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An Australian Government Initiative

PART A
PROGRAM GUIDELINES

PRIMARY MENTAL HEALTH, PSYCHOSOCIAL RECOVERY AND ALCOHOL AND OTHER DRUG SERVICES

NOVEMBER 2024

Leadership | Collaboration | Respect | Accountability | Innovation

About this document

This document provides guidance for health services commissioned by Murray Primary Health Network (PHN) to provide primary mental health, psychosocial recovery, and alcohol and other drug services for people across the Murray PHN catchment. The catchment of Murray PHN is significant in both size and diversity, and covers an area of almost 100,000 square kilometres, with a population of more than 644,000 people.

Outlined in this document are the scope, general principles for a stepped care approach, and service delivery, clinical governance obligations and workforce requirements specific to the provision of services in the Primary Mental Health, Psychosocial Recovery and Alcohol and Other Drug (AOD) programs funded by Murray PHN. This document, **Part A – Program Guidelines** must be read in conjunction with **Part B – Specific Program Information** relevant to each service program. Programs in Part B include:

1. Primary Mental Health Services
2. Psychosocial Recovery Services
3. Alcohol and Other Drug Services.

In addition, there is a separate guidance document on data capture and reporting specifications for all service providers which forms **Part C** of the suite of Murray PHN guidelines.

Part A has been informed by feedback and collaboration with commissioned service providers, partners of Murray PHN, Department of Health and Aged Care priority areas and PHN funding guidance. In addition, these guidelines have been informed by relevant practice and accreditation standards, clinical governance, lived experience and First Nations Peoples frameworks, and legislative requirements.

For further information or clarification about any information outlined in this document, contact the Mental Health and AOD team: MHAODTeam@murrayphn.org.au

Version	Document Title	Date released	Prepared by	Approved
5	Murray PHN Primary Mental Health, Psychosocial Recovery and Alcohol and Other Drug Services Guidelines	November 2024	A Bonsey, E Linneman	I Johansen
4	Murray PHN Primary Mental Health, Psychosocial Recovery and Alcohol and Other Drug Services Guidelines	September 2020	T Moriarty	E Reid
3	Murray PHN Primary Mental Health Program Guidelines	June 2019	S McConnachie	P Wilkinson
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1. Introduction

Murray Primary Health Network (PHN) is one of 29 Primary Health Networks across Australia. As a PHN, we work closely with the primary health system to identify opportunities to improve health outcomes in our community through better coordination and support of health services, and by commissioning services to address the health needs of our population.

Figure 1: Map of Murray PHN region

Murray PHN's primary mental health service planning and delivery has been guided by the Federal Productivity Commission Mental Health Inquiry Report (2020), the National Mental Health And Suicide Prevention Agreement (2022), the Fifth National Mental Health and Suicide Prevention Plan (2021): Progress Report 4 (2023), and the Royal Commission into Victoria's Mental Health System (2021).

A note on language and terms used throughout this document

Throughout this guide, terms such as ‘engagement’ and ‘lived experience’ have been used. These terms do not have commonly agreed definitions, and not all readers will identify with the use of these terms in the same way as they are presented. For clarity, Murray PHN uses the following definitions that are drawn from the National Mental Health Commission Mental Health Safety and Quality Engagement Appendix 1.

Term	Definition
Consumers	People who identify as having a living or lived experience of mental illness, irrespective of whether they have a formal diagnosis, have accessed services and/or have received treatment. Consumers include people who describe themselves as a ‘peer’, ‘survivor’ or ‘expert by experience’.
Carers	People, often family members and/or families of choice (including children and young people), who have a lived experience of providing or have provided in the past, ongoing personal care, support, advocacy and/or assistance for a person with mental illness. Carers include people in the consumer’s extended family, or families of choice and support networks, who play a meaningful support role. This role differs from the role of a paid carer.
Engagement	Refers to the methods, practices and actions that enable people to become involved in organisational planning and decision-making. This includes consumers, carers and other community members.
Indigenous and First Nations Peoples	Used interchangeably to refer to people who are Aboriginal and Torres Strait Islanders.
Kinship	A term that refers to the relationships, roles, responsibilities and obligations of many Aboriginal and Torres Strait Islander Peoples. Kinship relations and culture need to be described by local Aboriginal and Torres Strait Islander Peoples and are not easily understood in terms of relationships in the Western definition of family. An important aspect of kinship care and responsibility concerns which people can be involved in a person’s care and the people who can play leadership roles in the community.
Lived experience	A broad term that refers to the personal perspectives on, and experiences of, being a consumer or carer, and how this becomes awareness and knowledge that can be communicated to others. The term covers people’s core experiences around mental health challenges and service use that may have occurred in the past or may be ongoing (sometimes called living experience).

2. Scope

These guidelines are for the primary use of Murray PHN commissioned primary mental health, psychosocial recovery, and alcohol and other drug service providers and Murray PHN staff. This document is publicly available on the Murray PHN website to enable community-wide understanding of the purpose and scope of services. It is recommended that healthcare providers contact either Murray PHN or the relevant commissioned service provider for information related to eligibility criteria and access in the local area/region.

3. An integrated and coordinated system of care

An integrated approach to the delivery of primary mental health, psychosocial recovery, and alcohol and other drug services involves partnerships across the health and wellbeing service sectors to provide a unified system of care. The goal is service providers working together to develop localised pathways to close systems gaps, improve efficiencies and provide holistic care in a stepped care model of service delivery. While service regions may inform service planning and delivery, they should not restrict an individual from receiving services in their preferred location due to their place of residence or postcode.

Murray PHN expects integration and coordination between primary mental health, alcohol and other drug service providers, psychosocial recovery services, family violence and sexual assault services, housing and homelessness services, children and family services, healthcare services, general practitioners (GPs), psychiatrists, and other medical practitioners and allied health providers in the planning of integrated and coordinated care to ensure consumers receive the right care, in the right place, at the right time.

Murray PHN expects service providers to:

- design and implement models of care that are person-centred, recovery-oriented, trauma-informed, culturally safe and integrated with the local health system, particularly with GPs
- strengthen the primary care system to help individual consumers with mental health, alcohol and other drug, and psychosocial issues to have an integrated experience of a range of service needs, including family violence where relevant
- support GPs in their central healthcare role, ensuring consumers receive the right care, in the right place, at the right time
- define and communicate the levels of care they provide consumers, providers, referrers and community members.

An individual receiving primary mental health, psychosocial recovery, and alcohol and other drug service interventions should expect to have access to a range of services as required, according to their level of need and unique recovery goals, within a stepped care approach.

4. Stepped care and levels of need

Stepped care is defined as an evidence-based, staged system comprising a hierarchy of interventions matched to an individual's needs, ranging from low to high intensity interventions.

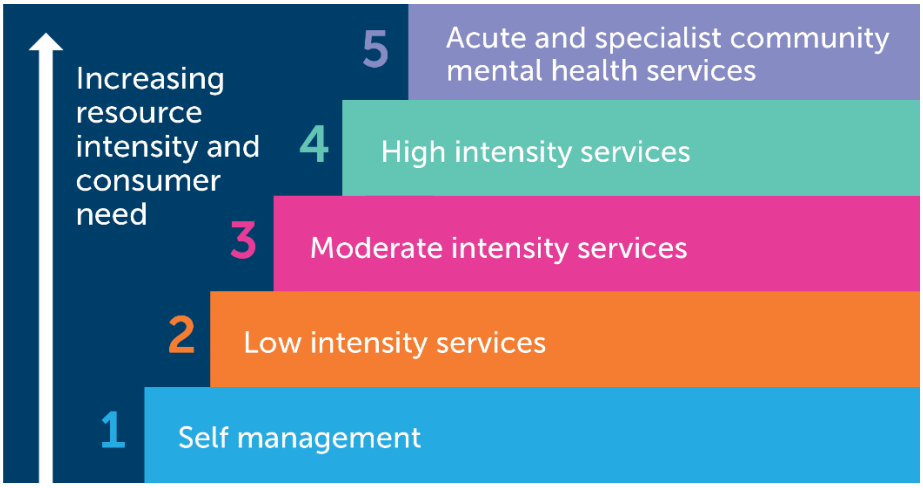
Stepped care recognises there is a spectrum of treatment needs, and this requires a spectrum of services across mental health, psychosocial recovery, and alcohol and other drug services. Stepped care is a different concept from 'step up/step down' services. While there are multiple levels in a stepped care approach, they do not operate in silos or as one-directional steps, but rather offer levels of care matched to the spectrum of mental health service needs. This spectrum, and the levels of care associated with it, is illustrated in **Figure 2** below.

A stepped care approach promotes person-centred care that targets the needs of the individual consumer. Rather than offering a 'one size fits all' approach, individual consumers will be more likely to receive a service that optimally matches their needs and makes the best use of workforce and technology.

Grouping the complex system of mental health services available in Australia into five levels provides a framework to think about stepped care, rather than implying that there is a natural division of service types into tiered categories. While some services are associated with a single level of care, most contribute to multiple levels. For example, GP mental healthcare can be associated with lower levels of care when it is provided in isolation, or higher levels when delivered in combination with other services or interventions.

The levels, therefore, are best thought of as combinations of interventions for consumers requiring that level of care, with the levels differentiated by the amount and scope of resources available. A consumer may use some or all interventions described at that level and move between levels of care as their needs change. Higher levels of care are associated with increasing severity of symptoms and distress.

Figure 2: Schematic representation of levels of care



5. Mental Health and Wellbeing Locals

Since 2021, the Victorian Government has funded Mental Health and Wellbeing Locals (Locals) to ensure adults and older adults experiencing mental illness or psychological distress, including those with co-occurring substance use or addiction, can access integrated treatment, care and support in the community, and closer to their support networks. Locals have been established in Benalla-Wangaratta-Mansfield, Greater Shepparton-Moira-Strathbogie, Bendigo-Loddon-Campaspe and Mildura local government areas and are a welcoming front door to the public mental health and wellbeing system (see **Table 1** below for more information). Locals are intended to provide easy-to-access, high-quality treatment, care and support for people aged 26 years and over experiencing mental illness or psychological distress, including those with co-occurring substance use or addiction, whose needs cannot be met by primary and secondary mental healthcare providers alone, but who do not require intensive episodic or ongoing care from tertiary area mental health and wellbeing services.

Locals, together with Victorian Government area-based mental health and wellbeing services and PHN primary mental health services, aim to close the service gap in the mental health and wellbeing system for people experiencing mental illness and psychological distress.

Murray PHN commissioned service providers are expected to liaise and work with Locals as part of the overall service system of care.

Table 1 – Locals in operation in the Murray PHN region

Benalla-Wangaratta-Mansfield	Wellways Australia in partnership with Albury Wodonga Health and Australian Community Support Organisation (ACSO)	• Benalla: 90-94 Nunn Street • Wangaratta: 5 Victoria Parade • Mansfield 31 Highett Street Open for walk-ins or call for support, 1800 000 842
Rural City of Mildura	Wellways Australia, in partnership with Mallee District Aboriginal Services, Mildura Base Public Hospital and Sunraysia Community Health Services	• 149 Deakin Avenue. Open for walk-ins or call for support, 1300 000 667
Greater Shepparton, Strathbogie and Moira	Wellways Australia, in partnership with APMHA Healthcare Ltd and GV Health	• 151-155 Maude Street. Open for walk-ins or call for support, 1300 000 559
Greater Bendigo, Loddon and Campaspe	Mind Australia in partnership with Bendigo & District Aboriginal Co-operative, Bendigo Health, Echuca Regional Health, The Salvation Army and Thorne Harbour Health Ltd	• General: Call for support, 1800 332 501 • Bendigo: 22/165-171 Hargreaves Street. Call for support, walk-in hours or to book an appointment (03) 5497 5600 • Echuca: 222 Ogilvie Avenue. Call for support or to book an appointment (03) 5412 6600

Further information about Locals and their Service Framework is available through the Victoria Department of Health.

6. Initial assessment and referral (IAR)

Applying the concept of stepped care with individual consumers begins at the referral and initial assessment phases of care. The Australian Department of Health and Aged Care released the Initial Assessment and Referral-Decision Support Tool (IAR-DST) guidance as a systematic and structured approach to assist PHNs in establishing assessment and referral systems founded on stepped care principles. Murray PHN requires most providers to use the IAR-DST in undertaking service provision.

The IAR-DST online tool (available at https://iar-dst.online/#/) and guidance documentation include information about the IAR-DST, and how to use it appropriately and effectively with people of different ages who present with mental health symptoms and/or psychological distress.

The IAR Guidance documents provide information on the IAR relevant to all age groups. They articulate the principles guiding the use of the **IAR eight domain assessment framework** and the IAR-DST to determine or confirm the most appropriate level of mental health treatment/care a person requires, based on their current symptoms and circumstances. The guidance documents also describe the IAR five levels of care in the primary mental healthcare system (**Figure 1** above), and the types of services and supports associated with each level of care.

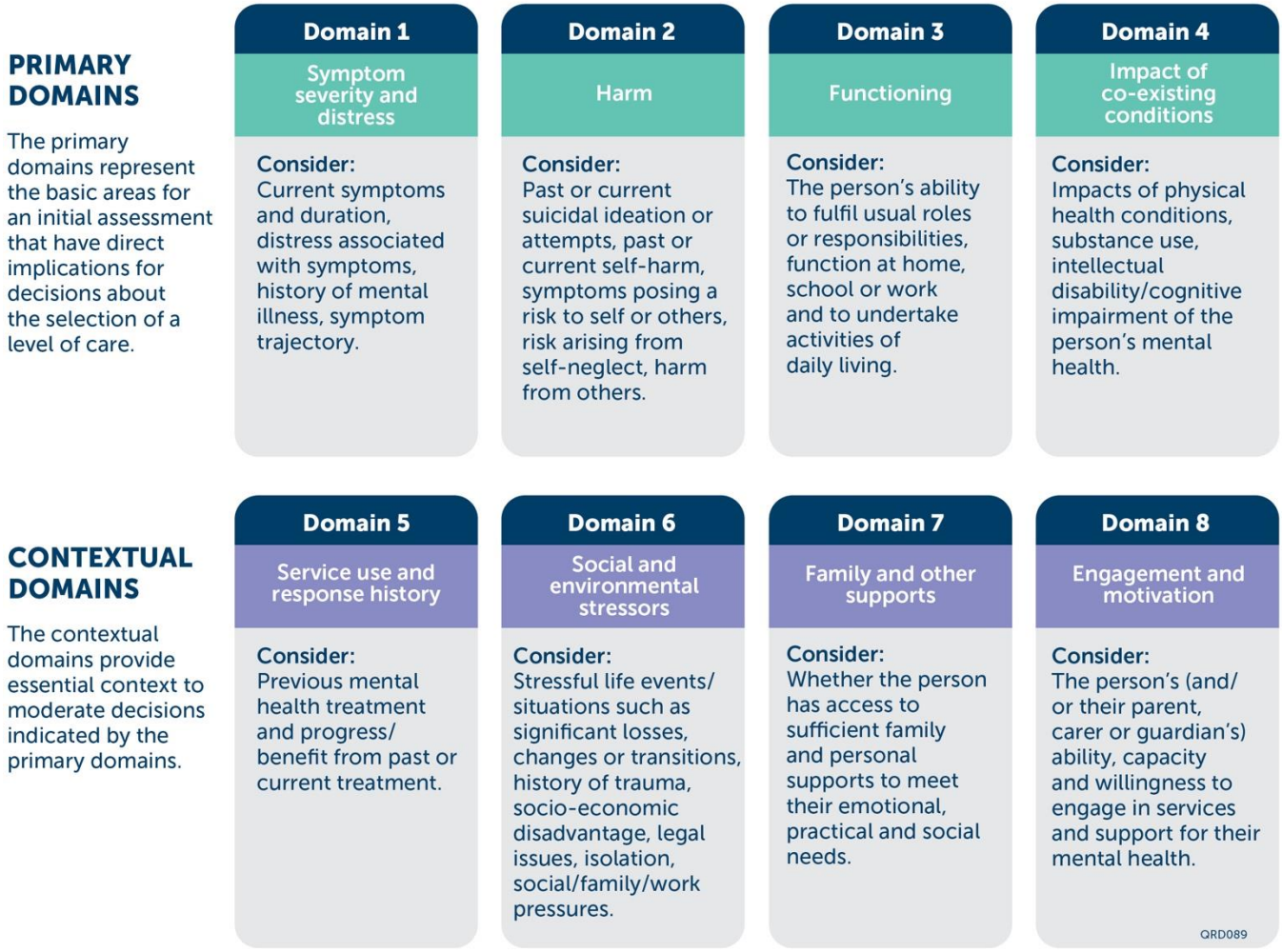
Aboriginal Community Controlled Health Organisations (ACCHOs) commissioned to provide Primary Mental Health and Psychosocial Recovery Services are not required to use the IAR-DST. There is no adaptation of the IAR-DST for First Nations Peoples and insufficient research has been undertaken to determine whether this tool would be appropriate for ACCHO models of care. However, ACCHO providers who consider the tool appropriate for their model of care are welcome to do so. In addition, commissioned providers of Psychological Treatment Services provided to children are not required to use the IAR-DST, although Murray PHN will eventually implement the IAR-DST adaption for children. Providers of Residential Aged Care Home (RACH) services will be expected to use the IAR-DST adaption for older adults from 1 January 2025.

Murray PHN expects all staff who use the IAR-DST to be appropriately trained to do so. While there is no requirement for health professionals to be of a specific discipline or have a clinical background to use the tool, appropriate clinical governance should be exercised by commissioned service providers to ensure validity.

The initial assessment domains

The initial assessment process identifies eight domains that are explored when considering the next steps in a referral process for an individual who presents to primary care with mental health symptoms and/or psychological distress (see **Figure 3**).

Figure 3: IAR domains



Detailed information on the eight domains and how to rate each domain for children, adolescents, adults and older adults is contained in the IAR Guidance resources available at https://docs.iar-dst.online/en/v2/index.html

- Part B - Children (aged 5-11)
- Part C - Adolescents (aged 12-17)
- Part D – Adults (aged 18-64)
- Part E – Older Adults (aged 65 and over).

While the IAR-DST Guidance documents use age to indicate the overall appropriateness of each rating guide, the final decision about the most appropriate rating guide to use with each person is based on the professional and/or clinical judgment of the development age of the consumer, considering contextual and developmental factors.

In addition to the eight domains that are assessed, five levels of care are described, based on the intensity of intervention required for the consumer. **Figure 4** below outlines the IAR domains alongside the levels of care and a description of likely consumer presentation at each level.

Figure 4: IAR domains and levels of care *(adapted from the Department of Health and Aged Care, National Initial Assessment and Referral for Mental Healthcare Guidance, 2019)*

Initial assessment domains	LEVEL OF CARE 1 Self-management	LEVEL OF CARE 2 Low Intensity Services	LEVEL OF CARE 3 Moderate Intensity Services	LEVEL OF CARE 4 High Intensity Services	LEVEL OF CARE 5 Acute and Specialist Community Mental Health Services
DOMAIN 1 Symptom severity and distress	Typically, no risk of harm, experiencing mild symptoms and/or low levels of distress - which may be in response to recent psychosocial stressors. Symptoms have typically been present for a short period of time. The individual is generally functioning well and should have high levels of motivation and engagement.	Typically, minimal or no risk factors, mild symptoms/low levels of distress, and where present, this is likely to be in response to a stressful environment. Symptoms have typically been present for a short period of time (less than six months but this may vary). Generally functioning well but may have problems with motivation and engagement. Moderate or better recovery from previous treatment.	Likely mild to moderate symptoms/distress (meeting criteria for diagnosis) Symptoms have typically been present for six months or more (but this may vary). Likely complexity of risk, functioning or co-existing conditions but not at very severe levels. Also suitable for people experiencing severe symptoms with mild or no problems associated with risk, functioning and co-existing conditions.	A person requiring this level of care usually has a diagnosed mental health condition with significant symptoms and/or significant problems with functioning. A person with severe symptoms, likely to be experiencing moderate or higher problems associated with domains 2 (Risk of harm), 3 (Impact on functioning) and 4 (Co-existing Conditions).	A person requiring this level of care usually has significant symptoms and problems in functioning independently across multiple or most everyday roles and/or is experiencing: – significant risk of suicide; self-harm, self-neglect or vulnerability – significant risk of harm to others – a high level of distress with potential for debilitating consequence.
DOMAIN 2 Harm					
DOMAIN 3 Functioning					
DOMAIN 4 Impact of co-existing conditions					
DOMAIN 5 Service use and response history					
DOMAIN 6 Social and environmental stressors					
DOMAIN 7 Family and other supports					
DOMAIN 8 Engagement and motivation					

7. Lived and living experience engagement and participation

Murray PHN recognises the strength of people with lived experience of living with mental illness, psychological distress, alcohol and other drug issues (including their families, carers and supporters). Engagement of those with lived and living experience as partners in the design, delivery and evaluation of stepped care services is vital to ensure it genuinely promotes person-centred care. Furthermore, the employment of people with lived and living experience as an integral part of the workforce needs to be considered in implementing stepped care.

Engagement strategies should recognise the uniqueness of those with lived and living experience and target input from them accordingly. For example:

- Design of low-intensity services aimed at specific cohorts of people, such as young people with mild symptoms or men with early signs of depression, should engage these groups in the design process
- Design of suicide prevention activities should engage with people with lived experience of suicidal thinking, behaviour and attempts
- The views and needs of carers, family members and supporters should always be sought
- Engagement of people with lived and living experience in the workforce delivering stepped care services is vital to embedding a lived experience perspective.

Effective lived and living experience participation needs to be appropriately resourced. This should include opportunities for consumers and carers to provide input and be engaged in and informed in an effective way. Murray PHN expects service providers to assess organisational readiness and demonstrate a commitment to active lived experience engagement and participation in service delivery.

8. Service delivery approaches

Murray PHN-funded organisations are expected to work in a recovery-oriented framework and deliver programs with a workforce trained in recovery-oriented principles and practice.

Cultural safety

Murray PHN acknowledges the knowledge, strength and wisdom held by our First Nations Peoples. We have a strong commitment to reconciliation and addressing the impacts of systemic racism and colonisation on the experience of health and wellbeing of First Nations Peoples in our region.

The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing is an important resource for the mental health system and is interconnected with strategic responses to Aboriginal and Torres Strait Islander Peoples' health. Service providers must apply the principles of this framework and ensure they have a clearly articulated strategy for delivering culturally safe, competent, sensitive and appropriate care for Aboriginal and Torres Strait Islander Peoples. In doing so, providers demonstrate an understanding of the importance of cultural healing and the cultural determinants of health.

Further guidance for best practice in cultural safety can be found at Reconciliation Australia and VACCHO.

All organisations delivering services for Murray PHN must do so in a way that is culturally safe.

Western services should observe The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy developed by the Australian Health Practitioner Regulation Agency. This strategy defines cultural safety, along with key elements and focus areas for action:

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.

To ensure culturally safe and respectful practice, health practitioners must:

- acknowledge colonisation and racism, social, cultural, behavioural and economic factors that impact individual and community health
- acknowledge and address individual racism, their own biases, assumptions, stereotypes and prejudices and provide care that is holistic, free of bias and racism
- recognise the importance of self-determined decision-making, partnership and collaboration in healthcare that is driven by the individual, family and community
- foster a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander Peoples and colleagues.

Cultural Humility Framework

Murray PHN has developed a Cultural Humility Framework (CHF) to provide guidance for building the capacity of Western health services to deliver culturally responsive and safe services to First Nations Peoples and communities. The CHF provides principles and measurable practical actions related to key elements for ongoing improvement in engagement with, experiences of and outcomes from service delivery. Murray PHN has developed a user guide alongside the CHF, designed to support organisations in implementing culturally safe practices in line with the framework. This is available at: https://murrayphn.org.au/focus-areas/first-nations-health-and-healing/cultural-humility-framework/

Key elements of the framework

KEY ELEMENT 1: GOVERNANCE

Governance structures and mechanisms support a whole-of-organisation approach to embedding cultural humility in all aspects of core business.

Focus areas

- **Leadership:** Those in organisational and team leadership positions demonstrate culturally responsive and safe knowledge, attitudes, behaviours and actions.
- **Governing documents:** A commitment to addressing First Nations health inequity through the provision of culturally responsive and safe service delivery is made visible in organisational governing documents.
- **Policy and practices:** A whole-of-organisation approach to addressing First Nations health inequity through the provision of culturally responsive and safe service delivery is embedded across organisational policies and practices.
- **Resources:** Adequate, appropriate and sustainable resources are allocated for initiatives to meet the needs and improve the experiences of service users.
- **Monitoring and evaluation:** Mechanisms to monitor and evaluate outcomes of strategies, including the identification of barriers and enablers for success are embedded across the organisation to inform continuous quality improvement processes.
- **Data management:** Data is collected, processed and shared in ways that uphold the principles of Cultural Safety and Indigenous data sovereignty and governance.

KEY ELEMENT 2: PARTNERSHIPS

The organisation embeds a commitment to privileging the voices of First Nations Peoples through mechanisms that enable respectful, mutually beneficial and self-determined collaborative partnerships with local Communities.

Focus areas

- **Understanding Community:** An understanding of demographic, health and cultural contexts of local Communities underpins targeted improvements in hearing and meeting the needs of service users.
- **Community collaboration:** The critical role of respectful, mutually beneficial and self-determined collaborative partnerships in meeting Community needs is recognised and reflected in organisational ways of working.
- **Consumer participation:** The voices of those who use the service are empowered and prioritised to inform organisational ways of working.
- **Feedback:** Organisations are culturally responsive in actively, adequately and accurately collecting and responding to feedback from service users and local Communities.

KEY ELEMENT 3: WORKFORCE

The crucial role of a culturally capable health workforce, including First Nations Peoples employed across all areas of service delivery, in meeting the needs of local Communities is reflected in organisational policy and practice.

Focus areas

- **First Nations employees:** Valuing and building a strong First Nations workforce is prioritised through developing culturally responsive recruitment and creating culturally safe workplaces.
- **Non-First Nations employees:** Building the cultural capacities of all non-First Nations employees to work in culturally responsive ways with colleagues, service users and Communities is valued and strategically prioritised.

KEY ELEMENT 4: INCLUSIVE CARE

An organisational commitment to improving the experiences of and outcomes for First Nations service users through the delivery of culturally informed, responsive and safe care is incorporated into policy and practice.

Focus areas

- **Understanding needs:** All employees providing care and services have a well-developed understanding and working knowledge of the individual, Community and population level health considerations for First Nations Peoples.
- **Welcoming environment:** The service provider creates and maintains culturally responsive and welcoming spaces that reflect First Nations cultural values, practices and needs.
- **Identification:** Processes are in place for accurate identification of First Nations service users and information is collected and managed in culturally responsive and safe ways.
- **Communication:** The organisation recognises that culturally responsive communication is the foundation for the delivery of care judged by First Nations Peoples as safe to approach and use.

Holistic care: ***The care/service provided incorporates holistic understandings of the determinants of health and wellbeing, tailored to the service user's needs, preferences and desired outcomes.***

Diversity

Victoria is one of the most culturally diverse regions in the world. Healthcare must respond to people's diverse cultural, ethnic, linguistic, and religious needs and preferences. Murray PHN expects service providers to deliver culturally responsive and equitable services to ensure the whole population receives quality healthcare.

9. Pathways to care

Referral pathways and requirements

Service providers must have and promote local access arrangements that optimise referral pathways and access to mental health, psychosocial recovery, and alcohol and other drug services.

In addition, service providers must ensure:

- individuals seeking treatment are appropriately assessed and referred to appropriate services when indicated
- comprehensive assessment is completed, including assessment of appropriateness, eligibility and risk before being added to a waitlist (to facilitate appropriate triaging and waitlist management)
- consumers are provided service navigation support if a more appropriate service response is indicated
- resources are targeted within the service area defined in the service agreement
- duplication of processing information is avoided
- expected levels of demand are managed appropriately
- waitlists are minimised and processes are in place for active waitlist management where they exist.

The role of the GP

Within a stepped care approach, the role of the consumer's GP is critical. GPs are often the first point of contact for people seeking help for mental health issues and related problems. The ongoing nature of the GP-patient relationship provides the opportunity to screen for and identify mental health, psychosocial recovery, and alcohol and other drug issues impacting patient wellbeing.

GPs are best placed to understand and manage a patient's mental health, psychosocial recovery, and alcohol and other drug needs in the context of their physical health, economic participation and social inclusion. GPs play an integral role in directing treatment through referrals to other service providers, from early intervention low-intensity services to higher-intensity clinical care coordination and case management.

GPs will often undertake the initial assessment with the consumer to determine the most appropriate level of care and continue to play the central role in the provision and coordination of physical and mental healthcare within the primary care setting. As part of a referral from the GP, people accessing Psychological Therapy Services may have a GP Mental Health Treatment Plan (MHTP) however, the absence of a MHTP should not be a barrier to accessing help.

While a MHTP is not required, communication with the consumer's GP is expected when the consumer has provided informed consent. Because the GP is central to the consumer's recovery journey, service providers are expected to communicate with the consumer's GP at critical stages of care.

While it is acknowledged that direct communication with GPs may not be possible, at a minimum, providers must communicate with the GP in writing:

- at the beginning of services to communicate:
  - receipt of referral (if relevant)
  - that the consumer is receiving service
  - the type of service being received
- the outcomes of any clinical case reviews
- on conclusion of services or referral/transfer to different level of care or service provider.

Head to Health phone service

Referral to Murray PHN commissioned services may occur through the Head to Health phone service which is a part of the National Service Model: Head to Health assessment and referral phone service. These referrals do not require a GP MHTP and commissioned service providers are expected to develop a strong collaboration with the Head to Health phone service provider to ensure a 'no wrong door' approach and a smooth consumer pathway to care.

Murray HealthPathways

To support a timely, appropriate referral, Murray PHN has developed Murray HealthPathways; a free, web based portal available for clinicians to plan, manage and coordinate consumer care through primary, community and secondary health systems and localised pathways across the Murray PHN region.

Supporting people with suicidal thoughts and behaviours

Murray PHN expects all commissioned service providers to play a key role in supporting consumers referred and/or presenting with suicide risk. Supporting people with suicidal ideation and risk is routinely experienced in primary mental healthcare and providers are expected to have appropriate clinical governance structures and leadership to assess, manage and escalate people to the level of care needed. If commissioned service providers need further support in developing their capability in responding to people experiencing suicide thoughts and behaviours, they should approach Murray PHN.

Crisis support

In addition, service providers must ensure there is a well-articulated after hours crisis support pathway (including how to access) communicated to consumers who are receiving treatment and on waiting lists. Appropriate after hours crisis support contact phone numbers and details must be provided to consumers accessing services.

Demand and waitlist management

Service providers must have an appropriate demand management strategy and processes in place to manage service access and risks (including suicide risk) of individuals referred to them. A single consolidated and centralised system for recording and tracking all referrals, from the date of referral to the date of discharge, must be in place.

Commissioned service providers should aim to provide each consumer an initial appointment for a comprehensive assessment within two weeks from the date the referral is received before adding them to a waitlist (to facilitate appropriate triaging and waitlist management). Where consumers are waiting more than four weeks from the date of their first contact with the provider for a comprehensive assessment, commissioned service providers are expected to initiate strategies to reduce the waiting time. The need for a comprehensive assessment in this timeframe is not required if referrals are received from the Head to Health phone service.

Service demand and waitlist strategies must include:

- active monitoring and support for consumers on the waitlist (including consumers who are awaiting their first appointment). Contact with consumers while on the waitlist must be recorded in the service provider client information management system. All communication with the referrer while a consumer is on the waitlist must also be recorded
- referring consumers to appropriate acute mental health services immediately if required
- prioritising consumers who have higher levels of need or complex needs within the scope of the service agreement

- responding to consumers who are referred due to a recent suicide attempt or at risk of a suicide attempt, by phone within 24 hours and with an appointment within seven days of the date the referral was made. The Department of Health and Aged Care has a key performance indicator for PHNs on how many consumers identified with identified suicide risk receive an appointment within seven days of the date of their referral (with a PHN KPI target of 100 per cent)
- advising consumers regarding the anticipated wait time for services
- educating consumers on the waitlist of support service options like e-mental health, psychoeducation materials, telehealth psychology/psychiatry services and low-intensity support options
- providing information to consumers on how they may contact emergency services should their situation change while on the waitlist.

In addition, Murray PHN expects service providers to have developed procedures (including relevant strategies above) for:

- triage and allocation
- timely response to referrals and confirmation of the first appointment
- waitlist management
- supporting consumers to access alternative programs that more appropriately meet their needs and maintaining that support until the alternative service is actively supporting the consumer
- management and response to consumers who do not attend the first and subsequent **two initial** appointments for comprehensive assessment (this includes an assessment of consumer risk based on referral information).

As per Murray PHN service agreements, providers (other than ACCHOs) are required to submit a monthly Waitlist Management Checklist updating Murray PHN on current waitlist numbers.

It is recommended that reminder text message systems (available through most client information management systems) be used for individuals accessing the service to maximise client engagement.

Change to levels of care

In accordance with Department of Health and Aged Care guidance, access to higher levels of care is generally facilitated when:

- the consumer has not experienced reduced symptoms/distress within a reasonable timeframe
- the consumer has not experienced recovered social and occupational functioning within a reasonable timeframe
- there is evidence of deterioration or changing risk of suicide, harm to self or others, or harm from others
- the consumer's identified recovery goals are not being or are unlikely to be met
- the consumer is experiencing new psychosocial stressors.

Generally, indicators for decreasing the intensity of care are when:

- the consumer has completed the recommended intervention in accordance with their care plan
- there are reduced symptoms/distress over a consistent period
- there is improved or recovered functioning through improved productivity, performance or reduced days out of the consumer's normal role
- there is not a risk of deterioration; the consumer is able to identify signs of deterioration and take appropriate action independently
- the consumer indicates they are ready for a low intensity service or are ready to cease care altogether.
- there is a decrease in service intensity which does not necessarily mean transferring care to a new provider. However, if the consumer's care is transferred to a new provider, the referring service provider must facilitate and assist the consumer to actively engage with the new service provider.

10. Service delivery modalities

People accessing commissioned services must have options about how, when and where they receive care. This includes being able to access face-to-face services in a range of community settings, such as clinics and other community-based settings and locations. Targeted outreach may also be delivered in individual/family homes, where a home visiting risk assessment has been undertaken prior to the consultation/intervention to ensure safety.

It is also expected that a range of modalities will be used in individual and/or group mode to enable timely support to consumers, especially in rural and remote settings. This can include:

- use of digital mental health resources
- telephone contact and consultations
- video conferencing sessions.

Service providers are encouraged to provide extended operating hours to improve consumer access and to work proactively with individuals referred to them to identify the appropriate service delivery arrangements that support the specific needs of the individual.

Digital health resources

The use of digital mental health resources, otherwise referred to as e-mental health, can benefit individuals and complement services across the stepped care approach, including for people living with a severe mental health disorder and those receiving psychosocial recovery and alcohol and other drug services. Types of e-mental health include information, self-directed support, therapeutic interventions and telepsychiatry.

Places to access digital resources include but are not limited to:

- e-mental health in practice: https://www.emhprac.org.au/
- e-mental health for Indigenous consumers: https://www.emhprac.org.au/resources/indigenous-resources/
- alcohol and other drug specific digital resources:
  - SMART Recovery
  - Turning Point
  - Head to Health services.

11. Privacy and consent

Informed consent

Commissioned service providers must obtain informed consent from an individual (or their parent/legal guardian for minors who are unable to provide informed consent) before any intervention is started. When obtaining and documenting consent to services, providers must ensure it is done so in accordance with privacy requirements set out in your commissioned services agreement terms and conditions. Murray PHN expects that all commissioned service providers will have an established procedure for gaining informed consent on initial assessment and use consent forms for all new consumers.

Consent to share information

Service providers must also ensure that permission is obtained from individuals (or their parent or legal guardian for minors who are unable to provide informed consent) before sharing any information about them. This includes sharing of anonymised information with Murray PHN and the Department of Health and Aged Care for the purposes of service reporting, review and evaluation. The Department of Health and Aged Care also requires commissioned service providers to seek permission from consumers to the sharing of anonymised data from the Primary Mental Health Care Minimum Data Set (PMHC MDS) with state and territory governments for future planning. This should occur routinely on initial assessment.

Further information regarding consent requirements for data sharing is outlined in Section 6 and Section 9 of Part C of the guidelines.

12. Service activity reporting and monitoring

Service reporting obligations

Funded services are required to collaborate with Murray PHN by contributing to information exchange and building knowledge about the characteristics of the health service system, community context and population health. Providers must comply with the regular reporting requirements outlined in funding agreements (including outcome measures). Performance and effectiveness outcomes inform the design and continuous improvement of services and address identified and current community needs and priorities.

Intervention data capture and reporting

The Department of Health and Aged Care established the Primary Mental Health Care Minimum Data Set (PMHC MDS) to enable PHNs and the department to monitor and report on the quantity and quality of service delivery, and inform improvements in the planning and funding of primary mental healthcare services. All primary mental health commissioned services must report service activity as defined by the PMHC MDS. For more information, visit: pmhc-mds.com

Specific details and further guidance on PMHC MDS collection can be found in Part C Data Capture and Reporting Guidelines.

Murray PHN currently uses a client information management system (Fixus) to capture client reporting data for some primary mental health services. Commissioned services can use Fixus to report PMHC MDS activity through this system and a user guide for Fixus is available online.

The Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS) collects information regarding alcohol and other drug treatment services, the types of drug problems for which treatment is sought and the types of treatments provided. Commissioned service providers must comply with AODTS MDS reporting requirements, in addition to using the Fixus client management system. For more information, visit Alcohol and Other Drug Treatment Services National Minimum Data Set - Australian Institute of Health and Welfare.

Measuring outcomes

Outcome measures must be used to establish a benchmark for tracking an individual consumer's progress. There are several tools, such as the Kessler Psychological Distress Scale (K10, K12 or K5) and the Strengths and Difficulties Questionnaires (SDQ), and Murray PHN is introducing the Social and Occupational Assessment Scale (SOFAS). K5 is recommended for Aboriginal and Torres Strait Islander people and residents in aged care. Primary mental health providers are required to collect outcome measures, at a minimum:

- at the beginning and end of service
- at the clinical case review
- when a consumer is being referred from one level of care to another
- more frequently, to monitor an individual's response to treatment, or if a sudden or marked change in their clinical presentation and mental state is observed.

Most of these outcome tools can be found at the Australian Mental Health Outcomes and Classification Network.

AOD service providers are required to use the K10, the Alcohol Use Disorders Identification Test (AUDIT) or Drug Use Disorders Identification Test (DUDIT) as appropriate. These evidence-based tools have been developed collaboratively in consultation with AOD services across Victoria and are available through the Victorian Department of Health and Turning Point websites.

Consumer feedback – YES PHN Survey

To measure consumer feedback, primary mental health and psychosocial providers are required to use the Your Experience of Service (YES) PHN survey (excluding PTS Children, PTS RAC and ACCHOs, unless otherwise agreed). This survey was developed following the Department of Health and Aged Care National Consumer Experiences of Care (2010) project and has been specifically updated to include a version for use by PHN commissioned service providers. It can be located at the Australian Mental Health Outcomes and Classification Network website.

Murray PHN requests service providers to offer the YES PHN Survey to the consumer ***following initial assessment and on exit from service at a minimum.*** Feedback informed care increases the engagement of consumers in their care journey and Murray PHN encourages service providers to collect the survey on a quarterly basis during continuous service engagement, in addition to the minimum requirements above. Providers are expected to use available data/information collected to inform service planning, development, review, continuous quality improvement and service evaluation.

Feedback and complaints

Lived experiences of healthcare have long been identified by consumers, carers and families, and services as important in understanding how health services are performing and driving quality improvement. As partners in service planning, design, measurement and evaluation, consumer and carer feedback, complaints and compliments should be sought in all aspects of service planning and delivery.

The National Standards for Mental Health Services and user guide, Australian Commission on Safety and Quality in Healthcare Standards and the Primary and Community Healthcare Standards require all healthcare services to seek feedback from individuals in receipt of their care. All health service providers in Victoria must also meet the minimum standards for complaint handling as laid out in Schedule 1 of the Health Complaints Act, 2016.

Service providers must have:

- a mechanism in place for consumers to make a compliment or complaint about the service
- information available on how to complete a compliment or complaint and assistance if required
- all consumer information on making a compliment or complaint available in a plain English brochure and other languages.

Further information on complaints can be found on the Health Complaints Commissioner website.

13. Clinical governance

Murray PHN expects that all commissioned service providers have a clinical governance framework in place.

As defined by the Australian Commission on Safety and Quality in Healthcare (ACSQHC), “Clinical governance is an integrated component of health service organisations’ corporate governance. It ensures that everyone, from frontline clinicians to managers and members of governing bodies, such as boards, is accountable to patients and the community for assuring safe, effective, integrated, high-quality and continuously improving health service delivery.”

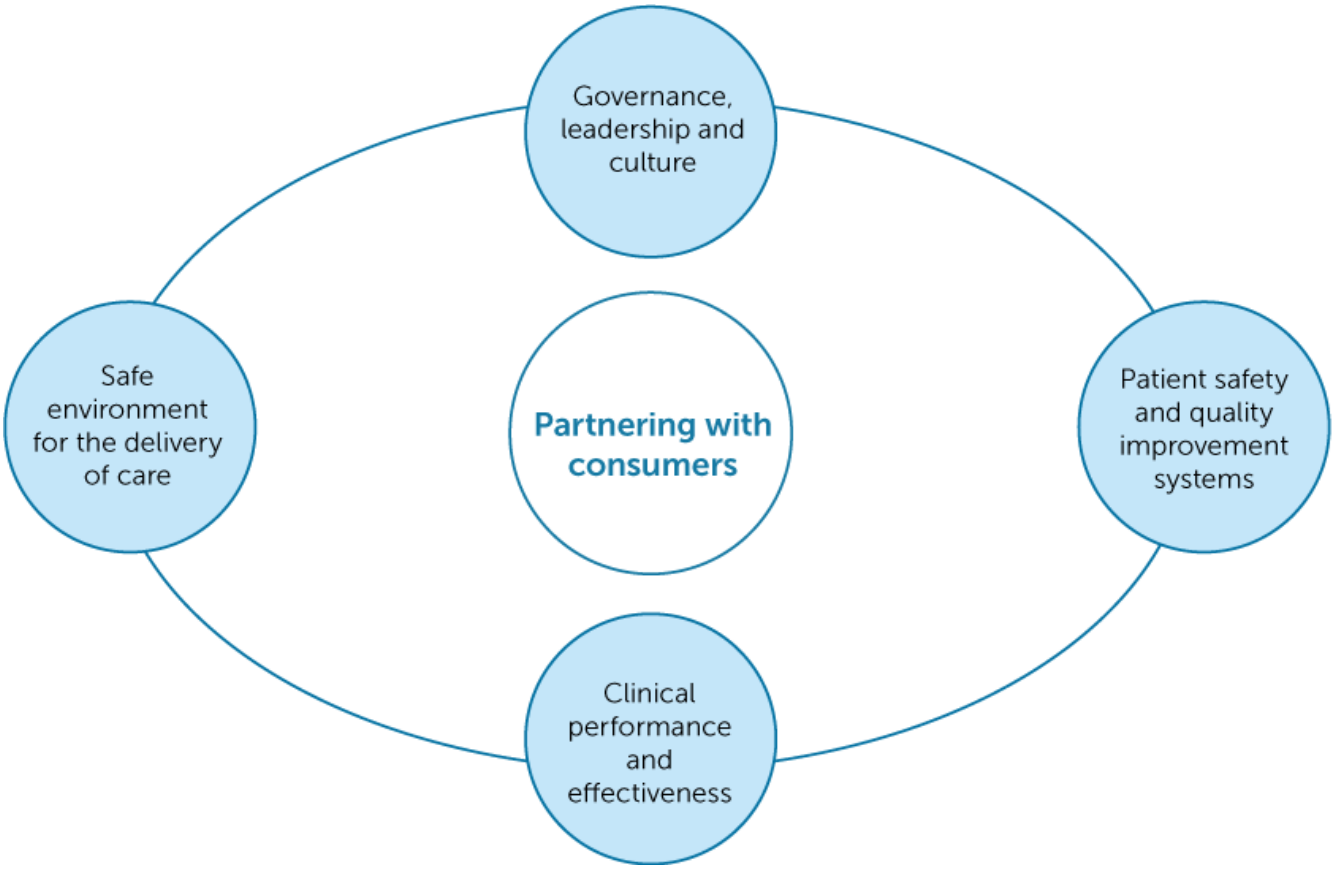
Clinical governance domains

Murray PHN has adopted the ACSQHC definitions of clinical governance and the five domains of the ACSQHC Clinical Governance Framework to guide its own clinical governance framework. These domains are outlined below in ***Table 2***.

Table 2 – Clinical governance domains

Domain	What this means to Murray PHN
Leadership and culture	Integrated corporate and clinical governance systems are established, and used to improve the safety and quality of healthcare for consumers
Partnering with consumers	Systems are designed and used to support patients, carers, families and consumers to be partners in healthcare planning, design, measurement and evaluation
Patient safety and quality improvement systems	Safety and quality systems are integrated with governance processes to actively manage and improve the safety and quality of healthcare for patients
Workforce/ clinical performance and effectiveness	The workforce has the right qualifications, skills and supervision to provide safe, high-quality healthcare to patients
Safe environment for the delivery of care	The environment promotes safe and high-quality healthcare for patients

Figure 5 National Model Clinical Governance Framework (NSQHS Standards)



Responsibilities of commissioned service providers

Service providers are required to meet clinical governance obligations set out in the ACSQHC framework and should have a clinical governance framework in place. Service providers should refer to the Murray PHN Clinical Governance Framework (2024) for further guidance regarding their clinical governance obligations and clinical risks.

Providers have multiple obligations to **report notifiable events** (clinical and non-clinical) and must comply. The Murray PHN Notifiable Event - Clinical Reporting Policy, Notifiable Event - Non-Clinical Policy and the Notifiable Event - Reporting Requirements for Commissioned Service Providers Procedure clearly outline these obligations and reporting requirements. All relevant Murray PHN service provider policies, procedures and reporting templates regarding clinical governance and notifiable event requirements are available at https://murrayphn.org.au/contact-us/.

As outlined further in section 14 below, these guidelines have introduced the opportunity to use a broader workforce in delivering Murray PHN services and service providers must ensure that appropriate clinical governance arrangements are in place to support and govern this workforce.

Murray PHN responsibilities

The Department of Health and Aged Care expects PHNs to ensure a high-level of service quality for mental health, psychosocial recovery, and alcohol and other drug services commissioned within a stepped care approach. Murray PHN will commission suitably qualified service providers to deliver services, through a transparent and robust commissioning process. Service providers may include:

- general practice
- private psychiatry practices
- private and non-government organisations (NGOs) mental health services
- Aboriginal and Torres Strait Islander Peoples primary healthcare services
- alcohol and other drug services
- community health services
- public health services.

The Murray PHN Clinical Governance Framework describes the context and role of Murray PHN in clinical governance and can be accessed on the Murray PHN website.

14. Workforce requirements

Commissioned service providers are expected to contribute to implementing the National Mental Health Workforce Strategy 2022-2032. Importantly, service providers should have in place:

- processes for the safe, appropriate and high-quality engagement of a broader mental health and social and emotional wellbeing workforce, including oversight
- professional development programs and training opportunities
- capacity for the appropriate and effective engagement and support of provisional/graduate professionals and those in the final years of their training if they are to be engaged in the delivery of services
- strategies to prevent burnout and workforce stress
- mechanisms in place for regular line-management and clinical supervision of the workforce
- strategies to improve recruitment and retention
- a defined scope of practice for all roles within services to ensure the safety and quality of services delivered.

Supervision and reflective practice

Integral to commissioned service providers' clinical governance framework is the management and monitoring of staff performance and practice. The supervision and support of service provider staff is central to the delivery of high-quality, safe and effective services and positive outcomes for consumers.

Management and clinical/professional supervision supports service provider staff to maintain personal and professional resilience, boundaries and wellbeing. It is an expectation that service providers ensure that staff have (and receive) monthly management and clinical supervision/ reflective practice arrangements. These arrangements should be provided in keeping with professional and peak body requirements.

Broadening the workforce

PHNs can support more flexible use of a broader workforce of appropriately trained service providers, particularly in areas of workforce shortage. With the release of Version 5 of these guidelines, Murray PHN is enabling the use of a broader workforce in the provision of care. This addresses the challenges of recruiting and retaining credentialled mental health professionals in regional Victoria and opens new opportunities. However, this capability introduces increased expectations and responsibilities for service providers to ensure a broader workforce is deployed appropriately, safely, and with strong clinical oversight and governance.

Murray PHN expects service providers to develop workforce models appropriate to their local context and that best support consumers. In particular, primary mental health service providers may expand workforces by actively planning for and recruiting:

- social workers registered with the Australian Association of Social Workers
- Australian Health Practitioner Regulation Agency registered occupational therapists
- provisional psychologists
- social and emotional wellbeing workers/ Aboriginal mental health and health workers
- registered nurses
- counsellors registered with the Australian Counselling Association or the Psychotherapy and Counselling Federation of Australia
- registered art, music, play or family therapists
- professionals with a Bachelor of Youth Work
- peer support staff with Certificate IV in Mental Health Peer Work or greater.

To ensure a high-quality standard of service delivery, staff engaged to deliver funded programs, where appropriate and required, must:

- be qualified, trained, and have relevant knowledge and skills for the requirements of the position description and scope of practice
- be registered with practising authorities and demonstrate evidence of the continuing professional development requirements for annual re-registration
- have membership with their discipline-specific professional association
- have a working knowledge and comply with relevant discipline-specific professional practice standards and competency standards.

It is expected that service provider recruitment and onboarding processes will gather evidence to confirm appropriately qualified staff are employed. Service providers must also maintain procedures and practice to verify registration and qualification requirements of staff and provide evidence of this. Recruitment and registration requirements must also ensure services comply with:

- standard terms in the Murray PHN Funding Agreement
- Murray PHN Program Guidelines (Part A) and requirements for program specific information (Part B) relevant to the program in which the staff is employed.

Developmental workforce models

Murray PHN is committed to the establishment of care models that are pragmatic, evidence-based, integrated within the local service system and meet the needs consumers. We support the development of a range of flexible developmental workforce models for service providers to ensure service delivery and future workforce, particularly where rurality and remoteness impact the recruitment of program-specified staff.

The use of graduates, interns and staff in training is encouraged and provides careers pathways and a recruitment and retention strategy relevant for rural and remote services. While candidates who have recently completed and/or are in their final years of training may traditionally come from the allied health, psychology and nursing professions, service providers may use staff from a broad range of professions, such as those outlined above. Graduates and staff in training bring contemporary evidence and knowledge from the education sector and this supports the capability of the primary mental health workforce.

Service providers must ensure graduates and those in training are closely supported and supervised in their practice. Service providers are therefore required to have appropriate clinical governance and supervision mechanisms to ensure this cohort is working within their scope of practice, have clear escalation pathways and feel supported in their practice. Workplace supervision arrangements (discipline-specific where possible), regular caseload reviews and other forms of reflective practice must be used.

Lived experience (peer) workforce

Lived experience work is recognised as a unique and separate discipline that offers a valuable contribution to the mental health sector. As its own discipline, lived experience work has distinct values, principles and theories that define it and the way it is practised.

The lived experience workforce consists of people employed in paid positions that require lived experience as an essential employment criterion, regardless of position type or setting. Lived experience workers apply diverse personal experience-based knowledge within a consistent framework of values and principles, and are a resource for change.

Regardless of the position, each worker is a change agent; a resource to support personal change in service users and work culture. One role of the lived experience workforce is to help service providers understand mental healthcare through the lens of lived experience and recovery.

Workforce development is not simply about creating new jobs; it is about ensuring organisational readiness and shifting the focus to the experience of mental illness. A history of lived experience positions in mental health services can be found in the Lived Experience Workforce Positions report available at the Centre for Mental Health Learning (CMHL) Peer Inside resource hub. The Centre for Mental Health Learning provides a range of professional development and training resources that may be also be helpful for supporting lived experience workers in mental health.

Peer support work

Peer support work is a professional role distinguished from other forms of peer support because of the intentionality, skills, knowledge and experience that peer workers bring to their role. Peer support workers are employed for their expertise developed from their personal experience of mental illness, alcohol and other drug disorders, and recovery as a mental health consumer or carer, and can be a key conduit between a consumer, carers and services they use.

The inclusion of peer support workers in the primary mental health, psychosocial recovery, and alcohol and other drug services sector can help to improve the culture and recovery focus of services, and help to reduce stigma in the workforce and wider service community.

Peer support is an integral component of an integrated mental health service model, and Murray PHN encourages service providers to build and develop their organisational capacity to engage the peer workforce to deliver intentional peer support services.

In addition, Murray PHN requires that service providers support peer workers to access:

- ongoing training and development
- discipline (peer) specific supervision
- participation in peer networks e.g. communities of practice
- connection to and engagement with state and national peak bodies.

Service providers should adhere to and uphold the National Lived Experience (Peer) Workforce Development Guidelines 2023 in incorporating peer support models. Service providers are also expected to assess their organisational readiness to successfully integrate the peer workforce and undertake other preparatory activities before starting. Providers are encouraged to use the Self-Assessment tool for Lived Experience Mental Health Employers to assess their readiness to support a lived experience workforce prior to embarking on model and workforce implementation. **Table 3** below outlines employer actions for lived experience workforce development.

Table 3 – Employer actions for lived experience workforce development

	Preparation: **Clarify**	*Preparation:* **Commit**	*Implementation:* **Co-develop**	*Transformation:* **Learn and grow**
Leadership and culture	**Build** ✓ Leadership understanding of: • Lived Experience workforce • Recovery-oriented practice • Diverse perspectives and needs ✓ Strengthen commitment to diversity and inclusion	**Prioritise** ✓ Mission statements recognise Lived Experience work as core business ✓ Build whole-of-workforce commitment to Lived Experience	**Lead** ✓ Identify champions and allies for the Lived Experience workforce ✓ Partner with people with lived experience to develop and implement workforce strategy ✓ Consider opportunities to develop Lived Experience leadership roles	**Embed** ✓ Lived Experience roles represent diverse culture and perspectives ✓ Person-directed and recovery-oriented service delivery and practices are established ✓ Safe sharing of lived experience is prioritised for the whole workforce
Policies and planning	**Review** ✓ Identify the gap between current practices to recovery-oriented practice standards ✓ Current levels of diversity in service users, workforce and community	**Review** ✓ HR and other policies for flexibility to support Lived Experience work ✓ Outline a Lived Experience workforce strategy ✓ Include Lived Experience in long-term budgets and plans	**Plan** ✓ Develop an implementation plan ✓ Develop position descriptions and recruitment processes ✓ Budget for sufficient numbers of roles and Full Time Equivalent and all necessary supports and training	**Grow** ✓ Lived Experience roles are employed at all levels sufficient to meet needs ✓ Career pathways are available for Lived Experience workers ✓ A range of supervision and training options are available to Lived Experience workforce
Development	**Educate** ✓ Whole-of-workforce about Lived Experience roles and the value of diversity ✓ People accessing services and their families about Lived Experience roles ✓ Provide service users with information on peer support services in the region	**Connect** ✓ Create opportunities to listen to service users ✓ Build relationships with Lived Experience agencies ✓ Form a co-development steering group ✓ Work with other organisations for co-learning	**Equip** ✓ Ensure access to appropriate supervision and training for Lived Experience workers ✓ Consider Lived Experience apprenticeships/ traineeships ✓ Enable connections for Lived Experience workers with Lived Experience networks	**Learn** ✓ Review and evaluate the impacts of and remaining challenges to embedding the Lived Experience workforce ✓ Evaluate to contribute to a Lived Experience informed evidence base

Note: This summary represents key actions that any employer may take to develop and embed a Lived Experience workforce. Actions for organisations with specific interests, including regional and rural services, involuntary services, and service planning and funding appear in separate checklists throughout the *National Guidelines*.

Workforce continuing professional development (CPD)

Clinical staff who require registration with regulation agencies must successfully complete CPD relevant to their scope of practice. This supports the workforce to maintain, develop, update and enhance their knowledge and skills, and deliver appropriate and safe care.

Registered clinicians must comply with registration and CPD standards, and service providers must ensure that clinical staff have the opportunity to undertake the required CPD. Information regarding regulatory CPD requirements can be located on the relevant agency websites.

Continuing professional development

Murray PHN is committed to providing valuable education and events for the primary healthcare workforce across our region. We coordinate and delivers continuous professional development (CPD) and community of practice forums for healthcare professionals. Service providers may stay informed of training updates by subscribing to Murray PHN's Events update.

Specific communities of practice

Murray PHN has established specific communities of practice to support providers in the following distinct areas:

- headspace/ youth enhanced services
- Primary mental health
- Psychosocial recovery services
- Psychological therapy services in residential aged care.

Communities of practice include a mixture of in-person and online events each year and aim to facilitate knowledge sharing, collaboration and professional development among providers. They improve health outcomes in the region by promoting best practices, fostering innovation and supporting the wellbeing of commissioned healthcare professionals.

Scope of practice

To support staff in practising within their area of qualification and competence, service providers should develop a scope of practice for their program roles. The following resources may help developing specific discipline guidance for working with consumers:

- The Alcohol and Other Drugs Skill Set (provides valuable skills for and AOD-specific capabilities for providing services to clients with AOD issues and is the minimum qualification for working in the AOD sector)
- The Australian College of Mental Health Nurses Standards of Practice
- The Australian Counselling Association Scope of Practice for Registered Counsellors (2020)
- The Australian Association of Social Workers Practice Standards for Mental Health
- The National Framework for Determining Scope of Practice for the Aboriginal and Torres Strait Islander Health Worker/Health Practitioner Workforce.

15. References

1. Australian Commonwealth Government

a. National PHN Guidance – Initial Assessment and Referral for Mental Health Care
b. The National Drug Strategy
c. Australian Mental Health Outcomes and Classification Network
d. National Mental Health Workforce Strategy 2022-2032.
e. National Framework for Recovery Oriented Mental Health Services Capability Domain 2E
f. National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing

g. Translating and Interpreting Service (TIS National) - an interpreting service provided by the Department of Home Affairs for people with limited English proficiency

2. Australian Commission on Safety and Quality in Healthcare

a. Australian Commission on Safety and Quality in Healthcare Standards,

b. Primary and Community Healthcare Standards

3. Australian Mental Health Commission Frameworks and Guidelines

a. Contributing Lives, Thriving Communities

b. Fifth National Mental Health and Suicide Prevention Plan, 2021: Progress Report 4

c. National Mental Health And Suicide Prevention Agreement

d. National Lived Experience (Peer) Workforce Development Guidelines

4. Health Complaints Commissioner

a. FOR PROVIDERS | Health Complaints Commissioner

5. Victorian State Government

a. Royal Commission into Victoria's Mental Health System

b. Victorian Department of Health Multicultural Action Plan 2023 - 2027

c. Mental Health and Wellbeing Locals

6. Other guidance

a. Reconciliation Australia

b. VACCHO

7. Murray PHN

a. Murray PHN User Guides for Fixus

b. Murray HealthPathways

c. Murray PHN Clinical Governance Framework

d. Murray PHN Cultural Humility Framework