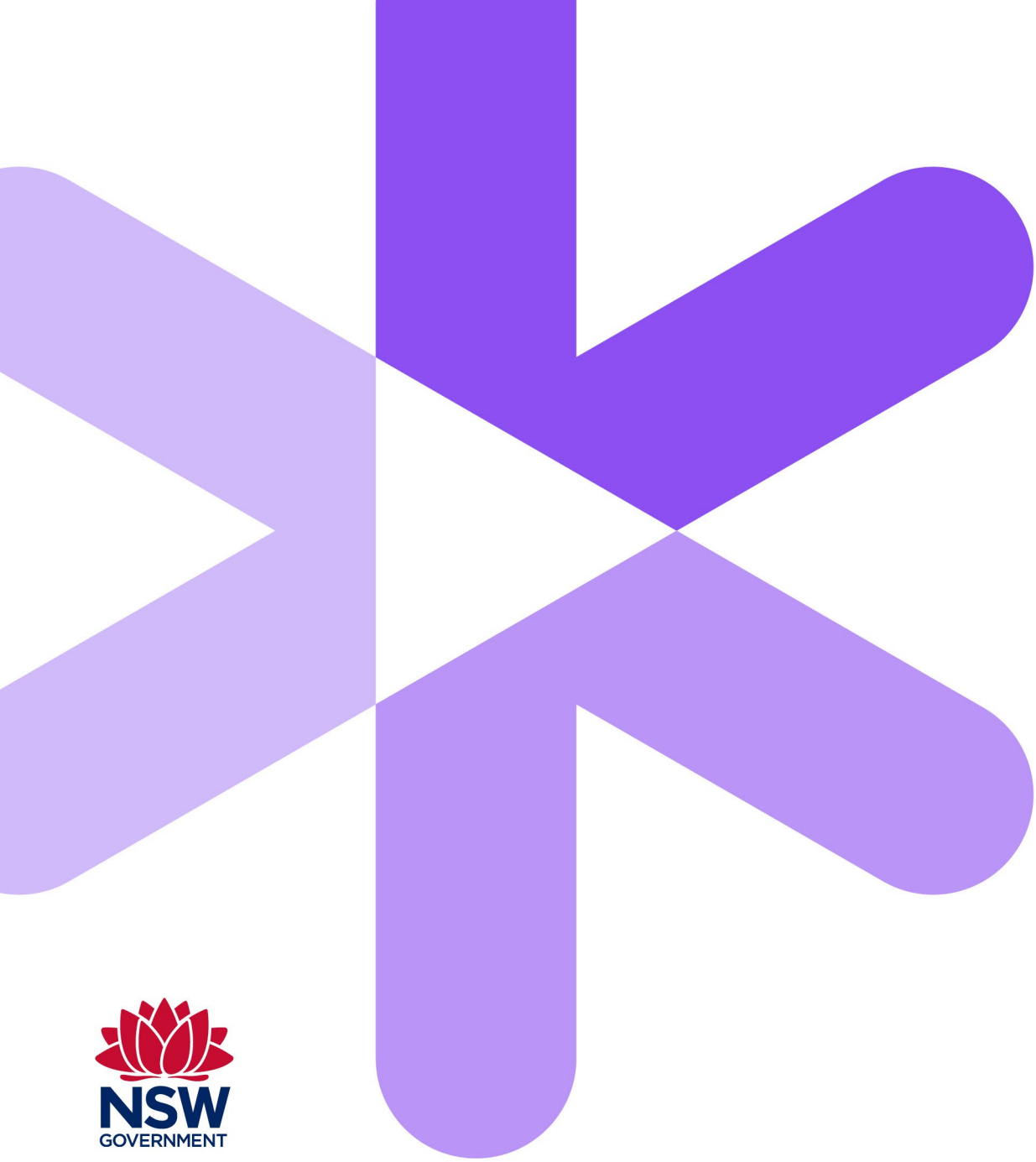
Mental Health
Community Living
Supports for Refugees

MH-CLSR Program Guidelines

Mental Health Branch
NSW Ministry of Health

First edition 2023



Published by

NSW Ministry of Health
Locked Mail Bag 2030
St Leonards NSW 1590
02 9391 9000

SHPN (MHB) 230097

Acknowledgements

The Ministry of Health pays our respects to the Cammeraygal people of the Eora Nation, the traditional owners of the lands on which the NSW Mental Health Branch is located. We acknowledge the ongoing connection that Aboriginal people have to this land and recognise Aboriginal people as the original custodians of this land. We pay our respects to the Elders, past, present and emerging throughout NSW and are thankful for their continued contributions and guidance in the Supported Living Programs.

> Contents

Acronyms and Definitions

CALD	Cultural and Linguistic Diversity
CLS	Community Living Supports
CMO	Community managed organisation (non-profit/non-government)
CRN	Client Reference Number
DCJ	Department of Communities and Justice
GP	General Practitioner
HASI	Housing and Accommodation Support Initiative
LCQ	Living in the Community Questionnaire (LCQ)
LHD	Local Health District
MDS	Minimum Data Set
MH-CLSR	Mental Health Community Living Supports for Refugees
MOH	Ministry of Health
NDIS	National Disability Insurance Scheme
NGO	Non-government organisation
SAMHSA	Substance Abuse and Mental Health Services Administration
SLA	Service Level Agreement
STARTTS	NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors
TAFE	Technical and Further Education (college)

1. Introduction

These Program Guidelines provide up to date information about the Mental Health Community Living Supports for Refugees (MH-CLSR) Program. It is designed as the key guidance document for community-managed organisations (CMOs) that are funded as MH-CLSR providers to use in implementing the program. The document may be used as a reference document for other non-government and government stakeholders in the sector engaged in delivering services to refugees and asylum seekers in NSW.

The Program Guidelines have been developed in consultation with contracted MH-CLSR providers and Local Health Districts (LHDs) where the MH-CLSR program is implemented. It will be reviewed periodically as program procedures and practices evolve.

1.1 Background

On 15 December 2014, the NSW Government announced a ten year reform of the mental health system. One of the key reform objectives is to enhance mental health care that is delivered in the community. An essential element of this is the expansion and strengthening of community-based psychosocial supports for people with mental health conditions. Psychosocial supports are increasingly recognised as critical to mental health recovery and the prevention of acute crises, hospital admissions and presentations to emergency departments. The NSW Government has committed to expand the availability of psychosocial supports.

NSW Health currently funds a range of psychosocial supports for people with severe mental illness. The Housing and Accommodation Support Initiative (HASI) and Community Living Supports (CLS) provide psychosocial supports alongside mental health clinical care across the state.

Evaluation evidence indicates that these types of supports reduce hospitalisations and lengths of stay in hospital, improve physical and mental health and wellbeing, stabilise housing tenancies, maximise independence, foster positive relationships and enhance life skills and community participation.

In November 2017, the Minister for Mental Health announced a further allocation of $4.8 million to expand psychosocial supports for refugees living with mental health conditions. This announcement was linked to the NSW Government's increased intake of refugees fleeing the conflict in Syria and Iraq. However, the funds can be used more generally to support refugees and asylum seekers experiencing mental health conditions besides those from the recent Syrian and Iraqi intake.

1.2 What is Mental Health Community Living Supports for Refugees?

Mental Health Community Living Supports for Refugees (MH-CLSR) is a unique program that aims to provide trauma-informed, recovery-oriented, culturally safe and responsive psychosocial supports to refugees and asylum seekers who are experiencing psychological distress, mental ill health and impaired functioning. The program is different from CLS and HASI in that people are not required to have a diagnosed mental illness to receive support. The program was developed in close consultation with non-government and government stakeholders and is targeted at locations of NSW where primary and secondary settlement of

refugees and/or significant service delivery to asylum seekers is concentrated. Services are provided in seven Local Health District Areas in NSW as follows:

- South Western Sydney including Fairfield and Liverpool
- Western Sydney including Auburn, Merrylands and Westmead
- Murrumbidgee including Wagga Wagga and Griffith
- Illawarra Shoalhaven including Wollongong
- Hunter New England including Newcastle and Armidale
- Mid North Coast including Coffs Harbour
- Sydney.

The MH-CLSR program:

- provides community living supports to assist a minimum of 79 people at any given time from a refugee or asylum seeker background to recover and transition to a quality life in the community;
- delivers a service model that is individualised and flexible, with a whole of family approach adopted as needed;
- enables the provision of supports to commence when people are still in inpatient care, to better support a successful transition to the community (noting that entry to the program is not restricted to people receiving inpatient care).

1.3 Program objectives and outcomes for clients

The objectives of MH-CLSR are to:

- improve the mental health, wellbeing and functioning of program clients
- increase social participation and community integration of program clients
- prevent acute mental health crises and avoidable admissions to hospital or presentations to emergency departments.

2. Key features of MH-CLSR

2.1 A recovery oriented, trauma informed, and culturally responsive framework

2.1.1 Recovery oriented care

MH-CLSR supports are recovery oriented – which means service providers support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations. Recovery refers to 'being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues'. [1] Recovery is a journey - sometimes lifelong, through which a person with a mental health condition achieves independence, self-esteem and a meaningful life in the community. Recovery-oriented practice encapsulates mental health care that:

- Recognises and embraces the possibilities for recovery and wellbeing created by the inherent strength and capacity of all people experiencing mental health issues
- Maximises self-determination and self-management of mental health and wellbeing
- Assists families to understand the challenges and opportunities arising for their family members.

The lived experience and insights of people with mental health issues and their families are at the heart of recovery-oriented culture. The concept of recovery was conceived by, and for, people living with mental health issues to describe their own experiences and journeys and to affirm personal identity beyond the constraints of their diagnoses.

Recovery-oriented approaches recognise the value of this lived experience and bring it together with the expertise, knowledge and skills of the mental health workforce. Recovery approaches challenge traditional notions of professional power and expertise by helping to break down the conventional demarcation between people with mental health conditions and service providers. Within recovery paradigms all people are respected for the experience, expertise and strengths they contribute.

In the context of MH-CLSR, communication and effective collaboration between partners, including the client, their family and carers, nominated clinical partner, the LHD mental health team, and the CMO delivering MH-CLSR is essential. Decisions regarding a client's recovery, including changes to their Support Plan, medication or recovery goals, should not be made hastily or in isolation without due discussion with other partners within the programs. Clients should be supported to make informed decisions that are in their best interests and likely to result in improvements in their mental health condition and other aspects of their life.

In most instances, it will be the responsibility of the MH-CLSR provider, in collaboration with the client, to facilitate this communication with clinical partners, families and carers and other stakeholders. Maintaining the health, safety and wellbeing of clients in MH-CLSR is of paramount importance. As the range of recovery approaches and models has expanded over time, there can be differing interpretations of recovery when applied to practice. It is important

[1] A national framework for recovery-oriented mental health services - Policy and Theory, 2013.

for MH-CLSR providers to review and discuss with the client and key stakeholders their understanding of the concept as a regular point of communication.

Key internal factors that can be attributed to the recovery process include:

- Hope
- Acceptance
- Self-will/self-responsibility/self-determination
- Spirituality
- Coping skills
- Family connections.

Key external resources that can be attributed to the recovery process include:

- Social and community support
- Secure housing
- Meaningful activity
- Medication and effective management of side effects
- Professional assistance from mental health services
- Networking with appropriate services
- Effective relationships and appropriate communication between organisational partners
- Family connections.[2]

For many MH-CLSR clients, access to immigration advice will be an important factor in their recovery process since it will assist reunion with family members and identify pathways to secure longer term immigration status.

It is noted that asylum seeker clients (on Bridging Visas) will not have access to social and public housing, Medicare or social security benefits, and Temporary Protection Visa holders may only have limited access to these. MH-CLSR providers will need to build effective partnerships with other service providers, community groups and charities for these clients to access these necessities as needed.

A key factor in assisting people to recover is the process of building effective relationships and partnerships between service providers, peers, community and cultural supports, the individual and where appropriate, their family and/or carers. People living with mental health conditions are not a homogenous group. People may be affected in different ways by their

---

[2] Dun, C and Fossey, C (2002) 'Promoting the process of recovery', in S. Pepper (Ed), *Towards Recovery (Volume 1).* New Paradigm Press, North Fitzroy.

mental health condition due to different life experiences including past and current trauma, their aspirations and social and cultural backgrounds. They may also have coexisting physical and mental health conditions and disabilities to manage. The level of personal support required will differ and often fluctuate in terms of both informal and formal structures.

Nevertheless, there are some similarities in the ways in which mental health conditions can manifest and affect the individual in terms of behaviour and thinking. Common factors that can influence a person's ability to maintain independent living include:

- Mental health conditions can affect a person's capacity to organise daily tasks such as cleaning, cooking, shopping and budgeting, and to access and sustain a tenancy. This includes the ability to work through administrative requirements, such as completing applications forms, liaising with landlords, or understanding property maintenance procedures.

- Lengthy periods of ill health and hospitalisations may disrupt relationships, housing options and employment and complicate the person's recovery pathway.

- Some people need to learn or regain confidence in their communication and practical skills for independent living.

- The person's development of independent living skills may have been interrupted at the time their mental health condition first affected them.

- People may need support to manage the diverse areas of their lives, and if a number of people and support services are involved, may need help to coordinate them.

- When a person becomes unwell, they may be reliant on others to notice, better manage or ensure support coordination.

- For many people living with mental health conditions the ability to choose, access and maintain safe and affordable housing provides the cornerstone to stabilise their health and wellbeing. With hope, abilities and strengths, this makes it possible to build a fulfilling life.

A number of strategies have been found to be useful in successfully addressing the factors that threaten a person's independence. These include providing financial management assistance, building up their home management skills, developing social, wellness and self-management skills and making links to relevant community services and options.

2.1.2 Trauma informed care

The Agency for Clinical Innovation in NSW Health outlines that trauma is defined as an event, series of events or set of circumstances that are experienced as physically or emotionally harmful or life threatening. Trauma can result in acute and/or ongoing adverse effects, distress or disruption to the individual's life. This may lead to a disruption of overall functioning, mental,

physical, social, emotional or spiritual wellbeing. This definition was adapted from the SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.[3]

Trauma can affect many aspects of an individual's life. For refugee and asylum seekers, recovery from trauma may be a life long journey, and can influence their social, emotional and physical wellbeing including their ability to cope with daily living and form personal and social relationships.

Refugees and asylum seekers have experienced varied trauma that is specific to their pre and post migration circumstances. Most commonly they experience psychological distress, mental ill health and impaired functioning arising from complex and chronic trauma, grief and loss. This trauma results from human rights violations including physical and / or sexual violence and torture, the loss of home, country, family and community, physical injuries and disabilities from war and conflict, detention, migration to and/or settlement and establishment in multiple countries. Symptoms include post-traumatic stress disorder, depression, anxiety, self-harm and suicide ideation. Social and cultural isolation and language barriers during settlement in a new country, and separation from family members due to war and fleeing persecution, often compounds the trauma experienced by refugees and asylum seekers.

Trauma informed care and practice is a strengths based approach which understands and responds to the impact of trauma. It is founded on five core principles – safety, trustworthiness, choice, collaboration and empowerment as well as respect for diversity. It features safety from harm and re-traumatisation, emphasises strength building and skill acquisition rather than symptom management, and fosters true collaboration and power sharing between workers and those seeking help at all service levels.[4]

This includes realising the prevalence of trauma, and how trauma is affecting an individual. Trauma informed care and practice ensures that an individual is treated and receives services in a sensitive way that does not re-traumatise them but leads to recovery from the trauma.

MH-CLSR providers are expected to provide trauma informed care and practice in the delivery of all services to refugee and asylum seeker clients. Some of these practices will include:

- providing assistance to understand mental illness and trauma and the treatment options available, with sensitivity to cultural differences
- managing feelings of dislocation and profound uncertainty
- managing feelings of grief and loss
- managing identity issues in the context of a new cultural environment

---

[3] Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach [Internet]. Rockville, MD: SAMHSA; 2014 [cited April, 2018]. Available from: https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884 . Cited in the Agency for Clinical Innovation website, Trauma Informed Care and Practice - https://www.aci.health.nsw.gov.au/networks/mental-health/trauma-informed-care-and-practice-in-mental-health-services

[4] 2014, Mental Health Australia web article 'Trauma Informed Practice', Dr Cathy Kezelman, President, Adults Surviving Child Abuse, https://mhaustralia.org/general/trauma-informed-practice

- managing risk of suicide and self -harm through identification and appropriate referral
- working alongside psychiatrists, mental health nurses and general practitioners to assist people to transition from complex or inappropriate medication regimes that may have commenced during detention to more suitable medications
- supporting transitions from refugee and asylum seeker services to mainstream health services.

2.1.3 Culturally safe and responsive services

MH-CLSR providers are required to demonstrate knowledge of local refugee and asylum seeker groups and their settlement needs. Services should always be delivered in the most culturally relevant way and be safe and responsive according to the client's circumstances, cultural, linguistic and religious background and need. The use of interpreters and translated material in relevant community languages is necessary when delivering supports to refugees and asylum seekers. Understanding of the refugee and asylum seeker experience as distinct from other migration experiences and understanding community norms, religious beliefs and cultural practices are essential to the delivery of these services.

MH-CLSR providers are expected to continuously improve and build their workforce capacity and capability to deliver services that are culturally appropriate, safe and responsive. A culturally capable workforce consisting of bilingual and bicultural workers and/or people from refugee and asylum seeker backgrounds is essential.

2.1.4 Use of interpreters and translated material

Linguistic accessibility is a critical factor in ensuring that supports are appropriate for refugees and asylum seekers experiencing psychological distress or mental ill health. The use of professionally qualified and accredited interpreters is essential in the delivery of all types of supports to clients in MH-CLSR.

This means that health care interpreters will be necessary when providing health related supports, and generalist accredited interpreters should be engaged where possible when providing all other supports that require technical use of language or translating more complex information to the client.

To build trust with the client and to enable effective service provision, it is recommended where possible MH-CLSR providers use face to face interpreters rather than the Telephone Interpreter Services (TIS).

Where possible MH-CLSR providers should provide written material that is translated into relevant community languages for their clients. It may be necessary to include an interpreter to explain the written material to clients since some clients may be illiterate in their own language.

2.1.5 Use of bilingual and bicultural staff

Bilingual and bicultural workers may be engaged to facilitate cultural understanding, build trust with the client and their family and to assist negotiate cultural differences. This will include assisting with activities such as accompanying and supporting a client to engage in community activities, appointments, and assisting with living skills etc.

However, these workers should not be utilised as interpreters when coordinating and / or providing supports to clients that require a higher or technical use of language unless they are qualified and have expertise in the area requiring interpretation and are capable of accurate interpreting. Where possible a professionally accredited interpreter (preferably face to face)

should be engaged for activities such as developing and reviewing the Support Plan, explaining consent, negotiating family conflict and providing therapeutic services, filling out official documents and forms and providing clinical care and technical expertise.

An accredited interpreter is someone who has obtained certification from the National Accreditation Authority for Translators and Interpreters (NAATI).

2.1.6 A whole of family approach

Working with the extended family and community is of particular importance for culturally and linguistically diverse clients. Ensuring a trauma informed and recovery oriented environment for the individual will require provision of support to family members of the person receiving MH-CLSR supports. Engaging the person's community and religious community may also be necessary in the provision of supports.

The client's entire family should be considered in the delivery of supports as appropriate. A whole of family approach should be adopted, where assistance with parenting functioning and family therapy is provided as needed, and children's trauma histories and associated issues are also considered. This approach should not be adopted in cases where there is known domestic and family violence in the home and adopting a whole of family approach may place the victim further at risk. Many refugee and asylum seeker families may have female headed households due to losing the male head of the family in war and conflict. This often results in conflict and cultural tension between the male children and their mothers as decision makers, due to the traditionally male dominated culture and family structures of their home countries. Children may also experience conflict with parents whilst negotiating between western cultural norms and traditional cultural expectations of them. Resolution of family conflict in a culturally sensitive manner should be included in the Support Plan as relevant, including family therapy and tools for effective parenting functioning.

Where it is possible and desired by the person receiving support, MH-CLSR providers should strive to meaningfully involve carers as active partners in delivering supports. This is consistent with the *NSW Carers Strategy, Caring in NSW 2020 - 2030* that aims to improve the position of carers in NSW. Service providers should recognise that working with families and carers can be pivotal to achieving the best possible outcomes for people receiving supports.

It should also be noted that some clients do not have biological family in Australia. This is particularly the case for asylum seekers and people on temporary visas. As a result, their 'family' in Australia may constitute other community members, flat-mates and / or friends. When there are no family members, significant people that a client identifies in their life should be consulted and included when providing supports.

2.1.7 A community oriented approach

MH-CLSR intends to maximise the opportunities for people to participate in their local community. It aims to assist the person to explore options and opportunities and make choices and links to develop the necessary skills for fuller community and/or workforce participation. MH-CLSR emphasises rehabilitation, recovery and social inclusion. In particular, it encourages engagement with education and employment where possible, to foster independence and self-reliance.

MH-CLSR providers should have comprehensive and culturally robust strategies for engagement activities with communities that include refugees and asylum seekers and community and religious leaders, to promote community recognition of MH-CLSR, help integrate clients into community life and encourage referrals into the program.

2.1.8 A partnership approach

A MH-CLSR provider refers to a community managed organisation providing psychosocial rehabilitation support services in each location in which MH-CLSR is delivered. MH-CLSR providers receive funding from the NSW Ministry of Health to deliver these supports.

The services provided are agreed to collaboratively with the client, the MH-CLSR provider, a clinical partner (providing mental health care), other relevant support services and the person's carers or family members (as agreed by the client). This agreement, known as the Support Plan, focuses on the person's individual goals to support in their journey toward recovery.

2.1.9 Types of partnerships

MH-CLSR providers should build partnerships with the related service system within each Local Health District to ensure that client needs are met. Community based psychosocial supports to clients should be provided in close partnership with mental health care and treatment providers such as psychiatrists and other medical practitioners as required. Partnerships should also be formed with other stakeholders who are providing support or services to the client such as settlement services, employment and educational services, housing and income support services, community and religious supports. The supports should be culturally responsive and incorporate the broader family and community context of clients.

The MH-CLSR provider should develop partnership with the client's clinical partner (this will either be staff in Local Health Districts, a private registered mental health practitioner from general practice or private and/or community-based organisations providing mental health care and treatment). This will ensure shared care approaches under which psychosocial supports complement mental health care and treatment and combine to support recovery and the development and maintenance of independent living.

Where local refugee and asylum seeker inter agencies or working groups exist, MH-CLSR providers should actively participate in these structures and be well networked with relevant local services and initiatives. Strong integration with local mental health services, including the Local Health District and STARTTS will also be essential.

Like HASI and CLS programs the MH-CLSR program is underpinned by an integrated care and support model. This involves a partnership between Local Health District mental health teams that provide mental health care and treatment and non-government organisations specialising in mental health that provide psychosocial supports. However, in MH-CLSR the partnership with the Local Health District will apply in those instances where the client is also a client of the Local Health District. Where this is not the case, the MH-CLSR provider will be required to work in partnership with the client's GP, psychiatrist or other provider of their mental health care and treatment.

MH-CLSR assumes that each local provider, the person receiving supports, and their family and/or carer are equal partners. Each partner should demonstrate understanding and respect for the perspective, roles and responsibilities of others. Roles and responsibilities should be clarified in planning meetings and appropriately documented. All partners will continually seek to improve individual outcomes via communication with each other and with other support agencies as relevant to the support plan.

2.1.10 Partnership with the family

Families and carers of refugees and asylum seekers are important partners in successfully delivering MH-CLSR supports. They often have unique expertise, understanding and abilities gained through providing support to the person over many years, which brings an additional perspective to clinical care and recovery. Information that they provide to service providers is frequently important in determining the need for treatment and support. Their understanding

of the person's strengths, difficulties experienced and dreams for the future can be invaluable. Collaboration between the person, their family and carers and their service providers in planning, taking steps and evaluating progress can significantly improve success.

The level and type of involvement that the family and/or carers will have in delivering MH-CLSR supports will vary and should be guided by the person receiving supports and in consultation with family and /or carers as appropriate. For example, establishing or strengthening family relationships may be a goal for one person while independence from family support may be another person's goal.

Where the person receiving MH-CLSR supports has given consent for their family and/or carers to be actively involved they may play an important part in supporting the person and helping to identify recovery goals and promote community participation. In this instance the nominated family member or carer should be invited to participate in all Support Plan reviews.

Families and carers may sometimes need additional mental health and recovery education or other assistance to support themselves more effectively and/or the person receiving MH-CLSR support. In many circumstances the partnership arrangements of the programs can either provide this support or provide information to families and carers about other services that may be of assistance.

2.1.11 Clinical partnerships

MH-CLSR clients should have a nominated clinical partner responsible for their mental health care and treatment that has agreed to support their participation in the program. This may be a refugee specialist health service such as STARTTS, a clinician at the Local Health District mental health service or a general practitioner or psychiatrist. Close coordination and communication should be maintained with the clinical partner as long as the person is a MH-CLSR client. The clinical partner should be closely involved in the development of the client's Support Plan and be involved in reviews of the plan and decisions about changes in supports.

2.1.12 Collaboration between clinical and psychosocial supports

MH-CLSR emphasises a collaborative relationship between clinical and psychosocial supports. Providers recognise the importance of both forms of support and encourage clients to utilise and engage with both clinical and psychosocial supports for as long as is required.

2.1.13 Partnership with Local Health Districts

LHD mental health services

Local Health District community mental health services provide a continuum of care from prevention and early intervention to emergency and acute care, to chronic and continuing care through to rehabilitation and recovery. These services are provided in both inpatient and community settings.

District community mental health teams consist of a range of staff and may include case managers (which by discipline could be a mental health nurse, social worker, psychologist, or occupational therapist) and a psychiatrist or psychiatric registrar. Each person receiving services from the community mental health team has staff members allocated to them who are responsible for their care and treatment.

Community mental health services also play a key role in applying to the Mental Health Review Tribunal for a Community Treatment Order, or review of such orders as appropriate. They also have a role in applying to the Guardianship Division (NCAT) for a Guardianship Order concerning the person and carer's needs where substitute decision making may be necessary

in order to make decision about personal or lifestyle matters for someone with decision making disabilities.

LHD services provided in the MH-CLSR program

A partnership approach is required between District mental health staff and MH-CLSR service providers. This is to enable the provision of complementary care and support services for clients that are either referred from the district to the MH-CLSR service provider (to assist clients transition back into the community), and for any MH-CLSR clients who may escalate to emergency departments or mental health inpatient units. The LHD should refer refugee and asylum seeker clients into MH-CLSR who are exiting mental health inpatient units. This is to assist their transition back into the community, prevent their condition from declining and resulting in hospitalisation or contact with the Mental Health Community Team or the police.

District community mental health services may provide care and treatment to people receiving MH-CLSR services. This may include:

- assessment of the functional impact of an individual's mental health condition or psychosocial disability and how it affects them in reaching their goals
- assessment of daily living skills
- monitoring medication management, support with medication adherence and addressing side effects that may affect daily living
- arranging regular medical reviews
- supporting the person to understand their signs of relapse
- development of a shared plan for early support and assistance
- supporting the person to better manage life stressors which could lead to relapse
- developing collaborative Support Plans so that the direction and purpose of care coordination are made explicit
- using a cognitive behavioural approach to identify lifestyle changes and methods of intervention that will positively impact upon the person's mental and physical health
- linking individuals with other treatment services including drug and alcohol or specialist psycho-therapeutic and healthcare providers
- engagement of the carers and/or family in the care planning and recovery process.

LHD governance and Service Level Agreements

More broadly, Local Health District mental health teams will play an important role in the implementation and governance of this program at the local level. This will take the form of a local partnership meeting anticipated to occur for one to two hours each month and to be convened by the funded MH-CLSR provider. This meeting is designed to promote collaboration with district mental health teams and to provide district oversight of local implementation. Discussing and prioritising referrals from the LHD to the MH-CLSR program, and MH-CLSR clients who have entered or are referred for mental health inpatient care will be an ongoing priority agenda item at these meetings. Other functions of this meeting may be to review program data, discuss referral pathways and local service delivery, manage risk, share information and build capacity, plan locally and mitigate any identified service issues.

Service Level Agreements (SLA) will be established between the LHD and the MH-CLSR service provider (a sample template is provided at **Appendix 1**), where roles, responsibilities and collaborative activities will be clearly outlined to fulfil service delivery targets. The requirement for MH-CLSR providers to form these agreements with LHDs are included in funding agreements.

District mental health teams may also facilitate the involvement of multicultural health teams as required in local governance meetings and/or consult with them as necessary regarding SLAs and other operational matters.

See **Appendix 1** for a Service Level Agreement sample template. Please note:

- The sample SLA should be used as a guide only.
- It is expected that each site will develop their SLA to reflect the unique needs of their service(s).

3. Providing supports in MH-CLSR

MH-CLSR providers will provide coordinated supports that are holistic, culturally responsive, recovery oriented and trauma-informed. Supports are underpinned by a Support Plan developed collaboratively with the client, the clinical partner, and where appropriate, their family and other key sources of support. Support Plans should emphasise recovery from mental ill health and promote participation in the community.

The level of supports provided should reflect the level of need as determined by assessment and regular reviews of the Support Plan. The nature of the supports provided to an individual varies depending on their support needs and goals.

3.1 Types of supports

Whilst individual counselling and therapy sessions are part of the service model, this is not an exclusive focus. The emphasis is on the provision of a broad range of community based psychosocial supports. The full range of psychosocial supports listed below must be made available:

- Development of holistic, integrated support plans and provision of support coordination
- Psychosocial interventions including trauma informed recovery oriented therapy/counselling, community support and peer support to assist with social integration, emotional regulation and personal change
- Assistance with daily living skills including self-care, personal hygiene, cleaning, shopping, financial management, cooking and using transport
- Support attending appointments with other health or welfare services
- Support to manage medication requirements and other aspects of mental health care and treatment
- Assistance building skills in parenting functioning and facilitating access to family therapy
- Provision of appropriate therapeutic, educational and community supports for children and young people
- Collaboration with school counsellors and therapists with regard to the wellbeing of school aged children and young people
- Facilitation of access to education, vocational training and employment opportunities
- Assistance in building and maintaining family and community connections
- Facilitation of participation in social, leisure, recreational, physical, cultural and community activities

3.2 Care coordination

Evaluation of the HASI program has found that the more community connections are provided in a coordinated way, the more positive the outcomes achieved by the person receiving supports. Success is encouraged by helping the person to connect with a range of local community services to meet their needs. For example, individuals may need support to develop budgeting skills, increase literacy, address drug and alcohol issues, have opportunities to meet friends, play sport or do exercise, achieve spiritual solace, find employment, successfully parent their children and manage their dental and physical health.

Rather than trying to provide everything, MH-CLSR providers are expected to work collaboratively to facilitate partnerships with a broad range of specialist service providers and promote good service and care coordination. This means that MH-CLSR providers take the lead role in facilitating local partnership activities on behalf of the client with LHD community mental health services, private clinical partners, housing providers and other service providers as needed.

Care coordination arrangements should be organised at a local level where the MH-CLSR provider works with the client to establish and maintain relationships with these partners including coordinating local meetings with them. MH-CLSR providers are the main contact point for the person receiving supports and work closely with them, their family members, guardians/carers and other key service providers to coordinate the required support services.

Note that care coordination may be distinct from case management. The distinction could be that an agency-specific case manager works with and guides the service needs of the client specific to that agency, where care coordination involves the MH-CLSR provider working with a client towards taking primary responsibility for the management and arrangement of their supports, including liaising with all relevant services to ensure appropriate coordination. For example, the MH-CLSR provider may facilitate access and/or transport a client to a program being provided by another service provider that is funded separately from MH-CLSR and/or the NSW Ministry of Health, until the client is ready to undertake these activities themselves more independently.

3.3 Care coordination and clinical partners

Where a person receiving MH-CLSR supports chooses to receive their mental health care from a clinical partner such as a private psychiatrist, general practitioner or the LHD mental health services, the MH-CLSR provider is required to establish a working partnership with that provider. The MH-CLSR provider must ensure that the clinical partner is aware of their responsibility within the program and that appropriate collaboration and care coordination occurs. The clinical partner must be involved in the development of the client's Support Plan. If they commence treatment where there is a pre-existing Support Plan in place, the MH-CLSR provider should encourage the client to provide a copy to the clinical partner.

The MH-CLSR provider should also ensure access to the clinical partner to their after-hours service for emergencies of a mental health and non-mental health nature.

This includes information regarding the Mental Health Line (1800 011 511), Transcultural Mental Health Line (1800 648 911) and other ways to access 24-hour services is provided to the client in case clinical support such as a GP is not available after hours. A coordinated approach needs to be taken to make sure all parties are aware of each other's roles and responsibilities.

In some cases where relevant, the LHD or private clinical partner may maintain their case management role until the individual's mental health condition has sufficiently stabilised.

Arrangements should be negotiated locally, documented and regularly reviewed as required. These care coordination arrangements should be made with and agreed to by the individual receiving the supports and their family as relevant.

4. Hours of support

4.1 Flexibility and individualised care

Refugees and asylum seekers can experience a range of mental health conditions, and a range of levels of psychosocial disability, and therefore have diverse support needs. It is the person's assessed needs for support that will determine the number of hours offered to them.

Supports are provided on an individual basis and are responsive to changing needs over time. As a client's condition improves or declines, hours of support are adjusted in response. Support Plans are regularly reviewed to ensure they reflect a client's current requirements for support. Individual choice should be promoted and respected.

Initially, MH-CLSR supports can be used to work with a person to engage them in the program. Consent is required for people to take part in the program in an ongoing way, as per the selection criteria. In some cases, a carer or guardian, where authorised, can formally consent to the individual's participation in the program.

People receiving supports are responsible for active participation in the program using a recovery framework to establish their goals. This includes regularly meeting with their MH-CLSR provider to work towards goals identified in their Support Plan. It is important that sufficient time be spent building rapport and trust and supporting the person to engage with planning their supports. The family and carers also have a responsibility to work with the support agencies and the person receiving supports as agreed in the support plan. The needs of the client's whole family should also be reflected in the support plan consistent with a whole of family approach adopted in MH-CLSR.

A person's goals will range from working towards gaining open employment or further education to improving their ability to maintain their current employment and engage with service providers. People are not excluded from MH-CLSR if they are not able to set goals, but are encouraged to engage with the service, and over time develop meaningful goals which support their recovery and community participation.

4.2 People in unstable accommodation

MH-CLSR is intended for people who have stable accommodation. However, supports may be provided to people who are inappropriately housed (for example living in hospital or with family or friends on a short term basis) when they enter MH-CLSR. These people may require a larger number of hours of support initially until their accommodation situation is resolved. In a small number of cases, supports may be provided to people who are homeless but are frequently in the same location and are accessible to service providers.

Some people may be living in social housing or in a private property that they rent or own, but their housing is at risk due to the impact of their mental health and coexisting conditions. These people may require supports focused on assisting them to sustain their tenancies.

4.3 Number of clients and hours of support

The MH-CLSR program is expected to support at minimum 79 clients at any one time state-wide and incorporates a range of acuity and severity in their conditions. It is recognised that these numbers may fluctuate from day to day as people enter and exit the program and their conditions change.

Supports should be made available as needed by clients, including after hours, on weekends and public holidays. The total hours to be provided each week should be calculated as 7 days x the daily hours.

Hours of support should be increased and decreased as required according to the need of individual clients. When clients first enter MH-CLSR they may require more hours to be supported to stabilise their situation, develop a support plan and establish a set of activities that promote their recovery. Over time, it may be possible to reduce the number of hours required each day or week as the person's condition improves and they require less direct support. Similarly, if a client's condition deteriorates, hours of support should be increased so as to arrest any further decline in their mental health condition and prevent avoidable hospitalisations.

4.4 How to use the hours of support

4.4.1 Allocating of hours of support

Hours of support should be provided as needed, at any time of the day or night and any day of the week including public holidays. The needs of people receiving MH-CLSR supports will likely fluctuate and change over time and consequently the support provided to an individual requires constant review. At times this will result in a person receiving less hours of support than they require, or not needing as many hours of support as have been allocated to them.

To minimise these discrepancies, all people receiving MH-CLSR supports should be matched to the most appropriate level of support according to their needs. The MH-CLSR provider should regularly monitor the use and availability of hours of support allocated for their area. If there are unutilised hours, a plan should be developed for how best to allocate these hours. This may facilitate an increase in hours for individuals requiring extra support and/or support being offered to additional people with a mental health condition on a short-term basis (e.g. to an individual recently discharged from an inpatient unit who requires support as they transition back into the community).

All individuals receiving support under MH-CLSR need to be registered by the MH-CLSR provider. That is, they need to have a client number allocated to them so that their support and funded hours can be reconciled against the number of hours available in each LHD. Data for each individual, including the support and funded hours they receive will be submitted as per the monthly Minimum Data Set requirements.

4.4.2 Activities for the hours of support

The hours must be allocated to activities that are directly linked with the client's Support Plan, and therefore to the client's recovery goals. People may need assistance with daily living skills including self-care, personal hygiene, cleaning, shopping, financial management, cooking and transport; facilitating access to education, vocational training and employment; support attending clinical services and maintaining medication and other aspects of clinical care; support in building family and community connections; participation in social, leisure and recreational opportunities; and brokering of other services and arranging referrals.

Hours of support do not only cover direct client contact time but include other activities necessary to support the client such as the development of support plans, communication with carers and family members, liaison with other service providers, recording of monitoring data and participation in partnership meetings. In regional areas, they may also include travel time if necessary.

Hours of support can be used to supply other services and supports to clients such as occupational therapists, social workers, physiotherapists, dentists, nutritionists and other providers. These services can be paid for from the hours of support allocated to the relevant client. However, hours of support cannot be 'cashed in' and spent on commodities. These expenses, if required, should come from other sources.

Service or activity provided to a client by another organisation (including another MH-CLSR provider) cannot be regarded or recorded as hours of support delivered by the MH-CLSR provider.

5. Workforce

5.1 Workforce capabilities

MH-CLSR requires a unique and dedicated workforce with specialised skills and significant insight into the experience of refugees and asylum seekers. An ideal range of workforce capacities will include:

- Mental health expertise
- Lived refugee experience
- Community services/community engagement expertise, especially as it applies to refugees and asylum seekers
- Cultural capability relevant to local settlement patterns and within the mental health context
- A comprehensive understanding of trauma-informed recovery orientation as a practice approach
- Bicultural workers and bilingual capacity relevant to local communities of refugees and asylum seekers

5.1.1 Use of bilingual and bicultural staff

The employment of bilingual and bicultural workers is encouraged to facilitate cultural understanding, build trust with the client and their family and to assist negotiate cultural differences. This will include assisting with activities such as accompanying and supporting a client to engage in community activities, appointments, and assisting with living skills etc.

However, these workers should not be utilised as interpreters when coordinating and / or providing supports to clients that require a higher or technical use of language unless they are qualified and have expertise in the area requiring interpretation and are capable of accurate interpreting. Where possible a professionally accredited interpreter (preferably face to face) should be engaged for activities such as developing and reviewing the Support Plan, explaining consent, negotiating family conflict and providing therapeutic services, filling out official documents and forms and providing clinical care and technical expertise.

An accredited interpreter is someone who has obtained certification from the National Accreditation Authority for Translators and Interpreters (NAATI).

5.2 Multi-disciplinary workforce

MH-CLSR provider agencies should employ multidisciplinary teams that may include but are not limited to:

- Social workers
- Psychologists
- Community support workers

- Peer workers
- Mental Health Nurses
- Occupational Therapists.

5.3 Workforce training and development

MH-CLSR providers are expected to undertake thorough orientation and regular comprehensive training of staff. It is imperative that staff are trained in culturally capable, safe and responsive service delivery to refugees and asylum seekers. This includes training in the appropriate and proficient use of interpreters.

Training must also be undertaken by staff to ensure a shared understanding of risk assessment, risk management plans, critical incident reporting and their roles in providing trauma informed recovery oriented psychosocial rehabilitation and support services.

The NSW Ministry of Health will make available resources to assist build a robust service system that is skilled in culturally capable, safe and responsive mental health care for refugees and asylum seekers. We will continue to explore other training options and development opportunities available to MH-CLSR providers, related service partners and LHD mental health teams.

NSW Health is committed to improving the physical health outcomes of people in its psychosocial support programs and other public mental health services. This aligns with the goal of holistic, person-centred care in the *NSW Strategic Framework and Workforce Plan for Mental Health 2018–2022*. Further the NSW Health guideline *Physical Health care for people living with mental health issues* outlines the measures that NSW Health will take to improve physical health.

The Physical health care for people living with mental health issues guideline details the role of NSW Health services to meet the physical health needs of people living with mental health issues. A collection of resources and tools to support implementation of the Guideline are available Physical health care for people living with mental health issues (nsw.gov.au).

The Mental Health Branch, in consultation with stakeholders, has developed and made available medication support guidelines to support CMOs and LHDs involved in the NSW Community Living Programs, including MH-CLSR. The *Principles and Guidelines for Medication Support in the NSW Mental Health Community Living Programs* clarify the medication support roles and responsibilities of CMOs and LHDs, the principles for medication support, exclusions from medication support, and escalation procedures from CMOs to LHDs. They are consistent with the key principles of the programs including person centred, recovery orientated and trauma informed practice.

6. Eligibility, referral and assessment

6.1 Eligibility

6.1.1 Mental health assessment

The MH-CLSR program is designed to provide psychosocial supports to refugees and asylum seekers who are experiencing psychological distress, mental ill health and impaired functioning. Unlike in CLS and HASI programs, people are not required to have a formally diagnosed mental illness to receive support in MH-CLSR. However, the MH-CLSR program will give priority to the people who have the highest level of need and are most likely to deteriorate in their mental health and require hospitalisation without MH-CLSR supports.

A potential client should be assessed by a registered mental health practitioner such as a psychiatrist, psychologist, social worker, occupational therapist or mental health nurse to be eligible to receive MH-CLSR supports. The clinical assessment must also include an up to date risk assessment and should provide relevant clinical documentation to indicate that the person is at risk of deterioration in their mental health without psychosocial supports.

These practitioners may be located within a Local Health District, a private practice including GPs, or a community based non-government organisation including the organisation providing the MH-CLSR program.

When a client is referred by a LHD into the MH-CLSR program, the LHD will usually undertake the mental health and risk assessment. The waiting time for LHD assessments is dependent on the resource considerations of each LHD at any given time and may vary. For clients referred to the program by sources other than a LHD, the MH-CLSR provider should seek other suitable sources within the broader community to conduct mental health assessments if LHD resources are unavailable to conduct the assessment for these clients.

When an LHD has made the referral into MH-CLSR and has conducted a mental health assessment and risk assessment of the client being referred, the transfer should be done in accordance with shared care process including providing all relevant clinical information to avoid deterioration of the client's mental health.

Clinical assessments should contain suitable information to inform an eligibility decision. The clinical assessment criteria, assessment tools and processes for non-LHD referrals should be determined by the practitioner undertaking the clinical assessment in consultation with the MH-CLSR provider.

If the individual has had a recent clinical assessment, then a copy should be attached to the referral form. This assessment needs to include current risk issues which might need to be addressed prior to providing MH-CLSR support. The MH-CLSR provider should determine the time frame for what constitutes a 'recent' clinical assessment based on the individual circumstances of the client.

If the person has not been assessed prior to referral, an assessment should be arranged by the MH-CLSR provider in order for their eligibility to be considered. The person should be referred to the LHD mental health service (subject to available resources), or another qualified practitioner (listed above) to undertake a comprehensive clinical assessment. The MH-CLSR

provider needs to be satisfied that the assessment is thorough and covers all required factors before proceeding with the referral. In the event that the MH-CLSR provider is not satisfied that the assessment is thorough, the LHD should provide the assessment.

6.2 Eligibility criteria

Eligibility criteria have been developed to ensure that MH-CLSR is accessible to people from a refugee or asylum seeker background in the greatest need of mental health psychosocial supports.

To participate in MH-CLSR, people must meet the following general eligibility criteria:

- Be a refugee of any age within the first 10 years of arriving in Australia, or an asylum seeker. Exceptions to the 10-year time frame may be considered in exceptional circumstances and on special recommendation from a mental health professional.
- Experience psychological distress, mental ill health and impaired functioning arising from complex and chronic trauma, grief and loss, torture, human rights violations, war/conflict, detention, migration and/or settlement and establishment, including symptoms of post-traumatic stress disorder, self- harm and suicide ideation.
- Be regarded by a registered mental health professional (such as a psychiatrist, psychologist, social worker, occupational therapist or mental health nurse) as being at risk of deterioration in their mental health without psychosocial supports. Priority must be given to those at risk of acute mental health crises, hospital admissions or presentations to emergency departments.
- Have genuinely consented to participate in the program (and/or where relevant have their guardian's consent) and are willing to consent to information sharing between key partners.
- Are willing to engage with psychosocial support services that are culturally appropriate.
- Are locatable by services on a regular basis so that supports can be provided with continuity.

6.3 Referral process

6.3.1 Obtaining consent

Before someone can be referred for MH-CLSR supports, they, or their legal guardian/substitute decision maker must consent to the referral being made. They, or their guardian, must also consent to their information being shared by the MH-CLSR provider with relevant service partners for the purposes of assessing the referral and if the referral is successful, for providing ongoing MH-CLSR supports.

Consent must also be sought from the client at the time of intake for their data to be used in the evaluation of the MH-CLSR program. This data will not reveal the client's personal identity, and will include de-identified information such as gender, age, cultural and religious background, refugee status etc., their support needs, services received, and outcomes achieved from receiving MH-CLSR services. However, consent to the use of client data in the evaluation is optional. The client can still remain part of the MH-CLSR program and receive MH-CLSR supports even if they do not consent for their data to be used for the MH-CLSR program evaluation.

Consent can also be provided on behalf of the applicant by their legal guardian. Where it is not possible to obtain written consent, evidence can be included to demonstrate that verbal consent has been granted by the applicant or by their legal guardian.

Informed consent is a key concept in the provision of health and social care. For MH-CLSR, informed consent means that the individual has a full understanding of what is involved in participating in the program. This is not just about signing a form. This is a process of making sure the individual is able to weigh up the benefits and responsibilities involved in participating in the program.

An interpreter or bilingual worker who is capable should be engaged to explain consent to the potential applicant in their own language, in a manner that translates any complex information and concepts in an understandable way to enable the person to give informed consent to being referred to receive MH-CLSR supports. This information about consent should include having their data used for assessment and evaluation purposes. It is the referrer's responsibility, prior to referral, to provide the individual, and their guardian if applicable, with as much information about the program as possible. This includes making individuals and guardians aware that people receiving MH-CLSR supports are expected to be active partners in the program and their care.

Consent should be obtained in writing where possible, and a translation of any written material should be provided to the person being referred as necessary. If a person being referred to MH-CLSR is unable to provide written consent, genuine informed verbal consent is acceptable if it is clearly documented in the individual's file notes. If consent has been given for referral and participation by a legal guardian rather than the individual themselves, MH-CLSR workers are expected to involve the person receiving supports in all aspects of individual planning and support, to the maximum extent each individual is able to engage in the process.

Consent may need to be re-obtained several times throughout a client's time in MH-CLSR. Consent should be obtained whenever personal, or health information needs to be shared between MH-CLSR and other stakeholders including the LHD.

Processes for obtaining consent should be consistent with the NSW Health Privacy Manual for Health Information http://www.health.nsw.gov.au/policies/manuals/Pages/privacy-manual-for-health-information.aspx.

6.3.2 Making a referral

Any person or organisation can refer a refugee or asylum seeker to receive MH-CLSR supports, and referrals can be made at any time. People can also self-refer.

It is anticipated that referrals into MH-CLSR may come from a range of sources including:

- A range of refugee health services including the NSW Refugee Health Service, Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), Transcultural Mental Health Centre and Hospital based refugee health clinics
- Settlement services
- Asylum seeker services
- Local Health District mental health teams
- Local Health District multicultural health teams / staff

- General practitioners
- Community health centres
- Migrant resource centres
- Individuals and networks within refugee and asylum seeker communities including families, community leaders and religious leaders
- Other community managed psychosocial support services

Referrals should be made in writing directly to the MH-CLSR provider. Referrals must be triaged by the MH-CLSR provider so that priority is given to referrals of greatest need, especially those who are at risk of acute mental health crises, hospital admissions and presentations to emergency departments. [See Appendix 4 for a sample of a MH-CLSR referral form]

Referrals should contain the following information:

- Written consent for the referral and use of client data by the applicant or their legal guardian, or evidence to demonstrate that verbal consent has been granted by the applicant or by their legal guardian.
- Results of a recent mental health assessment including a risk assessment undertaken by a registered mental health practitioner recommending the applicant receive psychosocial supports.
- Any other information about the applicant's mental health if available (i.e., diagnostic/treatment, psychosocial functioning, risk).
- Name, age, country of birth, ethnicity, religion, original nationality and current visa status in Australia including information on refugee / asylum status.
- Languages spoken including the level of English proficiency,
- If an interpreter is needed and preferred language for interpreting.
- Level of education (to determine level of literacy).
- Contact details of the person being referred.
- Name and contact details of the person / organisation making the referral, and reason for the referral.
- Details about the applicant's current support providers (if any), and what support is being provided (including the care plan if there is one).
- The person’s goals and aspirations and what they hope to achieve by participating in MH-CLSR.
- Information about the applicant’s daily activities, family/friend networks, community connections and who currently supports them and how (if known).

- The person's housing situation including if the person is a social housing resident and their Client Reference Number (CRN), if they have one. (The CRN is a number allocated to a person when their application for housing assistance is registered by a Housing Pathways housing provider. All social housing applicants or tenants have a CRN.)

- Contact details of the individual's closest family member or friend.

6.3.3 Referrals to and from LHDs

Communication should occur between the LHD and MH-CLSR provider for all referrals between organisations. Referral information should include client background, symptomology, any suicidal ideation and any barriers to clinical care.

A shared care approach is to be taken for all referrals between the MH-CLSR provider and the LHD, and joint care is to be provided as needed. The preference for this shared care approach is via case conferencing, however where necessary can occur via phone or other meeting/communication processes.

6.3.4 Receiving a referral

To be considered for supports the referred person must consent to the referral, meet the eligibility criteria listed above, and the referral should be supported by a clinical mental health assessment including a risk assessment that has been conducted by a registered mental health practitioner.

Referral acknowledgement

The MH-CLSR provider should provide the referrer and the individual being referred with written acknowledgement of the referral. The acknowledgement should clearly identify the next steps in the application process, including the timeframe for assessing the referral and details of a contact person should the referrer or the individual being referred want to further discuss the application.

Preliminary assessment review

MH-CLSR providers receiving referrals should do a preliminary review to check the individual has consented to the referral, is eligible for MH-CLSR supports and that all necessary information has been provided. If the person has not had a recent clinical assessment, the MH-CLSR provider will recommend that one be arranged. This preliminary assessment review should also include an assessment of the severity of the client's needs so that some estimation can be made of the number of hours of support required per day or per week, especially upon entering MH-CLSR.

If it is clear from the preliminary review that the person is not eligible for MH-CLSR, the MH-CLSR provider must inform the referrer and the individual referred in writing, including the reasons why they are not eligible. The letter should include information about any other appropriate support and/or mental health treatment services that may be available to the individual. The written advice of ineligibility should also include information about appeal rights regarding the decision.

6.3.5 Register of Applications

A Register of Applications should be maintained by the MH-CLSR provider. If a preliminary review of the referral determines the individual is likely to be eligible for MH-CLSR, the referral is placed on the Register of Applications. When hours of support become available, relevant applications from the Register of Applications undergo a more comprehensive assessment.

Note that being on the Register of Applications does not guarantee that the individual will be accepted into the program. When hours of support become available, a comprehensive assessment is conducted, and then a place in the program is offered to an individual based on relative need and suitability.

It is suggested that MH-CLSR providers review the Register of Applications periodically to update contact details and review continued need and eligibility.

Where there are no individuals on the Register of Applications and hours of support become available, MH-CLSR providers should actively liaise with stakeholder agencies in the sector to identify potential suitable individuals for referral to the program. The MH-CLSR provider should then compile a short-list of referred applications in a recommended order of priority based on relative need and suitability for the available supports. If there are MH-CLSR vacancies which cannot be filled, MH-CLSR providers should inform the Ministry of Health.

6.3.6 Referral to other services

If the hours of support are not available in MH-CLSR, the MH-CLSR provider should review if there are other services that may suit the individual either in an on-going or short-term capacity. The MH-CLSR provider should inform the individual, the referrer and where appropriate the individual's guardian or family members of these services and if required refer them to alternative services.

6.3.7 Referrals from Local Health Districts

Referrals from Local Health Districts should be prioritised to ensure that people who are already in contact with community mental health teams and/or those in mental health inpatient units are given priority into the program. The intention is to link refugees and asylum seekers with community based psychosocial supports to prevent their hospitalisation or to assist in their transition and recovery if they are leaving inpatient care. Local Health District referrals may also come from multicultural health teams and emergency departments.

For these clients, the MH-CLSR provider should consult with the Local Health District and design psychosocial supports that complement their mental health care and treatment. Services should be aimed to reduce times in inpatient mental health units and reduce the risk of readmission to hospital.

It is recognised however, that Local Health District referrals may constitute a relatively small proportion of the overall program client group. A larger group of people from a refugee and asylum seeker background who are experiencing psychological distress, mental ill health and impaired functioning may be referred through a range of community services and organisations listed in section 6.2 above.

6.3.8 Determining vacancy including priority

People with high levels of need and the most complex conditions are to be prioritised for entry into MH-CLSR. These include referrals from Local Heath Districts. These clients will require the most hours of support. Vacancies in MH-CLSR become available when hours of support become available. As clients exit MH-CLSR, it is likely that smaller numbers of hours will become available than are required by clients with the highest need who are on the Register of Applications. In these circumstances the hours available must be allocated to clients with the highest need, even if the number of hours is sub-optimal. As more hours become available, they should be added to the hours already allocated.

Clients requiring a high number of hours of support should not be left waiting on the Register of Applications while clients requiring a lower number of hours enter MH-CLSR. Other services

should also be utilised until a sufficient number of hours become available for clients with high levels of need.

6.4 Assessing applications

When hours of support become available in MH-CLSR, a more comprehensive assessment of the individuals on the Register of Applications takes place.

Depending on the available hours of support, the MH-CLSR provider will review the Register of Applications and generate a short-list of priority applications. The MH-CLSR provider should then arrange interviews with these individuals to confirm that they still require MH-CLSR supports and to generate a more detailed and current picture of their needs. Furthermore, MH-CLSR providers should ensure that the individual is informed of their responsibility to be an active partner in the program and provide appropriate consent to share information.

It should be made clear to the individual and family and/or carers at the time of interview that the process of short listing applications does not guarantee that the person will be offered entry to MH-CLSR as they will be assessed relative to other individuals on the waiting list.

6.4.1 Selection process

Determining the order of priority

The MH-CLSR provider will create the short-list of applications and determine order of priority based on the following:

- Eligibility for MH-CLSR supports and the number of hours available
- Individual/s with the highest need and best fit for the available hours. This means:
    - prioritise people referred by LHDs who are exiting mental health inpatient units or emergency departments
    - prioritise people who are at greatest risk of mental health deterioration if they do not access psychosocial supports.
    - when all other factors are equal, prioritise the applicant who has been waiting the longest.

Interview with the preferred applicant

Once a preferred applicant has been selected by the MH-CLSR provider, they should interview this individual. The interview should be arranged by the MH-CLSR provider in a mutually agreed location. Where relevant, and with the individual's consent, other people may attend the interview – for example, their advocate, a qualified interpreter, and a current service provider or support worker. If the individual chooses, their family and/or carers may also attend the interview.

The purpose of this interview is to confirm details, explain the MH-CLSR program, make sure the individual is still willing to participate and understands they are required to be an active partner.

If the individual has decided that they no longer want to participate in MH-CLSR, or the MH-CLSR provider determines that the person is not suitable, the MH-CLSR provider should then move to the next person on their short-list to arrange an interview.

Record of the assessment decision

The MH-CLSR provider should record in writing the outcomes of their decision, including reasons for selecting the successful individual, reasons for not selecting unsuccessful individuals, a recommendation about whether unsuccessful individuals should remain on the Register of Applications, and other services which may be available to support unsuccessful individuals.

Notify applicants of outcomes

Once the MH-CLSR provider has reached a decision, they should notify the successful applicant, and the person who referred them and/or referral agency, in writing. This should include the next steps for receiving MH-CLSR supports, and the timeframe involved.

The MH-CLSR provider will also need to notify other applicants who were contacted about the availability of hours of support and interviewed as part of the assessment process, if they were not successful at this time.

Applicants who are eligible but unsuccessful in being allocated a place should also be notified by the MH-CLSR provider of the outcome in writing, including information about appeal rights.

The MH-CLSR provider should provide applicants with information regarding the likelihood of a placement becoming available in a short, medium or long time frame. The information should include the average waiting time that applicants remain on the Register, acknowledging that this varies over time.

The referring agent should inform applicants about any other relevant services and arrange a referral if requested.

7. Receiving Supports

7.1 Entering MH-CLSR

When an individual has been identified by the MH-CLSR provider as suitable for MH-CLSR support, the following steps are taken before the supports commence:

1. **Written consent is obtained from the applicant**

The applicant's written consent to participate in the MH-CLSR program and receive supports should be secured. Consent must also be sought from the client at the time of intake for their data to be used in the MH-CLSR program evaluation. This data will not reveal the client's personal identity, and will include de-identified information such as gender, age, cultural and religious background, refugee status etc., their support needs, services received, and outcomes achieved from receiving MH-CLSR services. Consent to use of client data for evaluation purposes is optional, and MH-CLSR services must be provided even if the client does not consent to this.

Consent can also be provided on behalf of the applicant by their legal guardian. Where it is not possible to obtain written consent, evidence can be included to demonstrate that verbal consent has been granted by the applicant or by their legal guardian.

2. **A Clinical Mental Health Assessment and Risk Assessment is undertaken**

The applicant must complete a clinical mental health assessment by a registered mental health practitioner or attach the results of a recent mental health assessment including an up to date risk assessment undertaken by a registered mental health practitioner recommending the applicant receive psychosocial supports. Relevant clinical documentation to indicate that the person is at risk of deterioration in their mental health without psychosocial supports must be provided.

3. **A Support Plan is developed with the person**

A Support Plan, including a risk management plan, is based on a person's goals. It contains details of the services to be provided by the MH-CLSR provider and where relevant will also outline any services to be provided by LHD mental health services. The Support Plan will also include agreed responsibilities for participation by the person receiving MH-CLSR support, and where appropriate, their family and/or carers. Under normal circumstances the Support Plan would be the first formal agreement established between the person receiving MH-CLSR supports and a local MH-CLSR provider.

4. **LHD Mental Health Care Plan is updated**

This will be applicable for clients who are transitioning out of mental health inpatient care at LHDs and entering MH-CLSR to receive community based psychosocial supports. The Mental Health Care Plan contains details of the services to be provided by the LHD mental health service. The Mental Health Care Plan and the Support Plan together form a collaborative care and support plan covering all aspects of the person's care.

7.2 Discharge from LHD mental health services

Individuals who enter the program from hospital or another institutional environment will need planned transition time to adjust to moving from the institution to the community. There must

be a clearly documented plan, for the individual to re-access LHD mental health services if the need arises. The LHD mental health service must also complete a risk assessment at this time. No discharge should occur until all parties have agreed to the plan.

Adequate time must be made for the MH-CLSR provider to engage with the person and for the person to begin the planned community support activities which will continue after discharge. This will require active involvement from all MH-CLSR partners (MH-CLSR provider, LHD staff, people receiving MH-CLSR supports, carers and family members where appropriate, and other services where relevant such as housing providers and settlement services). It is expected that the MH-CLSR provider would actively participate in transfer of care and discharge planning processes.

7.3 Developing a Support Plan

Each client who has been assessed to receive MH-CLSR supports is to have a Support Plan developed within the first four weeks of commencing the program. This timeframe may be extended based on individual consumer circumstances.

A Support Plan is developed collaboratively between the person receiving MH-CLSR supports and the MH-CLSR provider, their family and/or carers, and any other agencies providing support as relevant. This will include the clinical partner providing mental health care (e.g., LHD mental health teams, private psychologist, psychiatrist, social worker, occupational therapist or mental health nurse), settlement services, housing or community support. It clearly identifies the goals of the client and what each of the providers will do, how services will be delivered and the roles and responsibilities of each of the partners in the care and treatment of the individual. It also contains key contacts for the person receiving MH-CLSR support.

The Support Plan is a shared document negotiated between all the parties and signed by the providers of the client's care and support as well as the person receiving MH-CLSR supports, and where relevant their family and/or carers or legal guardian. As a shared document, it enables all partners to define their roles and responsibilities in relation to each other as well as to the person receiving MH-CLSR support. This collaborative document brings the partnership existing at the service level to the client level. It should be based on principles of recovery and centred on the individual's own goals. It is therefore very important that all MH-CLSR partners are involved in development of this document.

Each Support Plan should define specific commitments to the person receiving MH-CLSR supports such as:

- The nature or range of services to be provided which are directly related to individual identified goals
- Plan of action to address identified risks
- The average number of hours, or range of hours to be provided by the MH-CLSR provider
- Lists of contact people and contact details relevant to the individual's housing, settlement needs, and clinical care and support.

Support Plans should reflect and consider the person's cultural and religious background and resulting needs. When developing a Support Plan MH-CLSR providers must consider the order of priority of support needs of the individual. An individual's visa may have restrictions including no access to social housing, Medicare and Centrelink benefits and /or work / employment restrictions. This is likely to be the case for asylum seekers living in the

community. If the individual is lacking stable and suitable accommodation or has insufficient income to support their basic needs, then assistance to address these issues must be the first priority within the Support Plan. Factors that need to be considered include:

- Sensitivity to the individuals' religious, cultural or community beliefs, practices and contexts, and appropriate responses to these in service delivery.
- Need for accredited interpreters and bilingual workers
- Involvement of the whole family in delivery of services
- The individual and their family and / or carer's understanding of mental illness and perceived causes of mental illness
- The individual and their family / and or carer's knowledge about health services.
- Making written information available appropriate to individuals' needs in relevant community languages
- Ensuring basic income is secured for living needs
- Securing affordable and stable housing and providing assistance to maintain a tenancy
- Risk management to prevent and manage relapse, symptoms of illness and risk of harm to self or others
- Supporting and improving the individual's physical health through regular health checks, chronic disease management and physical activity
- Management of medication and transitioning out of inappropriate medication
- Establishing or maintaining education, training or employment opportunities for the individual
- Supporting access to services such as disability, employment services, TAFE, Adult Migrant Education Services, supported employment or other services and facilities significant to the individual
- Building links with family, carers, friends and the community
- Suitable location for accessing preferred social and recreational activities

All other relevant documents should be attached to the Support Plan and be translated to the client's relevant language or explained to the client using a qualified accredited interpreter. Relevant documents should include:

- signed consent forms
- results of the client's clinical metal health assessment and risk assessment
- risk management plan or actions for any identified risks
- Mental Health Care Plan if the individual is transitioning out of mental health inpatient care (including consideration of relapse prevention)

- individual and family/carer or guardian contact details.

7.4 Identifying goals

Recovery is the corner stone of the MH-CLSR program. Recovery is a way of living a satisfying, hopeful, and contributing life even alongside the effects of mental ill health including trauma, psychological distress and impaired functioning, the side effects of medication and adjusting to a new culture and negotiating cultural differences. The MH-CLSR provider works with the person receiving MH-CLSR supports to identify personal, meaningful goals, based on the individual's strengths, hopes and desires. Goals should work towards social inclusion and support the individual's recovery journey.

Ability to self-identify goals will vary and will depend on the health and wellbeing of each person receiving MH-CLSR support. The individual's cultural and religious background and expectations, levels of education and literacy will also influence their ability to self-identify goals. A qualified health care interpreter should assist with this process, as well as including family members, guardians / carers as needed. For some individuals, the goals for recovery will be simply to sustain their tenancy, to avoid hospitalisation, to stay well rather than to see great improvements in their health, or to manage each day as it presents. For others, goals will be more complex and may include working towards attaining English language proficiency and / or gaining employment or educational qualifications. Whatever the goals, it is important that they are developed together with the person receiving MH-CLSR supports and, where possible, their family and/or carers.

Mental health conditions and recovery are dynamic. A person's goals will evolve and change over time. It is important that goals are reviewed at regular intervals and where required, new goals are developed to reflect what is most important to the person in their recovery journey.

7.5 Monitoring and reviewing Support Plans

Over time, individuals' needs are likely to change, depending on their recovery journey. Reviewing the individual's progress and making changes to the Support Plan ensures that the MH-CLSR supports are responsive to any changing needs.

In most instances, Support Plans should be reviewed at least every 12 weeks. The Support Plan should be reviewed by the MH-CLSR provider with the individual receiving supports. Also included should be any other relevant party who was involved in the development of the support plan including family members, guardians/ carers, relevant partner agencies or practitioners who are also providing support to the individual.

Where the needs of the person receiving MH-CLSR supports are considered either too high or too low for the number of hours they are receiving, the MH-CLSR provider, in consultation with the client and other mental health practitioners and support agencies should review the Support Plan to determine current support needs. In most cases, the new assessment will determine the best way for that person's needs to be met. Support will continue to be provided as their hours are increased or decreased.

Issues to consider when reviewing an individual's progress include:

Culturally and linguistically responsive support

- Are supports adjusted to meet the individual's cultural and religious needs?
- Are there any issues with access to and use of interpreters?
- Is written information provided to the individual translated and accessible?

Income

- Is the individual receiving an adequate income to meet their basic living needs?
- What support can be provided to ensure that income is sufficient and secure?

Housing

- Are the individual's current housing arrangements appropriate?
- Are there any tenancy management issues that require attention?
- Are there any current or emerging issues that may impact on housing stability?

Visa status

- Has the individual progressed in their visa application or obtained visa certainty for themselves and their family including obtaining a temporary protection or permanent protection visa; family reunion being approved or obtained Australian Citizenship?

Psychosocial support

- Does the support align with the individual's identified goals?
- What activities/outcomes have occurred against each of the goals?
- Are the individual's support arrangements appropriate?
- Is the frequency and nature of the support meeting their needs?

Treatment and clinical care

- Is the individual's current mental health treatment and care appropriate?
- Is there a plan to phase out of any inappropriate medication as identified and agreed with health practitioners?
- Are more supports needed to comply with medication requirements as identified by their health practitioners?
- Are physical health needs being considered?

Whole of Family support

- Are family members actively engaged?
- Are there any issues engaging family members?
- Is support being provided as needed to the family members of the individual?

Other care and support issues

- Are there any issues with family, carers or other support services that need to be addressed?
- Do other services need to be contacted or actions taken to improve outcomes?

Participation in community activities

- Does the Support Plan include engagement with the Individual's cultural and religious community?
- Does the Support Plan work towards inclusion in mainstream community activities?

Actions arising

- What are the actions arising from the review of the Support Plan?
- Who is responsible for the action and by when?
- How will the changes in the Support Plan be communicated to key stakeholders?

Monitoring and data

- Has the necessary data been collected and recorded?
- What, if any, other monitoring information or issues about the individual's progress need to be documented and/or communicated to partner stakeholders and the Ministry of Health?

After reviewing the Support Plan, the MH-CLSR provider is responsible for ensuring that the revised/new Support Plan is documented and signed by the person receiving the supports and any other service providers present. All parties to the agreement are given copies of the document.

7.6 Changes in circumstances

Recovery is neither linear nor time-limited. It is about people achieving their own defined optimal state of wellbeing and working towards a satisfying, personally meaningful and hopeful life. It is expected that throughout an individual's recovery journey their circumstances may change, as will their treatment, rehabilitation and support needs. It is common for people receiving MH-CLSR supports to experience periods of stability and relapse whilst remaining in the program.

When an individual's circumstances change and changes to service provision are proposed e.g., having hours of support increased or decreased, a thorough assessment of the person's current needs and goals should be undertaken. The proposed change to service delivery should be discussed, firstly with the person receiving MH-CLSR supports and their family and/or carers and then discussed between all MH-CLSR partners, either at a meeting, by teleconference or through email discussion. All partners should be involved in the decision making process, be comfortable with the changes and have a well-documented collaborative outcome. If no agreement can be reached, then the status quo should be enacted until the dispute can be resolved. In circumstances where all partners cannot be involved, they must be informed of any changes made.

At any time where there is a change in circumstances, a risk assessment must be undertaken (which includes an assessment of risk to income support, tenancy and mental health). Where a risk is identified a risk management plan or actions must be developed.

7.6.1 Hospitalisation

The MH-CLSR supports are designed to prevent individual's mental health deteriorating to a degree that they require hospital care. However, if a person receiving MH-CLSR supports is hospitalised due to an acute mental health episode or condition, the MH-CLSR provider has responsibility to:

- Provide information to the hospital staff about their knowledge of any causes or circumstances related to the admission
- Maintain contact with the individual throughout the hospitalisation as appropriate[5]
- Liaise with relevant services to coordinate the suspension of direct service delivery to the individual in their home
- Ensure the housing provider is informed that the individual will be temporarily not occupying the property (as appropriate)
- As appropriate, notify the individual's family, friends, advocates and community contacts about the individual's changed situation
- If required, renegotiate the individual's LHD Mental Health Care Plan or contribute to the development of one to facilitate their discharge.

Where a person is receiving community clinical mental health support from a qualified practitioner, the MH-CLSR provider and that practitioner need to work cooperatively with the LHD mental health service. The MH-CLSR provider must take a lead role to ensure this occurs.

As part of early discharge planning, the MH-CLSR provider and hospital staff should closely liaise to ensure the arrangements are fully in place to support the individual to resume their life in the community. This should include ensuring adequate transition time for the MH-CLSR provider to re-engage with the individual prior to discharge.

7.7 Transitioning out of MH-CLSR

People might exit MH-CLSR because they no longer need the support and have achieved their goals, the support is insufficient to meet their needs, or the individual is no longer willing to engage in the program.

Reasons for the individual exiting MH-CLSR should be recorded on the monitoring form. This is the form that the MH-CLSR provider sends to InforMH and is part of the Minimum Data Set.

7.7.1 People who no longer need MH-CLSR supports

If the person has reached a point in their recovery where they no longer need MH-CLSR supports to sustain their health and wellbeing, if agreed, a transition out of the program will commence.

As part of the transition plan, the MH-CLSR provider should assist the individual to establish or maintain services with other local service providers that can meet their lower support needs and help to sustain their health and wellbeing.

7.7.2 People whose needs cannot be met by MH-CLSR

If the individual’s support needs cannot be met by MH-CLSR, the MH-CLSR provider and the mental health care provider, other support services and with the individual and their family

[5] MH-CLSR providers should consult with hospital staff and use their professional judgement in determining the duration of contact and type of support to provide a client when in hospital care.

and/or carers, will explore options to move to a program with a higher level of support. Individuals should not leave MH-CLR until appropriate alternative support is in place.

7.7.3 People who refuse service

People receiving MH-CLSR supports have the right to refuse services, whether clinical services or psychosocial support services.

When this occurs, MH-CLSR providers should use assertive engagement and outreach approaches to attempt to engage with the individual and encourage them to continue to receive care, treatment and support. However, the MH-CLSR program has no authority to enforce services upon an individual without their full and ongoing consent. Individual consent is a cornerstone of successful program delivery. As participation in MH- CLSR is voluntary, it cannot be a requirement of a Community Treatment Order to participate in the MH-CLSR program.

7.7.4 Satisfaction survey

When an individual exits MH-CLSR, the MH-CLSR provider should discuss with the individual their experiences in the program and their reasons for leaving. It is suggested that the MH-CLSR provider design a short survey that the client can complete (with assistance from a bilingual worker or interpreter if needed). The survey should also contain a section for family members of the client to complete if they also received supports. If the client is a child or young person, the survey should have a section for the parent or guardian to complete. The survey should include whether:

- supports were culturally sensitive and relevant, and linguistically accessible
- supports assisted to meet their goals and if not, what can be improved
- the level of communication between the individual and the MH-CLSR provider and other support agencies were satisfactory
- there are any other suggestions for improving the program.

Where relevant, and where the individual agrees, future contact details should also be recorded. Information relating to the exit of a person receiving MH-CLSR support, including data gathered through the exit interview process should be incorporated into the MH-CLSR providers' reporting process.

8. Reportable incidents

8.1 Circumstances requiring immediate notification

The MH-CLSR provider must notify the NSW Ministry of Health within **five (5) Business Days** of a restrictive practice being authorised (under the MH-CLSR provider's internal processes) for a person receiving MH-CLSR services.

For this purpose a 'restrictive practice' is any intervention which restricts the rights or freedom of movement of a person receiving the service who displays challenging behaviours, where the primary purpose of that intervention is to protect that person or others from harm, and the person subject to the practice has not consented.

The MH-CLSR provider must also notify the NSW Ministry of Health within **twenty four (24) hours** if there are incidents that:

a) Relates to the program or services, and required an emergency response; or was a death, serious attempted suicide, serious injury or any criminal activity;

b) Has or may attract significant public interest and attention;

c) Causes or has the potential to cause harm to a client, CMO staff or the community.

8.2 Notification process

The MH-CLSR provider must report the use of a restrictive practice or incident as listed above using the Reportable Incidents Form in **Appendix 5**.

The form requires that the following information is submitted to the NSW Ministry of Health:

- A brief summary of what has occurred (include: date of incident, location, LHD involvement, MH-CLSR provider's last engagement with the client, how long the client has been serviced by the MH-CLSR provider, any supports the client was receiving from the LHD).
- The actions have been taken (including how the incident has been reported through the MH-CLSR provider's governance processes and to the LHD).
- If the MH-CLSR provider has discussed being involved in a collaborative investigation with the LHD.
- How the incident is being managed, and what is the current status of the situation. For this part the MH-CLSR provider should also include any people contacted for assistance or support including the client's clinical partner, family and / or friends, relevant community / religious support groups or representatives.
- Describe the support that has been provided to the family and to staff.
- Outline what future actions are planned.

The MH-CLSR Provider must also provide the following information to the Ministry of Health once the incident has concluded and any internal review conducted:

- Has an internal incident review taken place?
- Has additional support been provided to the client, their family or staff?
- How will the MH-CLSR provider be involved in any Local Health District analysis?
- Are any quality improvement and operational changes planned as a result of the incident?

9. Resolving disputes and complaints

9.1 Problems faced by people receiving MH-CLSR support

It is the role of the MH-CLSR provider to do their utmost to either resolve any problem identified by the person receiving MH-CLSR support or assist the individual to be appropriately referred to an agency that may be able to assist.

Some people receiving MH-CLSR supports will not feel willing or able to take action on a problem without assistance from an advocate or companion. In many cases, this will be the MH-CLSR provider. It is important that individual advocates do not have a conflict of interest when performing this role.

If the problem relates to the individual's housing, tenancy or payment of rent, then in the first instance, the individual should contact their housing provider with the support of the MH-CLSR provider. This support is especially important particularly if their tenancy issue is related to their refugee or asylum seeker status or mental health condition. Supporting the client to resolve difficulties in a culturally responsive way includes utilising interpreters and community advocates as needed.

Should the problem relate to the individual's mental health care and treatment, and specifically any mental health crisis or emergency, then in the first instance, the individual should contact their MH-CLSR provider or the afterhours LHD mental health crisis service.

For all other problems, the individual should contact their MH-CLSR provider. Relevant contact details and procedures relating to problems in any of the above areas should be listed in the client's Support Plan, as well as in the agreements between the individual and each support provider.

9.2 Disputes between people receiving MH-CLSR supports and MH-CLSR service partners

All MH-CLSR providers should have in place complaints and disputes handling policies and procedures. Information about this should be made available to all people receiving MH-CLSR supports in an appropriate language and format, as an attachment to their Support Plan.

In general, all complaints about a MH-CLSR service partner (organisations providing related support including, mental health treatment, settlement services, housing, employment or community activities) should be initially directed to that organisation by the person receiving MH-CLSR supports or by their advocate. If the matter is particularly sensitive or complex, the individual might seek the support of a trusted person to advocate on their behalf to help resolve the complaint.

If use of the local complaints procedure does not reach a satisfactory outcome, the individual may:

- for complaints relating to a service partner providing services not related to mental health, bring the matter to the attention of the MH-CLSR provider.

- for complaints relating to a local mental health service provider and /or the MH-CLSR provider, bring the matter to the attention of the LHD and the Ministry of Health. If required, they may also seek alternate dispute resolution through a conflict resolution or mediation service and seek a resolution through the Health Care Complaints Commission process.

Certain matters, concerning administrative decision making, may be able to be taken as a complaint to the NSW Ombudsman and/or Commonwealth Ombudsman.

9.3 Appeals

People receiving MH-CLSR supports and their carers or family members are considered equal partners in the MH-CLSR program at a local level. As such they should be actively involved in all decisions made about a person's care.

In some circumstances, individuals and/or their family and carers may disagree with a decision to withdraw or change MH-CLSR supports or not to offer services at all. In these circumstances the individual must be provided with an opportunity to appeal against decisions made by the MH-CLSR provider.

It is recommended that each partner agency participating in providing MH-CLSR support to the individual has an agreed approach for individuals and their family and/or carers who wish to lodge an appeal. These processes should be made clear to the individual and their family and/or carers on referral to the service and should form part of the attachments of the Support Plan.

Should the applicant believe that the appeals process warrants a formal complaint, then there may be external avenues available to them, for example through the Health Care Complaints Commission or the NSW Ombudsman.

Contacts for seeking further information and/or progressing appeals:

1. The NSW Tenants Website at www.tenants.org.au. This site provides tenancy information as well as contacts and location of the Tenants Advice and Advocacy Services across NSW. Or contact 1800 251 101 (free call number).

2. The Health Care Complaints Commission (HCCC) Website is at www.hccc.nsw.gov.au. To contact the HCCC Toll Free Number 1800 043 159 or (02) 9219 7444.

3. The NSW Ombudsman Website is at www.ombo.nsw.gov.au. Telephone 9286 1000.

9.4 Disputes between MH-CLSR service partners

All local MH-CLSR service partners should have in place complaints and disputes handling policies and procedures.

In circumstances where a difference of opinion or dispute arises between the MH-CLSR provider, the LHD, or another service that provides support to the individual, it is recommended that the workers involved in the dispute initially attempt to resolve the issue and reach agreement on a solution in the first instance.

If the workers are unable to reach an agreement, then the matter should be promptly referred to the appropriate line manager of the organisations (e.g., Team Leader, Area Manager). A meeting with documented minutes should then be organised between the disputing parties, with all stakeholders in attendance.

If the dispute is unable to be resolved by this process, the matter should be referred to a higher management structure of the organisations. Again, all correspondence, discussions (whether face to face or via telephone), email etc. should be documented.

If there is still no resolution, the issue should be escalated to the Ministry of Health for mediation.

When a complaint has been received by either party in relation to a joint program or employee of the other party, the managers of each organisation should be informed as soon as practicable. All complaints will be addressed as per each organisation's complaints management process. The Ministry of Health will provide support where appropriate.

10. Reporting and Performance Monitoring

A desired effect of the MH-CLSR program is to build evidence-based knowledge regarding best practice in psychosocial support models for refugees and asylum seekers living with mental health issues. MH-CLSR uses coordinated program evaluation and ongoing monitoring through data collection. This is to expand the knowledge base relating to effective recovery, to learn more about what works and to improve understanding of the role of psychosocial support in promoting mental health and wellbeing for this vulnerable group of people.

For this purpose, the Ministry of Health is committed to systematic monitoring of all its programs to ensure robust accountability to internal and external stakeholders, and to provide a basis for continuous program improvements. Overall program management and oversight is the responsibility of the NSW Ministry of Health's Mental Health Branch (MHB). This means that MH-CLSR service providers will provide all performance and financial reports to the NSW Ministry of Health. Performance monitoring and contract management is undertaken by the Mental Health Branch, with LHDs encouraged to advise the Ministry of local issues as needed.

Specific service data will be collected by MH-CLSR service providers and reported at regular intervals to InforMH - the NSW Ministry of Health data and information specialist unit. InforMH will analyse and map this data and develop summary reports that will identify service delivery trends and issues. Data reports will enable performance monitoring, program planning and service improvement. The Mental Health Branch will distribute these reports to all LHDs and MH-CLSR providers for their information.

The MH-CLSR monitoring system consists of the following components:

1. The Minimum Data Set (MDS) submitted monthly to InforMH
2. A quarterly Service Data Report to the Mental Health Branch
3. An Annual Program Report to the Mental Health Branch
4. A half year Statement of Revenue and Expenditure to the Mental Health Branch
5. An Annual Statement of Revenue and Expenditure to the Mental Health Branch

The NSW Ministry of Health provides templates for these reports. See **Appendix 2** – Table of Reporting Requirements for more detail.

There may also be some additional data that is specifically required regularly or occasionally, such as when a program evaluation is taking place. This data will be required to be sent to the NSW Ministry of Health or to the evaluator.

MH-CLSR providers are also required to provide additional information and report as reasonably requested from time to time.

10.1 Minimum Data Set

A minimum data set (MDS) is an agreed data set of client characteristics, demographic information, service activity, outcome measures and other information. It will provide a standardised basis for collecting data relating to client characteristics and supports provided.

This data set will also record outcome measure scores from the *Living In the Community Questionnaire* (LCQ). This tool has been developed as part of a national project to standardise outcome measurement in the community mental health sector. The MDS specification instructions note that the LCQ is to be completed at program entry and exit and twice a year in April and October and the scores for all 26 questions should be recorded in the MDS. The specification for the data set file is provided by InforMH.

MH-CLSR providers will be required to collect the monitoring data set for every client monthly and submit it to InforMH for analysis and reporting. The data should be provided in comma separated values (CSV) format by the 7th day of the following month. Data from individual agencies should be compiled into a single file for each agency prior to submission. The files should be sent to the nominated email address as noted in **Appendix 2**. InforMH will generate a simple monthly report on the 15th day of the following month showing the results of the MDS monitoring by agency in each LHD. This will display 22 indicators showing client characteristics, support activities and other information including achievements against benchmarks.

Other requests can be made for InforMH to produce reports less frequently such as annually but focusing more specifically on key program issues. This will particularly apply to those questions for which there are multiple choice answers including housing status, referral source, reasons for exiting and types of support activity.

10.2 Service data

Service data reflects the flow of clients into MH-CLSR and monitors the management of the register of applicants, as well as other service level data as necessary. The NSW Ministry of Health will provide a service data template to record data on new applications, rejections of new applications, number of applicants on the waitlist, data on the use of interpreters and whole of family support data. MH-CLSR providers will be required to complete the service data form and submit it to the Ministry of Health quarterly.

The NSW Ministry of Health will monitor the data to determine the extent to which MH-CLSR is meeting demand for supports.

10.3 Annual program report

Every twelve months, MH-CLSR providers will be required to submit an annual report. This report will be qualitative in nature and will allow for narrative accounts of service development activities, governance arrangements, quality improvement activities, client case studies and other descriptions of service delivery. It will also provide the opportunity to feed back to the Ministry of Health any plans for the following year and any other issues not accommodated elsewhere in the monitoring framework. The Ministry of Health will provide a template for this report.

10.4 Financial reports (half yearly and annually)

MH-CLSR providers will submit a half year Statement of Revenue and Expenditure, and an annual Statement of Revenue and Expenditure to the NSW Ministry of Health. These financial reports include a statement of revenue and expenditure, standard management board certification, certification by the service providers, officer bearers and an auditor's report.

The half year statement acquits the revenue and expenditure for the MH-CLSR Program according to specified categories in the preceding six months. The annual statement is independently audited and acquits the revenue and expenditure for the MH-CLSR Program according to its specified categories in the preceding financial year (1 July to 30 June). The six-monthly report does not need to be independently audited.

10.5 Reporting roles and responsibilities

Reporting is reliant on stakeholders submitting and preparing data within designated timeframes. Each stage of the reporting process is important for the delivery of the report. The roles and responsibilities of each stakeholder are outlined below.

MH-CLSR service provider

- accurate and regular data collection
- submission of data and information by the dates outlined in the funding agreement
- submission of accurate and complete data

InforMH

- produce monthly MDS reports
- track missing data and follow up with MH-CLSR providers
- produce data for quarterly reports
- review any data concerns
- action other data requests

Ministry of Health

- log and save reports in TRIM
- follow up missing reports
- identify underspends and facilitate underspend proposals process
- review/monitor budget items and activity reporting
- identify any issues and escalate where necessary
- liaise with stakeholders about the submission of data
- analyse and collate data each month
- consolidate monthly MDS reports
- field enquires about the MDS.

10.6 Evaluation of the MH-CLSR program

The NSW Government is committed to increasing transparency of expenditure on programs and providing a better understanding of their outcomes. There are clear expectations on all NSW Government agencies to evaluate their programs, both new and existing.

The evaluation of the MH-CLSR program is a significant opportunity to build the evidence base about the effectiveness of community based psychosocial support on refugees and asylum seekers, a particularly vulnerable cohort. The evaluation will examine program implementation and the effectiveness of the program in achieving outputs and selected impacts outlined in the MH-CLSR Program Logic at **Appendix 3**.

The end goal is to have an evaluation that clearly shows what a program such as MH-CLSR means for the health, wellbeing and resettlement of refugees, and for savings costs to government by providing community-based care and support that reduces hospitalisations and presentations to emergency departments. The evaluation intends to:

- examine program implementation and governance,
- assess the effectiveness of the program in achieving the outputs and selected impacts,
- describe the costs associated with program implementation, and based on the program reach, provide an estimate of the expected benefits of the program to government in monetary terms,
- outline a plan for future performance monitoring, impact and outcome evaluation, and
- collect relevant baseline data for any future evaluations.

At the start of implementing the MH-CLSR program, the evaluation will provide data on activities and outputs to enable adjustment to the program as needed. It will also inform future investment decisions and future MH-CLSR program evaluation.

The NSW Ministry of Health commissioned a rigorous independent two-year process evaluation of the MH-CLSR program that commenced in 2019 and was completed in 2021. The results of this process evaluation have now been published. A follow-up impact evaluation will commence in late 2023 – 2026.

10.6.1 MH-CLSR provider participation in the evaluation

MH-CLSR providers are expected to work in partnership with the NSW Ministry of Health and the independent evaluator to enable a robust and thorough evaluation.

MH-CLSR providers are expected to seek consent at the time of intake from individuals receiving MH-CLSR supports for their data to be used for program evaluation purposes. Additional data outside of what is part of the reporting requirements outlined above and in **Appendix 2** may also be requested for program evaluation purposes.

11. Program Governance

11.1 Partnership with Local Health District

Local Health District mental health teams play an important role in the implementation and governance of the MH-CLSR program at the local level. This will take the form of a local partnership meeting anticipated to occur for one to two hours each month and to be convened by the funded MH-CLSR provider. This meeting is designed to promote collaboration with District mental health teams and to provide district oversight of local implementation. Other functions of this meeting may be to review program data, discuss referral pathways and local service delivery, manage risk, share information and build capacity, plan locally and mitigate any identified service issues.

Service Level Agreements (SLA) will be established between the LHD and the MH-CLSR service provider (a sample template is provided at **Appendix 1**), where roles, responsibilities and collaborative activities will be clearly outlined to fulfil service delivery targets. The requirement for MH-CLSR providers to form these agreements with LHDs are included in funding agreements.

District mental health teams may also facilitate the involvement of multicultural health teams as required in local governance meetings and/or consult with them as necessary regarding SLAs and other operational matters. See section 2.4 above for further detail.

11.2 Refugee Mental Health Expert Advisory Panel

A panel consisting of key government and non-government stakeholders and experts in the field of mental health and refugee settlement is established to:

- provide advice to the Mental Health Branch on key issues and opportunities to improve the implementation and operation of the MH-CLSR program; and
- identify opportunities and key issues for the mental health of refugees and people seeking asylum in NSW and provide advice on strategies to address these.

The ongoing frequency of meetings will be subject to annual review.

11.3 State-wide Governance

A state-wide governance meeting is established by the NSW Ministry of Health for the MH-CLSR program to bring together LHDs, MH-CLSR providers and other relevant state-wide stakeholders. Representation from both District mental health and multicultural health staff is expected. This meeting will provide a forum for program data to be discussed, experiences of implementation shared, systemic problems raised and resolved, and for state-wide oversight of the program to be maintained.

Appendix 1: MH-CLSR Sample Service Level Agreement

1. Introduction

Mental Health Community Living Supports for Refugees (MH-CLSR) is a unique program that aims to provide trauma-informed, recovery-oriented, culturally safe and responsive psychosocial supports to refugees and asylum seekers who are experiencing psychological distress, mental ill health and impaired functioning. The program is different from CLS and HASI in that people are not required to have a diagnosed mental illness to receive support. However, the greatest priority for MH-CLSR supports are people with the highest level of need. This includes referrals from mental health inpatient units and hospitals.

MH-CLSR providers offer flexible delivery of care and care coordination through hours of support, rather than set packages, to ensure the care is tailored to a person's changing level of need. MH-CLSR supports are provided within the context of a trauma informed recovery-oriented practice approach, and in a way that empowers individuals to live in the community with optimum self-determination and independence.

MH-CLSR is a partnership between the MH-CLSR provider delivering and coordinating psychosocial supports, the clinical partner providing mental health clinical care (this may be the LHD or registered private practitioners such as psychologists, psychiatrists, occupational therapists, mental health nurses etc.), and other service providers such as settlement services, housing, education, employment and community support services. The MH-CLSR provider coordinates and delivers the provision of care and support services to refugees and asylum seekers with mental health conditions and high-level health and social support needs.

The MH-CLSR program:

- provides community living supports to assist a minimum of 79 people at any given time from a refugee or asylum seeker background to recover and transition to a quality life in the community;
- delivers a service model that is individualised and flexible with a whole of family approach adopted as needed;
- is based on the CLS model in that it will target individuals who have existing stable housing rather than impose pressure on the constrained availability of social housing; and
- enables the provision of supports to commence when people are still in inpatient care, to better support a successful transition to the community (noting that entry to the program is not restricted to people receiving inpatient care).

The objectives of MH-CLSR are to:

- improve the mental health, wellbeing and functioning of program clients
- increase social participation and community integration of program clients

- prevent acute mental health crises and avoidable admissions to hospital or presentations to emergency departments

In MH-CLSR, XXX MH-CLSR provider is contracted to deliver <insert hours of support> hours of support to approximately <insert number of clients> clients in XXX LHD. MH-CLSR funding is administered by the Ministry of Health with funding provided directly to XXX MH-CLSR.

2. Purpose of the Service Level Agreement

The aim of this Service Level Agreement (SLA) is to ensure an understanding of, and agreement to the roles and responsibilities of the parties, XXX LHD and XXX MH-CLSR provider in relation to the MH-CLSR program. A partnership approach is required between the LHD and MH-CLSR service providers. The requirement for MH-CLSR providers to form these agreements with LHDs are included in their funding agreements.

While it is acknowledged that each party has their own core responsibilities and areas of expertise, a partnership approach adds value and improves service delivery. The SLA also encourages parties to work with other stakeholders to ensure the best outcomes are achieved for the individual and the program. This will enable the provision of complementary care and support services for clients that are either referred from the LHD to the MH-CLSR service provider (to assist clients transition back into the community), and for any MH-CLSR clients who may escalate to emergency departments or mental health inpatient units.

3. Role of the LHD

The overall performance monitoring and governance function for the MH-CLSR program is the responsibility of the NSW Ministry of Health. Local Health Districts are not required to oversee the service provision and performance of individual MH-CLSR providers. Rather the LHD function is to partner the MH-CLSR provider in providing care and support to clients and to assist address local implementation issues for the program. This will include discussing referral processes, identifying and mitigating risk to clients, reviewing program data, and sharing information in order to build capacity of the program and to enable local planning.

Provide and accept referrals

The MH-CLSR program will prioritise referrals from Local Health Districts to ensure that people who are already in contact with community mental health teams and/or those in mental health inpatient units are given priority into the program. The intention is to link refugees and asylum seekers with community based psychosocial supports to prevent their hospitalisation or to assist in their recovery and transition back into the community if they are leaving inpatient care. Local Health District referrals may also come from multicultural health teams and emergency departments.

For these clients, the MH-CLSR provider should consult with the Local Health District and design psychosocial supports that complement their mental health care and treatment. Services should be aimed to reduce times in inpatient mental health units and reduce the risk of readmission to hospital.

It is recognised however, that Local Health District referrals may constitute a relatively small proportion of the overall program client group. A larger group of people from a refugee and asylum seeker background who are experiencing psychological distress, mental ill health and impaired functioning may be referred through a range of community services and organisations listed above.

The LHD should also liaise closely with MH-CLSR providers regarding any MH-CLSR clients whose condition has escalated to emergency departments or mental health inpatient units, to provide the optimal care to enable the client's recovery.

Conduct mental health assessments

A potential MH-CLSR client should be assessed by a registered mental health practitioner such as a psychiatrist, psychologist, social worker, occupational therapist or mental health nurse to be eligible to receive MH-CLSR supports. The clinical assessment must also include a risk assessment and should indicate that the person is at risk of deterioration in their mental health without psychosocial supports. These practitioners may be located within a Local Health District, a private practice including GPs, or a community based non-government organisation including the organisation providing the MH-CLSR program.

If the client is referred into MH-CLSR from an LHD, then the LHD should conduct the mental health clinical assessment including the risk assessment.

If the clinical mental health assessment has been undertaken by a clinician who is not from an LHD, and if the MH-CLSR provider is not satisfied that the assessment is thorough and covers all required factors before proceeding with the referral, the LHD should provide the assessment.

Provide clinical care as a MH-CLSR clinical partner

If a MH-CLSR client enters mental health inpatient care, or if an LHD client is transitioning out of inpatient care into the community and is referred to receive psychosocial supports from MH-CLSR, the LHD will play a key role in the client's clinical care.

If the LHD refers a client to MH-CLSR for psychosocial supports, then the LHD may also be the client's ongoing clinical partner and provide mental health clinical care as needed as they receive MH-CLSR supports. The LHD will actively contribute to the development of the client's Support Plan in the MH-CLSR program.

Individuals who enter the program from hospital or another institutional environment will need planned transition time to adjust to moving from the institution to the community. There must be a clearly documented plan, for the individual to re-access LHD mental health services if the need arises. The LHD mental health service must also complete a risk assessment at this time. No discharge should occur until all parties have agreed to the plan.

Adequate time must be made for the MH-CLSR provider to engage with the person and for the person to begin the planned community support activities which will continue after discharge. This will require active involvement from all MH-CLSR partners (MH-CLSR provider, LHD staff, people receiving MH-CLSR supports, carers and family members where appropriate, and other services where relevant such as housing providers and settlement services). It is expected that the MH-CLSR provider would actively participate in transfer of care and discharge planning processes.

The Mental Health Care Plan contains details of the services to be provided by the LHD mental health service. This must be updated by the LHD in consultation with the MH-CLSR provider once a client is referred for MH-CLSR supports. The Mental Health Care Plan and the Support Plan together form a collaborative care and support plan covering all aspects of the person's care.

District community mental health services may provide the following care and treatment to people receiving MH-CLSR services:

- assessment of the functional impact of an individual's mental health condition or psychosocial disability and how it affects them in reaching their goals
- assessment of daily living skills
- monitoring medication management, support with medication adherence and addressing side effects that may affect daily living
- arranging regular medical reviews
- supporting the person to understand their signs of relapse
- development of a shared plan for early support and assistance
- supporting the person to better manage life stressors which could lead to relapse
- developing collaborative Support Plans so that the direction and purpose of care coordination are made explicit
- using a cognitive behavioural approach to identify lifestyle changes and methods of intervention that will positively impact upon the person's mental and physical health
- linking individuals with other treatment services including drug and alcohol or specialist psycho-therapeutic and healthcare providers
- engagement of the carers and/or family in the care planning and recovery process.

Meet with the MH-CLSR provider once a month

The LHD mental health staff will attend a local partnership meeting for one to two hours each month convened by the funded MH-CLSR provider. District multicultural staff should also be invited to attend these meetings. District mental health teams may also consult multicultural health teams as required regarding SLAs and other operational matters. The meeting is designed to promote collaboration with district staff and to provide district oversight of local implementation.

At this meeting a standing agenda item must be to discuss and prioritise referrals from the LHD to the MH-CLSR program, and MH-CLSR clients who have entered or are referred for mental health inpatient care.

The meeting will also be used to discuss referral pathways, mitigate any identified service issues or risks to clients, review program data, and share information in order to build capacity and enable local planning.

In summary, the role of XXX LHD in relation to this SLA includes:

- Provide referrals into MH-CLSR program from mental health inpatient units and hospitals and accept referrals from the program
- Conduct clinical mental health assessments including risk assessments for all referrals from the LHD into MH-CLSR, and if requested by the MH-CLSR provider for clients referred by other sources (subject to available resources).
- Provide clinical care as a MH-CLSR clinical partner for all clients referred into MH-CLSR by the LHD and for other clients as requested by the MH-CLSR provider

- Provide appropriate support for the needs of families and carers

- Participate in local partnership meetings with the XXXX MH-CLSR provider and work collaboratively with them and other stakeholders to ensure the best outcomes are achieved for the individual and the program

- Establish communication channels with the MH-CLSR provider across varying levels of the organisations, and with other stakeholders

- Provide XXX MH-CLSR provider with up to date LHD risk assessments

- Ensure that the rights of individuals in MH-CLSR are respected, including in relation to privacy and confidentiality

- Allocate a LHD contact staff member for each individual referred by the LHD from hospital or inpatient unit into MH-CLSR to ensure that there is a primary worker involved in the individual's support planning

- Engage the MH-CLSR provider to participate in the pre-discharge process for individuals who are referred into MH-CLSR from mental health inpatient units or hospitals

- Establish, review and monitor the LHD Mental Health Care Plan every thirteen weeks in collaboration with the individual receiving support, their family/carer, the MH-CLSR Key Worker, and other relevant service providers

- Be involved in the development and review of the MH-CLSR Support Plan for the individual

- Provide LHD clinical mental health services to each individual who has been referred by the LHD to MH-CLSR or where the LHD is the primary clinical partner.

- Clinical mental health services to be provided in line with the needs identified in Mental Health Care Plan/Reviews, and in consideration of the goals in the MH-CLSR Support Plan. Services may include a range of assessments, treatment, rehabilitation and coordination with acute and/or in-patient services

- Promptly inform XXX MH-CLSR provider of any mental health concerns which may impact on the health and wellbeing of the individual receiving support, and liaise with them in the event of an emergency situation related to a mental health condition

- Inform the individual, family/carers and XXX MH-CLSR provider on appropriate pathways for accessing mental health services

- Provide access to extended hours mental health services for individuals in situations of psychiatric emergency

- Provide extended hours access to XXX MH-CLSR providers for consultation and advice around mental health crisis in relation to shared clients, via the State Wide Mental Health Access Line

- Promptly inform XXX MH-CLSR provider in relation to any critical incidents

- Inform XXX MH-CLSR provider if there is a change in the level of clinical care/support provided to the individual or a change of LHD contact staff

- Participate in exit planning from MH-CLSR when appropriate, with the individual, XXX MH-CLSR provider, families and carers.

4. Role of the MH-CLSR provider

Coordinate local partnership meetings with the LHD

The MH-CLSR provider will convene and provide secretariat for the local partnership meetings with the LHD. The meetings will occur once a month for one to two hours duration. As noted above, the meeting will discuss and prioritise referrals from the LHD to the MH-CLSR program, and MH-CLSR clients who have entered or are referred for mental health inpatient care.

The meeting will also be used to discuss referral pathways, mitigate any identified service issues or risks to clients, review program data, and share information in order to build capacity and enable local planning.

Participate in transfer of care and discharge planning processes

The MH-CLSR provider must actively work in partnership with LHDs when clients enter the program from hospital or mental health inpatient care, and also when MH-CLSR clients enter mental health inpatient units or emergency departments.

Where clients are exiting inpatient care, the MH-CLSR provider is expected to contribute to developing a discharge plan for this client with the LHD which will include for the individual to re-access LHD mental health services if the need arises.

The MH-CLSR provider will negotiate with the LHD for a transitioning client to engage in planned community support activities prior to their discharge, which will continue after discharge. These supports will require effective liaison with LHD inpatient teams, LHD community mental health staff and families and/or carers. This will commence some days prior to the person's discharge and continue after discharge until the individual no longer requires psychosocial supports. The transitional supports provided by the MH-CLSR provider will include:

- communication and liaison with the client, their carer and/or family and inpatient LHD staff prior to discharge from hospital;

- comprehensive assessment prior to discharge of the person's anticipated needs upon exit;

- practical support to ensure there is secure, clean and functional accommodation for the person leaving hospital;

- support to maintain compliance with clinical advice including medication and provide medication support;

- coordination to ensure the person transitions smoothly into MH-CLSR or other supports as required; and

- liaison with LHD community mental health teams to support appropriate clinical follow up in the community.

The MH-CLSR provider will engage the LHD to contribute to the development of the client's Support Plan and contribute to updating the LHD Mental Health Support Plan.

In summary, the role of XXX MH-CLSR provider in relation to this SLA includes:

- Coordinate local partnership meetings with the XXXX LHD and work collaboratively with XXX LHD and other stakeholders to ensure the best outcomes are achieved for the individual and the program
- Establish communication channels with XXX LHD across varying levels of the organisations, and with other stakeholders
- Ensure that the rights of individuals in MH-CLSR are respected, including in relation to privacy and confidentiality
- Allocate a Key Worker for each individual in MH-CLSR to ensure that there is a primary worker involved in the individual's support planning
- Participate in the pre-discharge process with XXX LHD for individuals who are referred into MH-CLSR from mental health inpatient units or hospitals
- Participate with the individual and XXX LHD staff in Mental Health Care Plan reviews and updates as appropriate
- Establish, monitor and review the Support Plan with the individual, LHD, relevant family and/or carer and other identified stakeholders
- Provide support to each individual in line with the needs identified in their LHD Mental Health Care Plan/Review and the MH-CLSR Support Plan
- Promptly inform XXX LHD of any mental health concerns which may impact on the health and wellbeing of the individual receiving support and liaise with the LHD community mental health service and/or Mental Health Acute Assessment Team in the event of an emergency situation related to a mental health condition
- Promptly Inform XXX LHD in relation to any critical incidents
- Inform XXX LHD if there is a change in the level of support provided to the individual or a change of Key Worker
- Participate in exit planning from MH-CLSR when appropriate, with the individual, XXX LHD, families and carers.

5. Ongoing coordination and communication

Staff members from both XXX MH-CLSR provider and XXX LHD mental health services are expected to interact directly on a regular basis where there are shared clients. Communication between frontline staff from all parties is expected to comply with the protocols indicated in the NSW Health Code of Conduct and the policy directive on Prevention and Management of Workplace Bullying in NSW Health

The LHD and MH-CLSR provider agree to notify each other immediately of any changes to a client's LHD staff contact, the MH-CLSR Key Worker, or about a variation to their support. For clients who are referred into the MH-CLSR program from hospital or mental health inpatient units, ongoing coordination involves both the LHD and MH-CLSR provider in partnership:

- monitoring the implementation of the Support Plan and Mental Health Care Plan and progress of activities and meeting of goals;
- reviewing the mental health outcomes of individuals receiving MH-CLSR support;
- working with the individual to review their Support Plan and identified personal goals for recovery; and
- ongoing communication between parties.

Where an individual is receiving clinical services outside the LHD mental health service (e.g., via a registered private psychologist, occupational therapist, mental health nurse or social worker), the MH-CLSR provider will ensure the LHD is kept informed of their progress through the Support Plan, with appropriate consent from the client.

The MH-CLSR provider agrees to notify the LHD if they are concerned about any deterioration in the mental health of an individual in MH-CLSR.

6. MH-CLSR Support Plan and the LHD Mental Health Care Plan

The Support Plan is developed by XXX MH-CLSR provider with the individual entering the program to facilitate individual directed care. The Support Plan is recovery focused and include the individual's needs and goals. The Mental Health Care Plan contains details of the services to be provided by the LHD mental health service. For individuals who transition from mental health inpatient units or hospital into the MH-CLSR program, both plans form a collaborative care and support plan covering all aspects of the person's care.

Where an individual is referred to MH-CLSR from a mental health inpatient unit or hospital, or where the LHD is the nominated clinical partner for the client, the MH-CLSR provider will develop the Support Plan in partnership with the LHD. The LHD must also update the individual's Mental Health Care Plan in consultation with the MH-CLSR provider prior to discharge and transition to MH-CLSR supports.

For all other clients in the MH-CLSR program the MH-CLSR provider will develop the Support Plan with the private clinical partner, the individual and their family and other service providers as relevant.

Goals in the Support Plan will direct the support provided and the interactions between XXX MH-CLSR provider, the LHD and the individual. The Support Plan will include details of:

- the comprehensive assessment conducted of the individual;
- their needs and goals;
- services to be/being provided by XXX MH-CLSR provider and by XXX LHD;
- services to be/being provided by other organisations including housing providers

- the role of family and carers;
- the monitoring process;
- the quarterly review process; and
- exit planning.

The individual receiving MH-CLSR supports, their family and/or carer and all parties to this SLA will receive a copy of the Support Plan. If the individual consents, a copy may also be provided to other organisations providing services to the individual.

The Support Plan will be reviewed every 13 weeks, in line with the LHD Mental Health Care Plan reviews, or sooner if the individual's support needs change. Any changes to the Support Plan must be discussed between the MH-CLSR client, families and/carers, the XXX LHD and the XXX MH-CLSR provider.

It is recommended that this review be conducted at the individual's home to empower the individual and also to allow XXX LHD and XXX MH-CLSR provider to be able to properly assess the individual's environment. However, the individual does have the right to a choice of venue for the review.

7. Rights of individuals in MH-CLSR

Parties to this SLA agree to:

- Provide culturally safe and responsive care and support to refugees and asylum seekers receiving services, including engaging qualified and accredited interpreters
- Respect the right of the individual to independence and self-determination
- Respect the individual's right to privacy and confidentiality, and only share individual information in accordance with the law (see section 10)
- Always treat the individual with respect and dignity
- Engage the whole family and deliver supports to other family members as needed
- Communicate effectively with the other party and stakeholders in the interests of seamless service delivery for the individual
- Act in accordance with the National Mental Health Statement of Rights and Responsibilities
- Make information available to individuals in relation to both internal and external complaints and appeals mechanisms.

8. Privacy and confidentiality

All parties are to adhere to their organisation's policies and guidelines on privacy and confidentiality in relation to individuals receiving support and their families and carers. All staff must sign confidentiality agreements.

It will be an entry requirement that individuals receiving MH-CLSR supports allow disclosure of relevant information between the parties. A signed consent form allowing such disclosure should be kept on the files of the both the XXX LHD and XXX MH-CLSR provider.

For the optimal operation of this partnership, information in relation to people with mental health issues receiving support will be shared between XXX MH-CLSR provider and the XXX LHD.

In order to ensure that confidentiality is not breached, the following protocols are to be followed when information is shared:

- Where possible, staff at both XXX MH-CLSR provider and XXX LHD should seek approval from the individual receiving support or their guardian/family/carer before specific information is passed from one party to the other.

- Where this is not possible, it is important for the party sharing the information to check that the general consent form provided by the individual when they entered MH-CLSR covers the sharing of the specific information.

Where a party is concerned that an individual's social housing tenancy is at risk due to deteriorating mental health or hospitalisation, consideration should be given to disclosing this information to the relevant social housing organisation. Disclosure of this information should be in accordance with the law. Guidance can be found in the Housing and Mental Health Agreement: Guidelines for Exchanging Client Information.

9. Critical Incidents

All parties agree that they will supply relevant information to each other in regard to any critical incidents that occur in relation to MH-CLSR participants. A critical incident includes (but is not limited to):

- assaults or threats against staff, individuals in the program or other people by individuals in the program;

- unexplained/suspicious deaths or significant bad outcomes;

- suicides or serious attempted suicides by an individual in the program;

- sudden deaths of an individual in the program;

- instances of domestic and family violence;

- unusual or serious exposure to blood/body fluids;

- criminal activity in or related to the individual's premises;

- fire, bomb or other threatening activities in facilities relevant to the program;

- serious threats affecting the program's operation;

- incidents involving assaults, and/or abuse, exploitation and neglect, including of the individual, children or other 'at risk' persons;

- serious safety incidents or accidents;
- any other incidents likely to cause public concern.

Verbal notification should occur immediately on one party becoming aware of any critical incident. If the parties agree that a written report is required, a report should be prepared by the parties within two working days of the incident occurring and being brought to the attention of the parties.

10. Settlement of disputes and complaints

In circumstances where a difference of opinion or dispute arises between the workers at XXX MH-CLSR provider and XXX LHD with regard to the care, treatment and support of an individual, it is recommended that the workers involved in the dispute initially attempt to resolve the issue and reach agreement on a solution in the first instance.

If the workers are unable to reach an agreement, then the matter should be promptly referred to the Team Leader*,* XXX MH-CLSR provider and the Team Manager for the local LHD community mental health team. A meeting with documented minutes should then be organised between the disputing parties, with all stakeholders in attendance.

If the dispute is unable to be resolved by this process, the matter should be referred to the General Manager Operations, XXX MH-CLSR provider and the Mental Health Partnerships Coordinator (or equivalent), XXX LHD.

If there is still no resolution, the issue should be escalated to the NSW Ministry of Health for resolution.

When a complaint has been received by either party in relation to an employee of the other party, the Team Leader, XXX MH-CLSR provider and the Team Manager for the local community mental health team within XXX LHD should be informed as soon as practicable. All complaints will be addressed as per each organisation's complaints management process.

11. Review of the Service Level Agreement

This agreement should be reviewed every twelve months. The review is to ensure that the SLA enables the XXX MH-CLSR provider and XXX LHD and any other stakeholders to work effectively together to meet the needs of the individuals receiving MH-CLSR support.

The MH-CLSR provider is required to participate in annual review and/or other evaluation processes as part of their funding agreement with the NSW Ministry of Health. XXX LHD will also be given the opportunity to have input to any formal review or evaluation of the program.

12. Acronyms

MH-CLSR	Mental Health Community Living Supports for Refugees
MH-CLSR provider	Community managed organisation providing psychosocial supports
LHD	Local Health District
SLA	Service Level Agreement

XXX (name of MH-CLSR provider)	A non-government, community managed organisation that provides psychosocial support services and care coordination to refugees and asylum seekers with mental health conditions and psychosocial disability
XXX LHD	XXX Local Health District

13. Definitions

Local Health District contact staff: The specialist mental health staff designated by XXX LHD to provide clinical care and treatment to an individual accessing psychosocial supports from Mental Health Community Living Supports for Refugees (MH-CLSR).

Key Worker: The worker designated by XXX MH-CLSR provider to provide non-clinical supports to the individual accessing MH-CLSR.

Support Plan: This plan is developed by XXX MH-CLSR provider with the individual receiving support to facilitate individual directed care. The plan outlines the supports the individual will receive and how they will be delivered to assist with the individual's recovery. XXX LHD will also provide input into the Support Plan.

Mental Health Care Plan/Review: This plan is developed and reviewed every 13 weeks between the individual receiving support and the Key Worker, with input from LHD contact staff, other clinical partner providing mental health care, family, carers and other service providers as deemed appropriate. It provides a framework for summarising the goals and clinical care and treatment concerns for the individual and identifies the person and/or service responsible for ensuring that those goals and concerns are addressed.

Parties: The parties to this agreement are XXX LHD and XXX MH-CLSR provider.

14. Document owners

Document Owners	Director, Mental Health XXX Local Health District
	CEO – XXX MH-CLSR provider
	Other stakeholders as needed
SLA Manager	Partnerships Coordinator, XXX Local Health District

15. Document control

Version	Date	Revision	Author and title

16. Approval

(By signing below, the parties agree to all terms and conditions outlined in this Service Level Agreement)

Signatures	Title	Date
	Director, Mental Health XXX Local Health District	
	CEO – XXX MH-CLSR provider	

Appendix 2: Table of Reporting Requirements

Report name	Content of report / report requirements	Due date	Reporting Period	Form and method of delivery of report	Details of recipient (name, title and email address)
Monthly reports					
Minimum Data Set (MDS) file	An agreed data set of client characteristics, demographic information, Service activity, outcome measures and other information.	The 7th day of each month.	Preceding month	Form: As specified in the Minimum Data Set Specification Delivery: email	INFORMH-IHASI@health.nsw.gov.au
Service Data Report	An agreed set of metrics which describe the status of the MH-CLSR program including the flow of clients into and out of the program, and the assessment of the eligibility of referrals.	Quarterly	Quarterly	Form: As specified in the *MH-CLSR Monitoring and Reporting Framework* Delivery: email	Senior Policy Officer – MH-CLSR portfolio MOH-MHCLSR@health.nsw.gov.au

Report name	Content of report / report requirements	Due date	Reporting Period	Form and method of delivery of report	Details of recipient (name, title and email address)
Six monthly report					
Half yearly Statement of Revenue and Expenditure	A statement which acquits the revenue and expenditure for the MH-CLSR Program according to specified categories.	31 January	Preceding six months (1 July to 31 December)	Form: As specified in the *MH-CLSR Monitoring and Reporting Framework* or an equivalent substitute report produced by accounting software, provided that it includes all requisite information. Delivery: email	Senior Policy Officer – MH-CLSR portfolio MOH-MHCLSR@health.nsw.gov.au
Annual reports					
Annual Program Report	An annual report of achievements against measures described in the MH-CLSR Service Performance Measures.	30 September	Preceding financial year	Form: As per the Annual Program Reporting template in the *MH-CLSR Monitoring and Reporting Framework*	Senior Policy Officer – MH-CLSR portfolio MOH-MHCLSR@health.nsw.gov.au
Annual Statement of Revenue and Expenditure	An independently audited statement which acquits the revenue and expenditure for the MH-CLSR Program according to its specified categories.	30 September	Preceding financial year (1 July to 31 June)	Form: As specified in the *HASI Plus Monitoring and Reporting Framework* or an equivalent substitute report produced by accounting software, provided that it includes all requisite information. Delivery: email	Senior Policy Officer, MH-CLSR portfolio MOH-MHCLSR@health.nsw.gov.au

Appendix 3: MH-CLSR Program Logic

Inputs	NSW Health Activities	MH-CLSR Service Providers Activities	Outputs	Short term impacts	Medium term impacts	Long term impacts	Outcomes
Funding Staff (LHDs, MH teams, MoH, Multicultural teams) Stakeholders (CMOs, NGOs, clinical partners, working groups) NSW Health infrastructure (IT, systems, policies and processes) Training providers	LHDs develop service level agreements with MH-CLSR services Establish formal partnerships between LHD multicultural health and mental health staff implementing program MoH develop and implement program guidelines to assist coordination	Employ multidisciplinary staff with cultural competence and mental health expertise Provide training to staff on cultural competency, interpreter use and mental health Develop service level agreements with LHDs Identify and establish partnerships with clinical partners Support consumers to identify and understand their psychosocial support needs and develop a care plan with their clinical partner, service providers and family Support consumers to access health services Develop and implement a model of care that supports flexible, whole of family psychosocial support Develop and monitor assessment	LHD and MH-CLSR services work in partnership Interpreters are accessed as needed, are appropriately engaged, and provide effective services. Care plans that address identified needs developed and implemented Consumers connected with clinical and community health and other service providers and supported to utilise these services MH-CLSR services and service providers are well coordinated with sound governance practices Culturally and linguistically responsive services provided by skilled and qualified workforce	Increased participation in relevant clinical and community based health services Services accessed more quickly Increased participation in family and community engagement activities Increased participation in educational, vocational	Improved compliance with medication and clinical care Care plan goals achieved Reduced acute mental health crises, avoidable admissions to hospitals, presentations to ED, mental health facilities Consumers are connected with family, carers, and	Improved daily living skills and greater independence and functioning Improved mental and physical health, wellbeing and continued recovery Increased personal, family and community participation	Sustained improvements in mental and physical health and wellbeing Reduced costs to Government

Inputs	NSW Health Activities	MH-CLSR Service Providers Activities	Outputs	Short term impacts	Medium term impacts	Long term impacts	Outcomes
	of services MoH subsidise and facilitate access to cultural competency training, interpreter use and mental health training LHDs prioritise referrals to MH-CLSR service providers	and referral systems Identify and establish formal partnerships with relevant service providers (these may include physical and mental health services/ practitioners; child/family therapists; immigration settlement services / community services; education providers, employment services and community and religious leaders) Work together with community and religious leaders to develop strategies to promote the program Develop and implement a plan to transition consumers both into and out of the program	Assessments conducted and referrals prioritised and made MH-CLSR program is promoted by religious /community leaders and settlement / community services Flexible, whole of family, psychosocial support services provided (which may include: trauma informed recovery oriented therapy /counselling, support with family functioning and daily living skills; community and social engagement activities and education and employment services /opportunities) Consumers appropriately transitioned in and out of the program	and employment programs	community Increased education Increased employment Improved responses to acute episodes	Increased economic participation	

Appendix 4: Sample MH-CLSR referral form

MH-CLSR RELEASE OF INFORMATION

APPLICANT'S AGEEMENT TO APPLY & RELEASE OF INFORMATION

The Privacy Act requires the applicant to sign this form giving their consent for the release of their information and details. The referrer and the applicant agree that no information has been withheld and that all information provided is accurate, correct and necessary for <<name of organisation(s)>> to provide a Duty of Care and meet obligations to staff.

I, _____, give my consent to <<name of organisation(s)>> to seek information from the following people concerning matters related to this application.

☐ Local Health District _____

☐ Medical Service / Professional _____

☐ Housing Provider _____

☐ Other _____

In addition, I give my consent to <name of organisation(s)> to release data about me for use in the evaluation of the MH-CLSR program. I understand that this data will not reveal my name, address or personal identity, and will include de-identified information such as gender, age, cultural and religious background, refugee status etc., my support needs, services received, and outcomes achieved from receiving MH-CLSR services. I understand that consent to this section is optional, and I can still remain part of the MH-CLSR program and receive MH-CLSR supports even if I do not consent for my data to be used for program evaluation purposes. [Note: cross this paragraph out if not providing consent]

I also give my consent to <<name of organisation(s)>> to keep a record of my referral. I understand that this information will be **coded to protect my identity** and will only be accessible to relevant services that I come into contact with.

I agree to allow <<name of organisation(s)>> staff to call me (or my designated contact person if I am not contactable) in order to update my information and to see if I am still interested in this support.

APPLICANT'S SIGNATURE: _____ Date _____

REFERRER'S SIGNATURE: _____ Date _____

Eligibility Criteria

To participate in MH-CLSR, an applicant must meet the following general eligibility criteria:

- Be a refugee of any age within the first 10 years of arriving in Australia, or an asylum seeker. Exceptions to the 10-year time frame may be considered in exceptional circumstances and on special recommendation from a mental health professional.
- Experience psychological distress, mental ill health and impaired functioning arising from complex and chronic trauma, grief and loss, torture, human rights violations, war/conflict, detention, migration and/or settlement and establishment, including symptoms of post-traumatic stress disorder, self- harm and suicide ideation.
- Be regarded by a registered mental health professional (such as a psychiatrist, psychologist, social worker, occupational therapist or mental health nurse) as being at risk of deterioration in their mental health without psychosocial supports. Priority must be given to those at risk of acute mental health crises, hospital admissions or presentations to emergency departments.
- Have genuinely consented to participate in the program (and/or where relevant have their guardian's consent) and are willing to consent to information sharing between key partners.
- Are willing to engage with psychosocial support services that are culturally appropriate.
- Are locatable by services on a regular basis so that supports can be provided with continuity.

Applicant Details

Last Name …….

First Names ……

Address ……

State ……. Post Code……

Telephone: ……. Mobile: ……

Date of Birth……./……/…… Male □ Female □

MRN Number..... CRN Number……

Date of arrival in Australia: …….

Visa Class: …….

Does the applicant identify as being:

□ Refugee

□ Asylum Seeker

□ Lesbian, Gay, Bisexual, Transgender and/or Intersex

□ Is an Interpreter required? □ **Yes** □ **No**

Language/s spoken.....

Health Information

Does the applicant have a diagnosed mental illness? □ Yes □ No □ Suspected

Primary diagnosis .....

If there is no diagnosed mental illness, does the applicant experience psychological distress, mental ill health and impaired functioning?

□ Yes □ No □ Suspected

Other conditions (e.g., drug and alcohol misuse, chronic health conditions)
.....

What are the applicant's primary goals?

……

……

…….....

What are the applicant's current unmet needs? Provide details.

……

……

……

Is there a current clinical mental health assessment available that has been conducted by a registered clinical practitioner (psychologist, psychiatrist, social worker, occupational therapist or mental health nurse)?

□ Yes (if yes, please attach) □ No

Is there a current risk assessment available?

□ Yes (if yes, please attach) □ No

Applicant's current circumstances

What are the applicant's current living arrangements?

……

……

……

Why do they need MH-CLSR support? (e.g., housing, tenancy/domestic issues or reaching goals including education, meaningful employment, social networking and social and community integration, family relationships etc.)

……

……

……

What types of support issue/s has the referrer identified?

……

……

……

……

How does mental illness impact on the applicant's daily functioning?

.....

.....

.....

What are the applicant's aspirations for participating in the program?

.....

.....

.....

Services Involved

Service	**Name and contact details**
Mental Health Service provider	
Psychiatrist	
General Practitioner	
School (if person is a child or young person of school age)	
Community or Settlement Services worker	
Other	

Note: MH-CLSR referrals cannot be considered until a clinical mental health assessment including a risk assessment is conducted by a registered mental health practitioner with the client. The Assessment must indicate that the client's mental health will deteriorate without psychosocial supports.

Please ensure that an up-to-date clinical mental health assessment including a risk assessment is attached to your referral. If this is not available, the MH-CLSR provider will assist to have one conducted with your client's consent.

Source of referral

Name ……Telephone…….....

Agency..……...……...

Estimated number of hours of support required per day:.....

Date referral submitted.....

Assessment of the referral

This referral will be assessed alongside other referrals by the MH-CLSR provider based on the eligibility criteria, the number of hours available and the highest need and best fit for the available hours. Priority will be given to:

- people referred by Local Health Districts who are exiting mental health inpatient units or emergency departments
- people who are at greatest risk of mental health deterioration if they do not access psychosocial supports.

When all other factors have been considered, priority will be given to applicants who have been waiting the longest to access psychosocial supports.

The MH-CLSR provider will inform the applicant of the outcome.

Please forward all referrals to:

<<name of agency receiving applications and contact address >>

Appendix 5: MH-CLSR Reportable Incidents Form

Any alleged misconduct and serious incidents must be reported within 24 hours to the NSW Ministry of Health, in accordance with the requirements of the Funding Agreement.

Notifiable Incidents

The Ministry of Health must be notified immediately of any of the following:

a) when the CMO becomes aware of Alleged Misconduct or a Serious Incident in relation to the provision or performance of the Services
b) serious complaints received in relation to the provision or performance of the Services or Organisation generally (written or verbal)
c) the occurrence of any event which may cause adverse publicity in relation to the Services or relating to a user of the Services, including where the Organisation is contacted by the media for comment
d) another NSW Government body or agency terminates an arrangement with the Organisation under which it receives funding; or
e) any current, pending or threatened Reputational Proceedings.

A **Serious Incident** means an incident that:

a) is likely to impact on the Organisation's ability to perform the project, provide the services or otherwise fulfil its obligations under the Funding Agreement
b) may affect or has affected the organisations obligations or its performance of those obligations under the funding agreement
c) relates to the project or services and required an emergency response; or was a death, a serious attempted suicide, serious injury or any criminal activity
d) has or may attract significant public interest and attention
e) an event which causes or has the potential to cause harm to a client, CMO staff or the community.

Sections A-C of the **Reportable Incident form** must be submitted within **48 hours** of the incident.

A. Provider Information

Date of incident		**Date of report**	
Provider Name		**Local Health District (LHD)**	
Provider Location		**Is the LHD aware of the incident?**	
Other parties involved in the incident			

B. Client Information

Client SLK		**Client Date of Birth**	
Client Gender		**How long has the Client been part of the program?**	
Cultural Background		**Language Spoken**	
Is the client still managed by the LHD?		**What supports was the client receiving?**	

C. Incident Summary

Please provide a summary of the incident and include date of incident, location, LHD involvement, MH-CLSR provider's last engagement with the client, how long the

client has been serviced by the MH-CLSR provider and any supports the client was receiving from the LHD.

What actions have been taken (including how the incident has been reported through your governance processes and to the LHD)? Have you discussed being involved in a collaborative investigation with the LHD?

How is the incident being managed? What is the current status of the situation? Include any people contacted for assistance or support including the client's Clinical Partner, family and / or friends, relevant community / religious support groups or representatives.

Please describe the support that has been provided so far to the family and to staff.

What future actions are planned? What is the projected timeline for submission of section D?

D. Actions arising from the Incident

The information below should be provided to the NSW Ministry of Health once the incident has concluded and any internal review conducted. Please attach your organisations internal incident report.

Has an internal incident review taken place? (Yes / No)

What additional actions have been taken? Has additional support been provided to the client, their family or staff?

How will the MH-CLSR provider been involved in any Local Health District analysis?

Are any quality improvement and operational changes planned as a result of the incident? Please detail these changes.

Any additional information

Appendix 6: Useful Programs and Links

In order to offer integrated, seamless mental health services and support that meets the needs of individuals, it is important to recognise that mental health is about far more than the absence of symptoms of mental illness. The delivery of supports and services in mainstream community environments, the promotion of tangible social connections that support individual recovery and the promotion of protective factors and reduction of risk factors that influence mental health is integral to holistic service delivery.

In order to achieve this and deliver the range of service required it is imperative that MH-CLSR providers work in partnership with a range of other service and support providers.

Here is a list of useful links that will direct you to related programs/documents/service providers:

Interpreting and translation services

- Health care interpreting and translating services:

  https://www.health.nsw.gov.au/multicultural/Pages/health-care-interpreting-and-translating-services.aspx

- Multicultural NSW interpreter and translation services:
  https://multicultural.nsw.gov.au/language-service-providers-nsw/

- The Australian Government Translating and Interpreter Services (TIS):
  https://www.tisnational.gov.au/.

NSW Government

NSW Health including NSW Ministry of Health: http://www.health.nsw.gov.au/

- Mental Health Branch:
  http://www.health.nsw.gov.au/mentalhealth/pages/default.aspx

- NSW Refugee Health Service:

  https://www.swslhd.health.nsw.gov.au/refugee/

- NSW Transcultural Mental Health Centre:

  http://www.dhi.health.nsw.gov.au/transcultural-mental-health-centre

Primary Health Networks: https://www.health.gov.au/our-work/phn

Partners in Recovery (PiR): http://www.pirinitiative.com.au/index_public.php

Multicultural NSW: https://multicultural.nsw.gov.au/

Department of Communities and Justice: https://www.dcj.nsw.gov.au/

Women NSW: http://www.women.nsw.gov.au/ (including domestic and family violence resources)

TAFE NSW: https://www.tafensw.edu.au/student-services/multicultural-student-support

Australian Government

Migrant Community Hubs: http://www.communityhubs.org.au/

Commonwealth Mental Health Programs: http://www.dss.gov.au/our-responsibilities/mental-health/programs-services

National Disability Insurance Scheme (NDIS): http://www.ndis.gov.au/

Disability Employment https://www.dewr.gov.au/employment/supporting-staff-disability#toc--disability-employment-services-

Non-government organisations

STARTTS - NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors: https://www.startts.org.au/

Settlement Service International: https://www.ssi.org.au/

Asylum Seekers Centre: https://asylumseekerscentre.org.au/

Funded MH-CLSR service providers

1. Anglicare Sydney: https://www.anglicare.asn.au/find-a-provider/anglicare-sydney (Western Sydney including Auburn, Merrylands and Westmead)

2. Australian Red Cross: https://www.redcross.org.au/ (Murrumbidgee including Wagga Wagga and Griffith)

3. New Horizons: http://newhorizons.net.au/ (Hunter New England including Newcastle and Armidale, Mid North Coast including Coffs Harbour, South Western Sydney including Fairfield and Liverpool, and Sydney

4. Grand Pacific Health: http://www.gph.org.au/ (Illawarra Shoalhaven including Wollongong)

Mental Health
Community Living
Supports for Refugees

For more information please
contact NSW Health

health.nsw.gov.au

NSW GOVERNMENT