6 Family Violence Information Sharing Scheme (FVISS) and the Child Information Sharing Scheme (CISS)

Alongside the MARAM Framework reforms, the Family Violence Information Sharing Scheme (FVISS) and Child Information Sharing Scheme (CISS) have been developed to improve ways that certain professionals share information about children, families, as well as authorised organisations assessing and managing family violence risk.

Under these schemes, information can only be shared by Information Sharing Entities (ISEs) - which includes designated mental health services. ISEs (key organisations and services) can share information related to assessing or managing family violence risk.

A guide to who can share information under the Information Sharing and MARAM Reforms https://www.vic.gov.au/ciss-and-fviss-who-can-share-information.

Guidance for organisations prescribed under the Child Information Sharing Scheme https://www.vic.gov.au/child-information-sharing-scheme> and Family Violence Information Sharing Scheme <https://www.vic.gov.au/family-violence-information-sharing-scheme>.

C.2.7 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* (Vic), 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.[38]

- 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.

C.2.8 Language Services Policy

The *Multicultural Victoria Act 2011* (Vic) 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 consumers and family, carers and supporters with limited English.
- Define when interpreters must be engaged.
- Are reviewed and updated regularly in consultation with relevant community stakeholders.
- Reflect the needs of their particular consumer and family, carer and supporter groups.

  More information can be found on our Language services policy and accompanying guidelines <https://www.health.vic.gov.au/publications/language-services-policy>,

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

Appendix D: Service 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 'broad front door' approach.
- 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.
- ED diversion is positioned as a medium – to long-term system aspiration, not an immediate operational function of Local Services.
- 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 support 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 with all involved.
- Consumer engagement and participation to identify 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. Local Services must ensure this engagement is guided by clear processes that respect consumer preferences, maintain privacy and confidentiality, and provide appropriate support for families, carers, and supporters in their role.
- 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 such as Connect Centres.
- 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. For more information refer to Section 5.1.6 High risk presentations of this document.

- Multidisciplinary biopsychosocial assessment to better understand the consumer's mental health, wellbeing and other needs, including co-occurring substance use or and/or dependence, 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 actively 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:
  - one-on-one 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, support 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. Refer to Section 6.4 Social Prescribing for more information.
- Care coordination to assist the consumer, their family, carers and supporters to understand, navigate and remain connected to the Local Service (while support is needed) and to 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 needs, determined in discussion with the consumer, their family, carers and supporters and their support team, considering accessible and available primary and secondary

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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.

Appendix E: Initial Assessment and Referral Tool

E.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 intended to assist health professionals to decide the most appropriate level of care a consumer will need across the five levels of care in a stepped care model. 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.

E.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, as described in **Table 3**.

Table 3: Assessment domains

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.

Domains	Description
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.

E.3 Levels of Care

The information gathered through the initial assessment domains is used to recommend a service type and level of 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. **Table 4** provides a description of each level of care.

Table 4: Levels of care

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**
Typically, no risk of harm, experiencing mild symptoms and/ or no/low levels of distress – which may be in response to recent psychosocial stressors. Symptoms have typically been present for a short period of time. The individual is generally functioning well and should have high levels of motivation and engagement.	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. Symptoms have typically been present for a short period of time (less than 6 months but this may vary). Generally functioning well but may have problems with motivation or engagement. Moderate or better recovery from previous treatment.	Likely moderate to severe symptoms and distress (meeting criteria for a diagnosis). Symptoms have typically been present for 6 months or more (but this may vary). Likely complexity of risk, functioning or co-existing conditions but not at very severe levels. Suitable for people experiencing severe symptoms with mild to moderate problems associated with risk, functioning and co-existing conditions.	Usually, a person requiring this level of care has a diagnosed mental health condition with severe symptoms and/or significant problems with functioning. A person with a severe presentation is likely to be experiencing moderate or higher problems associated with risk, functioning and co-existing conditions.	Usually, a person requiring this level of care has severe or very severe symptoms and severe problems with functioning independently across multiple or most everyday roles and/or is experiencing: • Very significant risk of suicide; self-harm, self-neglect or vulnerability • Very 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, brief	Moderate intensity services include a course of structured, reasonably	Periods of intensive intervention over long period of time, typically:	Specialist assessment and intensive interventions (Typically, state/territory

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**
	phone/online interventions and involve few or short sessions.	frequent and individually tailored interventions for mental health symptoms/distress (e.g. psychological interventions).	multidisciplinary support, psychological interventions, psychiatric interventions, and care coordination as multiple services are likely to be involved.	mental health services) with involvement from a range of mental health professionals.

Appendix F: Guidance on co-design minimum requirements

To achieve meaningful and effective co-design, providers should consider the following **minimum requirements for co-design**:

- Lived Experience Leadership. Co-design processes should centre the voices and expertise of individuals with lived experience of mental health challenges, as well as their families, carers and supporters. Their contributions should inform all stages of service planning, design, implementation, and evaluation.
- Inclusivity and Accessibility. Co-design should engage a diverse range of people, representative of the communities served by the Local Services. Processes should accommodate varying needs, ensuring accessibility.
- Commitment to Transparency and Collaboration. Co-design efforts should prioritise open and transparent communication with all participants. Participants should be provided with clear information about their roles, the purpose and scope of the co-design process, and how their input will be used. Collaboration should be underpinned by mutual respect, shared decision-making, and ongoing feedback loops.
- Capacity Building and Support. Adequate training, resources, and support should be provided for all participants to meaningfully engage in co-design. This includes briefing participants on the co-design process, equipping them with the necessary skills and knowledge, and addressing any barriers to their involvement.
- Outcomes-Focused Design. Co-design should aim to achieve tangible improvements in the accessibility, quality, and responsiveness of mental health and wellbeing services. Feedback loops should be established to share progress, outcomes, and learnings with participants and the broader community.

Further, providers should consider the following **desirable requirements for co-design**:

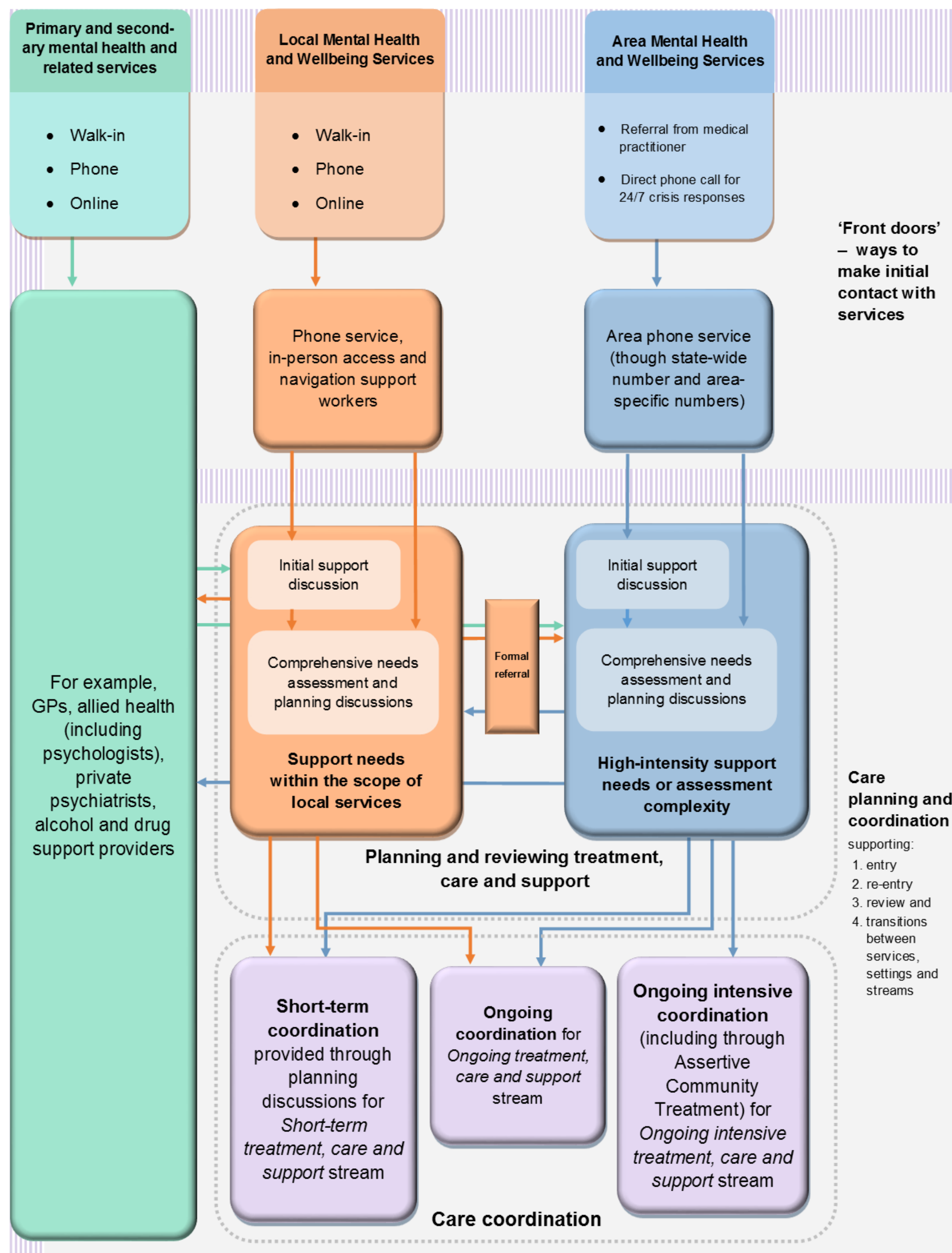
- Trauma-Informed Practice. Co-design should adopt a trauma-informed approach that recognises the impact of trauma on participants and prioritises emotional safety throughout the process.
- Continued Partnership. Beyond service development, there should be an ongoing commitment to partnering with consumers, families, carers, supports and communities in the evaluation and improvement of services over time.
- Innovation and Flexibility. Providers are encouraged to incorporate creative and innovative consultation methods, to engage individuals from diverse backgrounds effectively.
- Community Ownership. Embed practises that encourage communities to feel ownership over the services developed through co-design, fostering long-term engagement and trust.
- Integrated Feedback Channels. Establish mechanisms for ongoing input beyond the initial co-design phase, ensuring continuous improvement based on lived and shared experiences.

By embedding these considerations into the early stages of service design and delivery, Local Services will support a system that is person-centred, culturally safe, and responsive

to the needs and aspirations of those they serve. These considerations align in particular with recommendations from the Royal Commission into Victoria's Mental Health System – final report <https://www.vic.gov.au/royal-commission-victorias-mental-health-system-final-report> and Mind's Participation and Co-Design Practice Framework <https://www.mindaustralia.org.au/sites/default/files/2023-06/Participation_and_codesign_practice_framework.pdf>.

Appendix G: Referring service providers

Figure 5: Entry and referral pathways across primary and secondary health care services and Local Services and Area 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 co-occurring physical and mental health needs.
- General practitioners.
- Private psychiatrists, psychologists and mental health counsellors.
- AOD service providers (for people with co-occurring mental ill-health and substance use and/or dependence).
- Community Health Services and Maternal and Child Health Services.
- Helplines, including crisis helplines such as Beyond Blue, Lifeline and Suicide Line Victoria.
- Medicare Mental Health phone service (formerly Head to Health phone service).[39]
- Multiple and complex needs panels.
- Disability providers, including NDIS providers for participants who require mental health treatment and care.
- Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal Community-Controlled Organisations (ACCOs).
- Organisations supporting refugees and people seeking asylum.
- Community organisations supporting culturally and linguistically diverse and LGBTIQA+ 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 Connect Centres.
- Employment and education providers, including early childhood services, schools and tertiary education providers.
- Social support providers.
- Local government funded services.

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[39] https://www.health.gov.au/resources/publications/national-service-model-medicare-mental-health-phone-service

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Appendix H: Multidisciplinary team functions and disciplines

Table 5 below indicates the expected staff skills for each of the functions of the service model, and suggested discipline type.

Table 5: Multidisciplinary team functions and disciplines (indicative)

Function	Key knowledge and skills	Multidisciplinary team members (guide only)[40]
Operations manager	• Operational management experience and expertise in mental health service delivery. • Clinical mental health experience and expertise. • Risk management expertise and experience.	• Psychiatrist • Mental health nurse / mental health nurse practitioner • Allied Health working in Mental Health[41]
Clinical services manager	• Clinical mental health experience and expertise. • Clinical governance expertise and experience. • Leadership experience.	• Psychiatrist • Mental health nurse / mental health nurse practitioner • Mental Health Allied Health
Lived experience directors/ senior leaders (consumer and carer)	• Lived and living experience of mental illness and/or substance use and/or addiction or caring for a person experiencing mental ill-health or psychological distress. • Discipline-specific supervision experience and training. • Leadership experience.	• Appropriately qualified lived experience team members
Initial engagement	• Interpersonal, communication and engagement skills. • Knowledge, skills and values in mental health and AOD recovery.	• Peer workers – mental health (Certificate IV in Mental Health Peer Work) • AOD Peer worker – Self Help Addiction Resource Centre (SHARC) Peer Worker Training • Mental health support workers (Diploma in Mental Health, Certificate IV in Mental Health) • Koori Mental Health Liaison Officers (KMHLOs) and Aboriginal Health Liaison Officers (AHLOs)

[40] This includes use of prequalification and graduate/training positions across the disciplines.

[41] 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)[40]
Initial screening assessment	• Understanding of and commitment to consumer-led practice, as well as skills and experiencing in consumer-led service delivery. • 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. • Skills and experience in the Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM) to identify and respond to family violence, including an understanding of the legislative requirements of the Information Sharing Schemes (Family Violence Information Sharing Scheme (FVISS) and Child Information Sharing Scheme (CISS)). • Capability to identify family systems and address any needs identified to support families, carers and supporters.	• Mental Health Nurses • Psychologists • Social workers • Occupational Therapists • Medical trainees (psychiatry) • AOD qualified clinicians. (Certificate IV in Alcohol and Other Drugs)
Biopsychosocial assessment and care planning discussions (Noting a single professional would be likely to undertake an individual assessment, but may seek support and advice from other team members)	• Skills in consumer-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. • Skills and experience in the Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM) to identify and respond to family violence. Including an understanding of the legislative requirements of the Information Sharing Schemes (Family Violence Information Sharing Scheme (FVISS) and Child Information Sharing Scheme (CISS)).	• 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).

Function	Key knowledge and skills	Multidisciplinary team members (guide only)[40]
	• 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. • Skills and experience to assess any family and carer support needs. Including the needs of any consumers who are parents.	
Wellbeing supports	• Skills in consumer-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. • Skills and capability to provide family-inclusive support for consumers and their families, carers and supporters. • Skills and experience in the Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM) to identify and respond to family violence. Including an understanding of the legislative requirements of the Information Sharing Schemes (Family Violence Information Sharing Scheme (FVISS) and Child Information Sharing Scheme (CISS)).	• Peer workers – mental health (Certificate IV in Mental Health Peer Work) • AOD Peer worker • 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) • Training Art and music therapists • Vocational Support Workers • Aboriginal Health Workers • Multidisciplinary Aboriginal Social and Emotional Wellbeing Workers • Koori Mental Health Liaison Officers (KMHLOs) and Aboriginal Health Liaison Officers (AHLOs) • Transcultural Health Workers.
Peer work	• Knowledge, skills and values in mental health recovery and the promotion of wellbeing within an intentional peer model.	• Peer worker – mental health (Certificate IV in Mental Health Peer Work) • AOD Peer worker – Self Help Addiction Resource Centre (SHARC) Peer Worker Training

Function	Key knowledge and skills	Multidisciplinary team members (guide only)[40]
	• 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.	• Peer Cadets (targeted to individuals undertaking VET studies in Mental Health Peer Work or equivalent).
Clinical treatment, including structured psychological therapies and medication prescribing and review **Integrated mental health and AOD treatment and care interventions**	• Skills in consumer-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 mental ill-health or psychological distress and co-occurring substance use or addiction. • Skills and experience in medication prescribing, monitoring and review (medical/ nursing staff as suitably qualified). • 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. • Skills and experience in providing family violence informed, family inclusive practice and interventions.	• 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.
Care coordination	• Skills in consumer-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, including family violence services, housing and homelessness supports, financial counselling, legal services, employment and vocational support, aged care, justice, and disability supports. • Skills in building the capability of local health, social and community service providers to engage and support people	• Peer workers – mental health (Certificate IV in Mental Health Peer Work) • AOD Peer worker • Multidisciplinary Aboriginal Social and Emotional Wellbeing Workers. • Occupational Therapists • Social workers • Mental health nurses • Mental health support workers (Diploma in Mental Health, Certificate IV in Mental Health, Graduate Diploma of Counselling) • Koori Mental Health Liaison Officers (KMHLOs) and Aboriginal Health Liaison Officers (AHLOs).

Function	Key knowledge and skills	Multidisciplinary team members (guide only)[40]
	with a mental illness and co-occurring substance use and/or dependence to address barriers to access. • Knowledge of digital and telehealth mental health services.	
Physical health care	• Skills in consumer-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.	• General practitioners – trainee • Nurse practitioners and Nurses (including enrolled nurses) • Exercise physiologist • Physiotherapist • Diabetes educators • Dietitian • Aboriginal Health Workers • Transcultural Health Workers • Occupational Therapist.
Administrative staff (e.g. receptionist, data management staff)	• Well-developed interpersonal skills • Knowledge of mental ill-health and psychological distress and substance use and/or dependence its impacts. • Skills relevant to functions.	• Appropriately qualified.

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.*
- *Trauma informed practice is a core capability required of all workforce roles and should be embedded and clearly reflected across all relevant functions.*

Appendix I: Guidance on agreement minimum requirements

I.1 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.

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- 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.

I.2 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.

I.3 Consortium Partners and subcontractors

The proposal for any new service providers / partners must be signed by an authorised officer of the Service Provider and any consortium partners and/or sub-contractors.

In addition to any required departmental due diligence assessments, the following criteria must be met for new partners or subcontractors and relevant evidence relating to meeting these criteria must be provided to the department.

Service providers must:

- Be an incorporated legal entity.
- Be formally compliant with and accredited against at least one health, mental health or other quality standard that is certified by an independent body.
- Agree to meet all the department's Service Agreement requirements including program, contractual and quality requirements as outlined in the Service Agreement,[42] activity descriptions and applicable departmental policies outlined in the Service Agreement Requirements.[43]
- Provide the previous two years of financial statements with audit reports.
- Provide evidence of compliance with applicable insurance obligations.
- Provide evidence of updated governance and accountability of the consortium model that outlines processes in place between the (new) partners including (but not limited to):
  - Governance model and organisational structure specifying organisational lines of accountability, responsibility and escalation for the functioning of the service.
  - Statement of roles and responsibilities of each partner in the governance framework, including reporting structures of partners.
  - Processes in place between partners to make operational decisions and ensure accountability between partners and how risk will be managed and shared.
  - How service performance issues will be monitored, assessed and managed, how service quality and continuous improvement will be assured and how disputes will be resolved between partners.
  - How consumer records will be managed and how data will be collected and reported efficiently.

[42] Service Agreement: https://fac.dffh.vic.gov.au/service-agreement

[43] Service Agreement requirements: https://fac.dffh.vic.gov.au/service-agreement-requirements.

Appendix J: Application of Client Support Unit

Table 6 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 6: Application of Client Support Unit

Application of CSU	Description	Examples of activities
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. *Please note an hour of active consumer engagement in a group setting delivered by a clinician / wellbeing 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.* *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.*	• 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: – 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). • Assistance to family, carer and supporters, including a carer brief assessment, carer peer led supports/groups and supported referral to link to Connect 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. CSUs may be used to broker support to address pressing needs and are to be reported as consumer-facing support.

Application of CSU	Description	Examples of activities
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.	• 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.	Support to the overall consumer group of the service: • 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 mental ill-health or psychological distress 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).

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Appendix K: Useful resources

Resources are listed in alphabetical order

A national framework for recovery-oriented mental health services: guide for practitioners and providers

Website	https://www.mentalhealthcommission.gov.au/publications/national-lived-experience-peer-workforce-development-guidelines

About Victoria's Mental Health services

Website	https://rcvmhs.archive.royalcommission.vic.gov.au/

Carers Recognition Act 2012

Website	https://www.legislation.vic.gov.au/in-force/acts/carers-recognition-act-2012/003

Funded Agency Channel

Website	https://fac.dffh.vic.gov.au/

Initial Assessment and Referral Decision Support Tool

Website	https://iar-dst.online/#/ Refer to the *Documentation link* on the landing page for more details and guidance

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

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

Lived and living experience workforces (LLEWs) initiatives

Website	https://www.health.vic.gov.au/workforce-and-training/lived-experience-workforce-initiatives

MARAM Practice Guides and Resources

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

***Mental Health and Wellbeing Act 2022* (Vic)**

Website	https://www.health.vic.gov.au/mental-health-and-wellbeing-act

Mental Health and Wellbeing Commission

Website	https://www.mhwc.vic.gov.au/
Phone:	1800 246 054 (free call from landlines)
Email:	help@mhwc.vic.gov.au

Mental Health and Wellbeing Locals

Department of Health Website	https://www.health.vic.gov.au/mental-health-services/mental-health-and-wellbeing-locals
Better Health Channel	https://www.betterhealth.vic.gov.au/mental-health-wellbeing-locals

Mental Health and Wellbeing Outcomes and Performance Framework

Website	https://www.health.vic.gov.au/mental-health/research-and-reporting/mental-health-and-wellbeing-outcomes-and-performance-framework

Mental Health Lived Experience Engagement Framework

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

National Lived Experience (Peer) Workforce Development Guidelines

Website	https://www.mentalhealthcommission.gov.au/publications/national-lived-experience-peer-workforce-development-guidelines

Office of the Chief Psychiatrist

Website	https://www.health.vic.gov.au/chief-psychiatrist
Phone	1300 7672 99
Email	ocp@health.vic.gov.au

Royal Commission into Victoria's Mental health System

Website	https://rcvmhs.archive.royalcommission.vic.gov.au/

Safer Care Victoria

Website	https://www.safercare.vic.gov.au/
Email:	info@safercare.vic.gov.au

Victorian Agency for Health Information

Website	https://vahi.vic.gov.au/
Email:	vahi@vahi.vic.gov.au