

Community-based care in Area Mental Health and Wellbeing Services

Service Framework

Version 01

VICTORIA State Government | Department of Health

Community-based care in Area Mental Health and Wellbeing Services

Service Framework

Version history

Version	Date	Notes
1.0	October 2026	

To receive this document in another format email the Service Design Unit <mhwsystemdesign@health.vic.gov.au>.

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

© State of Victoria, Australia, October 2026 (2610681)

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

ISBN 978-1-76195-091-9 **(pdf/online/MS word)**

Available at Redesigning community-based mental health and wellbeing care <https://www.health.vic.gov.au/area-based-services/redesigning-community-based-mental-health-and-wellbeing-care>

Acknowledgements

Acknowledgement of Aboriginal and Torres Strait Islander people

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 their 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.

We have negotiated Australia's first Treaty between First Peoples in Victoria and the Victorian Government. 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.

Through the Victorian Treaty, we recognise the wrongs of the past, make peace, and walk together with greater respect, understanding and connection, and celebrate the strength, resilience and diversity of First Peoples 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.

Contents

1.	**Introduction**	**7**
2.	**Purpose of this service framework**	**7**
3.	**Service overview and features**	**10**
3.1	Service objectives	10
3.2	Target group	10
3.3	Service principles	11
3.4	Consumer-centred care	12
3.5	Developmentally appropriate care	13
3.6	Culturally safe and inclusive care	14
3.7	Lived and living experience	15
3.8	Inclusion of families, carers and supporters	15
3.9	Service settings, modes and duration	17
3.10	Service partnerships	17
4.	**Access and intake**	**18**
4.1	Access to community-based services	18
4.2	Intake and initial support	19
5.	**Service delivery (community-based care)**	**21**
5.1	Crisis response	21
5.2	Care planning and coordination	22
5.3	Treatment and therapies	24
5.4	Physical health support	26
5.5	Peer support	27
5.6	Wellbeing support	28
5.7	Educational programs and self-help	30
6.	**Workforce**	**31**
6.1	Workforce disciplines	31
6.2	Training and development	32
6.3	Workforce capacity	33

7.	**Roles and responsibilities**	**34**
7.1	Role of the department	34
7.2	Role of Area Services	34
7.3	Role of non-government organisations	34
7.4	Shared responsibilities within partnerships	34
8.	**System integration and pathways**	**36**
8.1	System context	36
8.2	Collaborative practice	37
8.3	Consultations and shared care arrangements	38
8.4	Streamed care pathways	39
8.5	Local Health Service Networks	42
9.	**Governance and accountability**	**43**
9.1	Clinical governance	43
9.2	Quality assurance	43
9.3	Data, monitoring and evaluation	44
9.4	Performance indicators and targets	44
9.5	Evaluation and research	44
9.6	Knowledge sharing	45
9.7	Mental Health Improvement Program	45
9.8	Intended Outcomes	45

Appendices	**47**
Appendix A: Glossary of terms	47
Appendix B: Key mental health and wellbeing system policies, frameworks and guidelines	51
Appendix C: How community-based services fit within the Victorian system	53
Appendix D: Expectations for crisis response times	55
Appendix E: Clinical oversight and standards	56

1. Introduction

Area Mental Health and Wellbeing Services (Area Services) provide acute treatment, care and support in inpatient, residential, rehabilitation, subacute and community-settings for people with significant, complex and high-intensity needs across the lifespan: for infants, children, young people, adults and older adults. They are delivered by public health services prescribed as designated mental health services <https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/context-of-the-act/terms-and-definitions#designated-mental-health-service> under the Mental Health and Wellbeing Act 2022 <https://www.legislation.vic.gov.au/in-force/acts/mental-health-and-wellbeing-act-2022/005>.

This service framework describes community-based mental health and wellbeing services delivered by Area Services (referred to hereafter as community-based services).

2. Purpose of this service framework

The purpose of the *Community-based care in Area Mental Health and Wellbeing Services: Service Framework* (the framework) is to guide local planning and delivery of community-based services by Area Services, and to promote consistent service delivery across Victoria.

The Department of Health (the department) expects Area Services to develop a local model of care for community-based services that meets the minimum expectations detailed in the framework, and deliver services in accordance with the Policy and Funding Guidelines <https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services> and each service's Statement of Priorities <https://www.health.vic.gov.au/funding-performance-accountability/statements-of-priorities>.

The framework aims to achieve individual and system-level outcomes by:

- Establishing the objectives, principles and key features that underpin the delivery of consistent, high-quality community-based services in **Section 3: Service overview and features**.
- Describing the minimum expectations for service delivery across the full suite of core clinical and non-clinical community-based service delivery components, outlined in **Figure 1** and detailed in **Section 4: Access and intake** and **Section 5: Service delivery (community-based care)**.
- Providing an overview of the workforce and governance arrangements, and relationships with the broader service system that support delivery of community-based services in **Section 6: Workforce**, **Section 7: Roles and responsibilities**, **Section 8: System integration and pathways** and **Section 9: Governance and accountability**.

Figure 1: Community-based care service framework overview

Area mental health and wellbeing service
Community-based care – service framework

Service overview and features (Section 3):

- Service objectives
- Target cohort
- Service principles
- Consumer-centred care
- Developmentally appropriate care
- Culturally safe and inclusive care
- Lived and living experience
- Inclusion of families, carers and supporters
- Service settings modes and duration
- Service partnerships

Service delivery components (Sections 4–5):

Access and intake
- Engagement
- Assessment
- Referral

Treatment and therapies
- Evidence-based
- Multi-disciplinary

Care planning and coordination
- Relational continuity
- Navigation

Wellbeing support
- Psychosocial
- Recovery
- Participation

Crisis response
- Extended hours
- Afterhours
- Outreach

Physical health
- Holistic care
- Integrated care

Peer support
- Embedded lived experience roles
- Choice

Education and Self-help
- Skills
- Self-management

Further guidance (Sections 6 – 9)

- Workforce
- Roles and responsibilities
- System integration and pathways
- Governance and accountability

Image: An overview of the main components of the Community-based care service framework. The service overview and features are contained in section 3, the service delivery components are contained in sections 4 and 5 and further guidance on workforce, system integration and pathways, roles and responsibilities and governance and accountability are contained in sections 6 to 9.

The framework guides community-based services delivered by Area Services as part of level 5 of the Victorian Mental Health and Wellbeing System (refer to **Section 8.1: System context** for further information). This includes through partnerships between Area Services and non-government organisations (NGOs) delivering some components of community-based services such as psychosocial supports (e.g. Early Intervention Psychosocial Support Response) and homelessness outreach programs.

This framework does not apply to Area Services delivered in community-based residential and subacute settings, such as:

- Prevention and Recovery Care <https://www.health.vic.gov.au/publications/mental-health-prevention-and-recovery-care> and
- Community Care Units <https://www.health.vic.gov.au/mental-health-services/community-care-units>.

Separate frameworks also guide level 4 services like Mental Health and Wellbeing Locals <https://www.health.vic.gov.au/publications/mental-health-wellbeing-locals-service-framework> (Local Services) and Children's Health and Wellbeing Locals (Child Locals). It is also not intended as guidance to level 6 specialist services, such as the Victorian Institute of Forensic Mental Health (Forensicare).

The framework describes the core community-based service components and the broad skill sets required to deliver those components. The framework does not specify the service models, organisational structures or team arrangements to be implemented in community-based services. The department expects Area Services to determine appropriate local arrangements for multidisciplinary teams with the appropriate skill sets to deliver the range of core service components, in accordance with the relevant workforce discipline frameworks, enterprise agreements, 'Our workforce, our future' <https://www.health.vic.gov.au/our-workforce-our-future>.

Guidance for services to implement the framework will be provided separately, including focus areas for change which the department and service providers will collaborate on to improve experiences and outcomes for consumers, families, carers and supporters accessing community-based treatment care and support.

For explanations of language and terminology, refer to **Appendix A: Glossary of terms**. This service framework should be read in conjunction with the Mental Health and Wellbeing Act 2022 <https://www.legislation.vic.gov.au/in-force/acts/mental-health-and-wellbeing-act-2022/005> and statewide mental health and wellbeing policies and frameworks, including those listed in **Appendix B: Key mental health and wellbeing system policies, frameworks and guidelines**.

The department expects that Area Services will adhere to the expectations set out in this document. Service providers considering any substantive variation to the framework must consult with the department prior to implementation to ensure consistency in the service functions, equity of access and fidelity to the principles and objectives of community-based services.

The framework will be subject to adjustment and refinement as required to meet consumer needs or respond to any interrelated mental health and wellbeing system reforms implemented by the department.

The framework is not intended to be a commissioning framework or a tender document.

3. Service overview and features

This section provides an overview of the objectives, principles and key features that underpin high-quality community-based services. Area Services are expected to design their local model of care for community-based services in accordance with the parameters laid out in this section.

3.1 Service objectives

The objectives of community-based services are to:

- Provide comprehensive, multidisciplinary and specialist treatment, care and support for people experiencing moderate to severe mental illness and/or psychological distress in community-based settings, that are tailored to meet the needs of the consumer.
- Lead complex care coordination to meet intersectional needs such as Alcohol and Other Drug use (AOD), other addictions, family violence, homelessness, physical health, trauma, gambling harm and forensic issues, including working in partnership with lived and living experience-led services, other community mental health and wellbeing supports and inpatient units.
- Maintain responsive supports for consumers following acute episodes of care, particularly those with persistent and episodic needs, to support them in the community to avoid escalation to inpatient or emergency services.
- Collaborate with other services and entities to work towards a more coordinated, effective and safe mental health service system for consumers and their families, carers and supporters.

3.2 Target group

Community-based services are to be targeted to people of all ages experiencing moderate to severe mental illness and/or psychological distress, including people with co-occurring substance use and/or dependence and complex needs. The common diagnostic groups for this target group include (but are not limited to):

- schizophrenia
- schizoaffective disorders
- severe depressive disorders
- bipolar and related disorders
- severe anxiety disorders
- personality disorders
- eating disorders
- addictive disorders.

These consumers require more intensive and/or specialist treatment, care and support than what can typically be provided by primary care or level 4 services.

This may include but is not limited to people who experience:

- Severe symptoms of mental illness and/or psychological distress; and/or
- Severe problems with functioning independently due to their mental ill health (noting that 'function' must be considered through a developmentally appropriate frame for children aged 0-12).
- Significant risk of suicide, self-harm or harm to others; and/or
- Complex co-morbidities and co-occurring needs (e.g. neurodevelopmental disorder, developmental delay, AOD, risks of family violence, forensic risks, dementia, physical health and/or disability challenges etc.).

Service capacity should be prioritised for people with the most severe and acute presentations, based on clinical judgement and assessment of risk, need and urgency through established triage processes.

The target cohort for community-based services includes people with moderate to severe mental illness and/or psychological distress, in recognition of evidence indicating that providing specialist multidisciplinary care earlier can prevent escalation, improve outcomes and reduce reliance on crisis, emergency and inpatient services.

This target cohort is also consistent with the assumptions underpinning the National Mental Health Service Planning Framework <https://www.aihw.gov.au/nmhspf>, which plans for specialist mental health services to support people whose needs exceed those that can typically be met in primary care, across a range of levels of severity and functional impairment.

3.3 Service principles

Area Services operate within the statutory framework of the Mental Health and Wellbeing Act 2022 <https://www.legislation.vic.gov.au/in-force/acts/mental-health-and-wellbeing-act-2022/005> (the Act). The Act establishes obligations for Area Services to deliver safe and high-quality treatment, care and support, as well as rights-based safeguards and oversight mechanisms.

Area Services are expected to deliver community-based services in accordance with the principles of the Act, which are summarised as:

- Promote and protect rights, dignity and autonomy.
- Ensure access to a diverse mix of care and support services.
- Promote recovery and full participation in community life.
- Promote supported decision-making in assessment, treatment and recovery.
- Support and involve families, carers and supporters (including children).
- Recognise and value lived experience of mental illness or psychological distress, including people with lived experience as leaders and partners in the mental health and wellbeing system.
- Identify and respond to medical and other health needs.
- Promote and protect health, wellbeing, safety and autonomy of children and young people.
- Protect the wellbeing and safety of dependents.
- Actively consider diverse needs and experiences, including gender and cultural responsiveness and understanding.
- Grow cultural awareness to provide culturally safe services.

The department website provides a handbook on the Act including the principles summarised in more detail here: Mental Health and Wellbeing Principles <https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/context-of-the-act/mental-health-and-wellbeing-principles>. The Act principles are also consistent with the Charter of Human Rights and Responsibilities Act 2006 and should be considered in tandem.

3.3.1 Compulsory treatment and supported decision-making

Area Services and the Victorian Institute of Forensic Mental Health (Forensicare) are designated under the Act to provide compulsory assessment and treatment if required, with the least restriction of people's rights, dignity and autonomy. Consumers may receive compulsory treatment under non-custodial supervision orders under the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 <https://www.legislation.vic.gov.au/in-force/acts/crimes-mental-impairment-and-unfitness-be-tried-act-1997/083> with consultation liaison offered by Forensicare to the Area Service providing ongoing care.

Only 'authorised persons' and 'authorised practitioners' (as defined by the Act) can exercise compulsory power under the Act. The Authorised Psychiatrist in each Area Service plays a critical role, holding legislated responsibility for key clinical decisions under the Act (see in particular number sections 79, 80, 82 and 83), ensuring treatment decisions are consistent with the Act's principles, and providing senior clinical leadership and governance for safe, high-quality care.

The Chief Psychiatrist's guidance on Decision-making principles for treatment and interventions <https://www.health.vic.gov.au/chief-psychiatrist/decision-making-principles-for-treatment-and-interventions-mental-health-and-wellbeing-act-2022> should be used along with the Act principles and Charter of Human Rights and Responsibilities Act 2006 <https://www.legislation.vic.gov.au/in-force/acts/charter-human-rights-and-responsibilities-act-2006/015> to provide humane, compassionate, safe and high-quality mental health and wellbeing services.

The independent Mental Health Tribunal <https://www.mht.vic.gov.au/> established under the Act oversees decisions about compulsory mental health treatment and protects patient rights by conducting hearings to identify the least restrictive way people can receive treatment they need.

Area Services must ensure all reasonable efforts are made to give effect to supported decision-making mechanisms, when compulsory assessments and treatment are provided in a community setting, including:

- Advance Statements of Preferences <https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/advance-statements-of-preferences> that outline the treatment, care and support that the consumer prefers if they become subject to a compulsory assessment and treatment order. Advance Statements of Preferences must be given effect wherever possible and may only be overridden by an Authorised Psychiatrist where the preferred treatment is not clinically appropriate or cannot be provided despite all reasonable efforts, with written reasons provided to the person and their nominated support person.
- Statement of Rights <https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/statement-of-rights> which sets out a person's rights and the processes that apply, while a person is receiving a mental health and wellbeing service. The relevant statement of rights must be given to a person and specified support people at key points during assessment and treatment. All reasonable steps must be taken to ensure the consumer understands their rights.
- Nominated Support Persons <https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/supported-decision-making/nominated-support-persons> (NSPs) which involves appointing someone to express the views and preferences of the consumer. NSPs can support the consumer to make and participate in decisions about their treatment, care and support.
- Second Psychiatric Opinion <https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/second-psychiatric-opinions> which may recommend changes to compulsory assessment and treatment orders, including support to understand their right to request to appeal a community treatment order.
- Access to Independent Mental Health Advocacy (IMHA) to ensure consumers understand and can exercise their rights under the Mental Health and Wellbeing Act 2022 <https://www.legislation.vic.gov.au/in-force/acts/mental-health-and-wellbeing-act-2022/005> if subject to compulsory assessment and treatment orders, including via an advocate at IMHA (telephone: 1300 947 820 or email IMHA <contact@imha.vic.gov.au>.).
- Supported decision-making including family, carers and supporters, as suggested by IMHA (Worksheet - Who will support me? <https://www.imha.vic.gov.au/who-will-support-me>).
- Considering the Act principles including dignity of risk of the consumer based on their expressed preferences using the Mental Health and Wellbeing Principles <https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/context-of-the-act/mental-health-and-wellbeing-principles>.
- Office of the Chief Psychiatrist guidance <https://www.health.vic.gov.au/chief-psychiatrist/resources-reports-bulletins> via regular bulletins on supported decision-making in practice.

3.4 Consumer-centred care

Community-based treatment, care and support is to be tailored to the specific needs and preferences of each consumer. Community-based services teams will:

- Work with consumers to develop care plans aligned with their needs, goals and preferences and communicate if the treatment team recommend changes to the plan.
- Welcome people with co-occurring mental health and AOD needs and engage in hopeful, respectful and non-judgemental conversations about their co-occurring needs, substance use or mental health symptoms.
- Maintain transparent communication, consistent contact and continuity of relationships with consumers where possible.
- Embed relational approaches and build therapeutic alliances that foster trust, respect and collaboration between service teams and consumers.
- Support consumers to choose the clinical and non-clinical treatments, care and supports that meet their recovery needs, informed by advice from the treatment team.

- Support consumers to have input into the type of practitioner(s), where appropriate and multiple options are available, such as matching based on cultural or linguistic backgrounds.

The National framework for recovery-oriented mental health services: Guide for practitioners and providers <https://www.health.gov.au/resources/publications/a-national-framework-for-recovery-oriented-mental-health-services-guide-for-practitioners-and-providers?language=en> offers a conceptual framework for practice, culture and service delivery which is centred on the needs of people who use the services.

3.5 Developmentally appropriate care

Community-based treatment, care and support is to be tailored to a consumer's developmental stage, with an appropriate degree of specialisation, recognising that needs, preferences and life circumstances change over time. The department's expectation is that community-based models of care will be tailored to:

- Infants and children (0 to 11 years) to receive early, family-inclusive and school-based supports:
  - 0–4 year-olds (encompassing infants, toddlers and preschoolers).
  - 5–11 year-olds (encompassing the breadth of the primary school years).
- Young people (12 to 25 years) to manage relationships with family and friends, stay engaged in education; access employment supports; and build capability to manage life transitions:
  - 12–17 year-olds (encompassing adolescence and the secondary school years).
  - 18–25 year-olds (encompassing early adulthood and, typically, entry to higher education, vocational education, TAFE, apprenticeships and the workforce).
- Adults (26 to 64 years) to build practical life skills to manage relationships, employment, parenting and other life stressors.
- Older adults (65 years and older) to stay connected with their communities and their families, carers and supporters; and maintain independent living.

Section 5: Service delivery (community-based care) of this framework includes tables describing high-level considerations of tailoring each service component to the key developmental stages.

The department provided Area Services with *Guidelines for age-based streaming for Area Mental Health and Wellbeing Services* in October 2024 to support consistent development of two age-based services:

- Infant, Child and Youth Area Mental Health and Wellbeing Services (ICY AMHWS) for 0–25-year-olds, across two dedicated service streams:
  - Infant, Child and Family service stream: for infants and children aged 0-11 years (inclusive of the child's 11th year) and their families, carers and supporters and
  - Youth service stream: for young people aged 12-25 years (inclusive of the young person's 25th year) and their families, carers and supporters.
- Adult and Older Adult Area Mental Health and Wellbeing Services (AOA AMHWS) for people aged 26 years and older, and their families, carers and supporters.

3.6 Culturally safe and inclusive care

Community-based treatment, care and support is to be delivered in a way that prioritises the cultural safety of consumers, families, carers, supporters and staff. Services should recognise intersectionality and the way multiple, overlapping identities and experiences, such as culture, sexuality, gender, disability, age and socioeconomic status, can influence access to care, experiences of care and outcomes.

Services should actively identify and address systemic barriers that affect access to culturally safe care for Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse (CALD) communities, lesbian, gay, bisexual, trans and gender diverse, intersex, queer and asexual (LGBTIQA+) communities, and other diverse populations.

This includes respecting and supporting the self-determination of Aboriginal and Torres Strait Islander consumers in decisions about their treatment, care and support.

3.6.1 Diversity and inclusion

Community-based teams are expected to recognise and respect each person's identity, experiences and preferences, supporting equitable access and outcomes. Community-based teams work with consumers and their families, carers and supporters to understand their preferences, foster trust and rapport, and support open conversations about barriers affecting their health and wellbeing. Victorian Transcultural Mental Health (VTMH) <https://vtmh.org.au/about/our-purpose/> is the specialist transcultural and intersectional mental health service to strengthen capability across the state.

Consistent with the Diverse Communities Mental Health and Wellbeing Framework <https://www.health.vic.gov.au/diverse-communities-mental-health-wellbeing-framework-blueprint>, community-based services:

- Provide access to language and cultural support, including interpreters, translation tools, cultural brokerage, tailored communication and multilingual practitioners.
- Partner with community-based services who cater to specific groups of people and their unique care needs. For example, culturally and linguistically diverse and multi-faith communities where there is trust with a local NGO who delivers mental health supports.
- Work closely with multicultural organisations to design and strengthen pathways to culturally appropriate supports, including from emergency department settings.
- Engage in regular training and development, for example application of the Embrace Framework <https://framework.embracementalhealth.org.au/> for mental health care delivery for multicultural communities.

3.6.2 Cultural safety

Community-based teams are expected to work with consumers to identify and meet social and emotional wellbeing needs and Aboriginal and Torres Strait Islander concepts of family and kinship in line with the 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>, including:

- Working closely with ACCOs to design and strengthen pathways to culturally appropriate supports, including from emergency department settings.
- Upholding people's care preferences, including supported transitions to continue care or additionally receive care from ACCOs.
- Actively reduce stigma and discrimination by training staff in inclusive practice, strengths-based approaches and embedding respectful language and welcoming environments.
- Supporting staff to participate in ongoing reflective practice to strengthen cultural safety, including the use of structured approaches (or tools) for staff to consider their interactions with Aboriginal and Torres Strait Islander people and ACCOs. An example of a tool is 'Aboriginal and Torres Strait Islander cultural safety continuum reflective tool' <https://www.health.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework-part-1>.

Area Services may also draw on existing funding and initiatives, including cultural safety grants <https://www.health.vic.gov.au/publications/aboriginal-cultural-safety-fixed-grant-requirements> and Koori Liaison Office roles, to support implementation of culturally safe care and strengthen engagement with Aboriginal and Torres Strait Islander communities in community-based services. These initiatives provide an opportunity to build workforce capability and embed culturally safe practice. Further guidance is also available via the Balit Durn Durn Centre <https://www.vaccho.org.au/balitdurndurncentre/>.

Following the 2026 Office of the Chief Psychiatrist Cultural Safety Forum (see recap in the June 2026 Quality and Safety Bulletin <https://www.health.vic.gov.au/chief-psychiatrist/resources-reports-bulletins>), the department has called on Area Services to implement a minimum of two cultural safety actions to align with the introduction of cultural safety to the Statement of Priorities.

3.7 Lived and living experience

Lived and living experience perspectives are to be embedded across multiple aspects of community-based services 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
- governance and leadership roles for the community-based service.

3.7.1 Supporting engagement through governance and workforce

To support greater lived and living experience engagement in community-based services and foster a culture that embeds lived and living experience leadership, Area Services may be guided by the following resources:

- The Mental Health Lived Experience Engagement Framework <https://www.health.vic.gov.au/publications/mental-health-lived-experience-engagement-framework> provides guidance on how people experiencing mental illness, and 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.
- The National Lived Experience Workforce Development Guidelines <https://www.mentalhealthcommission.gov.au/lived-experience/lived-experience-workforces/peer-experience-workforce-guidelines> provides detailed steps for Area Services to plan, develop and embed their lived and living experience workforce across all levels of their organisation.

Area Services are also encouraged to consider approaches of sector leaders, such as Mind Australia's Lived Experience Governance Framework <https://www.mindaustralia.org.au/our-evidence-base>.

3.8 Inclusion of families, carers and supporters

Inclusion of families, carers and supporters is core business of community-based care and is expected to be embedded across all aspects of service delivery in accordance with the Working Together with Families and Carers: Chief Psychiatrist's Guidelines <https://www.health.vic.gov.au/chief-psychiatrist/working-together-with-families-and-carers>. Families, carers and supporters are essential partners in care and bring valuable insight into consumer needs, experiences and preferences, with their involvement guided by the consumer's expressed wishes, consent and right to autonomy in all aspects of care and decision making.

Area Services must adopt a family-inclusive culture and practice, where the needs of families, carers and supporters are recognised and addressed in their own right, alongside their role in supporting the consumer. This includes recognising diverse definitions of family and supporting people who may not have traditional family structures through the development of alternative support networks.

Community-based teams can ensure family-inclusive and relational approaches by:

- Proactively identifying family members, carers and supporters.
- Assessing and responding to the needs of families, carers and supporters, including offering brief interventions, psychoeducation, carer peer workforce support, family-led supports, and referral to appropriate services e.g. pathways to The Orange Door <https://www.orangedoor.vic.gov.au/> or Mental Health and Wellbeing Connect Centres <https://www.betterhealth.vic.gov.au/mental-health-and-wellbeing-connect>.
- Identifying and meeting the support needs of families, carers and supporters through family-inclusive approaches such as single session family consultation or longer-term family inclusive therapy sessions where appropriate.
- Actively partnering with families, carers and supporters in care planning and review. Supporting families, carers and supporters through key transition points including discharge or transfer of care, recognising their role in care continuity (see **Section 5.2 Care planning and coordination**).
- Identifying and supporting dependent children of adult consumers, siblings of younger consumers and young carers and supporters, including through programs such as Families of Parents with a Mental Illness (FaPMI).
- Embedding clear communication and information sharing processes, ensuring families, carers and supporters are included in communication flows.
- Keeping families, carers and supporters' contact information up to date and readily accessible to staff, where the person has indicated it is safe and appropriate to do so.
- Checking in with the consumer and documenting when family, carer and supporter contacts have changed and including new supporters where identified.
- Ensuring families, carers and supporters are involved in transition planning where appropriate and with the consumer's consent.
- Providing flexible practical supports, including brokerage funding to families, carers and supporters, where appropriate.

Some consumers may not have access to family supports, including those who are no-contact or without family networks. In these situations, community-based services can help foster meaningful connections and build supportive networks outside of family structures. In other instances, consumers may choose to not involve their families, in that case the expectation is to still foster meaningful networks with the people around them. Area Services should maintain open communication with the consumer about whether there is a change in who they would like to have involved.

> Consistent with Royal Commission recommendation 61, guidance on balancing the expectation to involve families, carers and supporters with the right to safety and privacy is currently under development. Beyond what is contained in the framework, Area Services should look to future guidance from the Office of the Chief Psychiatrist and lived and living experience peaks regarding best practice.

3.9 Service settings, modes and duration

Community-based services are to be delivered as responsive to consumers' acuity and intensity and based on a short term or ongoing streams of treatment, care and support, by varying:

- Frequency of contact, with consumers in more acute phases receiving more frequent contacts.
- Duration of care.

Community-based service delivery may also be periodic, with consumers accessing more intensive care during periods of escalation and utilising alternative supports outside of the Area Service as needs stabilise.

Care may be delivered within defined episode lengths where appropriate, with some teams and services (such as Crisis Assessment and Treatment Teams or equivalent) providing time-limited episodes of care (for example, one to two weeks).

The needs of individuals are to be balanced with system objectives, including to support patient flow, timely access and equity of service provision.

Mode of delivery for care should be driven by consumer choice where possible to enable consumers to engage in a way that best suits their needs and preferences.

Community-based services are delivered through a mix of digital and place-based options such as specialist clinics, and through assertive outreach in community hubs and consumer's homes. Specialist clinics operated by Area Services will be safe and welcoming, with adequate privacy alongside creative and sensory elements to support engagement. This includes physical and psychological safety of consumers.

Community-based services are offered over extended service hours (i.e. not as part of crisis responses) to improve access for consumers who require after-hours support.

3.10 Service partnerships

Community-based services may be delivered through:

- Partnerships between Area Services and NGOs (including Aboriginal Community Controlled Organisations) to ensure consumers can access a holistic range of high-quality, safe and integrated treatment, care and support in their local community.
  - The nature of each partnership will vary and be shaped by consumer needs, and the strengths, expertise and experience of each partner in their local context.
  - The department may specify partnerships and/or the commissioning arrangements for a particular program. In those cases, the department will provide detail on delivering on those expectations. Roles and responsibilities within partnerships are outlined in **Section 7.4 Shared responsibilities within partnerships**.
- Collaborative arrangements with other service providers, which enable a coordinated approach to care for consumers, particularly as they move through care pathways and at key points of transition. Key pathways are outlined in **Section 8: System integration and pathways**.

3.10.1 Co-location

Co-location of Area Services, NGOs and other providers can enhance integrated and coordinated delivery of community-based care and should be prioritised to strengthen partnerships and collaboration. Where co-location is not achievable due to infrastructure or space constraints, Area Services and NGOs are expected to establish and sustain formal, high-functioning partnership arrangements that deliver equivalent levels of integration and coordinated care outcomes.

4. Access and intake

This section outlines how community-based services can be accessed. This guidance is focused on the expectations of assessment and intake practices of community-based services noting that access and intake functions are typically designed and operated across a whole Area Service.

New access and intake policy guidelines are under development to help people of all ages find and access treatment, care and support across the mental health and wellbeing system. The access and intake policy will describe expectations of services to apply an approach of 'how can we help?' and 'no wrong door', underpinned by three front-end components of access and navigation support, initial support discussions, and comprehensive needs assessment and planning discussions.

The new policy will include consideration of appropriate referral pathways for community-based services to support people to navigate to the appropriate level of service based on need. The work will also consider the potential for the adoption of standardised assessment tools and contemporary intake practices involving initial support. Further guidance will be provided about implications for community-based services upon the completion of this work.

4.1 Access to community-based services

Area Services design and operate access and intake functions at a whole-of-service level to deliver an initial response and support consumers and their families, carers, and supporters to access services appropriate to their needs. This should include processes to assist people to receive support from an external service if more appropriate. Access and intake functions are expected to consider a person's choice and preferences from the outset.

Community-based teams should establish a range of referral pathways and work with triage, access and navigation teams who are responsible for coordinating referrals and enabling access.

Consumers discharged from inpatient units will receive timely follow-up community-based care (in line with performance target of 88% of separations from an inpatient unit where the consumer received an ambulatory service contact within 7 days). The frequency of contact with consumers is to be responsive to acuity and intensity of needs, with consumers in more acute phases receiving more frequent contacts from community-based teams.

Emergency departments are considered a last resort for people to access mental health and wellbeing support. They should be accessed only when more appropriate community-based options are unavailable or unable to meet the person's needs.

4.1.1 Referrals

Area Services are expected to enable consumers to access community-based services through a range of referral pathways including:

- Self-referral (e.g. via Telephone Triage).
- Referral from community (e.g. primary care (GPs), level 4 services, NGOs, Aboriginal community-controlled organisations (ACCOs), family violence/integrated family services, housing services, schools/universities, families,

carers and supporters, helpline and other specialist mental health services, gambling harm support services etc.).
- Referral from a crisis service (e.g. emergency services such as Triple Zero, Urgent Care Centres, after-hours crisis outreach, police, or paramedic via Telephone Triage).
- Referral from bed-based care (e.g. inpatient, emergency departments, consultation-liaison psychiatry, Community Care Units, Prevention and Recovery Care Services and Secure Extended Care Units).
- Referrals from statewide services delivering level 6 specialist treatment, care and support.

Referrals should be informed by a comprehensive needs assessment and planning discussion with the consumer and their families, carers and supporters.

Community-based teams within Area Services may provide primary or secondary consultations to inform a decision to refer a consumer to community-based services for treatment, care and support.

Recognising that life circumstances and acuity of needs can change rapidly, consumers may be re-referred to community-based teams following a period of care through self-referral, or a supporter, carer, or GP. All providers making a referral must have the informed consent of that consumer.

Referral pathways are discussed further in **Section 8: System integration and pathways** as an enabler of broader system integration.

4.1.2 Access for diverse communities

Area Services must actively consider the needs and preferences of diverse groups to remove access barriers, including for:

- Aboriginal and Torres Strait Islander peoples
- CALD communities
- LGBTIQA+ communities
- people experiencing homelessness
- people with a disability
- people who identify as neurodivergent
- people in contact with, or at risk of coming into contact with, the criminal and youth justice systems
- people experiencing substance-related harms (including co-occurring substance use or addiction), gambling related harm
- people living in regional and rural areas.

Strengthened partnerships between Area Services and NGOs can leverage NGOs' existing connections with local communities to improve engagement with priority population groups and people who may experience barriers to accessing services.

4.2 Intake and initial support

Initial support discussions, assessments and needs identifications are typically led by intake and brief intervention teams within Area Services. These teams review information about the consumer (with consent) from referring services, to minimise the need for consumers to re-tell their stories, given this may lead to re-traumatisation.

4.2.1 Assessments

Comprehensive biopsychosocial assessments are to be completed by community-based teams to understand a consumer's mental health, wellbeing or other co-occurring needs.

Assessment processes must be tailored for developmental stage, in particular acknowledging the important role of families, carers and supporters. This includes family violence identification and screening obligations under MARAM, CISS and FVISS. Assessment and information sharing processes support the workforce to make recommendations about the appropriate mix of community-based services and supports required for each consumer. This information supports shared decision-making.

Allocation decisions are based on preferences of the consumer, the complexity of needs, service capacity and suitability of available supports. Recommendations may be made through team-based allocation meetings.

4.2.2 Re-engagement to community-based services

Re-engagement processes are to be proportionate and clinically informed, avoiding unnecessary duplication of assessment where recent and relevant information is already available within the Area Service. To support timely re-engagement of care, decision-making is to be informed by the consumer's prior care plans and documented history and streamlined assessment to identify changes since the consumer's previous episode of care.

Using existing information and considering the experience of care transition for the person supports continuity and promotes recovery. Streamlined re-engagement pathways for long-term or recurrent consumers of community-based services also reduces administrative burden on the service and supports patient flow by:

- Reducing delays at the point of discharge and subsequent re-engagement.
- Enabling timely access to community based support following inpatient or bed-based care.
- Minimising avoidable escalation to emergency departments or acute settings.

Minimum expectations

Undertake timely, comprehensive assessment to understand consumer needs, strengths and goals, and determine appropriate care.

Enable access to community-based services including by accepting referrals, and engaging consumers following initial assessment by Telephone Triage or another team.

Involving consumers, their families, carers and supporters in decisions about access and referrals.

Provide streamlined intake for consumers re-entering community-based services.

5. Service delivery (community-based care)

This section outlines the core components of community-based services delivered by Area Services, covering a comprehensive range of treatment, care and support. Area Services are expected to develop a model of care which comprises all the functions described in this section, including maintaining delivery of community-based programs specified in the Policy and Funding Guidelines <https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services>.

A summary of the minimum expectations for each component appears in a call out box at the end of the sub-section.

5.1 Crisis response

Area Services are expected to deliver a range of crisis and emergency services available in the community and provide timely assessment and support for a person experiencing an acute state of psychological distress or risk where their safety, wellbeing, or ability to function is severely compromised.

Crisis responses provided by Area Services may be initiated directly through triage clinicians or through a referral from another service, where the consumer is assessed as having significant, immediate risks that are most appropriately managed by Area Services.

Crisis responses delivered by Area Services, including by community-based teams, are expected to be holistic and integrated, delivering timely, least-restrictive treatment. At a minimum, Area Services are expected to provide access to crisis assessment at all times (24 hours a day, 7 days a week), noting that delivering face-to-face crisis responses on a 24/7 basis is not feasible for all services. Area Services may instead offer crisis responses with 'extended hours' and use telephone or digital modes of delivery to provide coverage over periods of lower demand.

Crisis assessment and response functions may be shared and integrated across multiple Area Services where required, to enable greater centralisation and efficient use of triage functions over large regions. This should focus on partnerships within Local Health Service Networks in the first instance.

Refer to **Appendix D: Expectations for crisis response times**.

5.1.1 Role of community-based teams in crisis responses

Community-based teams play a key role in delivering crisis responses, including through involvement in onsite clinical assistance (e.g. Police Ambulance, Clinical Early Response (PACER)), other crisis response services (e.g. in Emergency Departments or alternative crisis response settings) and crisis outreach teams (e.g. Crisis Assessment and Treatment Teams (CATT)).

Community-based teams are expected to:

- Undertake assessments for people experiencing crisis or psychological distress, including those who are accessing or have previously accessed support through community-based teams.
- Provide community-based short-term crisis treatment, including through assertive outreach models.
- Provide onsite clinical assistance to first responders, wherever possible, by providing assessment and brief intervention for people experiencing crisis or psychological distress.

> Work is progressing to improve mental health crisis responses through a phased implementation approach. Recent work has focused on the design of a comprehensive and networked system of mental health crisis supports including exploration of enhancements to assertive outreach by integrated community mental health and emergency mental health teams as part of the Area Service crisis response functions.

The 2026-27 Victorian State Budget included funding to support trials of an enhanced crisis outreach model across two metro locations over two years. The trials will help strengthen community-based mental health responses and reduce reliance on emergency departments for people experiencing mental health crisis or psychological distress in trial locations. Further guidance will be provided about implications for community-based services as this work progresses.

There may be instances where community-based teams recommend that a consumer access more intensive treatment, care or support. Such recommendations should be made in accordance with the Act, including the Mental Health and Wellbeing Principles <https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/context-of-the-act/mental-health-and-wellbeing-principles>, and should respect the consumer's expressed preferences, autonomy and dignity of risk.

Minimum expectations

Extended hours crisis response with focus on face-to-face service delivery.

After-hours access to crisis assessment via telephone or digital modes of delivery.

Community-based assertive outreach.

5.2 Care planning and coordination

Community-based teams are expected to lead care planning and coordination in collaboration with consumers and their families, carers and supporters to assess, plan, deliver and monitor consumers' treatment, care and support, using an integrated multidisciplinary approach that prioritises relational continuity.

Community-based teams should ensure there are 'no wrong doors' for people with co-occurring mental health and AOD needs and provide viable support pathways and access to integrated treatment, care and support.

Care planning and coordination should vary in intensity in response to the needs of the consumer. For consumers with moderate to severe mental illness who require ongoing, intensive and coordinated support, community-based teams provide individualised case management as part of integrated care planning and coordination. Statewide Complex Needs Advisory Panel (SCNAP) <https://www.health.vic.gov.au/chief-psychiatrist/governance-and-committees> may be accessed to support care planning and coordination for individuals with highly complex needs.

Care planning and coordination aims to provide consumers with seamless, person-centred treatment, care and support that is responsive to their needs and aligned to their individualised recovery plan by:

- Facilitating consumers' collaboration in their care planning and monitoring, including family, carers and supporters according to the preferences of the consumer.
- Developing and maintaining care, safety, and recovery plans in collaboration with consumers, their families, carers and supporters (such as safety planning interventions). Recognising and responding to the consumers' cultural and identity-based needs and social determinants of mental health and wellbeing, such as accommodation, safety, income and family relationships.
- Actively planning for and supporting safe and coordinated transitions, including entry to and exit from services, changes in level of care and key life transitions to minimise disruption and promote care continuity.

- Supporting the consumer to identify services and supports that meet their needs and contribute to their recovery goals, including planning and scheduling appointments and making referrals.
- Coordinating multidisciplinary and multi-agency input into care planning, facilitating communication across clinicians and services, and acting as a key point of contact and advocate for the consumer.
- Building the consumer's capability for self-advocacy and making supported decisions, using the Mental Health and Wellbeing Principles <https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/context-of-the-act/mental-health-and-wellbeing-principles>.
- Coordinating and navigating complex systems to support understanding of multi-agency roles, responsibilities and accountability for consumer outcomes.

Care planning and coordination is a skilled function that is delivered in a multidisciplinary team-based approach. This function can be delivered by workers from a range of disciplines, with input from lived and living experience workers. Lived and living expertise is particularly valuable when working collaboratively with consumers to develop Advanced Statements of Preferences, identifying early warning signs and relapse prevention strategies, and providing illness education.

Community-based teams are expected to establish and maintain networks with a broad range of service providers, including health, disability, housing, education, employment and community services, to facilitate integrated and coordinated delivery of support.

Area Services should align their care planning and coordination practices to the National Guidelines to improve coordination of treatment and supports for people with severe and complex mental illness <https://www.health.gov.au/resources/collections/national-guidelines-to-improve-coordination-of-treatment-and-supports-for-people-with-severe-and-complex-mental-illness?language=en>.

Community-based teams will prepare for and communicate with consumers about transitions to other services, including to other AMHWS.

Where recommendations or decisions are developed through multidisciplinary processes, consumers should be encouraged to participate in these conversations and supported to understand which service is responsible for the different aspects of their care, the types of support they can expect to access and the role each service will play in the delivery of these supports.

The following table describes key considerations for tailoring care planning and coordination functions to meet the developmental needs of consumers across the two age-based services:

Infant, child and youth – 0 to 25 years	Adults and older adults – 26 years and older
• Critical role of families, carers or supporters in supporting care planning and coordination, particularly for younger children. • Supporting development of autonomy for adolescents and young people. • For school-aged children, inclusion of their education provider in care planning and coordination (with consent of the consumer and family, carers or supporters; noting consent is not required under CISS for child safety and wellbeing).	• Support adults with a 'no wrong door' approach when they seek help for the first time, present with a range of complex or co-occurring care needs (such as AOD use) or are experiencing major life changes, such as securing stable housing, navigating employment, managing chronic health conditions or addressing safety concerns such as family violence. • Support for parents and family relationships. • Potential social isolation among adults and older adults.

Infant, child and youth – 0 to 25 years (contin.)	Adults and older adults – 26 years and older (contin.)
• Consideration of developmental needs as children and young people transition between age streams. • Refer to the Our Workforce, our future: Infant, Child, Youth and Family Companion Guide <https://www.health.vic.gov.au/our-workforce-our-future/guides-resources>.	• A network of service relationships that includes employment, housing and other services targeted to building capability and independence. • For older adults, recognition of physical health decline, loss of loved ones and changes in caregiving responsibilities. • A network of service relationships with aged care providers for older adults.

Minimum expectations

Collaborative care planning and coordination to assess, plan, deliver and monitor consumers' treatment, care and support, using an integrated multidisciplinary approach that prioritises relational continuity.

Ensure consumers seeking support for co-occurring mental health and AOD needs are met with a 'no wrong door' approach that is welcoming, respectful and non-judgemental.

Involve families, carers and supporters in decisions about care planning. Uphold principles of the Act in care planning, care coordination and case management practice, including supported decision-making.

Care is coordinated across providers over time, including actively supporting safe transitions between providers.Consumers and their families, carers and supporters are offered opportunities to engage with peer support in a way that reflects their preferences.

5.3 Treatment and therapies

Community-based services are expected to include a comprehensive range of trauma informed, evidence-based treatment and therapies appropriate for the target cohort. Treatment and therapies delivered in community-based settings encompass a range of clinical services, therapeutic interventions, peer and wellbeing supports, which are tailored to the consumer need and preferences and delivered by multidisciplinary teams.

The broad types of treatments and therapies delivered by community-based services include:

- **Psychological and relational therapies** (i.e. 'talking therapies') such as Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT), family therapy, mindfulness and single-session therapy. These therapies can be offered in individual, group or family-based settings.
- **Medical treatments** such as prescribed medications and non-medication treatments (e.g. electro-convulsive therapy).
- **Psychosocial and clinical treatment approaches** that integrate therapeutic work, psychoeducation and care coordination.
- **Allied health therapies**, including social work, occupational therapy, speech pathology, dietetics, and creative therapies such as art and music therapy.
- **Integrated treatment, care and support** for consumers experiencing co-occurring mental health and substance use or addiction, consistent with the Integrated Treatment

Care and Support Guidelines <https://www.health.vic.gov.au/mental-health-reform/recommendation-35>. For example, harm reduction, 'reasons for use', motivational interviewing and naloxone programs.

- **Peer work** as a modality that operates alongside and across treatments and therapies to support engagement, recovery and experience of care. See **Section 5.5 Peer support**.

The availability of some specific treatments and therapies varies across areas due to local resources, service configuration and workforce capacity (particularly in rural and remote areas).

The following table describes key considerations for tailoring treatment and therapies delivered in community-based settings to meet the developmental needs of consumers across the two age-based services:

Infant, child and youth – 0 to 25 years	Adults and older adults – 26 years and older
• Availability of evidence-based treatments and therapies for neurodevelopmental and behavioural disorders, family-based and parenting interventions and speech pathology. • Provision of outreach in accordance with youth specific models, such as Intensive Mobile Youth Outreach Service (IMYOS) for young people aged 12-15 years, which include family, school and other community supports. • Youth focussed treatment and therapies – including co-occurring AOD needs.	• Treatments, therapies and outreach models for adults and older adults which respond to cognitive decline, reduced mobility or co-occurring physical health issues. • Adult focused treatment and therapies embed capability to address co-occurring AOD needs and other addictions such as gambling harm.

Minimum expectations

Provide trauma informed, evidence-based mental health treatment, care and support appropriate to the consumer needs, preferences and level of acuity consistent with the Act principles.

Treatment, care and support is delivered through a multidisciplinary approach.

Where required treatment is not available, referral pathways are in place to ensure timely access to the appropriate treatment, care and support.

5.4 Physical health support

Community-based services are expected to include delivery of physical health supports which complement mental health care and contribute to overall wellbeing and health outcomes. This may include a range of integrated community-based treatment, care and support for co-occurring physical health needs such as:

- Healthy eating programs.
- Group-based exercise programs, such as walking groups and gym classes.
- Exercise physiology.
- Wellbeing clinics led by dietitians and exercise physiologists.
- Community health services including dental care, dietetics and exercise programs.

Physical health supports are delivered in accordance with the Equally Well Victoria <https://www.safercare.vic.gov.au/publications/equally-well-victoria-2nd-edition-2025> (Safer Care Victoria) priority areas to close the gap in life expectancy for people with serious mental health concerns.

Community-based services may embed general practitioners, dietitian and physiotherapists within their multidisciplinary teams to support integrated treatment for co-occurring mental health and physical health challenges. Services may also maintain networks with a broad range of medical and health service providers, such as community health services and bulk billed Medicare funded general practitioners, to provide physical health support on an in-house or in-reach basis.

The following table describes key considerations for tailoring physical health supports to meet the developmental needs of consumers across the two age-based services:

Infant, child and youth – 0 to 25 years	Adults and older adults – 26 years and older
• Availability of family-oriented approaches for infants and young children including supporting parents with routines for sleep, feeding and sensory regulation. • Availability of age-appropriate health education, such as puberty and sexual health education, to help children and young people understand their bodies and physical health in simple and safe ways. • Empowerment of young people to make informed choices about their physical wellbeing through assessments, preventative care and developmentally appropriate interventions.	• Availability of a wide-range of physical health supports for adults and older adults including metabolic screening, preventative health care (e.g. smoking cessation), women's health services, sexual and reproductive health services. • Consideration of older people's physical health needs in the context of aging, including collaborating with aged care providers.

Minimum expectations

Clinicians monitor physical health needs as part of holistic care including making referrals to other practitioners as appropriate.

Physical health is integrated into treatment planning, including coordination with primary care and other providers.

5.5 Peer support

Peer support is when individuals are employed to draw from their own personal lived and living experiences to offer support and guidance to others who are in similar situations. Peer support workers are expected to be embedded within community-based teams and perform a variety of roles including providing individual support, education programs, coaching and group-based activities, in line with the peer workforce discipline frameworks.

Peer support can be delivered by both:

- Consumer peer support workers who focus on building mutual and reciprocal relationships where recovery and understanding of emotional, social, spiritual and physical wellbeing are possible. Peer support workers play an important role in intake and review, given their expertise in building trust and rapport during the first point of contact with consumers.
- Family or carer peer support workers who use their personal lived and living experience of supporting someone with mental ill health and/or psychological distress (including those with experience of substance use or addiction), to support families, carers and supporters who are supporting a family member or friend who is experiencing mental ill health and/or psychological distress in an unpaid capacity.

The delivery of peer support should involve working collaboratively with consumers to understand their preferences, offering choice in the type of support provided, including alignment with cultural, sexual, and other diverse identities via individual or group support.

Area Services are expected to build peer support and family-inclusive practice expertise within their workforces and foster a culture of person-centred and recovery-oriented service delivery. A broad range of training and capacity building initiatives are available to support this – a comprehensive list can be found on the department's Lived and living experience workforce initiatives <https://www.health.vic.gov.au/workforce-and-training/lived-experience-workforce-initiatives> webpage.

The following table describes key considerations for tailoring peer supports to meet the developmental needs of consumers across the two age-based services:

Infant, child and youth – 0 to 25 years	Adults and older adults – 26 years and older
• Access to youth peer support workers capable of providing age-tailored approaches to address the distinct social, psychological, and recovery needs of young people. • Provision of structured peer support groups, such as 'CHAMPS' and 'Space4Us', for children in families where a parent has a mental illness. To help children and young people build confidence, learn new skills and connect with peers who share similar experiences.	• Access to peer support workers for older people, capable of supporting recovery needs in the context of aging. • Adoption of practice models, such as Intentional Peer Support (IPS) which supports practitioners to develop relationships to gain new perspectives, build awareness of personal and relational patterns, and support and challenge each other to try new approaches.

Minimum expectations

Provide access to peer support, as a distinct and valued component of multidisciplinary care.

Consumers and their families, carers and supporters are offered opportunities to engage with peer support in a way that reflects their preferences.

5.6 Wellbeing support

Community-based services are expected to include delivery of wellbeing supports, otherwise known as 'psychosocial supports'[1] , which help consumers 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 focus on creating the conditions for recovery, including functional improvement, cultural safety, resilience, life satisfaction, independence and community participation; and are appropriate for consumers who require more sustained care over the medium to longer-term, complementary to clinical interventions.

A wide range of clinicians and practitioners may contribute to the provision of wellbeing supports as part of multidisciplinary care teams.

Wellbeing supports delivered as part of community-based services may be categorised into five types:

- **Capacity-building supports** that support consumers to build their skills and confidence to manage their mental health and psychological distress and make informed choices about their support needs. This includes supports for building practical life skills and independence, such as managing daily household tasks, planning and preparing meals and navigating public transport.
- **Community connection supports** that promote social inclusion and help consumers to choose and connect to local community and group activities focused on mental health and wellbeing such as social skills training and development.
- **Housing and homelessness supports** to help consumers secure and maintain housing, and to live independently in the community.
- **Education, training, building life skills and employment supports** to help consumers, achieve their education, life skills and employment goals.
- **Connections to other supports** such as legal, disability (including NDIS), financial, family violence, migration and refugee, cultural, gambling harm supports, child and family services.

The delivery of wellbeing supports in community-based services may also be guided by Wellbeing in Victoria: A Strategy to Promote Good Mental Health 2025-35 <https://www.health.vic.gov.au/mental-health/prevention-and-promotion/wellbeing-strategy>. The strategy focuses on creating the social, physical, economic, and environmental conditions that help people to feel and function well at every stage of life by:

- Meeting basic needs before other aspects of wellbeing.
- Building connections between people, communities and culture.
- Creating a sense of worth and meaning for individuals.
- Promoting safety and respect for all people.
- Building capabilities to navigate the ups and downs of life.

The following table describes key considerations for tailoring wellbeing supports to meet the developmental needs of consumers across the two age-based services:

[1] The national Psychosocial Project Group (PPG) describe 'psychosocial support' as: "non-clinical and recovery-oriented services, delivered in the community and tailored to individual needs, which support people experiencing mental illness to live independently and safely in the community."

Infant, child and youth – 0 to 25 years

- Psychosocial support programs for young people aged 16 – 25 years, including programs such as the Youth Outreach Recovery Support (YORS) program, are delivered through structured partnerships with NGOs.
- Access to family-centred wellbeing supports for infants, children and young people, such as group-based parenting supports, supports long-term recovery by building capability of caregivers.
- Engagement in education <https://www.vic.gov.au/mental-health-and-wellbeing-toolkit> is a protective factor for the wellbeing of school-aged children and young people and may be supported by accessing wellbeing supports in schools, such as outreach, counselling and support groups.

Adults and older adults – 26 years and older

- Psychosocial support programs aimed at improving independence for adults with persistent and significant impairment due to a mental illness, such as the Early Intervention Psychosocial Support Response (EIPSR), are delivered through partnerships with NGOs.
- Community programs aimed at building connection, such as those established through the Local Connections trials <https://www.health.vic.gov.au/mental-health-services/social-prescribing>, may be accessed to help address social isolation, which is a common experience faced by older adults. Also available via Neighbourhood Houses <https://www.nhvic.org.au/> and the local government area programs <https://www.vic.gov.au/know-your-council>.

Minimum expectations

Provide access to integrated wellbeing and psychosocial supports.

Treatment, care and support addresses social and functional needs, including connection to community, housing, education and daily living.

Partnerships and referral pathways are in place to connect consumers with appropriate wellbeing supports to complement community-based care delivery.

NGOs have a proven track record in delivering effective, strengths-based, recovery-oriented wellbeing and psychosocial supports within community settings, underpinned by strong local relationships and lived experience informed practice. There are many examples of successful partnerships between Area Services and NGOs which support delivery of integrated, recovery-oriented care as part of psychosocial support programs like the Early Intervention Psychosocial Support Response (EIPSR).

Strengthening and expanding partnerships between Area Services and NGOs could increase capacity for delivery of integrated and coordinated wellbeing supports, aligned with clinical care and recovery goals.

The department is developing further advice on the partnership and commissioning arrangements that would support this.

5.7 Educational programs and self-help

Community-based services are expected to include delivery of educational programs to support mental health recovery through a framework of shared learning and co-production. These supports help consumers to actively self-manage their mental health and wellbeing, in alignment with the principles of recovery, self-determination and personal growth.

Area Services are expected to provide mental health and wellbeing educational and self-help programs through structured curricula and learning modules. Such programs may be offered via a range of delivery options, including individual and group-based approaches, and through digital technologies such as websites or apps. They can also help people understand and connect to resources within the broader community.

The following table describes key considerations in tailoring educational programs and self-help to meet the developmental needs of consumers across the two age-based services:

Infant, child and youth – 0 to 25 years	Adults and older adults – 26 years and older
• Educational programs for infants, children and young people, such as Alfred Health's Discovery College should employ age-appropriate teaching practices and play-based learning, and include targeted education for families, carers and supporters. • Digital tools and programs for young people, may enable young people to access personalised self-management guidance that aligns with their digital literacy and preferences for privacy. • Family-focused educational programs may complement delivery of pharmacological and psychosocial treatments for infants, children and young people.	• Educational programs for adults and older adults, such as Mind Australia's Recovery Colleges, should create learning environments that support consumers to build skills in managing difficult emotions, practising mindfulness, setting goals and strengthening communication skills, and should include the provision of mental health education for families, carers and supporters. • Carer support services (such as Carer Gateway and Carer Connect Centres) can also be integrated to support carers by providing access to self help resources, education and guidance.

Minimum expectations

Provide access to mental health and wellbeing education and self-help programs through structured curricula and learning modules.

Education and self-help interventions are an emerging component of community-based services, with the evidence base and practice continuing to evolve. Area Services may consider leveraging programs and courses offered by existing providers in the sector to deliver this component of community-based care, such as Mind Australia's Recovery College and Alfred Health's Discovery College.

6. Workforce

This section describes the diverse workforce disciplines and competencies required to deliver high-quality community-based services. Area Services are expected to locally determine workforce arrangements including role specification and multidisciplinary team structures to deliver the core service components of community-based care in accordance with the relevant workforce discipline frameworks, enterprise agreements, 'Our workforce, our future' <https://www.health.vic.gov.au/our-workforce-our-future> (previously known as the Mental Health and Wellbeing Workforce Capability Framework).

6.1 Workforce disciplines

Community-based services are delivered by highly-skilled, multidisciplinary teams of specialists employed by Area Services, and NGO-employed workforces under partnership arrangements, that respect and value all professional contributions to support collaborative, holistic care. The specific roles and contributions of different disciplines and workforce groups will vary based on the local service model.

The key disciplines involved in community-based services include (but are not limited to):

- Psychiatry (i.e. psychiatrists and psychiatry registrars).
- Mental Health Nursing (i.e. registered nurses, enrolled nurses and nurse practitioners).
- Psychology (i.e. psychologists and clinical psychologists).
- Social Work (i.e. social workers).
- Occupational Therapy (i.e. occupational therapists).
- Other allied health disciplines (such as speech pathologists, dietitians, exercise physiologists, physiotherapists, music and art therapists and counsellors).
- Lived Experience (Peer) Workforce (i.e. consumer and family/carer lived experience workers).
- Alcohol and Other Drug Workforce (i.e. AOD practitioners, addiction medicine specialists).
- Other psychosocial and community mental health disciplines (such as psychosocial practitioners, community mental health workers, recovery coaches and social support workers).
- Aboriginal Social and Emotional Wellbeing Workforce.

Area Services may complement a diverse and multidisciplinary workforce by partnering with NGOs to deliver community-based services. NGO workforces have a range of skills and expertise, particularly in allied health, community and wellbeing supports.

Management, administrative and operational support workers are an essential enabler of community-based service delivery and may include:

- Operational leaders, such as service managers and team leaders.
- Administrative and other support staff, including reception, medical secretaries, data quality and reporting staff.
- Education and training coordinator(s) to support workforce development, by working closely with leaders to identify and address workforce development needs.
- Relationship-building staff member(s) to manage strong, collaborative relationships with other providers in the service system.

6.1.1 Workforce capabilities

The workforce delivering community-based services is expected to have the requisite capabilities aligned with the 'Our Workforce, our future' framework <https://www.health.vic.gov.au/our-workforce-our-future> to deliver (at a minimum):

- Highly specialised treatment, care and support to people experiencing moderate to severe symptoms of mental illness and psychological distress.
- Coordinated and integrated responses within a multidisciplinary team, and across services and settings, to address co-occurring needs.

- Relational practice to develop therapeutic alliance and support recovery-oriented care.
- Outreach, in-home and flexible care models to support accessibility.
- Trauma-informed approaches to crisis de-escalation and high-risk circumstances.
- Capability development, coaching and leadership to build system capability.

6.1.2 Role clarity and scope of practice

Area Services are responsible for defining the roles and responsibilities for all workers within multidisciplinary teams to support delivery of the local community-based model of care.

Roles should be aligned to capability, enabling workers to deliver discipline-specific interventions to their full scope of practice (i.e. the full range of skills that a mental health professional has been educated in and is authorised and competent to perform).

In determining roles and responsibilities, Area Services may consider the knowledge, skills and scope of practice outlined in the following frameworks:

- Alcohol and Other Drug (AOD) Lived Experience Workforce Discipline Framework <https://www.sharc.org.au/about-sharc/sharc-discipline-frameworks/>
- Alcohol and Other Drug (AOD) Family Lived and Living Experience Workforce <https://www.sharc.org.au/about-sharc/sharc-discipline-frameworks/>
- Mental Health Consumer Lived Experience Workforce Discipline Framework <https://the-collective.au/frameworks/mental-health-consumer/>
- Harm Reduction Lived and Living Experience Workforce Discipline Framework <https://www.hrvic.org.au/fuse>
- Mental Health Family Carer Lived Experience Workforce Discipline Framework <https://tandemcarers.org.au/discipline-framework>

Other disciplines frameworks can be found in **Appendix B: Key mental health and wellbeing system policies, frameworks and guidelines**.

In addition, the Lived Experience Workforce Guidelines <https://www.mentalhealthcommission.gov.au/lived-experience/lived-experience-workforces/peer-experience-workforce-guidelines> from the National Mental Health Commission are a useful resource.

6.2 Training and development

Area Services are required to resource, manage and sustain a capable workforce that have the necessary knowledge, skills, experience and capability to deliver all components of community-based care. This includes:

- Identifying training and development needs, and providing access to appropriate local and statewide options for training, professional development focused on community-based models of care, such as those offered via the Victorian Collaborative Centre for Mental Health and Wellbeing <https://vccmhw.vic.gov.au/>, MHPOD <https://www.mhpod.gov.au/>, Lived Experience Workforce Initiatives <https://www.health.vic.gov.au/workforce-and-training/lived-experience-workforce-initiatives> and The Collective <https://www.sharc.org.au/sharc-programs/the-collective/>.
- Establishing a discipline-specific and interdisciplinary program of structured learning, professional development, supervision and reflective practice. This may be inclusive of both the Area Service and NGO workforce, whereby clinicians provide supervision and guidance to NGO staff, and NGO staff support clinicians to embed wellbeing practice. Supervision practice must align with the industrial instrument under which staff are employed (i.e. enterprise agreement).
- Establishing structured pathways for graduates and early career pathways into community-based services, to build a sustainable pipeline of multidisciplinary workers with the skills required for specialised community-based care.
- A focus on building capability to respond to co-occurring needs such as substance use or addiction, disability and neurodevelopmental disorders; and work effectively with families, carers and supporters; and work with

consumers from diverse backgrounds in a culturally safe and appropriate way (including relevant accreditation and e-learning modules aligned with national standards).
- Workforce development should include access to training, supervision and professional development opportunities that support culturally safe practice. This may include relevant accreditation and e-learning modules aligned with National Safety and Quality Health Service (NSQHS) Standards.

6.3 Workforce capacity

Area Services are expected to establish staffing models that meet relevant industrial obligations and prioritise continuity of care and oversight over a consumer's journey through their local community-based model of care. The aim is to ensure all consumers who access community-based services are supported and/or connected with the right supports at every stage.

This requires supporting staff to maintain manageable levels of allocated consumers, that reflect the intensity of the services they provide. For example, practitioners that deliver higher intensity services will be allocated a relatively smaller volume of consumers compared to those that deliver lower intensity services.

Area Services face a range of workforce challenges in delivering community-based services, including shortages, variable capability and experience delivering integrated and holistic models of care, difficulty attracting and retaining staff to regional service locations and the complex industrial arrangements supporting the diverse disciplines they employ.

Significant investments have been made in recent years to support Area Services to build and diversify the workforce employed by Area Services to deliver community-based care. These include growing and supporting the lived and living experience workforce, providing more opportunities for allied health and mental health nursing graduates, and new pathways into mental health and AOD specialisation for junior doctors.

The department will also provide further guidance to services about workforce implications of the partnership model for community-based services, in particular with respect to establishing and maintaining multi-disciplinary teams involving NGO-employed workforces.

7. Roles and responsibilities

This section outlines the roles and responsibilities of Area Services and partner NGOs in delivering community-based services, with oversight provided by the department.

7.1 Role of the department

The department will work closely with Area Services and partner NGOs to:

- Provide system stewardship by setting expectations that drive best practice and continuous improvement.
- Set expectations that include operational requirements, outcomes measurement, performance monitoring, workforce capability requirements and commissioning settings.
- Monitor and manage community-based Area Service performance, including refining this service framework based on learnings and the reform context.

Refer to **Appendix E: Clinical oversight and standards** for details regarding key clinical oversight mechanisms, including the Office of the Chief Psychiatrist.

7.2 Role of Area Services

Area Services are responsible for delivering all components of community-based care described by this framework, and providing clinical expertise, oversight and governance to guide community-based service delivery. This includes:

- Delivering specialised mental health treatment, care and support in community-based settings.
- Providing primary and secondary consultations to level 4 and other services to support clinical decision-making and system capability building.
- Building broader system capability in community-based care through clinical leadership and oversight.

Area Services (as the department-funded service) are responsible for establishing formal partnership, service delivery and/or sub-contracting agreements with NGOs to enable the delivery of the full range of community-based service components to meet local needs.

Area Services also have a role in supporting access to the NDIS for people with a psychosocial disability.

7.3 Role of non-government organisations

Non-government organisations (NGOs) play a critical role in delivering wellbeing, recovery oriented and wraparound supports that address the broader determinants of mental health and wellbeing. They are also well positioned to provide non stigmatising, accessible and human rights centred services, grounded in dignity, choice, inclusion and cultural safety, where consumers, families, carers and supporters feel respected, empowered and able to engage in care.

NGOs partnering with Area Services to deliver community based services are expected to:

- Deliver wellbeing supports including but not limited to peer, housing, education, training and employment supports for consumers, families, carers and supporters.
- Work in partnership with Area Services to support smooth transitions, information sharing and integrated models of community-based care.
- Report on service performance and outcomes as required to partnering Area Services and the department.
- Participate in shared care arrangements to bridge service gaps, particularly for consumers who may not require ongoing clinical services.

7.4 Shared responsibilities within partnerships

Where partnerships are established between Area Services and NGOs for the delivery of community-based services, the department expects that arrangements will:

- Be built on mutual respect, shared accountability and transparent communication that fosters trust and active collaboration between Area Services and NGO staff.
- Promote two-way dialogue between partners, in recognition that both Area Services and NGOs bring unique perspectives, expertise and strengths to community-based service delivery.

- Be supported by clear governance structures, formal agreements and shared protocols which enable timely and effective decision-making.
- Establish clear communication channels, such as team meetings, emails and newsletters, to foster collaboration at both the operational and leadership level.

See **Section 9: Governance and accountability** for further guidance on clinical governance and quality assurance, including for NGO services operating in partnership.

> As noted at the end of **Section 3.10 Service partnerships**, the department is exploring ways to strengthen and expand service delivery partnerships between Area Services and NGOs underpinning community-based services. Further guidance will be provided separately to this framework.

8. System integration and pathways

This section outlines how community-based teams within Area Services work collaboratively with the broader service system to ensure continuity of care and seamless transitions for consumers and their families, carers and supporters, in line with the Royal Commission's vision for an integrated and responsive mental health and wellbeing system.

8.1 System context

The Victorian mental health and wellbeing system consists of six levels, as shown in **Figure 2**, which consumers access according to their strengths and needs. The levels progressively increase in the intensity of supports and services provided, and in capability to support people experiencing more significant and complex mental health conditions.

All six levels of the system work collaboratively together and in the best interests of consumers, carers, families and supporters who may move between these levels as their needs change over time.

Figure 2: Mental health and wellbeing system levels



Image: *A horizontal bar graph demonstrating the six levels of the Victorian mental health and wellbeing system. Level one is described as families, carers and supporters, informal support, virtual communities, and communities of place, identity and interest. Level two is described as a broad range of government and community services. Level three is described as primary and secondary mental health and related services. Level four is described as Local Mental Health and Wellbeing Services. Level five is described as Area Mental Health and Wellbeing Services. Level six is described as statewide services.*

Source: Adapted from Royal Commission into Victoria's Mental Health System, Final Report, 2021, Vol 1, p470

- **Levels 1** and **2** include non-mental health specific services that focus on promotion, prevention and early intervention to support good mental health and wellbeing, with the aim of reducing the need for people to access other levels of the system.
- **Level 3** (e.g. general practitioners) provides primary and secondary care to people with mild to moderate mental health needs, including navigation support and warm referrals to Local and Area Services.
- **Level 4** Mental Health and Wellbeing Locals (Local Services), provide easy-to-access, high-quality treatment, care and support to adults and older adults 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.[2] For infants, children and young people, the Children's Health and Wellbeing Locals (Child Locals) and Commonwealth's headspace centres offer similarly accessible and high-quality supports for those with mild to moderate mental health support needs and those experiencing behavioural, emotional or relational difficulties.
- **Level 5** (e.g. Area Services) provides evidence-based responses via acute and/or specialist treatment, care and support, including compulsory treatment, to people with moderate to severe mental illness and/or psychological distress of all ages.
- **Level 6** (e.g. statewide services) provides highly specialised care for consumers with the most complex and intensive needs, where Area Services do not have the scale, specialisation or available workforce to do so safely and efficiently.

Private health providers also deliver high-intensity, acute and/or specialist treatment, care and support comparable to those delivered by public level 5 and 6 services but cannot support compulsory treatment. This may include bed-based mental health services, psychiatry, psychology and other allied health services.

Refer to **Appendix C: How level 5 fits within the Victorian system** for further information on the levels of the mental health and wellbeing system.

Work is still underway to refine the six levels of the mental health and wellbeing service system.

The Next Phase of Reform outlines plans for the 'design and implementation of a service capability framework' which will define the six functional levels of the service system in terms of scope of care, the complexity supported and the functions delivered, ensuring consistency, clarity, and safe care delivery. This is consistent with the use of capability frameworks for other parts of the Victorian health system.

Key level 4 services, Local Services and Child Locals, are not yet available statewide. The department acknowledges that in locations where Level 4 services are not yet operational, community-based teams within Area Services will often see consumers present with less complex needs and may span level 4 capability to meet the needs of their consumers.

8.2 Collaborative practice

Community-based teams within Area Services are expected to work collaboratively with other services in the mental health and wellbeing service system (inclusive of private mental health service providers) and the wider health and human services sector (such as AOD, gambling harm and family violence) to ensure consumers experience smooth, timely transitions between supports, including by:

- Providing timely and supportive response to referrals from a range of sources (as described in Section 5.1.1 Referrals) to navigate the consumer to the appropriate care.

[2] Mental Health and Wellbeing Locals are a new stream introduced following the Royal Commission to deliver integrated mental health and wellbeing treatment, care and support for people who need more support than they can receive from primary and secondary mental health and related services but do not require the type and intensity of care delivered by Area Services.

- Actively supporting a consumer's transition to another service by communicating directly with the team and confirming that the service has accepted the referral.
- Sharing relevant information about the consumer with other services, to avoid consumers having to re-tell their story and ensure that the service understands the consumer's history, context and current needs (with informed consent; noting consent is not always required for infant, child and young people under FVISS and CISS).
- Only discharging consumers when immediate acute and specialist care needs are met, and a clear plan for ongoing support is in place. This includes post discharge follow-ups, with decision-making input such as timing and frequency to be determined based on the consumer's needs and the Office of Chief Psychiatrist's Transfer of Care and Shared Care Guidelines <https://www.health.vic.gov.au/chief-psychiatrist/transfer-of-care-and-shared-care>.

8.3 Consultations and shared care arrangements

Community-based teams within Area Services contribute their specialised skillsets to uplift service capability across the system. This collaboration ensures mental health needs can be identified and addressed sooner within levels 3 and 4 of the service system, before the need for more intensive and specialised treatment, care and support.

This function aims to support primary and secondary care providers, such as general practice and community health services, through:

- Primary consultation.
- Secondary consultation.
- Comprehensive shared care.

8.3.1 Primary consultations

Primary consultation involves practitioners from community-based teams within Area Services meeting directly with a consumer of another service to provide expert opinion to assist their care. A member of the referring care team can also be present for a primary consult. These consumers are not considered an ongoing consumer of the community-based Area Service and therefore clinical responsibility remains with the referrer.

8.3.2 Secondary consultation

Secondary consultation involves practitioners from community-based teams within Area Services providing information, advice and expertise to another service provider, often without a consumer present. General advice can also be provided to build capabilities on clinical and wellbeing issues, without necessarily being tied to an individual consumer. For example, community-based teams within Area Service may provide secondary consultation to:

- Level 4 services including Local Services, Child Locals and the Commonwealth's headspace centres to support care planning and coordination and decision-making.
- General practitioners and primary care teams to safely manage presentations in the community through specialist programs such as FAPMI and Forensic Clinical Specialist Program.
- Emergency services to support pre-hospital care and guide first responders on appropriate de-escalation strategies.
- Other health and human services such as AOD, gambling harm and family violence.

Community-based teams within Area Services may also access secondary consultations from other community and health services to complement existing support. For example, gambler's help services can be accessed for advice to help community-based Area Service practitioners identify and respond to gambling addiction challenges.

8.3.3 Comprehensive shared care

Comprehensive shared care is a structured approach to integrated care across multiple autonomous service providers with primary and secondary care practitioners or private practitioners contributing to elements of a consumer's care.

This often involves a lead clinician acting as the consumer's main mental health care provider, with practitioners from community-based teams within Area Services delivering specific components of a consumer's treatment, care and support.

Comprehensive shared care requires agreement on:

- shared activities
- roles and responsibilities of each provider
- care pathways
- outcomes monitoring systems
- a well-established clinical governance framework
- appropriate communication and information sharing processes to support the delivery of shared care.

Shared care should consider the important role of families and carers as key informal supports within the broader care network.

8.4 Streamed care pathways

Area Services are expected to deliver care through a streamed model, with care organised around groups of consumers with similar levels of need, intensity and support required (including specialisation). For community-based services, this includes:

- Organising care delivery to reflect different levels of need and intensity, including short-term, ongoing and ongoing intensive care.
- Supporting consumers to receive timely, appropriate care in the least restrictive environment, including in the community wherever possible.
- Enabling continuity of care, with services adapting as a person's needs change rather than requiring re-entry to the system.
- Supporting consumers to enter through multiple access points ("no wrong door") and be connected to the most appropriate level of care, including referrals and shared care between level 4 services and NGO programs.

> The Royal Commission identified a need for a service system that enables people to move flexibly between different levels of care based on their needs. At present, with the absence of a fully developed and consistently available psychosocial support system, and inconsistency in the availability of level 4 services, there are limits on the system's capacity to operate as a fully realised streamed model. Broader work beyond this framework, including psychosocial reforms and the development of a mental health and wellbeing capability framework, will provide more guidance on streaming in the next stages of reform.

8.4.1 Types of Pathways

Area Services support consumers to move between community-based services and other parts of the system. This includes:

- Working with NGO programs and wellbeing support services to provide flexible and responsive support including referrals to psychosocial supports, residential recovery programs, non-Area Service-based housing services, employment support and peer-led recovery programs.
- For consumers no longer requiring intensive treatment care and support, level 4 services, primary care, private service providers, Mental Health Community Support Services (MHCSS) or other community services (e.g. education, housing).
- For consumers that require specialist support via Statewide Services (level 6), providing planned, timely and coordinated transitions to specialist inpatient services.

8.4.2 Pathways within Area Services

Referrals and transfers within the same Area Service—including transitions to and from bed-based care or an emergency department to community-based care—are expected to be timely, straightforward and clinically led, to support continuity of care and minimise service

fragmentation. Internal referral pathways should be designed to enable seamless transitions between service components and must not create unnecessary administrative or procedural barriers.

In particular:

- Transfers from bed-based care to community-based care should be facilitated through streamlined internal processes, without requiring onerous paperwork, duplicate assessments or re-referral.
- Signed consent or additional authorisation should not be required where information sharing and referral are necessary for continuity of care and are otherwise permitted under relevant legislation and policy.
- Clinical handover processes should prioritise clear communication, shared care planning and continuity of relationships, rather than administrative compliance.
- Internal referrals should be coordinated by the Area Service to ensure consumers experience a single, connected service system, rather than navigating multiple entry points.

These arrangements are intended to support safe, timely discharge; reduce reliance on emergency departments; and ensure consumers receive the right care, at the right time, in the least restrictive setting, within their local Area Service. Area Services should plan for transition and ongoing recovery.

Age-based services

Infant, Child and Youth Area Services (0 – 25 years) and Adult and Older Adult Area Services (26 years and over) work together to ensure continuity of care for consumers transitioning between age-based services. Where family members are receiving support from different services, treating teams should work collaboratively, where appropriate and consistent with legislative requirements, to support a coordinated and family-inclusive approach to care. For example, this may include collaboration between Area Services where a parent and child are both receiving care.

Their shared responsibilities include facilitating warm referrals, shared care and staffing arrangements and joint transition planning, to strengthen transitions between services for young people as they reach 26 years of age.

Some children may need treatment, care and support in both the Infant, Child and Family (0–11) and Youth (12–25) service streams of ICY Area Services as they grow and develop. It is expected that ICY Area Services will have shared operational and clinical governance across the entire age range of 0-25 years, which will help to provide continuity of care and a 'safety net' against disruptions in treatment, care and support for children who need to transition to the Youth service stream. The timing of transitions is flexible given individual developmental considerations, and some consumers may benefit from support from both age stream services during the transition period. At all times, decisions about transition between services, and service streams, will be made in partnership with consumers and their families, carers and supporters.

Crisis and bed-based services

It is expected that community-based teams within Area Services will work collaboratively with other Area Service teams delivering crisis and bed-based services to identify, manage and respond to escalating needs including crises and emergencies.

This includes effective collaboration with Community Care Units (CCUs), Secure Extended Care Units (SECUs), Prevention and Recovery Care (PARC), Youth Prevention and Recovery Care (YPARC) services and inpatient units. Responsibility for clinical decision-making and transfer of care between community-based teams and other Area Service teams shall occur in accordance with clearly documented clinical governance and accountability arrangements. Community-based teams will also ensure access to drop-in safe spaces or crisis telehealth phonelines for navigation and/or brief intervention, and support consumers in inpatient settings with discharge planning into community.

8.4.3 Pathways between Area Services and other services

Area Services will work closely with other parts of the service system to ensure smooth transitions and continuity of care for consumers and their families, carers and supporters as their needs evolve to require either lower or higher levels of specialisation.

Level 3: Primary care

Area Services are expected to facilitate pathways to general practitioners, to ensure consumers can continue to be safely and holistically supported in the community. This involves the timely sharing of discharge summaries and working collaboratively with the general practitioner to meet the consumer's intersecting mental health and physical health needs.

Area Services are also expected to facilitate pathways for general practitioners to refer existing or previous consumers to an Area Service in the case of changed need, preference and context including for example higher intensity of symptoms or where a review is required. A comprehensive shared care approach (refer to **Section 8.3 Consultations and shared care arrangements**) may be used to support this.

Level 4: Local Services, Child Locals and Commonwealth funded headspace services

Area Services are expected to formalise operational relationships with level 4 services to enable:

- Primary and secondary consultations to assist with assessment, care planning and confirming diagnoses and/or referral decisions.
- Capacity and capability building through liaison, education and support.
- Referral pathways, including establishing clear re-entry protocols to avoid re-triaging consumers who may need to transition between settings based on their changing needs. Local Services (for adults and older adults) 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.
- Shared care arrangements, including consideration of shared triage and/or decision-making tools, intake processes, governance arrangements (i.e. dual clinical governance arrangements) and workforce where appropriate.
- Additional support, guidance and resources as required, particularly during early stages of implementation for new services.

Area Services may refer to the Mental Health and Wellbeing Locals Service Framework <https://www.health.vic.gov.au/publications/mental-health-wellbeing-locals-service-framework> for more information on the above arrangements.

> The department and the Commonwealth have jointly committed to collaborate on the development of a framework to strengthen integration between headspace services and Infant, Child and Youth Area Mental Health and Wellbeing Services (ICY AMHWS). The guidance will set out the key expectations for collaboration and integration between headspace services and ICY AMHWS to support more consistent access, stronger coordination and better continuity of care for young people moving between service settings.

Level 6: Statewide services

Area Services are expected to support clear pathways for consumers who may require ongoing specialised care for clinical conditions that cannot be safely met through levels 4 or 5. This includes access to specialist eating disorder, perinatal, neuropsychiatry, personality disorder, complex trauma, dual disability, brain disorder and other highly specialised services.

Area Services will request consultation and advice from statewide services as required to support consumers with complex needs and build capability within local teams. This may involve statewide service functions being delivered in community-based settings where appropriate

(e.g. via primary consultation), to minimise the need for consumers to travel long distances and promote equitable access to specialist care.

Other support services

Area Services will support consumers to navigate pathways to psychosocial support programs such as the National Disability Insurance Scheme (NDIS) and Commonwealth-funded psychosocial supports for consumers who are not eligible for the NDIS, such as those commissioned via Primary Health Networks.

Area Services have a responsibility to minimise service gaps and help consumers to seamlessly navigate between State and Commonwealth-funded services that address broader mental health and wellbeing needs, including disability support and support for daily living and community participation.

Area Mental Health and Wellbeing Services should also work collaboratively with GPs, private psychiatrists, private psychologists and other community providers through shared-care, consultation and coordinated-care arrangements.

Broader service system

It is expected that Area Services will establish collaborative arrangements with the broader care system within the local region to meet holistic needs in community-based settings. These broader services include but are not limited to:

- Aboriginal Community Controlled Health Organisations
- Allied health services
- AOD and harm reduction services.
- Disability services including NDIS providers and partners
- Eating disorder services
- Employment agencies
- Family services
- Family violence and child protection services
- Gambling harm support services
- Housing and homelessness services
- Legal and financial services
- Medical services
- Non-legal advocacy services
- Primary care services
- Refugee and asylum seeker services
- Specialist LGBTIQA+ inclusion health care services.

8.5 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.

As part of the Local Health Service Networks policy framework <https://www.health.vic.gov.au/research-and-reports/local-health-service-network-policy-framework>, Networks are to develop Mental Health and Wellbeing Collaboration Plans (MHW Collaboration Plans) which aim to improve access, equity and flow for consumers by strengthening collaboration across the mental health and wellbeing system in their region. Not all health services within a network are designated mental health services, so those services delivering level 5 mental health services may play a more significant role in the development of the Collaboration Plans.

The MHW Collaboration Plans focus on identifying common regional priorities where a collaborative approach will meaningfully improve access, equity or flow, and setting out collaborative arrangements with stakeholders to address the common priorities. This service framework is one input to the collaborative planning process and may inform common priorities at a network level where there is an agreed benefit to shared regional implementation.

Detailed guidance on the scope and expectations for the MHW Collaboration Plans has been provided to each Network.

9. Governance and accountability

Clear governance, quality assurance, performance monitoring and continuous improvement practices enable Area Services to consistently deliver high-quality and safe care. Area Services operate quality and governance arrangements through which staff with peer, clinical and operational expertise review and endorse guidelines, data and service user feedback, and identify systemic issues and improvement opportunities.

9.1 Clinical governance

Area Services must establish and maintain robust clinical governance structures, in alignment with the requirements of the National Model for Clinical Governance <https://www.safetyandquality.gov.au/resources/2026-national-model-clinical-governance-pdf>, Victorian Clinical Governance Framework <https://www.safercare.vic.gov.au/best-practice-improvement/clinical-governance/framework> and Chief Psychiatrist Guidelines <https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrist-guidelines>.

Area Services hold overarching responsibility for clinical governance of community-based services, including when delivering integrated treatment, care and support in partnership with NGOs. Services may transfer clinical governance to, and from, authorised clinicians in primary care, private mental health care and/or level 4 services within agreed clinical governance frameworks.

> A partnership model is under development to strengthen mechanisms for accountability between Area Services and NGOs delivering community-based services through partnerships. It will address important considerations such as clinical governance and risk management, information sharing, escalation thresholds and include protocols for resolving conflict and disagreements between provider partners.

9.2 Quality assurance

Area Services are required to deliver high-quality, safe services that comply with relevant accreditation standards and legislative requirements, including, but not limited to, the following (where applicable):

- National Safety and Quality Health Service Standards (second edition) <https://www.safetyandquality.gov.au/resources/national-safety-and-quality-health-service-standards-second-edition>.
- National Safety and Quality Digital Mental Health Standards <https://www.safetyandquality.gov.au/national-standards/digital-mental-health-standards>.
- Quality Improvement Council Health and Community Services Standards <https://www.qip.com.au/standards/qic-health-and-community-services-standards/>.
- Charter of Human Rights and Responsibilities Act (2006) <https://www.legislation.vic.gov.au/in-force/acts/charter-human-rights-and-responsibilities-act-2006/015>.

Area Services must achieve and maintain accreditation through a recognised body such as the Australian Health Service and Quality Accreditation Scheme, International Society for Quality Health Care or Joint Accreditation System of Australia and New Zealand. This requirement also applies to any sub-contractor(s) engaged by Area Services.

Sub-contractors engaged by Area Services are likely to include NGOs who partner to deliver care. All NGOs have different areas of expertise and value add to support recovery-oriented models. The National Safety and Quality Mental Health Standards for Community Managed Organisations <https://www.safetyandquality.gov.au/national-standards/mental-health-standards-community-managed-organisations>

and Victorian Social Services Standards <https://www.vic.gov.au/social-services-regulator-social-services-standards> can give confidence to Area Services about quality of care delivered by NGO partners.

9.3 Data, monitoring and evaluation

The department oversees and manages the overall performance of Area Services, including their community-based service delivery, through regular performance monitoring and operational reviews, in accordance with the Victorian Health Services Performance Monitoring Framework <https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework>. The department also conducts an annual Mental Health and Alcohol and Other Drugs (AOD) Workforce Census to support workforce planning, monitor workforce trends, and inform service system development.

9.4 Performance indicators and targets

The department monitors community-based services delivered by Area Services against targets specified in the formal agreement (Statement of Priorities) between the department and the community-based Area Service. These targets are guided by business rules outlined in the Victorian Health Services Performance Monitoring Framework <https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework>.

Area Services report against key performance indicators and targets, including:

- Service delivery activity which includes community mental health service hours and contacts (as measured by National Weighted Activity Units <https://www.ihacpa.gov.au/health-care/pricing/pricing-framework-australian-public-hospital-services>) separated out by clinical and non-clinical hours, average length of cases (days) and average treatment days.
- Service quality and outcomes which includes mental health consumer and carer experience (as measured by the Your Experience of Service and Carer Experience surveys), proportion of cases with significant improvement in Health of the Nation Outcomes Scale (HoNOS) at closure and mental health inpatient re-admission within 28 days.
- Access and responsiveness including urgent Telephone Triage responses within timelines, emergency department to mental health bed transfers within eight hours and follow-up within seven days of separation.
- Compliance and standards which includes compliance with data, incident and complaints reporting requirements and maintenance of accreditation against an accepted accreditation standard.
- Financial performance including expenditure targets over a 12-month period and other key performance expectations as agreed in the Statement of Priorities.

The department works with Area Services to identify areas of underperformance and implement tailored strategies to address the area(s) of concern.

Monitoring of NGOs occurs via service agreements and contractual arrangements established with the Area Service.

9.5 Evaluation and research

Area Services are required to participate in evaluation activities delivered by the department to inform policy, funding and service model decisions. This may include compliance with requirements from a certified Human Research Ethics Committee.

Responsibilities for ongoing research, innovation and continuous improvement of community-based services will be shared between Area Service quality, safety and improvement units, funded Area Service mental health research academics, the Victorian Collaborative Centre, Safer Care Victoria and the department.

9.6 Knowledge sharing

Area Services are required to:

- Share learnings with other Area Services to build capacity and capability across the broader service system.
- Establish and maintain operational policies and processes for how they incorporate consumer feedback and complaints to improve service delivery.
- Consistently review processes and systems to minimise unnecessary administrative burden.

The department will convene both targeted and larger community of practice forums between Area Services to support knowledge sharing and feedback loops. Learnings and feedback will be used to refine this service framework over time, and ensure it remains responsive to evolving needs, evidence and reforms.

9.7 Mental Health Improvement Program

Area Services are expected to support the implementation of quality improvement initiatives established by the Mental Health Improvement Program (MHIP), led by Safer Care Victoria. MHIP contributes to guiding mental health and wellbeing services to deliver evidence-based practice across the state. The priority areas for reform are outlined on the MHIP webpage <https://www.safercare.vic.gov.au/best-practice-improvement/mental-health-improvement-program/about#goto-keyreform-initiatives>. Broader responsibility for driving practice improvement across mental health and wellbeing services sits with the Mental Health and Wellbeing Division (MHWD), together with Safer Care Victoria.

9.8 Intended Outcomes

The delivery of community-based services contributes to the achievement of outcomes across all four domains of the Victorian 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>.

The four domains of the Outcomes and Performance Framework describe what success looks like in Victoria's mental health and wellbeing system. Each domain contains a series of outcomes, with respective indicators and measures, which together define how success will be measured.

Below is an overview of the key outcomes and indicators that most strongly align with community-based service delivery.

Domain	Outcome	Indicators
Domain 1: Victorian Population	Communities support and enable mental health and wellbeing.	• Increase social inclusion and community connection. • Increase supportive, respectful relationships. • Increase community conversations about emotional wellbeing. • Increase local liveability and access to nature.
Domain 2: Services	Mental health and wellbeing services are safe, inclusive, and accountable.	• Increase people's experiences of physical and psychological safety. • Increase cultural safety of care and support. • Increase accountability in responding to feedback and complaints.
	Mental health and wellbeing services are holistic and effective.	• Increase people's experiences of whole-of-person care and support. • Increase effectiveness of care and support. • Increase people's satisfaction at the results from their care and support.

Domain (contin.)	Outcome (contin.)	Indicators (contin.)
Domain 2: Services (contin.)	Mental health and wellbeing services are person-driven and compliant with human rights.	• Increase person-driven and dignified care and support. • Increase care and support that is compassionate and trauma-informed. • Increase positive experiences of care and support.
Domain 3: Workforces	The mental health and wellbeing workforce has the necessary skills, knowledge, and capability to work to the top of their individual and collective scopes of practice.	• Increase workforce skills, knowledge, and capability. • Increase workforce partnering with consumers and families, carers, and supporters. • Increase diversity of learning opportunities.
Domain 4: System Stewardship	The mental health and wellbeing system is accessible.	• Increase people being able to access the care and support they want, when they want, where they want. • Increase the mental health and wellbeing system's capacity to provide appropriate, culturally safe, and timely care and support. • Increase perception of the mental health and wellbeing system as open, safe, and welcoming.
	Wellbeing is supported in the places people learn, live, and work.	• Increase positive mental health and wellbeing for children and young people in education settings.

Appendices

Appendix A: Glossary of terms

The department recognises that language is powerful, with words carrying different meanings for each person or community. There is no single set of definitions used to describe people's experience of mental health challenges.

Term	Definition
Area Mental Health and Wellbeing Services (AMHWS)	Area Mental Health and Wellbeing Services (AMHWS) are government funded, regionally organised public mental health services that provide specialist, multidisciplinary treatment, care and support to people experiencing moderate to severe mental illness within a defined geographic catchment, across inpatient, community and outreach settings.
Adult and Older Adult	Adult and Older Adult (AOA) refers to individuals aged 26 years and over, typically encompassing both adult (approximately 26–64 years) and older adult (65 years and over) populations within the mental health and wellbeing system, who may require tailored assessment, treatment, care and support based on age related needs, life stage, and complexity.
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 to reduce the need for emergency department presentations or hospitalisation; and provide a more seamless experience of support for consumers.
Carer / supporter	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 and/or support to another person with whom he or she is in a care relationship. Care relationship is further defined in the Carers Recognition Act 2012, and more on this webpage: Carers, caring and respite care services <https://www.betterhealth.vic.gov.au/servicesandsupport/carers-caring-and-respite-care-services> Paid carers such as professional staff in services, disability support carers or residential workers are not included in this definition.
Clinical services	Services delivered by registered health professionals exercising professional therapeutic, assessment, treatment or care functions (e.g. psychiatrists, psychologists, mental health nurses, occupational therapists, social workers in clinical roles).
Community-based services	Level 5 mental health and wellbeing services delivered within the community, rather than in hospital-based inpatient settings.
Consumers	People who identify as having a lived or living experience of mental illness or psychological distress, irrespective of whether they have a formal diagnosis, who have accessed mental health services and/or received treatment.
Crisis response	A mental health crisis is an acute state of psychological distress or risk where a person's safety, wellbeing, or ability to function is severely compromised, requiring immediate assessment and support. Mental health crisis response is a health-led, integrated system that provides timely, least-restrictive support.

Term (contin.)	Definition (contin.)
Cultural safety	Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism. Definition sourced from: AHPRA Aboriginal Strategic Oversight Group <https://www.ahpra.gov.au/About-Ahpra/Aboriginal-and-Torres-Strait-Islander-Health-Strategy.aspx>.
Diverse communities	Diverse communities include multicultural and multifaith, LGBTIQA+, disability communities and other marginalised communities, approached through an intersectional lens.
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 <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).
headspace	headspace is an Australian Government-funded national service that provides early intervention mental health support to young people aged 12–25 years. Delivered through a network of community-based centres and online services, headspace offers accessible, youth-friendly care across mental health, physical and sexual health, alcohol and other drug support, and vocational services. headspace also plays an important role in connecting young people with broader health and social supports as part of coordinated, person-centred care.
Integrated care	Integrated care is a person-centred approach planned with the consumer, their families, supporters and carers, and delivered through coordinated multidisciplinary teams working across settings and levels of care. It supports the comprehensive delivery of quality services across the life span, enhances quality and outcomes, ensures the effective use of resources, and enables continuous improvement and action on the broader determinants of health.
Integrated treatment (AOD)	A coordinated response to a person's mental illness or psychological distress which may be co-occurring with substance use (such as AOD), addiction and/or other needs It may involve a mix of clinical and non-clinical types of treatment, care and support.
Lived and living experience	People with lived/living experience identify either as someone who is living with (or has lived with) mental illness or psychological distress, or someone who is caring for or otherwise supporting (or has cared for or otherwise supported) a person who is living with (or has lived with) mental illness or psychological distress. People with lived and living experience are sometimes referred to as 'consumers' or 'carers', acknowledging that the experiences of consumers and carers are different.

Term (contin.)	Definition (contin.)
Mental health and wellbeing	Mental health and wellbeing does not refer simply to the absence of mental illness 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.
Multidisciplinary	An approach where people with different professional roles, skills and expertise work together, each contributing their specific knowledge, to plan and deliver coordinated care while maintaining clear roles and responsibilities.
NDIS	The NDIS is an Australian Government-funded program that provides individualised support to people with permanent and significant disability. It aims to help participants achieve their goals by funding reasonable and necessary supports, including assistance with daily living, access to health and community services, and participation in social and economic life. The NDIS also plays a key role in coordinating with other service systems, including mental health and wellbeing services, to support integrated, person-centred care.
Non-clinical	Non-clinical refers to activities, supports and programs that help people manage their own recovery, build capability and independence, strengthen social and community connections, and maximise participation in community life. This includes supports that assist people to pursue their personal goals, develop daily living and self-management skills, access education, training, employment and housing opportunities, maintain relationships, and participate fully in their communities. Non-clinical supports are recovery-oriented, person-centred and focused on promoting wellbeing, inclusion and quality of life.
Non-government organisations	Non-government organisations (NGOs) are independent, non-profit organisations that provide services to the community and do not operate to generate profit for members or shareholders (where applicable). For the purposes of this framework, this may include Community Health Services (that are not operated by public health services). NGOs deliver community-based supports across a wide range of areas, including but not limited to physical health; community health services; family violence services; family services; First Nations social and emotional wellbeing; support for lesbian, gay, bisexual, trans and gender diverse, intersex, queer and asexual (LGBTIQA+) communities; homelessness and housing; psychosocial and wellbeing supports.
Partnerships	Structured, collaborative relationships between different organisations, providers, or sectors that work together to plan, deliver, and improve mental health care in a coordinated and integrated way.
Peer support	Help and support that people with lived and living experience of mental health challenges or psychological distress, including those who have experienced drug related harms or addiction, are able to give to one another. It may be social, emotional or practical support but importantly this support is mutually offered and reciprocal, allowing peers to benefit from the support whether they are giving or receiving it. Peer support workers use their personal lived and living experience to support other people through a shared understanding of mental health challenges, service use recovery and system navigation. Peer support work such as the IPS focusses on building mutual and reciprocal relationships where understanding and emotional, social, spiritual and physical wellbeing and recovery are possible.

Term (contin.)	Definition (contin.)
Peer support (contin.)	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 or addiction), to support families or carers who are assisting someone with mental health challenges or psychological distress.
Practitioner	Qualified worker who is responsible for assessment, treatment, care and/or support for consumers experiencing mental ill health and/or psychological distress. This term includes a range of disciplines including both clinical and wellbeing staff who are trained to deliver mental health treatment, care and support.
Recovery-oriented	An approach where the consumer's own understanding of recovery is central, and services support choice, self-determination and shared decision-making, focusing on people's strengths, goals, needs and aspirations rather than symptoms alone.
Relational approach	The relational approach aligns with the concept of relational care described by Griffiths et al. (2025) <https://www.tandfonline.com/doi/full/10.1080/01612840.2025.2488335>. Practised at the individual, group and organisational levels, it places relationships at the centre of care and support, recognising that trust, respect and genuine connection are fundamental to positive outcomes. The approach emphasises personalised, holistic and recovery-oriented support, and promotes meaningful collaboration between the workforce, people using services, families, carers and communities.
Social and emotional wellbeing	Being resilient, being and feeling culturally safe and connected, having and realising aspirations, and being satisfied with life; for Aboriginal and Torres Strait Islander people. This is consistent with Balit Murrup, Victoria's Aboriginal social and emotional wellbeing framework <https://www.health.vic.gov.au/publications/balit-murrup-aboriginal-social-emotional-wellbeing-framework-2017-2027>.
Streaming	Consumer streaming refers to organising service delivery by grouping consumers into different 'streams' based on the intensity, duration, and type of care they need, so they can be directed to the most appropriate level of treatment, care and support.
Treatment, care and support	Types of responses in the mental health and wellbeing system. • 'Treatment' typically refers to clinical interventions. • 'Care' typically refers to coordinated activities. • 'Support' typically refers to non-clinical wellbeing support.
Wellbeing supports	Supports that focus on a person's overall wellbeing, mental health recovery, rehabilitation and community participation (social and economic). Wellbeing is about: being resilient; being and feeling culturally safe and connected; having and realising aspirations; and being satisfied with life. This includes but is not limited to psychosocial supports.

Appendix B: Key mental health and wellbeing system policies, frameworks and guidelines

This service framework sits within the broader Victorian health and mental health and wellbeing system and must be understood alongside relevant policy, legislative, regulatory, and practice guidance frameworks outlined in the table below.

As publicly funded health service providers, Area Services are also subject to the department's funding, performance, and accountability frameworks <https://www.health.vic.gov.au/hospitals-and-health-services/funding-performance-and-accountability>.

Areas	Links
Key legislation and policies	Mental Health and Wellbeing Act (2022) and Handbook 2023 <https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook> Victorian Statewide Mental Health and Wellbeing Service and Capital Plan <https://www.health.vic.gov.au/publications/statewide-mental-health-and-wellbeing-service-and-capital-plan> The Next Phase of Reform: Victorian Mental Health and AOD Workforce Strategy <https://www.health.vic.gov.au/mental-health-wellbeing-reform/our-next-phase> Performance monitoring framework <https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework> Victorian Clinical Governance Framework <https://www.safercare.vic.gov.au/best-practice-improvement/clinical-governance/framework> Policy and Funding Guidelines for health services <https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services>
Service delivery	Wellbeing in Victoria: A Strategy to Promote Good Mental Health 2025 – 2035 <https://www.health.vic.gov.au/mental-health/prevention-and-promotion/wellbeing-strategy> Victorian Suicide Prevention and Response Strategy 2024-34 <https://www.health.vic.gov.au/prevention-and-promotion/suicide-prevention-response-strategy> Acute Community Intervention Service Guidelines 2014 <https://www.health.vic.gov.au/mental-health-services/acute-community-intervention-service> Victorian AOD Strategy 2023 - 35 <https://www.health.vic.gov.au/alcohol-other-drugs/victorian-aod-strategy> Early Intervention Psychosocial Support Response (EIPSR) Service Framework (*released to services but not published*). Hospital Outreach Post-suicidal Engagement (HOPE) Service Framework (*released to services but not published*)
Workforce and governance	Victorian Clinical Governance Framework 2024 <https://www.safercare.vic.gov.au/best-practice-improvement/clinical-governance/framework> Victorian Mental Health and Wellbeing Workforce Capability Framework ('Our Workforce, Our Future') <https://www.health.vic.gov.au/our-workforce-our-future> Mental Health and Wellbeing Outcomes and Performance Framework 2024 <https://www.health.vic.gov.au/mental-health/research-and-reporting/mental-health-and-wellbeing-outcomes-and-performance-framework> National Model for Clinical Governance, 2026 <https://www.safetyandquality.gov.au/resources/2026-national-model-clinical-governance-pdf>

Areas (contin.)	Links (contin.)
Discipline-specific and clinical guidelines	Lived Experience Workforce Guidelines <https://www.mentalhealthcommission.gov.au/lived-experience/lived-experience-workforces/peer-experience-workforce-guidelines> Clinical Practice Guidelines for Mood disorders, Anxiety disorders, Deliberate self-harm, Schizophrenia, Eating disorders <https://www.ranzcp.org/clinical-guidelines-publications/clinical-guidelines-publications-library?page=1> Australian Clinical Guidelines for Early Psychosis <https://www.orygen.org.au/Training/Resources/Psychosis/Guidelines/Australian-Clinical-Guidelines-for-Early-Psychosis> Alcohol and Other Drug (AOD) Lived Experience Workforce Discipline Framework <https://www.sharc.org.au/about-sharc/sharc-discipline-frameworks/> Mental Health Consumer Lived Experience Workforce Discipline Framework <https://the-collective.au/frameworks/mental-health-consumer/> Harm Reduction Lived and Living Experience Workforce Discipline Framework <https://the-collective.au/frameworks/harm-reduction/> Mental Health Family Carer Lived Experience Workforce Discipline Framework <https://tandemcarers.org.au/discipline-framework> Community Mental Health Nurse – Transition to Specialty Practice Competency Framework <https://www.safercare.vic.gov.au/publications/community-mental-health-nurse-transition-to-speciality-practice-competency-framework> Acute Community Intervention Service guidelines (ACIS guidelines) <https://www.health.vic.gov.au/mental-health-services/acute-mental-health-services> Lived and Living Experience Leadership Framework 2026-36 <https://www.health.vic.gov.au/lived-and-living-experience/leadership-framework>
Local mental health and wellbeing services	Mental Health and Wellbeing Locals Service Framework <https://www.health.vic.gov.au/publications/mental-health-wellbeing-locals-service-framework>
Bed-based services	Youth Prevention and Recovery Care Centres (YPARC) Statewide Service Framework 2023 (*released to services but not published*).
First Peoples and diverse communities	Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework 2017–27 <https://www.health.vic.gov.au/publications/balit-murrup-aboriginal-social-emotional-wellbeing-framework-2017-2027> Diverse Communities and Wellbeing 10-year Framework 2025 <https://www.health.vic.gov.au/diverse-communities-mental-health-wellbeing-framework-blueprint>

Appendix C: How community-based services fit within the Victorian system

System Level	Provider type	Who is the service for?	Levels of care*	Workforce, intervention and funding characteristics
LEVEL 5	Area Mental Health and Wellbeing Services (Area Services) and NGO partners, including: • **0-25 years:** Infant, Child and Youth Area Mental Health and Wellbeing Services. • **26+ years:** Adult and Older Adult Area Mental Health and Wellbeing Services.	People of all ages experiencing moderate to severe mental illness and/or psychological distress, including people with co-occurring substance use and/or dependence and other complex needs. This may include but is not limited to people who experience: • Severe symptoms of mental ill health and/or psychological distress; and/or • Severe problems with functioning independently due to their mental ill health (noting that 'function' must be considered through a developmentally appropriate frame for children aged 0-12). • Significant risk of suicide, self-harm or harm to others; and/or • Complex co-morbidities and co-occurring needs (e.g. neurodevelopmental disorder, developmental delay, AOD, risks of family violence, forensic risks, financial security, dementia, physical health and/or disability challenges etc.).	**Acute and specialist** • Specialist assessment and intensive interventions (short-term, ongoing or intensive).	• Multidisciplinary teams with highly specialised skillsets that deliver a range of intensive community-based, emergency, inpatient, rehabilitation and recovery services in community, hospital or outreach settings. • This may include but not limited to: staff with expertise in psychiatry, psychology, occupational therapy, social worker, mental health nursing, allied health, AOD and peer support, and care coordination. • Skilled in high intensity, acute and integrated treatment, care and support.
LEVEL 4	**26+ years** • Mental Health and Wellbeing Locals Also includes: • Private practitioners (e.g. psychologists, psychiatrists etc). • Community health services • PHN commissioned mental health services (e.g. Stepped Care services)	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. They 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	**Moderate to high intensity** • Periods of intensive intervention (short-term to ongoing)	• Multidisciplinary teams with outreach capacity and broad-based expertise. • This may include but not limited to: staff with expertise in psychiatry, psychology, occupational therapy, social worker, mental health nursing, allied health, AOD and peer support, and care coordination. • Skilled in early intervention and moderate intensity integrated treatment, care and support including moderate to high-intensity therapy and care planning.

System Level (contin.)	Provider type (contin.)	Who is the service for? (contin.)	Levels of care* (contin.)	Workforce, intervention and funding characteristics (contin.)
LEVEL 4 (contin.)	**0-25 years** • Child Locals: 0 - 11 years. Also includes: • headspace network (12 – 25 years), including headspace Plus (Commonwealth program, not overseen by the Chief Psychiatrist). • Youth Specialist Care Centres. • Youth Enhanced Services. • Private practitioners (e.g. psychologists, psychiatrists etc). • Community health services.	Infants, children, young people and families experiencing behavioural, emotional or relational difficulties requiring mild to moderate intensity support. There is no requirement for a diagnosis of a mental health condition	**Mild to moderate intensity**	• Multidisciplinary teams including but not limited to paediatricians, psychiatrists and psychologists. • Supports include diagnosis, neurodevelopmental assessment and treatment and family supports • headspace centres are PHN-commissioned and led by an NGO/ health service. • Children's Health and Wellbeing Locals are led by community health services in partnership with ICY AMHWS and family services.
LEVEL 3	• General Practitioners (GPs). • General health and community providers. • Private practitioners. • Community health services. • NGOs - delivering moderate mental health support such as Partners In Wellbeing via telehealth.	People experiencing mild to moderate mental health needs, or those beginning to experience psychological distress.	**Mild to moderate intensity** • Moderate intensity services (e.g. psychological interventions). • Primary and secondary care with extra support (e.g. via a mental health plan).	• Broad-based, generalist workforce with mental health capability; who are often the first point of contact that can act as a gateway to more intensive services if needed. • Trained in low-intensity interventions and digital delivery. • May work in PHN-commissioned services, private practice or community health services.

* Levels of care as defined using Initial Assessment and Referral Decision Support Tool (IAR-DST) v2 <https://docs.iar-dst.online/en/v2/index.html>

Appendix D: Expectations for crisis response times

Levels of urgency are described as per Triage codes with response time expectations, as per the Statewide mental health triage scale: Guidelines (2012) <https://www.health.vic.gov.au/publications/triage-scale-mental-health-service-guidelines>.

Triage Code	Description	Response Time
A – Emergency	Life-threatening or imminent risk of harm to self/others. Requires immediate intervention, often involving emergency services or ED presentation.	Immediate
B – High Urgency	Severe risk or acute distress requiring rapid intervention.	Within 2 hours
C – Urgent	High distress or risk, but not immediately life-threatening.	Within 8 hours
D – Semi-Urgent	Moderate risk or distress requiring timely follow-up.	Within 72 hours
E – Non-Urgent	Low risk, routine care needs.	Planned response
F – Referral	Consumer does not meet service criteria; refer to alternative provider.	As appropriate
G – Information Only	Advice or navigation support provided; no further action required.	Immediate advice

Appendix E: Clinical oversight and standards

Role of the Office of the Chief Psychiatrist:

The Chief Psychiatrist is responsible for clinical leadership and expert clinical advice to clinical mental health service providers. They are expected to:

- Promote the highest standard of clinical practices and care in mental health and wellbeing services provided by clinical mental health service providers.
- Support continuous improvement and promote the rights of consumers.
- Develop, publish and promote standards, guidelines and practice directions, and assisting services to comply with them.
- Assist services to develop and maintain clinical governance frameworks to improve quality and safety.
- Provide clinical leadership in relation to obligations under the Act, including providing proper consideration to the mental health and wellbeing principles.
- Conduct clinical reviews and investigations into service provision.
- Promote cooperation and coordination between clinical mental health service providers and providers of health, disability and community support services.

The Office of the Chief Mental Health Nurse <https://www.safercare.vic.gov.au/about-us/senior-officers/chief-mental-health-nurse> provides strategic leadership and collaboration between the Department of Health and the mental health nursing workforce. The Chief Mental Health Nurse plays a key role focusing on leading education and training initiatives, advancing best practice standards, supporting workforce planning and development, and providing professional leadership.

Clinical governance responsibilities

Area Services are responsible for ensuring the safety of all consumers that access their services. This responsibility is reflected through defined clinical governance arrangements, with clear accountability to identified clinical leaders, including the authorised psychiatrist. This includes:

- Establishing and implementing safety and quality frameworks and clinical governance standards to support the safe delivery of all aspects of the Area Services, including but not limited to privacy arrangements, after-hours arrangements and physical building design.
- Documenting clear clinical governance arrangements, including identified clinical leadership roles (e.g. clinical director and authorised psychiatrist) to support timely implementation of clinical protocols, clinical workforce recruitment and sharing of clinical information (e.g. medical charts) between Area Services and NGOs.
- Defining clear clinical governance and risk assessment roles, including the delineation of responsibilities between clinicians, senior clinical leaders and authorised psychiatrist to support timely clinical decision-making, escalation of care and management of clinical risk within Area Services.
- Establishing shared agreements, policies and processes to identify, respond to, and report incidents that may affect consumer safety through oversight by senior clinical leadership and the authorised psychiatrist.
- Providing access to discipline-specific supervision and clinical oversight, including overseeing team-based clinical reviews and escalation if more intensive responses are required.
- Embedding risk management processes and clear escalation mechanisms into all aspects of operations, clinical practice and service delivery ensuring that risks are identified early and escalated to the appropriate level of clinical authority.

- Complying with all occupational health and safety laws and regulations, including establishing clear procedures and protocols for post-incident support, after-hours arrangements and workload management.
- Ensuring collaborative arrangements for shared consumers in partnerships and contracts, including protocols for warm referrals, information sharing and transfer of care between providers with clear clinical oversight and accountability.
- Ensuring all clinical care is evidence-based, safe and high-quality delivered in accordance with approved clinical standards.
- Developing care, safety and recovery plans with consumers and their families, carers and supporters with oversight to ensure plans align with assessed clinical risk and legislative requirements.
- Providing staff with practical guidance to balance person-centred care with safety, including clear protocols for proportional risk management to an extent that is appropriate to the actual level of risk.

Incident management and reporting

Area Services are required to:

- Collect and submit de-identified service and outcomes data to the department on a quarterly basis as part of regular reporting requirements and as a condition of funding.
- Prepare and submit a bi-annual report to the department that deidentifies and thematically analyses the complaints that have occurred in the previous six-month period, and outlines the actions taken to address the complaints.
- Produce information in their annual reports about actions taken to give effect to one or more of the *Mental Health and Wellbeing Act 2022* principles.
- Document clinical and other health information in medical records.
- Report and act upon safety information via Victorian Health Incident Management System.
- Use Client Management Interface/Operational Data Store (CMI/ODS)[3] for reporting, in accordance with requirements outlined in the Victorian Department of Health's Bulletins and Program Management Circulars <https://www.health.vic.gov.au/research-and-reporting/bulletins-and-program-management-circulars-pmc>.
- The Mental Health and Wellbeing Commission can receive and manage complaints about an Area Service's failure to make reasonable efforts to comply with the *Mental Health and Wellbeing Act 2022* principles.

[3] The CMI / ODS will be replaced by a new statewide electronic mental health and wellbeing record as per recommendation 62 of the Royal Commission.


VICTORIA
State
Government
Department
of Health