NSW Health

Community Living Supports

Service Model

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Acknowledgement of Country

NSW Health recognises Aboriginal people as the First Nations people of Australia. We pay respect to the traditional custodians of Country and acknowledge the wisdom of Elders who have passed, those of today and tomorrow, and pay respect to Aboriginal communities of the land on which we live and work across NSW.

Recognition of lived experience

We acknowledge people in our communities with lived experience of mental health conditions and those who care for them when they need it. We acknowledge that each person's journey is unique and valued. We recognise their adverse experience of stigma, but also their strength and resilience. We respect and value their generous contributions, which guide us to continually shape, reflect upon and deliver quality, person-centred care and community supports.

The term 'lived experience' in the context of CLS covers a broad range of experiences including people who have been diagnosed and/or self-identified with lived experience of a severe mental health condition, or ongoing mental distress.

The lived experience of Aboriginal people reflects ongoing impacts of trauma, racism, and colonisation as specified in community-led definitions of social and emotional wellbeing. Social and emotional wellbeing is the foundation of physical and mental health for Aboriginal people, recognising that connection to land, sea, culture, and spirituality all influence wellbeing.[(2)]

This service model applies language that reflects the principles of recovery-oriented practice. The term 'mental health *condition'* is used throughout in recognition that a person is not labelled by a mental health diagnosis (e.g. a person or people with a mental health condition).

Families, kin, carers, and community

Families, kin, carers and other supporters play an important role in a person's recovery. In line with the *Mental Health Act 2007 (NSW)*[(3)], the *Carers (Recognition) Act 2010 (NSW)*[(4)], and the *NSW Carers Strategy: Caring in New South Wales 2020-2030*[(5)]. Support networks can be engaged as partners in care in the planning and recovery process and relevant decision-making.

Involvement of any additional party, including family and carers, must be based on the wishes of the person receiving CLS supports, although this may vary over time. When consent to involvement of appropriate family, friends, kin or carers fluctuates, then consent should be re-tested regularly and efforts made to build consent to re-engage with informal supports. CMO and LHD staff must also follow their organisation's policies and guidelines on privacy and confidentiality for individuals receiving support and families and carers.

Thank you to contributors

We thank all the organisations and individuals who contributed to the development of this service model.

NSW Health values the self-agency, choice and rights of people with a lived experience of mental health conditions, and their friends, families, carers and kin, in the delivery of their mental health care. We are committed to delivering CLS programs that are holistic, relational, person-centred, and recovery focused.

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1 Introduction

Summary

The Community Living Supports (CLS) service model provides direction for community managed organisations (CMOs) and local health districts (LHDs) delivering the CLS program for people with severe mental health conditions under the auspices of the Mental Health Branch, NSW Ministry of Health.

CLS is a holistic and culturally responsive service that builds on the strengths and aspirations of people with severe mental health conditions, working together to create meaningful goals and personal change for a fulfilling life within their communities.

An estimated 3% of Australians experience a severe mental health condition in a given year. The aim of psychosocial support is to improve people's lives by creating social connections, amplifying purpose, empowering people with choice, and building self-determination and agency.

Aboriginal people are overrepresented in CLS, with 17% of people receiving supports in 2023-24 identifying as Aboriginal. The vision of the NSW Aboriginal Mental Health and Wellbeing Strategy 2020–2025(1) is for all Aboriginal people in NSW to have access to holistic and culturally safe services that provide the best opportunity for improved mental health and social and emotional wellbeing.

The service model outlines how CMOs will deliver activities across six interconnected stages: awareness of CLS; application or referral; eligibility assessment; goal setting and support planning; tailored, flexible support; and exit. It sets out referral pathways to CLS, eligibility criteria for Aboriginal and non-Aboriginal people, the risk management approach between CMOs and LHDs, operating hours, and guidelines for delivering culturally responsive supports to priority populations.

The service model prioritises strong integration between LHDs and CMOs and coordination with other services such as National Disability Insurance Scheme (NDIS)-funded providers, housing providers, private clinicians, alcohol and other drugs services, and Aboriginal health services and community organisations. The service model requires and complements robust governance structures that can be customised at a local level within statewide standards.

CMO staff providing CLS should be well trained to fulfill their roles. For staff employed in peer work/lived experience designated positions, relevant lived experience is required. The service model emphasises the need for an appropriately skilled staffing mix with access to monthly peer supervision and culturally appropriate professional development and support. It highlights the importance of a qualified peer workforce to provide appropriate, culturally responsive psychosocial supports.

The service model notes the importance of ongoing data reporting to the effective management of the program, including the Living in the Community Questionnaire (LCQ), the Your Experience Survey (YES), and the Minimum Data Set (MDS), as well as critical incident reporting.

Purpose of this service model

This service model provides direction for CMOs and LHDs delivering 'Community Living Supports' for people with severe mental health conditions under the auspices of the Mental Health Branch, NSW Ministry of Health.

This CLS program combines and updates the previously separate Housing and Accommodation Support Initiative (HASI) and CLS programs.

Consultation and evidence

Several forms of evidence were collated to inform this service model including:

- in-person and online consumer and carer consultations and yarning sessions
- stakeholder perspectives from Aboriginal community representatives
- consultation with LHDs
- consultation with CMOs and workers currently providing HASI and/or CLS in NSW, and the Mental Health Coordinating Council
- consultation with other stakeholders, including from other government agencies and non-government organisations that interface with HASI and/or CLS in NSW
- research literature on current best practices in delivering psychosocial support programs
- grey literature including policies, program descriptions, evaluations, and reviews of Australian and international psychosocial support programs with similar aims and scope to the HASI and CLS programs
- analysis of activity, outcome, and other data gathered within the HASI and CLS programs, including formal program evaluations, and about demand for psychosocial supports across NSW.

Background

An estimated 3% of Australians experience a severe mental health condition in a given year.[6,7] Severe mental health conditions may be experienced as episodic or persistent. People living with severe mental health conditions may experience psychosocial disability and require psychosocial support.[6,8] In 2021, an estimated 17% of people who reported having a long-term mental health condition reported needing help or supervision due to the condition.[7]

For a mental health condition to be classified as 'severe', it typically requires meeting criteria for a 12-month mental disorder plus one of the following in the previous 12 months: an episode of mania, a suicide attempt, or at least two areas of severe role impairment on the disorder-specific Sheehan Disability Scale.[9,10]

The aim of psychosocial support is to improve people's lives by creating social connections and fostering healthy relationships, amplifying purpose, empowering people with choice, and building self-determination and agency. These are powerful protective factors for mental health that can lead to longer periods of wellness and reduce the frequency and intensity of acute episodes of mental ill health. This in turn reduces lifelong impacts of illness and the need for hospital and crisis-based services, as well as their associated costs.[11-14]

It is estimated that, at a minimum, one-third of the total Aboriginal and Torres Strait Islander population may be affected by intergenerational trauma as descendants of the Stolen Generations.

Due to the significant impacts of colonisation, intergenerational trauma and ongoing racism, Aboriginal people experience multiple stressors that are predeterminants of mental ill health. Racism experienced by consumers may impact a person's decision about seeking help from health services, as well as the engagement and adherence to treatment. This has a significant impact on mental health context and experiences for Aboriginal people, and indicates a strong requirement for culturally safe services and cultural healing.[15,16]

Housing and Accommodation Support Initiative and Community Living Supports

Until 2024, the NSW Ministry of Health funded two separate statewide programs to assist people with severe mental health conditions to live independently in their communities: HASI and CLS. Evaluations in 2012 and 2022 found that these programs were effective.[17-20]

The service model for the programs was reviewed in 2024 following an extensive statewide consultation process, merging them into the single, rebranded CLS program described in this document.

The 2024 review highlighted key strengths of the HASI and CLS programs, which continue to be recognised as priorities in this service model. They include:

- flexibility to suit individual needs
- focusing on goal-based recovery
- service integration between LHDs and CMOs
- managing access to the programs
- staff training and skills.

The 2024 review also highlighted opportunities to improve the programs, which have been addressed in this service model:

- merging the two programs
- managing and sharing information
- alignment of KPIs with program aims
- integration with housing providers
- consistency of approach statewide
- hours of service availability.

Related policies

This service model has strong links with related legislation and policies, including:

- *Mental Health Act 2007 (NSW)*, which outlines that everybody has the right to the mental health care they need[3]
- *Mental Health and Cognitive Impairment Forensic Provisions Act 2020 (NSW)*[21], which outlines the specific care and treatment requirements for forensic consumers, including those who may be in the community
- NSW Health's 'Principles for effective support when working with someone with a mental health condition'[22]
- *Vision 2030: Blueprint for Mental Health and Suicide Prevention*[15]
- *National Agreement on Closing the Gap 2020*[23]
- *NSW Aboriginal Health Plan 2024-2034*[24]
- *NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025*[1]
- *Gayaa Dhuwi (Proud Spirit) Declaration Framework and Implementation Plan*[2]
- *Carers (Recognition) Act 2010 (NSW)*[4]
- *NSW Carers Strategy: Caring in New South Wales 2020-2030*[5].

2 Service model overview

Vision

People with severe mental health conditions live and recover in their communities the way they want to.

Purpose

A holistic and culturally responsive service that builds on the strengths and aspirations of people with severe mental health conditions, working together to create and achieve meaningful goals and personal change for a fulfilling life within their communities.

Objectives

- Deliver individually tailored, and person-led psychosocial supports that help people to create meaningful goals, build independence in daily life and contribute to recovery within their communities.
- Reduce the frequency of hospital admissions and length-of-stay for people with severe mental health conditions.

Service values and principles

Value or principle	Definition
Create a welcoming environment	Create a welcoming, inclusive, and accessible environment with language, images, and inviting physical spaces. Ensure people feel known, believed, supported, and safe.
Adopt a whole-person approach	Take a person-first and holistic approach, including psychosocial, cultural, and spiritual mental health and wellbeing, alongside physical health.
Respectful and empowering relationships	Build supportive, respectful and empowering relationships with the person being supported and their support network including informal carers and supporters, families and kinship groups.
Use trauma-informed care and practice	Recognise the prevalence and impacts of trauma and ensure that organisational, management, and service delivery systems will not re-traumatise people.
Promote recovery and personal change	Support each individual on their own unique path to recovery, recognising that the experience is subjective and different for everyone.
Deliver person-led, tailored services that promote choice and empowerment	Design and deliver tailored services in partnership with each person accessing the service to meet individual needs and aspirations.
Integrate cultural ways for cultural safety	Create a culturally inclusive and responsive approach by recognising and incorporating cultural ways of being, knowing and doing, including for Aboriginal and culturally diverse communities.
Provide holistic and culturally safe services for Aboriginal people	Ensure cultural safety, security, and inclusion of cultural identity in ways of working with Aboriginal people.
Ensure equity and access	Increase awareness of the service among referring groups and partners and make referrals easy to ensure that everyone who needs it can access CLS, including members of priority groups.
Prioritise access based on support needs	Prioritise people with severe mental health conditions, high levels of impairment, complex needs, and high-risk factors.
Support family, carers, and kin	Involve family, carers, and kin consistent with the person's preferences wherever possible and with consent and support for their ongoing involvement.
Value, celebrate, and promote choice and autonomy	Value and promote each person's right to make decisions and choices about their own life, including through the use of supported decision-making practices and frameworks. Ensure choices are embedded in all aspects of service delivery.
Foster a culture of hope, optimism, and recovery	Embody and use language that promotes a culture of hope, optimism, empowerment, and recovery.
Integrate community-based psychosocial supports across the continuum of care	Deliver strong, integrated, and effective responses across the continuum of care, including providing psychosocial supports starting when people are still in inpatient care or a correctional facility.

Stages of the service model

CMOs will deliver activities across six interconnected stages of the CLS journey. Each stage builds on the strengths and aspirations of people with a severe mental health condition. Each person will have their own unique journey through the service. For some, the journey will be linear and follow the six stages outlined below and in Figure 1. For others, it may be more iterative as they evaluate, adjust, and refine their goals and/or move in and out of the program over time.

- **Stage 1:** Awareness of CLS
- **Stage 2:** Application or referral
- **Stage 3:** Eligibility assessment
- **Stage 4:** Goal setting and individual support planning
- **Stage 5:** Flexible support tailored to needs, preferences, and goals
- **Stage 6:** Program exit.

Figure 1: Stages of the service model

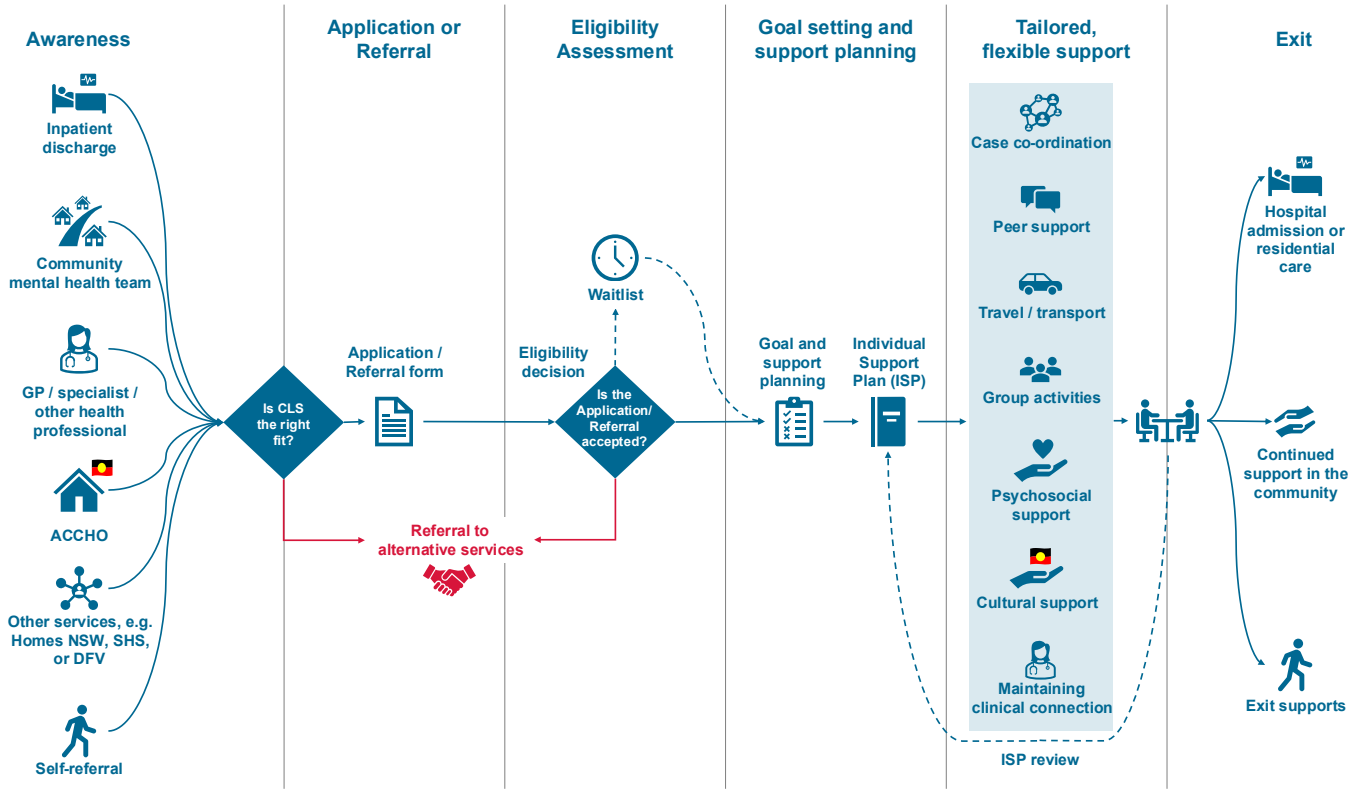

Figure 1 illustrates the six stages to provide a holistic and culturally responsive service that builds on the strengths and aspirations of people with mental health conditions or distress who access CLS.

Stage 1. Awareness of CLS

Partnerships between CMOs, LHDs, and other local service providers are fundamental to CLS. CMOs are responsible for developing and maintaining those partnerships to facilitate appropriate referrals and ensure integrated services and seamless support. That includes raising awareness of, and building familiarity with, the program and eligibility criteria among referrers through targeted communications, information products, in-services, and similar activities.

Stage 2: Application or referral

Most referrals to the program are expected to be received from LHDs. If the LHD refers someone to the program, or the person is receiving other clinical supports through the LHD:

- the LHD will give the CMO a clinical mental health assessment and a risk assessment (i.e. risk of the person harming themselves or others)
- either the LHD or the CMO will do a functional assessment (i.e. an assessment of the person's functional capacity) using the tools defined in the Service Level Agreement (SLA).

The clinical, risk, and functional assessments are required before a person can start the program.

There should be agreed processes for non-LHD referrals. People are eligible for CLS even when they do not or have not received services from an LHD clinical mental health team. For example, some people access clinical care through General Practitioners (GPs) and other service providers, and CMOs can get information from and provide supports along with these providers.

CMOs will use a 'no wrong door' approach to ensure accessibility from multiple points of entry.

They will accept self-referrals, and other referring bodies may include but are not limited to:

- Aboriginal Community Controlled Health Organisations (ACCHOs)
- GPs, private clinicians, and Primary Health Networks
- other agencies such as the NSW Department of Communities and Justice (including Homes NSW and Corrective Services NSW)
- social housing providers
- family and carers
- other services such as specialist homelessness and domestic and family violence services.

Each region should have an established process to ensure fair access for people who were referred from or receive clinical support outside the LHD. The CMO and LHD should agree to this process, as well as the clinical assessment criteria and the referral form.

Where someone who is referred is receiving mental health services elsewhere and these services are able to perform the necessary clinical or functional assessments (e.g. a private psychiatrist or ACCHO), the LHD can choose whether it will do the clinical or functional assessments. Otherwise, the LHD must ensure:

- the person's treating clinician does a clinical assessment and provides enough information to inform a decision about the person's eligibility
- either the CMO or an external party does a risk and functional assessment before the person starts the program
- the person's treating clinician (LHD or external) is expected to be a genuine partner in the person's recovery by continuing to provide integrated clinical mental health care.

Both the referrer and the person they referred should receive:

- a notification when the referral is received
- details on next steps, including application review, eligibility, and selection.

Stage 3: Eligibility assessment

All referrals are assessed for eligibility against the criteria defined in the Eligibility criteria section of this service model to ensure equity and consistency. If a person is not eligible for the service, they must be provided with appropriate information and referrals, and the policies, procedures, and processes for appeals (nominated carers or other support workers can assist in this process if appropriate consent is given). If a more suitable alternative service is available to meet the person's needs, such as Mental Health Community Living Supports for Refugees (MH-CLSR) for refugees and people seeking asylum, consideration should be given to referring the person to that service.

CMOs and LHDs collaboratively manage a streamlined referral process that is accessible and user-friendly. For those who need it, CMOs can assist people to complete referral forms, however this does not replace the expectation that referrers will provide reasonable and appropriate information as part of the referral process.

The selection process considers assessments and level of need. Referrals should summarise the person's history and the relevant mental health clinical and risk assessments.

A local committee should meet regularly to review referrals, determine eligibility and coordinate ongoing supports. Each region should also have a process for quick and flexible program entry where necessary.

During the selection process, the reviewers should:

- consider the clinical, risk, and functional assessments
- assess all supporting information to determine the level of need
- assess whether the program is suitable for the referred person
- manage the waitlist of eligible people when service demand exceeds supply (the waitlist does not guarantee a place in the program and openings will be offered based on relative need and suitability)
- refer the person to other services if the program does not suit their needs, or if the waitlist is long and they need interim support.

Once reviewers reach a decision, they should notify:

- the referred person in writing or by phone, and advise the person of the next steps and timeframes if eligible
- the referring agency or person in writing.

Where openings in the program are limited, CMOs and LHDs should give priority to:

- people with the most significant support needs
- people needing step-down care and support
- people at risk of hospital admission
- people who identify as Aboriginal and/or Torres Strait Islander
- people leaving a correctional facility or in contact with the community justice system, such as being on parole, serving a community-based detention order or having a forensic patient status
- people at risk of homelessness, e.g. living in public or community housing or a boarding house (with a risk to tenancy).

Stage 4. Goal setting and support planning

CMOs provide community-based psychosocial supports that complement the clinical mental health services the person receives from an LHD or another organisation. Together, these organisations design approaches that respect the individual nature of recovery, consider any trauma history or diverse needs a person may have, and are integrated across clinical and community settings in a region.

The CMO staff works with the person to develop a trusting relationship with a sound knowledge of their history and preferences as a basis to help them identify and prioritise goals that are meaningful and personally tailored to their values and needs. A whole-person, strengths-based relational approach underpins the formation of goals and support plans. Expectations should be set with the person at the point of entry to the program. As part of the goal-setting approach, the person will be asked about their preferences for family, carer and kin involvement, and information-sharing.

Building rapport with Aboriginal people in culturally safe ways is vital to ensure that culture and cultural identity are included in goal setting and planning. It may take additional time to appropriately discuss and transition between entry, goal setting and transition planning with Aboriginal people accessing the service.

Individual Support Plans (ISPs) document personal goals and needs, and how they change over time. This helps CMOs provide flexible support hours and types of support and to prioritise people with complex needs. ISPs document:

- a person's mental and physical health goals and needs
- supports the CMO will provide
- services the LHD will provide that complement the clinical care plan from a GP or private clinician, where relevant
- services other organisations, including housing providers, Aboriginal organisations, and NDIS-funded providers, will provide if relevant (where a person receives support from another service, the focus will be on strengthening, complementing, and supplementing support to achieve identified goals, not duplicating services)
- strategies to build or re-build healthy relationships and support networks.

The ISP should:

- encourage person-led goals that fit into the recovery framework, not service-driven goals
- ensure that each support is linked to a personal goal
- be culturally informed and appropriate, especially for a person who identifies as Aboriginal or is part of a culturally and linguistically diverse community
- include the LHD's input where relevant as a best practice approach.

Where a person needs the support of more than one worker at a time due to complex needs or increased risk, this must be agreed between the CMO and LHD. This may be on an individual basis or at an operational level, such as a policy about late working. The agreement can be verbal or written, time-limited or ongoing. It should include the process for people who are linked to the LHD, as well as people who are not.

Once complete, the person owns the ISP and keeps a copy for their records. They can share it with other relevant parties as they see fit.

Throughout their involvement with the program, the CMO will support the person to work towards their goals, set new ones, and develop new skills or enhance existing skills. They will also adapt the person's supports to achieve this. ISPs are reviewed at least every 13 weeks, and the review should include all parties involved in the person's care. Involvement of additional parties (such as family and carers or housing providers) who contribute to the ISP is at the discretion of each person receiving CLS supports. The ISP should outline this review process and be routinely updated in line with the person's support needs. Reviews may be more frequent than every 13 weeks, depending on each individual's circumstances.

Stage 5: Tailored, flexible support

The CLS model of flexible, individualised supports respects the dynamic nature of recovery. It incorporates these elements by collaborating with the person accessing support, family members, carers, LHDs, CMOs, and other support providers on activities such as:

- identifying and working towards unique recovery goals
- accessing local mainstream social, leisure, and recreation opportunities aligned with those goals
- building daily living skills, such as cleaning, cooking, self-care, shopping, and using public transport
- developing relationships and advocating appropriately with other service providers such as dentists, drug and alcohol treatment providers, GPs, occupational therapists, nutritionists, physiotherapists, and immigration services
- independently managing medication and following clinical advice
- understanding and making decisions about medical advice they receive about physical health and addressing lifestyle risk factors
- building or re-building and maintaining relationships and connections
- building and maintaining community integration and connections and dispelling stigma
- participating in Aboriginal community activities that recognise individual and collective wellbeing and reflect healing concepts, where a person identifies as Aboriginal
- maintaining tenancies and managing accommodation issues, such as by helping a person to understand lease terms and how to manage their accommodation
- supporting people to navigate other services, including the NDIS, such as by completing paperwork, gathering evidence, and following processes
- supporting access to education, vocational training, and work
- staying connected to the community if the person is in hospital and supporting discharge/ transfer planning.

Flexible and individualised supports change over time to respond to a person's changing needs. Support is tailored to each person, putting them first and increasing choice. For example, the hours and types of support a person receives will vary based on their individual needs at any point in time, their ISP, and their care plan with the LHD, if relevant.

Support hours may change as often as week to week. The minimum is 5 support hours per week or a total of 65 hours over 3 months, and the maximum is 40 hours per week or a total of 520 support hours over 3 months.

Regular support planning and communication with the person, their family and the LHD or private clinician will help build trust and understanding to help ensure the right level of support and manage the risk that people receive too few or too many support hours. These discussions should be part of the 13-week ISP review cycle, or more frequent, and include at minimum the individual, CMO, and LHD/or private clinician, noting that additional parties (such as family and carers) can contribute to the ISP at the discretion of the person receiving CLS supports.

The program is designed to provide individual support hours, but groups are also important for social interaction, relationship building and skill development. When CMOs arrange group support, they should offer a range of group sizes and activities to suit different individual needs, preferences, personalities, and abilities. They should not rely on group activities to meet benchmark hours.

It is important that people understand that they do not lose or risk losing their place in a program if they reduce their support hours. People in CLS should feel confident that their hours will be adjusted to reflect their current need without fear of losing support services.

The program is designed to provide support hours face to face. Up to 2 hours of travel per week is acceptable to support a person in areas with limited public transport options, otherwise remote support may be considered. Additional travel would be appropriate in instances where travel ensures that a person can access culturally safe support or engage in cultural activities on Country or within their preferred community.

Stage 6: Exit

When people leave CLS, their exit will ideally be planned. Most exits are likely because the person has reached a point in their recovery where they no longer need the intensity of CLS supports to sustain their health and wellbeing. CMOs will discuss the goal of transitioning from CLS supports with all people at or near entry to the program. The focus is on setting people up for success, providing clarity on the purpose of the service, and managing expectations.

A planned exit involves documenting an agreement from all parties about ongoing clinical support, transition of psychosocial support (where appropriate), as well as the agreed timeframes. When a person leaves the program, they should be involved in decision-making and have a good understanding of their support options, living arrangements, and how they can reconnect with support services in the future if needed. Families and carers or other informal supporters could also be canvassed for contextual information and assistance in the exit planning process, where consent to engage carers has been provided.

Once goals have been achieved based on a shared agreement between the CMO and the person, the CMO will initiate transition and appropriate referrals, including warm handovers. The CMO will ensure people are connected with appropriate clinical and psychosocial support services before they exit (and/or move to a new geographical location). This includes providing information and escalation pathways to carers and informal supporters, only where consent is provided. Outgoing support plan documentation will indicate a summary of goal achievements, indicators of decline to look for in the future, and relevant contact details. If the person is exiting CLS due to a change in location or transition from NSW Health mental health services, LHD services will provide information as consistent with PD2019_045 *Discharge Planning and Transfer of Care for Consumers of Mental Health Services.*

As housing is not part of CLS, exiting the program does not compromise a person's access to social or public housing. When a social housing tenant leaves the program:

- they stay in the property for the rest of their lease, if they meet their tenancy obligations
- the housing provider must be made aware and the person informed about the tenancy support options in the area, in case the tenancy becomes at risk.

If a person has been receiving tenancy support for a private rental or social housing and plans to exit the CLS program, the CMO will meet with the person and the housing provider to ensure they understand their tenancy rights and obligations.

Some exits from the program may be unplanned. This includes if the person:

- leaves suddenly or unexpectedly without an established exit plan
- disengages by choosing not to accept clinical and psychosocial supports and does not respond to assertive outreach and engagement (temporary disengagement by an Aboriginal person due to sorry business is not considered to be an exit from the program)
- goes to prison or hospital for an extended period (hospitalisation for shorter periods is not considered to be an exit from the program and CMOs should continue to work with the LHD to provide appropriate supports to the person)
- is lost to follow-up and cannot be found by canvassing informal support networks or identified carers (Designated Carers, Principal Care Providers).

An individual may also leave CLS because:

- it cannot meet the high level of support they need and they transition to a higher support service
- they transition to another service provider, such as the NDIS, and no longer need support from CLS.

In these cases, the CMO will continue supporting the person until another service is available. The CMO should consult the person, their family (if appropriate), and the LHD or private clinician before connecting the person with other local providers that can meet their support needs.

If a person is discharged from or leaves an LHD mental health service, this does not mean they are leaving the CLS program. If they still need and want to engage with psychosocial supports, the person can continue in the program, and the CMO will work with other clinical service providers rather than the LHD.

Eligibility and access

Referral pathways

Most people are referred to CLS by the LHD inpatient or community mental health team that provides their clinical care, but there are no restrictions on where program referrals originate. People can refer themselves, and other groups such as Aboriginal organisations, the Department of Communities and Justice (DCJ), and Corrective Services NSW (CSNSW) can submit referrals.

People leaving correctional facilities and forensic settings often have a range of highly complex needs. CSNSW primarily refers people leaving correctional facilities to the services they need. Justice Health and Forensic Mental Health Network (JHFMHN) – a pillar of NSW Health – refers people who have been receiving mental health treatment in custody or from select forensic mental health units.

DCJ links public housing tenants with extra supports where a tenancy is at risk, additional support needs are identified, or antisocial behaviour is identified. DCJ may also refer people into the program via its Antisocial Behaviour Management Policy if the person has shown minor or moderate antisocial behaviour and is likely to have a severe mental health condition.

Eligibility criteria

People are eligible for CLS if they meet the following criteria:

- Diagnosis – be clinically assessed as having a severe mental illness with high levels of psychosocial impairment (exceptions are in place for Aboriginal people, people aged 16-24, and refugees or people seeking asylum)
- Age – at least 16 years old (people aged 15 to 24 could be referred to Youth Community Living Support Services in LHDs where it is available)
- Location – live in an area of NSW where CLS services are offered and stay there for some time so that they can meet with a local support provider
- Experience – high levels of complex needs and need for high levels of psychosocial support
- Consent/ desire to engage – a key pillar of CLS is that the person accessing the services wants to receive support, engage in the program, and recover and achieve goals, and consents to being referred to and participating in the program (access should not be declined because a person cannot clearly define their goals at the time of referral, and CLS supports cannot be a mandated support under orders made by the Mental Health Review Tribunal)
- Other programs – not accessing another program that provides the same support (although they may also access the NDIS as long as duplicate services are not provided).

CLS does not require a formal diagnosis of a severe mental health condition for Aboriginal people, people aged 16-24, refugees, or people seeking asylum. Members of these populations are eligible without a diagnosis if they meet the other criteria above and:

- identify as an Aboriginal person and would benefit from social and emotional wellbeing supports due to factors such as unresolved grief and loss, trauma, abuse or domestic violence, substance misuse, removal from family or family breakdown, cultural dislocation, racism, discrimination, or social disadvantage, or
- are aged 16-24 years old and have functional impairment due to psychological disturbance, which a mental health professional has identified, or
- are a refugee or person seeking asylum and have psychological distress, mental ill health, and impaired functioning.

Informed consent to participate in the program means that the person – or the person's guardian if they have one for health and medical decisions – has received and understood all relevant information to make an informed choice. The person may provide consent on a form or verbally, as long as they receive all the relevant information. CMOs must keep a clear record of consent, along with who can advocate to the person to accept help and support.

The eligibility criteria for CLS does not exclude people who are experiencing homelessness or other issues, such as substance use, or people who are accessing other LHD services. People with other issues such as alcohol or drug use must have a primary mental health diagnosis, and the main reason for the referral must be a mental health condition. CMOs and LHDs must consider:

- the risks, and staff safety
- how the person can access supports to treat other issues.

There is no upper age limit for people to access CLS, until the person is too frail to participate in the program. People may access the program while living in an aged care facility, if the facility cannot meet their psychosocial support needs. A person can be receiving aged care services (outside a residential aged care setting, i.e. home or supported accommodation) at the same time as receiving CLS support, if services provided are not duplicated.

Because people's circumstances change, someone who has been found ineligible for the program may become eligible later. Similarly, a person can return to the program after they have left, providing that they meet the eligibility criteria.

Where space in the program is limited, individuals will be prioritised based on the severity of their mental health condition, circumstances, or need. The selection process will consider the person's clinical and risk assessments and level of need.

Risk management

CMOs and LHDs must agree on the risk management tools they use for CLS.

Even after providing the relevant assessments for a referral, LHDs must keep CMOs informed about the person's changing mental health status and risk. This means giving the CMO updated comprehensive clinical and risk assessments and history:

- at ISP reviews
- whenever the person's clinical presentation changes
- when the person is admitted to hospital, so the organisations can work together on support plans
- when the person is discharged from a hospital, mental health inpatient unit, or community mental health service (including providing a copy of the discharge summary, and any associated documents).

CMOs must develop a risk management plan (RMP) when a person enters the program. The CMO bases the RMP on the details above and any other available information. For example, if the person is not linked with the LHD, the CMO will use information from sources such as the person, the referring clinician, other service providers, family, carers, and kinship groups.

The RMP outlines safety concerns that may affect the person's ability to participate in the program. This may include:

- current legal issues or police involvement
- verbal abuse or threatening behaviour
- harmful alcohol or drug use
- disorientation, confusion, or other traits that make the person vulnerable in the community.

Operating hours

CLS services operate primarily during business hours: 9am to 5pm, Monday to Friday.

By exception, and with the agreement of the LHD, CMOs may temporarily provide support out-of-hours to address the person's specific needs and goals. For example, a person being discharged from hospital on a Friday afternoon may need support that evening, or during the weekend. It is not intended that the planned CLS supports defined in a person's ISP will be scheduled out-of-hours.

Priority populations and culturally responsive supports

Services must be appropriate for priority groups including:

- people leaving inpatient care
- people leaving correctional facilities
- people experiencing or at risk of homelessness
- Aboriginal people
- members of culturally and linguistically diverse communities, including refugees and people seeking asylum
- LGBTIQ+ people.

CLS recognises people as being members of priority populations if they identify as such. They are not required, and should not be asked, to show proof of community membership, such as Aboriginal descent or acceptance by the community where they live.

Providing appropriate services includes cultural competence, which is more than cultural awareness. It is a set of behaviours, attitudes and policies that come together to enable a system, agency, and individuals to work effectively in cross-cultural situations. Cultural competence is a key part of CLS. To ensure cultural safety, CMOs must foster meaningful, trusting relationships with Aboriginal communities, culturally and linguistically diverse communities, and the general community.

Aboriginal mental health and social and emotional wellbeing

Ongoing intergenerational trauma still affects Aboriginal people today. Intergenerational trauma is different for each person, but may be contributed to by:

- being displaced from traditional lands
- children being separated from their families, including Stolen Generations survivors and descendants from past government child removal practices
- policies and services conflicting with culture
- the lasting impacts of colonisation
- social and cultural determinants of mental health and wellbeing.

Service providers must recognise that such history affects how Aboriginal people trust and engage with services, and how Aboriginal people experience access or barriers to support. To address this, services must provide culturally appropriate, safe and person-centred services that meet the cultural and psychosocial needs of Aboriginal people and acknowledge:

- intergenerational trauma
- the strengths of Aboriginal people, families, kinship and culture, and the resilience of Aboriginal communities.

The vision of the *NSW Aboriginal Mental Health and Wellbeing Strategy 2020–2025*[1] is for all Aboriginal people in NSW to have access to holistic and culturally safe services that provide the best opportunity for improved mental health and social and emotional wellbeing. It is also designed to support and assist NSW Health services in working respectfully in partnership with Aboriginal services, people and communities.

The NSW Implementation Plan for Closing the Gap outlines the holistic approach being taken to achieve the commitments of the National Agreement in this state. The plan sets out the NSW Government's approach to working in partnership with Aboriginal organisations and communities, and strategies for delivering progress against the National Agreement's Priority Reforms and Socio-Economic Outcomes.

CMOs must have clear strategies to ensure that supports are appropriate for Aboriginal people and consistent with the NSW Government's commitment to Aboriginal Mental Health and Wellbeing and Closing the Gap. It is expected that this will include hiring Aboriginal workers and training all service delivery staff in Aboriginal cultural competency and awareness, involvement with Aboriginal communities and organisations, partnering with local ACCHOs to support and integrate with the CLS program, having well-established linkages with LHD Aboriginal Mental Health teams in relation to referral pathways and governance, and taking an inclusive, whole family and community approach.

CLS operations

CLS supports

CLS supports should help people accessing the program to:

- receive psychosocial supports that promote daily living
- receive clinical and peer-based services to maintain mental and physical health through a range of providers
- boost independence, life satisfaction, and overall wellbeing
- maximise participation in the community
- stay out of hospital or stay for less time
- lower emergency presentation rates and risk of relapse
- maintain successful tenancies
- successfully transition back to the community, where relevant.

Integration with LHD services

Mental health services are integrated if they provide coordinated care and support across clinical and community settings, which makes the services stronger and more sustainable. The goal of integrated mental health services is to:

- enable joint planning, decision-making, and information sharing
- limit people having to re-tell their story
- reduce silos that block information and coordinated care
- reduce the ‘revolving door’ of hospital admission, discharge, and re-admission
- ensure all services and supports are consistently working towards the wellbeing of the person
- ensure people do not ‘fall through the cracks’ when they leave services.

People aged over 65 years also have access to the Older People’s Mental Health (OPMH) as a specialist stream of LHDs that has dedicated knowledge of the aged care system. If an older person is eligible for CLS, the OPMH services can act as a referring service, coordinate care and provide specialist clinical support.

SLAs between LHDs and CMOs define how the parties will work together. In general, LHDs are responsible for:

- providing clinical mental health services in community and inpatient settings, from prevention, early intervention, emergency and acute care, through rehabilitation and recovery
- managing local program governance and operations
- overseeing program partnerships
- providing referrals and participating in eligibility assessment decisions
- participating in the provision of integrated clinical care and psychosocial supports.

In general, CMOs are responsible for:

- providing and coordinating psychosocial supports
- enabling program partnership
- engaging families, kin and carers
- engaging in continuous effort to improve the program, awareness, and integration in the community
- maintaining program awareness and relationships that facilitate referral amongst Health, NSW Government and CMO partners

Integrated services can also involve partnerships outside the health sector, such as with housing, employment, education and community services. Local SLAs encourage the parties to work with other stakeholders to achieve the best individual outcomes for people receiving CLS supports.

Coordination with other services

Partnerships between CMOs, LHDs, and other local service providers are fundamental to CLS. CMOs are responsible for developing external partnerships and ensuring integrated services and seamless support. This includes building and maintaining effective working relationships with other providers, including NDIS-funded providers, housing providers, private clinicians, alcohol and other drugs services, and Aboriginal health and community organisations.

A person who receives CLS supports may already be a NDIS participant when they enter the program, or may seek support via CLS to test access to the NDIS. Where the person also receives support from a NDIS-funded service, the focus of CLS supports will be on strengthening, complementing, and supplementing NDIS funded supports to achieve identified goals. CLS providers should avoid service duplication, and help people apply for the NDIS if that is what they want. Where the CMO is also a provider of NDIS-funded services, they will consider and document appropriate controls to ensure that services do not overlap, that the funding source for different services is clearly delineated, and that appropriate separation is maintained to manage any actual or perceived conflict of interest.

The Housing and Mental Health Agreement 2022 recognises that housing and mental health are closely related. Having a safe and secure place to call home is a foundation for health and wellbeing. In turn, having good health and wellbeing helps people to sustain housing and access housing supports. The agreement between NSW Health, LHDs, DCJ, DCJ Districts, and community housing providers from the Social Housing Management Transfer Program covers collaboration between the parties to ensure that people who need housing get help to apply for it, meet their tenancy obligations, maintain successful tenancies, and live independently and with dignity as they recover. By building effective working relationships and regularly communicating with housing providers, CMOs can ensure that people receive timely supports before they are in crisis, or their leases are terminated.

The integration of clinical care and psychosocial supports in the community is fundamental to the CLS program. Where the person receiving CLS supports receives clinical services from private clinicians, including GPs, specialist mental health clinicians, and Primary Health Networks, CMOs must build and maintain meaningful partnerships with those clinicians.

To provide appropriate cultural safety and supports for people who identify as Aboriginal, CMOs must foster meaningful, trusting relationships with Aboriginal communities and services. This includes maintaining appropriate service integration with Aboriginal health services and Aboriginal community organisations. Building and maintaining effective working relationships with Aboriginal organisations helps CMOs to gain recognition in the community and informs how they support Aboriginal people who access the program. CMOs are required to either work with an existing group, or establish their own Aboriginal cultural reference group, tailored to the local community.

Substance use and/or addiction issues do not exclude people from eligibility for, or participation in, CLS, but may affect a person's support needs and the other services they use. CMOs must establish effective working relationships and service interfaces with alcohol and other drugs services to enable coordinated service delivery and appropriate referrals.

Other examples of key stakeholders with which CMOs may need to build relationships and coordinate services may include:

- culturally and linguistically diverse organisations
- CSNSW
- aged care services
- non-government providers, such as domestic and family violence, and legal services
- education providers, such as TAFE NSW.

Program governance

The SLA between local CMOs and LHDs defines how CLS operates in each region. Standard SLA terms across NSW define at a high level:

- roles and responsibilities of the parties, including for addressing physical, as well as mental health
- functional assessment tools for referrals
- how the parties:
    - create effective referral pathways
    - develop support plans that complement clinical care
    - share information
    - work together to provide wrap-around supports to people accessing the program.

SLAs can be customised locally to specify service numbers and detail how the parties will work together, but cannot vary the standard terms in ways that would materially increase service delivery costs or reduce service volumes without agreement from the Mental Health Branch. Local SLAs may not conflict with the terms of a CLS funding agreement or key program documentation.

CMOs and LHDs agree the duration of the SLA, usually 12 months or the full contract period. Once the parties sign it, or amend an existing agreement, a copy must be sent to the Mental Health Branch. The parties should review the SLA every year to ensure that it reflects current local practices and the program requirements defined by the Mental Health Branch. The parties will collaborate in good faith to ensure that reviews are completed in a timely manner.

Governance is also a key part of ensuring that the program meets people's needs. The Mental Health Branch oversees high-level program issues. Forums at multiple levels meet regularly to discuss issues, advise on policy and operations, and help with program delivery.

A Peak Stakeholder Forum discusses program issues from the perspective of key populations and priorities and advises on policy and operational matters as needed. This forum includes Aboriginal organisations, government departments and statutory agencies, and non-government organisations and peak bodies.

The Mental Health Branch also convenes a CLS stakeholder forum at least twice a year. This group includes management-level representatives from CMOs, and key contacts from LHDs and the NSW Ministry of Health more broadly. CMOs and LHDs must participate in person, by video or teleconference. Representatives from other service providers involved in the program, such as DCJ and housing providers, may also be invited. This group addresses local issues that affect program delivery but may also have broad policy implications, and helps with ongoing program planning, development, and service delivery.

Local committees take a regional approach, as each LHD has a different demographic and program size. This includes selection and coordination committees, which provide local governance to meet the needs of the region. The CMO and LHD in each region set the committee's structure, members, and meeting frequency. In determining the membership of local committees, consideration must be given to how the perspectives of priority populations will be represented, including people experiencing or at risk of homelessness, Aboriginal people, members of culturally and linguistically diverse communities, and LGBTIQ+ people.

Perspectives of Aboriginal people as a priority population, for example, could be represented through membership of an Aboriginal person on the committee and well-established linkages with the governance of LHD Aboriginal Mental Health teams.

The committee's structure and membership should be reviewed at least annually to ensure it is operating as needed. Responsibilities of these committees generally include:

- providing program governance
- discussing practices in the region
- reviewing applications and referrals
- allocating program vacancies
- managing partnerships.

These responsibilities may be fulfilled by a single committee, or split across two committees: one for program eligibility and selection, and another for program management and governance.

Membership of these committees must include local representatives from the CMO and the LHD. Other core partners and service providers connected with the program, such as DCJ and housing providers, may be involved as members of a committee, attend meetings as required, or be engaged through other arrangements to meet regularly and discuss program governance.

The roles, responsibilities, and terms of reference for each committee should be outlined in the SLA.

People accessing the service have a right to escalate issues, such as disagreements with decisions made by the CMO and/or LHD or dissatisfaction with the service they receive.

Roles and responsibilities

The three primary parties involved in delivery of the CLS program must develop and maintain strong links and working relationships with each other. They are:

- CMOs
- LHDs
- Mental Health Branch, NSW Ministry of Health.

Organisation	Roles and responsibilities
Community managed organisations	• Partner with the person to create a tailored ISP that reflects their personal goals, needs, and preferences • Deliver tailored services within the scope of service delivery options • Build the capacity of the person to continue to succeed after exiting the program including by reinvigorating healthy relationships • Serve as the main contact for the person receiving psychosocial support while in the program • Coordinate partnerships with other service providers, including the LHD, housing providers, and local Aboriginal networks • Create a welcoming environment and inviting spaces with language and images and provide physical spaces for psychosocial support and leisure/recreational groups and activities • Collaborate with LHDs to map and develop place-based collaborations and partnerships with community organisations and services • Collaborate with clinical and peer work mental health services in community and inpatient settings at transition and across all stages of care including prevention, early intervention, emergency, rehabilitation, and recovery • Map, connect and work in partnership with ACCHOs to build awareness of place-based organisations, services and events • Report any alleged misconduct, serious incident or notifiable incidents • Report regularly on outcome measures via the Minimum Data Set • Submit quarterly service data, which shows the flow of people into the service, as well as two financial reports a year and an annual qualitative report.
Local health districts	• Provide clinical mental health services in community and inpatient settings, across all the different stages of care including prevention, early intervention, emergency, rehabilitation, and recovery • Lead place-based collaborations and partnerships with community organisations and services • Ensure early and timely communication with CMOs so that people who are eligible for CLS are identified and support planning commenced prior to discharge from hospital, to ensure seamless continuity of care • Provide clinical services and assess how the person's mental health condition affects their function and capacity to reach their goals • Participate in decision-making about eligibility, admission, and planned exits from the program

Organisation	Roles and responsibilities
	• Share adequate information on risk assessments, medical information relevant to psychosocial support, and support network contact details at entry (where consent has been given by the person accessing services) • Collaborate on incident management • Coordinate semi-regular meetings/roadshows with CMOs to review ways of working, including service gaps, data reviews, sharing successes, and ideas for innovation • Provide relevant and up-to-date lists of local/partner organisations to the CMOs • Map, connect and work in partnership with ACCHOs to build awareness of place-based organisations, services and events (and provide linkages to CMOs) • Ensure interpreter services are available for clinical appointments as required.
NSW Ministry of Health, Mental Health Branch	• Manage overall program strategy, delivery, and governance • Lead development and review of program SLAs between LHDs and CMOs • Manage contracts • Allocate resources and funding to support the CMO-LHD partnership approach and monitor efficient and sustainable use of services • Establish clear processes for escalation and collaboration by CMOs and LHDs on emerging service needs and gaps • Address policy and operational matters • Establish centralised best practice processes across services and align with service-level data through KPIs (e.g. referral processes, collaborative care planning) • Establish and monitor service-level data measures that include consumer outcome measures • Develop clear, transparent, consistent data standards and/or forms to facilitate consistency of data collection, e.g. minimum requirements for referral forms • Foster partnerships (not hierarchies) at the local and state levels • Provide clear information on access to services for priority groups • Report on and evaluate the program.

Workforce

Staffing mix and profiles

CMOs are required to understand the diverse needs of people accessing the CLS program locally and align their staffing profiles to provide appropriate, culturally responsive supports. This includes integrating lived/living experience roles (e.g. peer workers, or wellbeing coaches) and culturally identified positions into the service, with clear direction on their scope of practice and appropriate professional development opportunities and ongoing supervision and support.

Training and supervision

Program providers must deliver regular, comprehensive training for all staff to help create and maintain a highly skilled workforce that operates in a psychosocially and culturally competent way.

CMOs will ensure that workers have access to monthly supervision, culturally appropriate professional development, and ongoing support. Regular, comprehensive staff training should ensure that staff understand:

- recovery-focused supports, supported decision-making, and dignity
- relevant evidence-based therapeutic approaches, e.g. motivational interviewing, dialectical behaviour therapy, values-based work, and Aboriginal-specific validated modalities
- trauma-informed care and practice
- cultural competence
- reasonable adjustments for people with disability
- referral processes and paths
- ISPs and relevant outcome measures
- risk assessments and incident reporting
- their role as it relates to medication, alcohol, and other drugs
- data entry requirements and practices.

People working in lived/living experience roles must have completed, be working towards or willing to complete the Certificate IV in Mental Health Peer Work. Training may also be supplemented with Intentional Peer Support training, or similar.

Anyone working with Aboriginal people must have access to appropriate cultural supervision, training and support.

Lived/ living experience of mental health conditions

Workers with lived experience of mental health conditions are integral to recovery-oriented psychosocial supports. They have a unique skill set and can support others on their recovery journey.

Peer workers draw upon their own personal lived experience of mental health conditions and recovery to provide authentic engagement and support for people accessing psychosocial supports. Peer workers are in a unique position to build connections and rapport with people accessing CLS supports by inspiring hope and role-modelling recovery.

The service, the people accessing it, fellow staff and employees with lived/living experience all benefit from a Peer Workforce. It creates hope for people in the program, strengthens services and ultimately helps the program achieve its goals.

Cultural experience

Aboriginal workers are a special resource for Aboriginal people who receive CLS supports. Aboriginal workers not only use a recovery-oriented and trauma-informed approach, but they also understand:

- a person's cultural strengths and societal challenges
- intergenerational trauma and the local mental health issues of Aboriginal families and communities.

The lived experience and knowledge of Aboriginal workers are important in supporting both Aboriginal and non-Aboriginal people, and can contribute to the organisation's shared responsibility to:

- teach mental health service staff about Aboriginal people's health beliefs and needs
- design and influence culturally safe services
- envision a comprehensive model of care, including a focus on healing, whole-of-person and community-based approaches
- provide the wrap-around supports needed for people who have related issues in areas such as health, employment, and justice.

Employing designated Aboriginal positions to provide cultural support, including the Peer Workforce, is a priority for reform under the *NSW Aboriginal Health Plan 2024-2034*[24] and the *NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025*[1]. NSW Health expects that CMOs will employ culturally identified positions.

Aboriginal Mental Health and Wellbeing Peer Workers (Aboriginal Peer Workers) identify as Aboriginal and are of Aboriginal descent. Aboriginal Peer Workers have connections to community and will utilise their lived experience to support Aboriginal people and cultural safety in services. Aboriginal Peer Workers demonstrate knowledge and understanding of the local Aboriginal community. They engage and involve Aboriginal community when drawing from lived experience.

Similarly, culturally and linguistically diverse communities require a unique and dedicated workforce with specialised skills. The employment of bilingual and bicultural workers facilitates cultural understanding, builds trust, and supports navigation of cultural barriers. For refugees and people seeking asylum, it is important for services to demonstrate knowledge of local refugee and asylum seeker groups, their experiences, and their settlement needs.

Outcomes, Data, and Evaluation

Reporting obligations

Funding agreements with CMOs define performance measures, as well as program benchmarks and deliverables for each region. Under these agreements, CMOs must submit certain data for every person who participates in CLS each month. CMOs must provide data in the format specified by the Ministry and LHDs, which may change from time to time, for example as new technologies become available.

CMOs also submit quarterly service data, which shows the flow of people into the program (applications and admissions, people found eligible and ineligible, and the waitlist), as well as two financial reports per year and an annual qualitative report. The annual qualitative report is a chance for CMOs to communicate their plans for the next year and any issues that the monitoring framework does not cover. It may include narrative accounts of the services or situations such as:

- personal stories about participants
- complexities around referrals
- workforce impacts
- interactions with other programs
- development and quality improvement activities
- governance arrangements.

CMOs should also regularly assess consumer outcomes by giving every person accessing CLS the Living in the Community Questionnaire (LCQ) on entry, exit, and twice per year while participating in the program, on a schedule defined by the Ministry. Every person in the program should have the opportunity to complete a satisfaction survey, as this feedback informs quality improvements. The Your Experience Survey (YES) is a national questionnaire that gathers information from people about their care and support experiences. People leaving the program should also do an exit interview about their experience.

CMOs must report any alleged misconduct, serious incident or notifiable incident about the program within 24 hours of learning about it. The Mental Health Branch must also be notified within 24 hours if:

- there is a notifiable incident affecting a person or staff involved in the program
- there is a serious complaint about the program or their performance (written or verbal)
- anything happens that could bring negative publicity to the program or a person accessing the program, including when the media contacts the CMO for comment
- another NSW Government body or agency that funds the program ends an arrangement with the CMO
- there are any current, pending, or threatened reputational proceedings.

Any time a CMO notifies the Mental Health Branch for these reasons, it must provide a written report within 48 hours, using the appropriate form.

CMOs and LHDs must follow the process defined in the SLA when sharing relevant information about reportable incidents.

People accessing CLS are equal partners in decision-making about their supports. People have a right to escalate issues, such as where they disagree with decisions the CMO and/or LHD makes or are unhappy with the service they receive. CMOs should provide information about the right to do this when people start the program and provide reminders regularly throughout the person's engagement with the program. Efforts should be made to resolve issues with the relevant CMO before escalating them.

Minimum Data Set

The MDS standardises data collection about people accessing the CLS program and the supports they receive. The MDS contains information about every person accessing the program. Rather than using people's names, it identifies individuals with a statistical linkage key. This unique code links to other NSW Health data sets to enable program evaluation, link with other data sources (e.g. admission data), and understand how they interact.

The MDS collects data in a variety of categories, including demographic information about people, the supports they receive, their living arrangements, admissions to hospital, community treatment orders, and more. For example, the MDS is used to measure how priority groups and members of diverse communities access the program.

Measures

Funding agreements between the NSW Ministry of Health and CMOs document key service performance measures, such as relationships and governance with LHDs, support planning, partnerships, service delivery, and quality improvement. These measures are defined at the program level, not in local arrangements.

Funding agreements also set program benchmarks and deliverables for each CMO and region, including:

- daily support hours the CMO will provide in each region
- people they will support at a given time
- Aboriginal people they will support at a given time
- referrals they will accept from the LHD
- people in the program who need more than five hours of support a day.

The Mental Health Branch will track activity against these items using data the CMOs provide each month in the MDS. To foster open communication with CMOs and LHDs, quarterly reports are prepared by the Mental Health Branch to show how the program is running, based on quantitative data.

Related policies

This service model has strong links with related legislation and policies, including:

- *Mental Health Act 2007 (NSW)*, which outlines that everybody has the right to the mental health care they need[3]
- *Mental Health and Cognitive Impairment Forensic Provisions Act 2020 (NSW)*[21], which outlines the specific care and treatment requirements for forensic consumers, including those who may be in the community
- NSW Health's 'Principles for effective support when working with someone with a mental health condition'[22]
- *Vision 2030: Blueprint for Mental Health and Suicide Prevention*[15]
- *National Agreement on Closing the Gap 2020*[23]
- *NSW Aboriginal Health Plan 2024-2034*[24]
- *NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025*[1]
- *Gayaa Dhuwi (Proud Spirit) Declaration Framework and Implementation Plan*[2]
- *Carers (Recognition) Act 2010 (NSW)*[4]
- *NSW Carers Strategy: Caring in New South Wales 2020-2030*[5].

3 Background and timeline

The CLS program has evolved over more than two decades.

Timeframe	Program evolution
2002	HASI begins as a partnership between: • LHD mental health teams that provide clinical care • NSW Department of Health-funded CMOs that provide psychosocial supports • the Department of Communities and Justice. It offers 100 high-support packages.
2005-07	HASI introduces another 736 support packages ranging from very high to low support. Over time, accommodation stopped being provided as part of the program due to housing availability.
2007	HASI in the Home commences for people who have secure accommodation, such as a rental property or their own home. Unlike the earlier stages of HASI, people did not have to be eligible for or living in social housing to participate.
2009	A culturally appropriate version of the HASI program begins for Aboriginal people. It includes 100 support packages – 58 new packages and 42 transferred from other HASI programs.
2012	The Social Policy Research Centre at the University of New South Wales (UNSW) evaluates HASI and finds that the program: • reduces hospital admissions and lengths of stay • supports recovery, independence, and housing.
	HASI Plus, a high-intensity transitional program, begins. It provides recovery-focused, community-based supports for people with severe mental illness and a related significant functional impairment who require housing with 16 to 24 hours of support every day. It offers 60 places.
2014	The report *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024* is published. In response, the NSW Government commits to increasing community-based psychosocial supports.
2016	CLS is introduced, providing a flexible model of support for an additional 535 people across NSW.
2017	HASI is re-tendered in line with NSW Government procurement and probity policies and procedures. Its three programs - HASI, HASI in the Home and Aboriginal HASI - merge into one. HASI adopts the CLS flexible support model.
2019	The Recovery and Resource Support Program rolls into HASI to reflect the NSW focus on providing psychosocial supports to people with complex needs.
	Mental Health – Community Living Supports for Refugees (MH-CLSR) commences, offering culturally appropriate supports to at least 79 refugees and people seeking asylum.
2020	HASI Plus is expanded; a new site in Kempsey, Mid-North Coast is commissioned to offer an additional 10 places.
2022	The Social Policy Research Centre (SPRC) at UNSW undertakes a 3-year longitudinal evaluation of CLS and HASI from November 2017 to January 2020. Findings were made public in 2022 and demonstrated the programs make a real difference to people's lives, help people to improve their mental health and wellbeing, think about their physical health, connect more with their local community and to reduce hospitalisations and length of stay.
2024	The HASI and CLS programs are comprehensively reviewed, including analysis of contemporary evidence about effective psychosocial support programs and extensive statewide consultation with consumers, CMOs, LHDs, and other stakeholders. The two programs are combined to form the enhanced CLS program described in this service model.

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5 Glossary and acronyms

Term, acronym or abbreviation	Definition
ACCHO	Aboriginal Community Controlled Health Organisation
CLS	Community Living Supports
CMO	Community managed organisation
CSNSW	Corrective Services NSW
DCJ	NSW Department of Communities and Justice
GP	General Practitioner
HASI	Housing and Accommodation Support Initiative
ISP	Individual Support Plan
JHFMHN	Justice Health and Forensic Mental Health Network
LCQ	Living in the Community Questionnaire
LGBTIQ+	LGBTIQ+ is used in reference to lesbian, gay, bisexual, transgender and gender diverse, intersex, queer, and the + represents people of other diverse sexualities and genders not captured in the letters of the acronym.
LHD	Local health district
MDS	Minimum Data Set
MH-CLSR	Mental Health – Community Living Supports for Refugees
NDIS	National Disability Insurance Scheme
RMP	Risk management plan
SLA	Service Level Agreement
YES	Your Experience of Sevice

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