



Australian Government

Department of Health, Disability and Ageing

Commonwealth Psychosocial Support

Program guidance

Psychosocial support for people with severe mental health challenges and associated psychosocial functional impairment living in the community



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Overview

The Department of Health, Disability and Ageing (the Department) provides funding to Primary Health Networks (PHNs) to commission psychosocial support services for adults with severe mental health challenges and associated psychosocial functional impairment who are not accessing similar supports through the *National Disability Insurance Scheme* (NDIS) or state and territory-based programs.

What are psychosocial supports?

‘Psychosocial supports’ are non-clinical community-based supports that aim to facilitate recovery in the community for people living with mental health challenges – through a range of services to help people manage daily activities, rebuild and maintain connections, build social skills and participate in education and employment¹.

What are severe mental health challenges?

People living with **‘severe mental health challenges’** experience significant distress or **difficulties in their day-to-day psychosocial functioning**. This can impede their ability to attend school, work or volunteer; carry out household responsibilities and manage daily activities; maintain healthy relationships; or live independently and safely in the community. People living with severe mental health challenges may require care from specialist community mental health teams or a range of community services to support their recovery.

People living with severe mental health challenges may be diagnosed or have symptoms that may indicate the presence of mental illness, such as (but not limited to) mood (affective) disorders (e.g. depression, bipolar disorder); anxiety disorders; personality disorders; psychotic disorders (e.g. schizophrenia, schizotypal and delusional disorders); eating disorders; substance use disorders; and trauma-related disorders. Not everyone living with severe mental health challenges will have or identify with a specific label or diagnosis.

The terms ‘mental illness’, ‘mental disorder’, ‘mental health condition’, ‘mental health issues’, ‘mental health challenges’ and other terms may be used across a range of programs to describe a range of mental health and behavioural challenges, which can vary in both severity and duration. For this program, the term ‘severe mental health challenges’ is used for consistency.

What is recovery?

*The National Framework for Recovery-Oriented Mental Health Services*² suggests there is no single description or definition of ‘recovery’ – it is different for everyone, with non-clinical personal recovery goals different from clinical or functional recovery.

Some commonly cited characteristics of recovery include it being a unique and personal journey; an ongoing experience and not the same as an end point or cure; a journey rarely

¹ Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra – Volume 3, Chapter 17

² *A National Framework for Recovery-Oriented Mental Health Services: Policy and theory*, Commonwealth of Australia, 2013

taken alone; and non-linear, with it being frequently interspersed with both achievement and setbacks.

Background

The Commonwealth Psychosocial Support Program (the Program) commenced on 1 July 2021, building on and consolidating Commonwealth funding for psychosocial supports outside the NDIS.

As part of the 2024-25 Mid-Year Economic Fiscal Outlook (MYEFO), the Australian Government has provided \$272.1 million to extend the Commonwealth Psychosocial Support Program for two years from 1 July 2025 to 30 June 2027.

This builds on previous investments of \$171.3 million over two years from 1 July 2021 and \$260.2 million over two years from 1 July 2023.

Future funding arrangements beyond this are being negotiated with state and territory governments in the context of the National Mental Health and Suicide Prevention Agreement and the response to the NDIS Review.

Commonwealth Psychosocial Support Program

The Program provides short-term, low intensity support to people living with severe mental health challenges who are currently not accessing services under the NDIS or state and territory led programs.

The Program aims to strengthen the capacity of people to live independently and safely in their community, achieve personal recovery goals, form meaningful connections in a supportive environment, and reduce the need for acute care.

Program funding is provided to Primary Health Networks (PHNs) to commission person-centred, recovery-focussed psychosocial support services.

PHNs are also funded to support:

- the use of a capacity and strengths-based assessment tool for determining suitability, support needs and ensuring services are tailored to people's needs, with assessments undertaken by service providers with program participants
- service navigation support to provide information, advice and referral assistance to program participants, their families and carers
- discretionary testing of eligibility for the NDIS for people with long-term and/or complex support needs
- brokerage, which can be made available through commissioned service providers to support program participants' recovery needs for PHNs who feel it would be of benefit to their program participants
- regional loading for service providers in recognition of the higher cost of delivering services in regional and remote communities.

Program aims and objectives

Planning and commissioning of services should consider the key outcomes of the Program, as defined below:

Short Term:

- Program participants have continued access to support
- Streamlined and improved access to (including in regional and remote areas), timeliness and appropriateness of psychosocial services
- Improved overall experience and coordinated access to holistic supports for people.

Medium Term:

- Improved program participant recovery outcomes
- Increased capacity, confidence, self-reliance/independence and reduced distress for program participants
- Improved coordination and integration of psychosocial services within the broader mental health and community support system

- Reduced demand for more expensive interventions (e.g. crisis services, acute or inpatient facilities) and reduced mental health related hospitalisations.

Longer Term:

- Increased social and economic participation of program participants (including carers/families)
- Improved quality of life, health and wellbeing of program participants (including carers/families)
- More people living with severe mental health challenges able to live independently and safely in the community; and
- Improved sustainability and equity in the psychosocial support system.

Who is the Program for?

Program eligibility

Under the Program, psychosocial support service providers are commissioned to work in partnership with people (alongside their families and carers, as appropriate) to achieve recovery goals.

The Program is designed to support people living with severe, often episodic, mental health challenges who:

- have needs that can be appropriately met through short-term, low intensity support to live independently in the community, as determined through a capacity and strengths-based assessment tool
- are not restricted in their ability to fully, and actively, participate in the community because of their residential setting (e.g. prison or a psychiatric facility)
- are not receiving similar psychosocial supports through a state or territory government program or the NDIS, where there is potential for duplication of service offerings. However, people who have been found eligible for the NDIS but have not activated their plan or where there are no NDIS service providers in the region, should continue to be supported until these NDIS services actually commence.
- are aged 16 years and over, noting exceptions can be made for people younger than 16 years subject to approval by the PHN. There is no upper age limit for the Program, as long as there is no duplication of service offering for people. Alternative supports may be appropriate for older people such as through My Aged Care.

A clinical diagnosis is not required for people to access services; however relevant eligibility criteria is required to be met (e.g. program participants must not be receiving similar psychosocial supports through a state or territory government program or the NDIS).

Accessing the Program

Service providers are required to maintain open referral and access pathways into the Program. Potential program participants can access the Program through a broad range of entry pathways including self-referral, referral by friends and family or other community services. A formal referral from community mental health or clinical services must not be

required, and there is no requirement for people to be a registered consumer of state mental health services. When a provider is unable to accept new participants, any people requesting access should be directed to alternative supports.

Demand management and waitlists

Service providers may be required to put in place policies and procedures to prioritise and manage fluctuating demand and variations in staffing levels, including wait lists and referral pathways to alternative services. Where possible, providers should consider whether limited or alternative supports can be provided to people on a waitlist for specific types of supports and services (for example, remote support or group support while waiting for, or in between, face-to-face individual supports). Service providers should maintain clear and transparent waitlist management practices, including proactive communication with people on the waitlist and referrers regarding waitlist status, regular review of people's needs while on the waitlist, and reporting of waitlist numbers and unmet demand to PHNs in line with reporting requirements.

Where providers foresee that they cannot provide any full, limited or alternative support to program participants on a waitlist within a reasonable timeframe from the referral due to various reasons such as capacity constraints, where possible, they should consider referring the applicant to another CPS service provider in the region.

Program participant disengagement

Where a program participant disengages from the Program or cannot be reached, a genuine attempt should be made to contact the person and offer additional or alternative supports, including supports for the person's chosen family, carers and kin where appropriate (for example, where the person may benefit from changes to the family or home environment or strengthened support network).

If the person cannot be reached after a period of three months and after at least three contact attempts in this time, they should be formally exited from the Program. If there is permission to contact a family member, carer or referrer (if applicable), then it would be appropriate to contact that family member, carer or referrer (if applicable).

Soft re-entry points should be established to enable streamlined re-entry to supports as required, noting there may be wait lists. PHNs, or service providers on behalf of PHNs, should maintain wait lists to be able to report accurate information and advice on local unmet demand to the Department. Soft re-entry allows the Program to support a greater proportion of the community during episodes of increased need.

Program participants who no longer meet the required eligibility criteria (e.g. are receiving similar psychosocial supports through a state or territory government program, community supports such as community social groups, or NDIS funded supports), should be notified and supported to transition from the Program to other supports as appropriate and available.

Movement between PHN regions

Where program participants move between regions there should be, where possible, a 'warm handover' between service providers to ensure continuity of care for the person so the person, their family and any relevant carers can fully participate in this process. PHNs and

service providers should facilitate the appropriate exchange of information (with the agreement of the program participant) where possible, including access to brokerage through the Program.

Exiting the Program

Program participants can exit the Program at a time they choose, or as agreed with the service provider.

Service providers may exit a program participant when:

- their goals have been reached
- they have been accepted and are now accessing psychosocial supports through the NDIS or another program
- the Program is unable to assist them with their identified goal
- a Program team leader or service manager judges that the program participant presents a risk to the safety of other program participants or service staff
- they move into long term (six months or more) accommodation or residential setting (such as a psychiatric facility or imprisonment) that limits their ability to fully and actively participate in the community
- they do not return to the Program after a period of disengagement.

Wherever possible, service providers should ensure that people exiting the service have adequate alternative supports in place should they require them. This may include access to relevant mainstream services, family support, and strategies in place to deal with crises, should they occur.

Service delivery

What services are in scope?

Psychosocial support services cover a range of non-clinical supports that focus on building personal capacity and stability in one or more of the following areas:

- social skills, friendships and family connections
- day-to-day living skills
- financial management and budgeting
- finding and maintaining a home
- vocational skills and goals
- maintaining physical wellbeing, including exercise
- managing substance use issues
- building broader life skills, including confidence and resilience; and
- building capacity to live independently in the community.

What services are out of scope?

The following services are outside the scope of funding:

- **Provision of Clinical or Specialist Medical Services:** Service providers and PHNs are to encourage people to access these services and assist with referral processes.
- **Provision of Personal Care and Domestic Help:** Support workers may assist people in learning how to complete household domestic activities, as well as prompt them to undertake tasks and help them find assistance to undertake tasks they cannot manage themselves.
- **Crisis Support:** Services delivered are not to manage or respond to crises. Support workers are not expected to be the contact for mental health emergencies or to manage program participants through such an event. People should be encouraged and assisted to seek clinical mental health support, and supported to develop a crisis plan.
- **Capital Works:** Funds cannot be used for capital works, construction or installing facilities or fixtures.
- **Duplicated services:** Services may not duplicate existing funded activities that are primarily the responsibility of state and territory governments, or are more appropriately funded through other programs, such as NDIS or primary mental health care services.

Service delivery model

Services can be delivered through a range of formats, including individual support, place-based services (e.g. Clubhouse models), group activities and outreach support. A flexible approach should be taken to tailor supports to the needs of program participants, including regular reviews to ensure relevance and responsiveness to people's changing needs. Supports can also be delivered using technology (e.g. telephone or videoconferencing) where appropriate and available.

Service delivery should support the facilitation of care coordination and non-clinical and clinical activities to enable the appropriate delivery of psychosocial support services (e.g. through communication and transfer of relevant information to ensure safe care transitions; processes to support team-based approaches, such as care plans, case conferences, assignment of a care coordinator role; and facilitated access to other health and social support services). Some program participants may have co-occurring conditions, such as intellectual or cognitive disability, neurodevelopmental disorders (e.g. autism), and/or substance use disorders. Referrals to services including other commissioned services and programs that can provide relevant support, and assistance should be considered where appropriate.

Support needs may be episodic and may occur across a number of domains, including help with physical and mental health; employment; substance use; social isolation; family, domestic and sexual violence; access to appropriate housing; and navigating the justice system.

Some program participants may experience hospital admission/s, either planned or due to mental health crisis, in the duration of their participation in the Program. It is crucial that service provision includes contingency plans for such situations, ensuring continuity of low-intensity support during their hospital stay and smooth transition back into needs-based supports on discharge to aid their recovery where they are no longer accessing support through a state/territory program.

The Program may be delivered through an integrated hub model with other mental health and suicide prevention commissioned services to deliver holistic care with the approval of the Department. It is important that separate reporting, accountability, and adherence to program guidelines is maintained.

Duration of support

Supports should be provided under a recovery-framework and should seek to provide positive outcomes within an agreed period. The capacity and strengths-based assessment tool can be used to define this period.

It is anticipated that most program participants will have an initial support period of between three and six months if they do not have severe and persistent mental health challenges. It is understood that consumers can have varying levels of need over time, additional support can be provided over a longer period of time if deemed appropriate, following a support plan review.

Intensity of support

Program participants requiring more intensive support services for a period greater than 12 months, should be supported to test for NDIS eligibility. This will ensure access to appropriate ongoing support and acknowledges personal circumstances may affect the duration of supports required.

The intensity of support provided is flexible and should be negotiated with each person based on the outcomes of the capacity and strengths-based assessment. Targeted individual support can be provided in times of increased need. This recognises some people may need varying levels of support over time, due to the episodic nature of their mental health challenges.

Examples of activities that may be provided under the Program are outlined in the table below:

Service type	Activity examples
Individual supports	<ul style="list-style-type: none"> • Support to work towards individual recovery goals. For example, confidence to catch public transport, developing a meal plan, and accessing education and training • Making decisions to support with problem solving and skill building • Assistance to plan, face challenges and develop resilience and management/coping strategies • Providing emotional support and opportunities for social connections • Providing practical assistance. For example, accessing housing assistance or government support payments • Support to re-connect and improve relationships with family and friends to increase support networks • Assistance with navigating the mental health system and accessing other appropriate services, including Alcohol and Other Drugs services, transport, advocacy and housing

Service type	Activity examples
	<ul style="list-style-type: none"> • Support to test NDIS eligibility • Building knowledge and capacity to improve physical and mental health • Participating in the program participant's care team and providing advocacy support, noting the important role carers and family will often play in supporting a loved one • Providing opportunities to practice life skills (e.g. grocery shopping).
Group supports	<ul style="list-style-type: none"> • Psycho-educational groups covering emotional wellbeing promotion activities, such as mindfulness and self-care • Information sessions/workshops aimed at enhancing daily living skills (e.g. budgeting, nutrition) • Visits from other service providers and organisations to provide information on services, eligibility and referral pathways • Visits to continuing education centres to explore study options • Opportunities for social connection and skill building, including participation by families, carers and friends in activities, such as: <ul style="list-style-type: none"> ○ Art/craft activities ○ Cooking classes ○ Gardening groups ○ Drop-in spaces. • Opportunities to contribute and engage in meaningful activities, such as volunteering • Exercise/physical activity groups (e.g. dance, walking, yoga) • Excursions to community events and cultural experiences.

Workforce

The workforce delivering the Program may have varied backgrounds, academic qualifications, work experiences and knowledge. Staffing models and workforce profiles are determined by service providers according to funding, local needs, the needs of program participants, the availability of staff and worker profile. Where possible, teams should be designed to have a diverse knowledge base and cultural backgrounds with consideration of program participant numbers to support a sustainable workforce and maintain high-quality care. Service providers are encouraged to employ peer workers with lived experience. The role of peer workers within the team may vary and be tailored to the service.

Service navigation

Early and easy access to health and other services are key factors in promoting positive outcomes and sustained recovery, particularly for people living with severe mental health challenges who are at higher risk of experiencing complex health, financial and other stressors and issues.

PHNs are funded to assist with service navigation in their regions and will be responsible for planning and commissioning supports. The aims of service navigation are:

- program participants, families and carers have a better understanding of the service options available across a range of service domains
- program participants have increased and informed choice in accessing a broader range of relevant health and support services to achieve recovery goals and manage their conditions on a day-to-day basis in the community
- program participants are supported to access and engage with specialised services that address the social determinants of health, including access to safe and appropriate housing
- General Practitioners (GPs), program managers and service provider staff have a better understanding of services available in their regions to support the social, mental and physical health needs of people living with severe mental health challenges and promote coordinated multi-disciplinary care
- PHNs, Local Hospital Networks and Local Area Coordinators develop a joint understanding of psychosocial referral pathways, available supports, service gaps and emerging issues.

Where there is capacity, strategies are implemented to mitigate identified barriers to this objective:

- help is provided to program participants, together with their families and carers, to access the supports needed to promote mental and physical health; and
- program participants are assisted with accessing stable, safe and appropriate housing, given the strong link between stable housing and positive mental health outcomes.

Funding for service navigation may be used to upskill and assist carers, family and kin to navigate and engage with available supports and services for program participants.

Service navigation should contribute to:

- better integration across local health and community services
- improved access to holistic, person-centred, multidisciplinary care
- reduced fragmentation in the service system for people living with complex psychosocial needs.

PHNs should establish coordinated referral processes to support access to psychosocial, clinical and primary health care and implement standardised intake processes across providers where people's mental and physical health needs assessments are reviewed against available services. This ensures all eligible service information is provided to program participants, their families and carers to assist with health care access. Carers and families should also be provided with support information, such as a referral to the Carer Gateway at www.carergateway.gov.au.

Where PHNs have already commissioned similar services and models that support the new funding and activities, PHNs may choose to extend or supplement these services rather than establish separate or new programs provided the outcomes outlined in the guidance material can be met.

Where PHNs have implemented the Initial Assessment and Referral Decision Support Tool (IAR-DST) guidance, service navigation activities may be integrated into established

processes to support the referral of people with psychosocial support needs into a stepped care service model.

Regional loading

Regional weighting to funding levels has been applied in relation to services delivered to people living in outer regional, remote and very remote Australia. This recognises the higher costs associated with delivering services in these locations and aims to improve service availability and access for people living with severe mental health challenges in these communities

NDIS testing support

PHNs are funded to support participants who may meet the eligibility criteria for the NDIS by assisting them to test or retest their NDIS eligibility and apply for the NDIS. This support assists people with collecting the evidence to submit an access request and to 'walk with people' while they take part in this process. People accessing NDIS testing support must have severe, often episodic, mental health challenges, consistent with the aims and objectives of the Program. Additional resources about the NDIS and NDIS testing support is available through CPSP Empower.

Funding is provided for up to 30 per cent of program participants to test or retest their eligibility for the NDIS each year. NDIS testing should be guided by people's individual needs and readiness.

Capacity and strengths-based assessment tool

Service providers should undertake a capacity and strengths-based assessment with program participants within six to eight weeks of Program commencement to assess suitability, identify support needs and goals and the period of time they will likely require supports. PHNs and service providers will collaboratively identify the most appropriate strength-based assessment tool to be used for the program participant demographic of the region.

PHNs and service providers will work to ensure that intake processes are person-focused, culturally safe, and conducted at a pace that people are comfortable with.

Based on the assessment and determination of eligibility, an individualised support plan will be developed together with the person, which should outline the following:

- the person's strengths and existing supports
- the person's recovery goals and support needs
- activities to be undertaken to achieve recovery goals and meet support needs
- services to be referred to, if needed; and
- a care/crisis plan in the event the person becomes unwell, or crisis occurs, noting a family member or carer may play a critical support role in such events. This care plan should also include information such as treating GP and/or other services to better support holistic care.

Support plans should be reviewed regularly as well as following any significant events in the person's life that may affect their support needs.

Brokerage funding

Brokerage funding is available to support program participants' recovery needs for PHNs who feel it would be beneficial. The Department recognises that some program participants will require greater funding support. PHNs have flexibility to determine whether to provide brokerage through commissioned service providers.

Purpose

Program participants should principally access supports and services from service providers, and brokerage is not intended to be used to shift responsibility from these service providers. The Department recognises that, in some circumstances, it may be appropriate for service providers to purchase services and supports when the person's needs are identified but not immediately able to be met through normal channels.

Service providers should also be aware of the availability of other supports and services, including any other brokerage funding sources, which may be used to supplement Program supports and services.

Scope

The following criteria apply to the use of Brokerage funding:

- Use of brokerage aligns with the overall aims and objectives of the Program to provide short-term, low intensity support to people living with severe mental health challenges and strengthen their capacity to live independently and safely in their community.
- Brokerage is provided in the context of other individual supports and aligns with the person's recovery goals.
- Brokerage must not be the first or only service funded through the Program to be provided to the person.
- Brokerage is used to purchase services, supports or goods on a one-off or short-term basis where these services, supports or goods cannot be provided through normal channels or alternative services.
- Brokerage must not be used to fund recurring or ongoing expenses such as rent or regular food shopping.
- Brokerage must not be used to outsource any Program activities or purchase supports that should be provided by commissioned service providers.
- Brokerage must only be used once all other appropriate funding options and community services have been explored.
- Services, supports or goods purchased with brokerage represent value for money and the amount of funding provided should be proportionate to the expected benefit for the person.
- Services, supports or goods purchased with brokerage funding are capable of withstanding public scrutiny, and will not bring the Program, the Department or the PHN, into disrepute.

- Adequate funding is available within the overall budget to meet all other requirements under the agreement, including the needs of other program participants.

The following table provides some examples of the types of services and supports that may and may not be purchased with brokerage funding, and is not intended to be prescriptive or exhaustive:

Item	Explanation
In-scope for brokerage funding	Minor home improvements and modifications, such as block-out blinds or mattresses
	Minor capital improvements can lead to better health and mental health outcomes, such as improved quality of sleep.
	Access to clinical supports or authorised health practitioners e.g. psychiatrists or clinical psychologists, for assessment or diagnosis to assist and support the person's NDIS application or access to other supports and services
	Provides additional assistance in applying for the NDIS or other supports and services that require a clinical diagnosis, assessment or referral (such as State-funded programs) when accessing some clinical supports may be prohibitive.
	Medications while any issues regarding access to a health care card or Medicare are being resolved
	Purchasing medicine will enable a program participant to maintain their physical and/or mental health if they are having trouble accessing medication they need immediately while longer-term arrangements are finalised.
	Emergency short-term accommodation
	Brokerage is available for when a program participant needs to live out of home for a short period and no other appropriate accommodation options are available. Emergency short-term accommodation may be needed if a person's usual support network is not available for a short period.
	One-off emergency house cleaning
	A program participant may need one-off help to clean a tenancy if they are at immediate risk of being evicted.
	Mobile phones and laptops
	A low-cost mobile phone or laptop may assist a program participant to find employment, volunteering or educational opportunities, and stay connected to their families, friends and community.
	One-off transport costs, e.g. taxi fee, bus or train card, assistance to obtain driver's license, assistance to obtain a package of driver lessons
	A program participant may not be able to access transport options to an important Program activity, medical appointment, job interview or educational class, especially in more regional or rural areas where there is less access to public transport.

Item		Explanation
Out-of-scope for brokerage funding	Entertainment, including restaurants and cafes, gambling and gaming, movies or concerts, holiday travel or other recreational activities	Regular Program group activities should be used to provide opportunities for social connection and group recreational activities.
	Medium to long-term accommodation	Brokerage is not sufficient to meet the housing needs of program participants on an ongoing basis. People should be supported through Service Navigation to access alternative services offering support with housing.
	Ongoing living expenses such as groceries, rent, transport and utilities	Brokerage is for one-off ad-hoc expenses not for regular ongoing living expenses.
	Ongoing medical expenses and treatments	Other government-funded services and supports are available to assist with ongoing medical expenses including access to a health care card or Medicare.

Budget

The amount of funds allocated to brokerage from the Program budget must not exceed 20% of the total funding in any PHN region.

Service providers may approve brokerage up to \$250 (excluding GST) for a single instance without prior approval. If a service provider considers a program participant would benefit from the use of brokerage exceeding \$250 in any single instance, the provider must seek prior written approval from their commissioning PHN.

Brokerage will have a cap of \$1,000 (excluding GST) for any one program participant over their lifetime with the Program, except for in exceptional circumstances. If a service provider considers that a program participant has exceptional circumstances and would benefit from brokerage of more than \$1,000, they must seek prior written approval to provide additional brokerage from the commissioning PHN.

PHNs may request providers ask participants if they have accessed brokerage funding through the Program prior to utilising brokerage to assist with monitoring brokerage use.

Record-keeping requirements for service providers

Service providers must:

- retain records for all brokerage transactions, including:
 - date and type of goods or services purchased
 - tax invoices
 - an explanation of how the purchase supports the consumer's recovery goals
 - evidence that alternative options were explored before using brokerage funding
- report brokerage expenditure to the PHN in the format specified, ensuring the data can be traced to individual instances if required by the Department.

Reporting requirements for PHNs

PHNs are required to:

- Maintain a record of all brokerage approvals exceeding \$250 in any one instance or exceeding \$1,000 for a program participant over their lifetime with the Program.
- provide these records to the Department upon request.
- submit a summary of approvals of brokerage funding exceeding the lifetime cap to the Department every six months via email at psychosocialsupport@health.gov.au, using the reporting template provided at [Attachment A](#).

PHNs must also include the following in their 12-Month Reports:

- total amount of brokerage funding used
- number of consumers who accessed brokerage funding
- average amount of brokerage per consumer
- most common types of goods or services purchased
- number of purchases where the individual amount exceeded \$250
- number of consumers who have received more than \$1,000 in brokerage funding.

PHNs must inform the Department through email to psychosocialsupport@health.gov.au of breaches of the brokerage guidelines. PHNs may be asked to provide further information on actions taken to address breaches and undertake remedial action, such as further staff training.

Commissioning

There are a number of sectors central to the success of providing psychosocial supports. These include primary care (health and mental health), state and territory specialist mental health systems, the mental health and broader non-government sector, alcohol and other drug treatment services, income support services, as well as education, employment and housing supports.

PHNs, in consultation with community mental health service providers, states and territories, clinical services, and carers, should commission and coordinate services based on local needs, and what services and supports are already available.

Planning and commissioning decisions should be informed by the voices of people with lived experience, including carers, family and kin. Formal policies or mechanisms should be in place to support the engagement with people with lived experience.

Ideally, services should be embedded within, or linked to, clinical services to support a multidisciplinary approach to meeting the needs of people living with severe mental health challenges, and form part of a multi-agency care plan.

PHNs should review their regional mental health and suicide prevention plans when undertaking service needs analysis and activities and take into consideration the needs of people with co-occurring health conditions and dual diagnoses, such as alcohol and other drug challenges, intellectual disability, acquired brain injury and autism spectrum disorder.

Specific responsibilities of PHNs and service providers

Standards and guiding principles

Service providers are required to operate in accordance with (and where appropriate, be accredited against) any service, professional, and/or workforce standards that may be relevant to their organisation, including:

- National Standards for Mental Health Services 2010
- National Practice Standards for the Mental Health Workforce 2013
- A national framework for recovery-oriented mental health services: Guide for practitioners and providers, the NDIS National Recovery Framework (2021)
- National Safety and Quality Mental Health Standards for Community Managed Organisations (2022), and
- National Safety and Quality Standards for mental health (2017)
- National Lived Experience (Peer) Workforce Development Guidelines (2023).

The delivery of activities is underpinned by the following guiding principles³:

- **Recovery focussed:** Services operate under a recovery framework by increasing choices and opportunities for people to live a meaningful, satisfying and purposeful life.
- **Flexible and available:** People feel comfortable contacting support workers at times of need and play an active role in choosing the frequency of contact and setting, pace and delivery of supports.
- **Regular and reliable:** Regular contacts provide opportunities to build routine, continue steady progress towards goals and build confidence. Services demonstrate reliability by keeping appointments, following through on offers of support, and returning calls within reasonable timeframes.
- **Proactive:** Services are proactive in initiating contact and advocating on behalf of program participants. Proactive service provision can assist in building trust and rapport and support people to feel comfortable with accessing services.
- **Based on genuine understanding:** Services endeavour to understand the story and experience of each person. Training in mental health, as well as a capacity to listen without stigma or stereotyping can help ensure people feel heard, seen and understood.
- **Respectful, authentic, positive:** Services are delivered in a manner that supports consumer engagement and promotes hope, and the development of positive, motivated, partnerships.
- **Valuing the lived experience of mental health challenges:** People with lived experience, including carers, family and kin, are involved in the leadership, design,

³ Evaluation of National Psychosocial Support Programs, *Voices of Lived Experience findings* - University of Sydney, 2020 (unpublished)

delivery and monitoring and evaluation of services. The voices of people with lived experience inform continuous improvement.

- **Person-led:** Services address the specific support requirements and goals of each person, while building on strengths to empower program participants to take an active role in their recovery journey.
- **Clear and transparent:** Program participants are provided with information on the Program processes and service options, including their rights and how to raise a concern about services. Planning and delivery of programs and services are conducted in partnership with program participants and their families, kin and/or carers.
- **Relational and inclusive of families, carers, supporters and kin:** Services recognise and support healthy relationships in a person's life, and include families, carers, supporters and kin in care planning where this is agreed by the program participant.
- **Cultural safety:** Services are delivered in ways that are culturally appropriate, safe and relevant for specific groups including First Australians, people from diverse cultural backgrounds and people who identify as LGBTQIA+.
- **Strengths-based:** Services focus on the strengths, abilities and resources of people to build resilience and increase capabilities and wellbeing through social and environmental opportunities.
- **Trauma-informed:** Services are delivered under a trauma-informed framework promoting safety, trust, choice, collaboration, respect and empowerment.
- **Complementary to existing service systems:** Service providers build and maintain strong linkages and partnerships with local health and social services to streamline referral pathways, facilitate services for program participants, and build complementary support systems.
- **Clinically integrated:** Service providers ensure program participants have opportunities to improve their mental health outcomes, including access to clinical mental health services. Service providers assist people with accessing these services and engage in a multi-agency care team approach to ensure integrated and holistic service delivery.
- **Building and retaining a skilled and resilient workforce:** PHNs and service providers contribute to the growth and retention of a highly skilled, diverse and inclusive mental health workforce including peer workers. The quality of care and support is dependent on the quality of workers and **jobs**. This includes providing supports in the workplace, ongoing training, and opportunities for professional and personal development. It also includes sustainable commissioning practices including sufficient notice periods for contract adjustments.

Regular reporting and data collection

Data collection requirements for the Program will be set out in funding schedules. PHNs will provide:

- service and outcome data via the Primary Mental Health Care Minimum Data Set (PMHCMDS); and

- 12-month reports via the *Primary Health Operational and Commissioning Unified System* (PHOCUS) for key performance reporting and *Primary Health Networks Program Electronic Reporting System* (PPERs) for audited financial reporting.

The Department will continue to monitor the data collected to assess performance of the Program. An independent evaluation of the Program will be undertaken from mid-2025 to mid-2027 to measure the impact of the Program and understand opportunities for improvement.

Critical incident reporting

PHNs must inform the Department through email to psychosocialsupport@health.gov.au and relevant PHN State Team of critical incidents that occur in connection to the provision of supports or services under the Program. This may include, but is not limited to, notifications, allegation or complaints received in relation to:

- death of a program participant
- serious injury of a program participant
- violence, abuse or neglect of a program participant
- serious misconduct by a worker.

This covers incidents that may have occurred during the course of supports or services being provided or that arise from the provision, alternation or withdrawal of supports or services.

PHNs may be asked to provide further information.

Details provided vary on a case-by-case basis depending on the incident, but it is generally useful for the PHN to consider the following and provide information where relevant:

- Provider name
- Program and activity under which the provider is commissioned
- Location of incident
- Description of incident
- Background and supporting information
- Response or follow-up actions required
- Proposed management or support strategy
- Next steps.

PHNs should analyse critical incident information to inform service improvement through the implementation of preventative measures and responses to adverse events.

Sector support and capacity building services

CPSP Empower

The Department funds CPSP Empower, based at Flinders University, for sector support and capacity building services to assist PHNs and commissioned psychosocial support service providers deliver the Program. This includes:

- networking and information sharing opportunities, including regular workshops, communities of practice and e-newsletters
- development of online training modules, webinars, articles and tools to support ongoing professional development of staff and good practice delivery of psychosocial support services
- providing personalised site visits and tailored training sessions to address specific needs and challenges
- ongoing support and advice (online, over the phone or in person) for PHNs and commissioned service providers.

PHNs should promote CPSP Empower to staff and commissioned psychosocial support service providers.

Translating and Interpreting Services

The Australian Government funds Translating and Interpreting Services (TIS) for PHN-commissioned mental health services. Approved PHN-funded mental health service providers, including providers delivering the Program, can use TIS National's interpreting services for free.

TIS National, provided by the Department of Home Affairs, delivers high quality, cost-effective and secure interpreting services for people who do not speak English and for agencies and businesses that need to communicate with their non-English speaking clients.

Language services are designed to ensure that people with limited or no English language proficiency can access the services and programs they need, removing a significant barrier faced by Australians from diverse cultural backgrounds when accessing mental health support.

Full eligibility details and how to register can be found on the [Department's website](#).

TIS National's immediate phone interpreting service is available by calling 131 450.

More information about the service or to make and view online Telephone, Onsite and Video Remote bookings can be found at www.tisnational.gov.au.

PHNs are encouraged to promote TIS to staff and commissioned psychosocial support service providers.

Attachment A: Brokerage funding – six-monthly reporting

Clients exceeding \$1,000 brokerage funding over the lifetime

De-identified client (e.g. client SLK)	Total brokerage funding provided as of [date]	Comments/rationale
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All information in this publication is correct as at June 2025

