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| Assertive Outreach and Support program requirements  Program requirements for funded agencies delivering Assertive Outreach and Support |
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| To receive this document in another format [email the central Complex Needs and Forensic Disability Team](mailto:central.complexneeds@dffh.vic.gov.au) at <Central.ComplexNeeds@dffh.vic.gov.au>.  Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.  © State of Victoria, Australia, Department of Families, Fairness and Housing, June 2024.  Except where otherwise indicated, the images in this document show models and illustrative settings only, and do not necessarily depict actual services, facilities, or recipients of services. This document may contain images of deceased Aboriginal and Torres Strait Islander peoples.  In this document, ‘Aboriginal’ refers to both Aboriginal and Torres Strait Islander people. ‘Indigenous’ or ‘Koori/Koorie’ is retained when part of the title of a report, program, or quotation.  ISBN 978-1-76130-583-2 (online/PDF/Word)  Available at the [Department of Families, Fairness and Housing Complex Needs web page](https://providers.dffh.vic.gov.au/complex-needs-services) at <https://providers.dffh.vic.gov.au/complex-needs-services>. |
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Preface

The program requirements template has been developed based on examples of program requirements documentation used within the department already, used in other jurisdictions in Australia and is informed by a range of research associated with best practice in Service Agreement management and the findings of the *Victorian Auditor –General’s report Contract Management Capability in DHHS: Service Agreements* *(2018).*

Glossary of key terms

**The following is a glossary of key terms used within this document**

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| **Term** | **Description** |
| Activity | Includes descriptive information on the objectives, client group and service model that is being funded and includes the performance measures, program, and other requirements. |
| Assertive Outreach and Support (AOS) | A pilot program to deliver assertive outreach and case management support to people with complex needs experiencing significant service gaps and who pose an unacceptable risk to others |
| Assertive Outreach | Assertive outreach is an early intervention service to overcome barriers to accessing services. It is provided flexibly in the place of residence or community to build capacity for people with complex needs to improve their engagement with targeted interventions and services.  Assertive outreach provides:   * an early intervention service to address barriers to access, including service refusal and avoidance. * intensive and flexible support addressing barriers to accessing services, including environmental, social, and criminogenic barriers. * recognition of the potentially difficult, chaotic, and challenging life circumstances which make it difficult for people to engage in conventional treatment settings. * proactive approaches and acknowledgement that for some people it is not simple to access relevant services required to address their needs. |
| Case Management | Case management refers to work undertaken directly with the client based on the client’s goals and needs. It specifically describes the interventions and actions to be developed to achieve the desired personal outcomes for the client.  Case management is where a service provider holds responsibility for ensuring the described actions are implemented. The responsibilities of a case manager include assessment, planning, facilitation of referrals and linkages, advocacy, monitoring and review of the progress of the case management plan and case closure.  Case management within the context of the AOS pilot program is intended to enhance a person’s access to services. |
| Complex Needs Coordinator | The departmental role providing coordination is referred to as Complex Needs Coordinators. For the purpose of these program requirements, all coordinators providing the Multiple and Complex Needs Initiative (MACNI), Support for High Risk Tenancies (SfHRT), AOS pilot program and broader complex needs services will be referred to as Complex Needs Coordinators.  Complex Needs Coordinators provide assistance navigating the service system and offer higher-level advocacy and coordination as required. |
| Complex Needs Panel | Area-based panels that provide a formal mechanism for review, consultation and decision making for all clients with complex needs. Complex Needs Panels also assume specific responsibility for clients eligible for MACNI.  The Complex Needs Panel provides a collaborative forum for the discussion of service delivery options for clients with complex needs and considers and aims to address the needs of clients who pose significant challenges for the service system and community. This client group are likely to require a significant multi-disciplinary service response to meet their needs. The frequency of each Area’s panel will vary. |
| Crimes Mental Impairment and Unfitness to be Tried Act 1997 (CMIA) and  Statewide Complex Needs Advisory Panel (SCNAP) | The SCNAP is a panel that provides multidisciplinary clinical consultation and advice, and oversight of service responses for people who are subject to CMIA proceedings or CMIA supervision orders; and people who are within the target cohort for the Complex Needs Project Initiatives, including the AOS pilot program. |
| Engagement Plan | The Engagement Plan will identify creative strategies the AOS service provider will use to maintain open communication with the client and encourage their participation in the AOS pilot program.  An Engagement Plan is required for individuals who have not consented to the program. |
| Funded Agency Channel | <<https://fac.dhhs.vic.gov.au>> is a website that supports the partnership relationship between the funded organisation and the funding department. |
| Individual Support Plan (ISP) | An ISP is a person-centred planning document that includes a client’s goals, the supports the individual needs to reach those goals, strategies to be implemented, how the service provider will support them to achieve these goals and the date of the next ISP review.  An ISP commences when individuals provide consent. |
| Multiple And Complex Needs Initiative (MACNI) | MACNI is funded by the Department of Families, Fairness and Housing, the Department of Justice and Community Safety, and Homes Victoria, delivered by the department’s local area Complex Needs teams.  MACNI provides targeted, time-limited, and flexible interventions to a small number of people aged 16-years and over with combinations of mental illness, substance dependency, intellectual impairment, acquired brain injury, and who pose a risk to themselves and/or others.  MACNI provides individually tailored service responses based on a comprehensive assessment of need, service system capacity and case-by-case considerations. |
| National Disability Insurance Scheme (NDIS) | The NDIS provides funding to eligible people with disability. It is jointly governed and funded by the Australian and participating states and territory governments. |
| Organisation / Funded Organisation / Service provider | Organisation is used to define the entity that is funded by the department through a Service Agreement to deliver services on its behalf. |
| Program requirements | A document that details the way in which the services must be delivered in order to meet the conditions of the Service Agreement. |
| Service Agreement | A contract between the department and an organisation to deliver services on behalf of government.  The Department of Families, Fairness and Housing uses a Service Agreement version of the Victorian common funding agreement to fund organisations to deliver services.  Service Agreements set out the key obligations, objectives, requirements, rights, and responsibilities of the organisation in delivering services, and the department in providing funding to the organisation.  The Service Agreement establishes the standard terms and conditions that apply to all funded organisations and provides organisation-specific information regarding funding and payments in its schedules. |
| Service Agreement Requirements | Service Agreement Requirements document supports the Service Agreement by outlining the departmental responsibilities, policies, and obligations that *all* funded organisations must comply with. To meet the terms of the Service Agreement, funded organisations must ensure they comply with:   * the Service Agreement * the standard policies and obligations in the Service Agreement Requirements * specific policies and obligations in each relevant activity description. |
| Support for High Risk Tenancies (SfHRT) | SfHRT is a funded program that sits within the local area Complex Needs program and provides targeted support for people with multiple and complex needs who are at risk of losing their social housing tenancy. This support includes information, consultation, care coordination and/or provision of brokerage to maintain a tenancy. The target cohort for SfHRT are predominately public housing tenants, however services are also offered to tenants in community housing (excluding brokerage). |

# Introduction

## Aboriginal Acknowledgement

The Victorian Government proudly acknowledges Victorian Aboriginal people as the First Peoples and Traditional Owners and custodians of the land and water on which we rely. We acknowledge and recognise that Aboriginal communities are steeped in traditions and customs built on an incredibly disciplined social and cultural order. This social and cultural order has sustained up to 65,000 years of existence. We acknowledge the ongoing leadership role of the Aboriginal community. 

## Department of Families, Fairness and Housing

The Department of Families, Fairness and Housing (DFFH or the department) is responsible for the development and delivery of policies, programs and services that support and enhance the wellbeing of all Victorians. The department takes a broad view of the causes of ill health, the drivers of good health, the social and economic context in which people live, and of the incidence and experience of vulnerability. This allows us to place people at the heart of policy-making, service design and delivery.

## Relationship to other resources

The key related documents and resources referred to in the development of these program requirements are:

* Assertive Outreach and Support Policy Intent
* AOS Activity Description.

# Program Requirements

## 2.1 Purpose of program requirements

These program requirements establish the requirements and responsibility of the department and the funded organisation for the oversight and delivery of the Assertive Outreach and Support (AOS) pilot program. These program requirements outline the essential prerequisites that must be delivered to meet the Service Agreement obligations and include participation in the evaluation of the pilot program. The AOS pilot program will be piloted until 30 June 2025 and deliver assertive outreach and case management support to people with complex needs who experience significant service gaps and present an unacceptable risk of harm to others.

Prior to the commencement of service delivery to clients, AOS service providers are required to obtain DFFH approval of their service delivery model. The approved service delivery models will form part of the program requirements for that provider.

This document is subject to review in response to issues and opportunities for improvement identified through evaluation of the pilot.

## 2.2 Legislative context

The AOS pilot program is not established under specific legislation but is enabled by various Victorian statutes and informed by policy reform activities that are underway to improve the Victorian government’s response to people with complex needs.

Development of the AOS Policy Intent, program requirements, and service provision framework are aligned to and consistent with requirements for similar services (where applicable) for people with complex needs. This includes consideration of requirements under the *Human Services (Complex Needs) Act 2009*, *Mental Health Act 2014,* and the *Disability Act 2006*.

Clients participating in the AOS pilot program may be subject to orders under various legislation including the *Serious Offenders Act 2018*, the *Sentencing Act 1991,* and the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (CMIA)*. Service providers will not have responsibilities under these Acts but will need to be aware of requirements that apply to the AOS pilot program service user and may collaborate with authorised bodies to best support the person.

Information required for service delivery and evaluation will be collected in accordance with the *Privacy and Data Protection Act 2014* (Vic), *Public Records Act 1973* (Vic), *Health Records Act 2001* (Vic) and other applicable legislation.

The rights of people outlined in *the Charter of Human Rights and Responsibilities Act 2006* and United Nations Convention on the Rights of Persons with Disabilities have been embedded as a principle in the development of the AOS pilot program.

## 2.3 Policy context

DFFH is responsible for developing and delivering policies, programs and services that support the health, wellbeing and safety of all Victorians.

#### Complex Needs Project

The Complex Needs Project was established in August 2021 to drive policy and service initiatives across DFFH and the Department of Health (DH) to improve the service response for people with complex needs who experience significant service gaps and present an unacceptable risk of harm to others.It has been estimated that up to 200 people in total will be in scope of the broader project initiatives. **Note:** the AOS pilot program is only expected to be activated for a small sub-set of the cohort.

Initiatives of the Complex Needs Project include:

* developing new services, including trialling assertive outreach and case management approaches (the AOS pilot program).
* establishing a multidisciplinary clinical panel to advise on overcoming the most significant service gaps (the SCNAP).
* developing new policy, clinical and practice leadership functions via funding to positions across Community Operations and Practice Leadership (COPL) and Disability, Complex Needs and Emergency Management Divisions to enable DFFH and DH to collaborate and better support the target cohort including enhancing the delivery and design of holistic services for people with complex needs
* improved governance, policy coordination and integration across DFFH including accountability and reporting.

#### Better, Connected Care

Better, Connected Care is a whole-of-Victorian-government reform which brings together government departments, government entities and the community sector to collaboratively deliver more integrated services that meet the needs of clients who come into contact with and use multiple government services. Better, Connected Care aims to deliver a client centred and integrated service system where clients can access the services they need to make lasting positive change to their lives. The reform has a focus on building stronger partnerships and earlier intervention, to achieve improved client outcomes and reduce demand on acute services.

#### Complex and Forensic Needs – Integrated Response (the Integrated Response)

DFFH is responsible for the delivery and coordination of critical services to respond to people with multiple and complex needs. The Integrated Response connects to, and complements, the Better, Connected Care framework, which is the overarching government reform agenda for people with multiple and complex needs using multiple service systems.

The Integrated Response is designed to respond to current challenges in the complex and forensic disability service system including barriers to access and to the effective integration and coordination of services. The aim will be to drive improved coordination of supports for people with multiple, complex and/or criminogenic needs including those supported through MACNI, SfHRT, Forensic Disability service responses and initiatives of the Complex Needs Project.

#### Royal Commission into Victoria’s Mental Health System

In 2019, the Royal Commission into Victoria’s Mental Health System was established and in 2021, delivered the Final Report. The report set out a 10-year vision for a balanced, flexible, and responsive system through 65 recommendations, in addition to nine recommendations from the Interim Report. The Victorian government has accepted all recommendations. These reforms aim to rebalance the system so that more services will be delivered in community settings and extend beyond an acute health response to a more holistic approach across the community.

In addition, there will be significant change to the governance of the mental health system and the legislation that supports it. These structural changes will help drive the long-term improvements needed across the system.

## 2.4 Program objectives

The objective of the AOS pilot program is that individual protective factors are increased through ensuring the health, wellbeing, clinical and functional support needs of people within the target cohort are met, resulting in reduced risk of harm to the community.

This will be achieved through delivery of assertive outreach and case management.

The objective of assertive outreach is to support people with complex needs to overcome barriers to accessing services and improve their engagement with targeted interventions and services.

The objective of case management is to enhance a person’s access to services through a collaborative, structured process of assessment, planning, intervention, and review of services delivered, that responds to the risk and needs of a person with complex needs.

This program aligns with all five areas of the focus outlined in the DFFH Strategic Plan 2022-23:

* children, young people, and families are safe, strong, and supported
* Victorian communities are safe, fair, inclusive, and resilient
* all Victorians have stable, affordable, and appropriate housing
* Aboriginal voice, knowledge and cultural leadership drive Aboriginal policy, legislation, and system reform
* our systems are high-performing and responsive, meeting the needs of all Victorians.

## 2.5 Program logic and outcomes

Across Victorian health, social support and justice sectors, a wide range of tailored and coordinated services exist to support people with complex needs. However, some people continue to face barriers accessing the services they need due to varying eligibility criteria for different services, the availability of appropriate services and suitability of standard service responses, a lack of coordination between services, and the capability and willingness of services to manage challenging behaviours and risk of occupational violence.

The persistence of these barriers means that a small cohort of people with complex needs who pose unacceptable risk to community safety, may not be engaging with services that can support them to achieve better outcomes for themselves, and reduce the risk of harm they pose to others.

The target cohort is people aged 16 years and older, with complex functional needs related to mental illness, psychological distress, cognitive impairment, neurodiversity, substance use and/or trauma who pose an unacceptable risk of harm to others.

The theory of change for the AOS pilot program is that protective factors are increased through ensuring people’s health, wellbeing, clinical and functional support needs are met, resulting in reduced risk of harm to the community. Refer to Table 1 for more information.

During the pilot period, an evaluation provider engaged by DFFH will further develop this theory of change with key stakeholders and support the development of outcome measures that will be evaluated over the course of the pilot.

Table 1: Theory of change

| **Strategic interventions:**  Early and responsive services.  Assertive outreach using creative and person-led engagement strategies (i.e., allowing person to decide on pace of and intensity of engagement).  Case management including Individual Support Plan (ISP) development to identify support needs, service barriers and gaps.  Flexible funding that is individualised and can be easily scaled up or down as needed.  Use of existing multi-disciplinary panels to escalate and resolve individual and system issues. | Arrow pointing right | **Theory:**  Engaging with individuals when they need it and at their pace increases likelihood of service engagement and better outcomes.  Promoting safety and wellbeing for all is an iterative and continuous process that considers the individual’s needs and interpersonal and environmental risks.  Protective factors are increased when people’s health, wellbeing, clinical and functional support needs are met.  Program builds capacity of service sector to support people with complex needs.  Shared risk and decision-making supports service providers to engage with complex and high-risk clients. | Arrow pointing right | **AOS outcomes**  People can access the services they need.  Improved health and wellbeing.  Reduction of risk to community.  Reduction of involvement with the criminal justice system.  Better understanding of the target cohort.  Improved service capacity and capability for this cohort. |
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## 2.6 System and organisational requirements

### 2.6.1 Registration

Service providers that deliver AOS services will hold an existing Service Agreement with DFFH and must have already demonstrated compliance with the Human Services Standards[[1]](#footnote-2).

If the pilot program is recommended to continue following the evaluation outcomes and falls within a prescribed social service under the *Social Services Regulation Act 2021*, organisations delivering the program will be required to become registered under this Act from 1 July 2024.

### 2.6.2 Governance

Service providers will:

* establish and maintain appropriate levels of internal program governance and oversight, including management of risk and safety planning. DFFH will be notified of internal governance arrangements established by service providers and will be advised of any changes to these arrangements over the period of service delivery.
* participate in the Operational Management Group meeting for the pilot area and any other DFFH developed governance arrangements for the purpose of operationalising, monitoring, and reporting on the delivery of the pilot program.
* attend Complex Needs Panel meetings as required and present ISPs and/or Engagement Plans and brokerage funding requests to the relevant Complex Needs Panel.
* prepare for the SCNAP in consultation with the Complex Needs Coordinator where an individual requires secondary consultation or as required. The SCNAP may provide secondary consultation and advice for individual AOS clients. Collaboration and partnerships

Service providers should have strong linkages with a range of government departments, community service organisations and specialist services, including cultural and Aboriginal-specific services for assessment, planning and action to better address the risks and needs of clients engaged with the pilot program.

Should a service provider be in partnership with another service provider, for example an Aboriginal Community Controlled Organisation (ACCO), a memorandum of understanding or similar should exist.

Service providers will refer clients to appropriate mainstream services identified through the planning process. Where significant concerns exist about the wellbeing of a client, service providers are required to escalate these concerns to the appropriate service (i.e., police, ambulance, etc.) and notify the DFFH Complex Needs Coordinator.

### 2.6.3 Policies and procedures promoting cultural competence

Service providers will:

* have policies, processes and/or practice guidelines in place to promote the cultural competence of the workforce, to increase accessibility and safety for staff and clients from Aboriginal and cultural and linguistically diverse communities.
* collect information on the cultural identity of clients, where appropriate, and in a culturally sensitive way.
* have established protocols for mutually respectful and collaborative partnerships between culturally-specific and mainstream services.

### 2.6.4 Continuous learning and quality improvement

Service providers will:

* continually explore better ways of providing services through strategic planning, learning opportunities, evidence-based practice, professional development, and participation in evaluation processes.
* use client feedback, service data and outcomes of complaints and allegations, where appropriate, to support program improvement.
* report critical client incidents to the department in line with departmental policies, including using the Client Incident Management System (CIMS). Service providers will have a system in place for reviewing aggregated reported incidents to learn from and prevent the reoccurrence of serious incidents.

## **2.7 Operational management requirements**

### 2.7.1 Information sharing

As the program is designed to help people connect with the services they need, it is expected that most people will provide consent to receive AOS services, including consent for the collection, use and disclosure of information for this purpose and related to the collection of data for the evaluation of the program.

Information required for service delivery and evaluation will be collected in accordance with the *Privacy and Data Protection Act 2014 (VIC) (PDP Act)*, *Public Records Act 1973 (VIC)*, *Health Records Act 2001 (VIC)* and other applicable legislation.

Information will be collected, used, or disclosed as required for the purpose of delivering and evaluating the program, with the consent of the client, unless required by law for example in line with Family Violence and Child Information Sharing Schemes.

If consent has not been provided by the client, AOS service providers will only be able to collect, use or disclose information in accordance with an exception, such as Information Privacy Principle 2.1(d) of the PDP Act and Health Privacy Principle 2.2(h) of the Health Records Act, where the provider reasonably believes that the use or disclosure is necessary to lessen or prevent— (i) a serious threat to an individual's life, health, safety or welfare; or (ii) a serious threat to public health, public safety or public welfare.

Service providers will implement a process to ensure a relevant exception applies where consent is not forthcoming.

Service providers will ensure that only nominated authorised users access the secure SharePoint folder established for the pilot program for the purpose of transferring information back to DFFH and should notify DFFH of any changes to authorised users.

### 2.7.2 Record keeping

Information required for service delivery and evaluation will be collected and stored in accordance with the *Privacy and Data Protection Act 2014* (VIC), *Public Records Act 1973* (VIC), *Health Records Act 2001* (VIC) and other applicable legislation.

Service providers will:

* use information systems to ensure electronic documents and records are secure, safe, and accessible only by appropriate management and staff.
* store physical client records safely and securely, in a manner that can only be accessed by appropriate management and staff.
* collect data and client information in line with the reporting and accountability requirements in the Service Agreement and other departmental guidelines.
* store client records and information safely and securely at the closure of the case for a period of seven (7) years to enable retrieval in accordance with legislative requirements and departmental policy.

Current and former clients will be able to access and update information regarding services provided to them in line with the freedom of information provisions and relevant legislation.

### 2.7.3 Complaint and allegation management

Service providers will:

* have documented procedures in place for managing complaints and allegations by clients, including reporting through CIMS if required.
* have processes and disciplinary procedures to respond to allegations of misconduct in ways that ensure clients are protected from future harm.
* maintain a written record of all complaints and allegations made, actions taken and outcomes.

### 2.7.4 Individual feedback

Service providers will:

* have a feedback system in place to allow for staff, clients, families, and other support persons to provide views on the program and service delivery.
* define the standard of service that clients can expect to receive and make the information about that standard accessible to them.
* maintain appropriate records of client feedback and use this information to inform service planning.

### 2.7.5 Staffing competency, recruitment, and pre-employment checks

Service providers will:

* have policies, processes and/or practices in place to ensure staff have the required skills, qualifications, knowledge, values, competencies and cultural competence for their positions and responsibilities to meet the needs of clients.
* undertake an analysis of staffing levels to ensure the individual needs of clients are met and the service provider acts to recruit staff where vacancies occur.
* ensure all applicants for staff positions are subject to pre-employment screening as detailed in the Service Agreement and Service Agreement Requirements including a valid Working with Children Check (WWCC).
* have a staff recruitment strategy in place that:
  + considers the individual and cultural needs of the clients
  + enables the program to meet targets and service agreement obligations
  + highlights the roles and expectations of staff
  + enables specific training requirements for staff in relation to the clients that they support.

Service providers must document:

* how salaries to be provided to management and service delivery staff are commensurate with the level of skill, knowledge and experience required by each role to perform the required responsibilities.
* their policy with regards to the development of a learning culture, training provision and requirements for staff. Some of these obligations include:
  + participation in cultural competence training to ensure appropriate skills to work with Aboriginal people and those from culturally and linguistically diverse backgrounds
  + opportunities to understand the theories that underpin the client care requirements, to provide a clear rationale for interventions and to ensure staff can identify specific behaviours and triggers, and the response to these behaviours
  + supervision and leadership training for those in supervisory and management positions
  + opportunities for reflective practice to allow staff the opportunity to reflect on their practice and hone their skills in relation to service delivery.

### 2.7.6 Staff training, development, and supervision

Service providers will:

* have policies and procedures to provide accessible pre-service, induction and ongoing training for management and service delivery staff to enable them to effectively perform their roles and meet client needs.
* have policies and practices that promote professional development to enable staff members to gain any competencies they need to meet their job requirements.
* have staff supervision policies in place (such as level of supervision and arrangements for after-hours support) that are reviewed regularly and specify that each staff member has an appropriately skilled manager.
* regularly review staff performance and identify staff learning needs.

### 2.7.7 Prioritisation, allocation, and demand management

Service providers will have processes in place to monitor and improve the timeliness of responses to clients and actively respond to changes that may impact on demand for services and their capacity to respond.

### 2.7.8 Service reporting requirements

Service providers will collect service data and provide data reports to the department in accordance with the service agreement and/or practice requirements as set out in the Activity Description (17085). Administration of brokerage will be in line with Flexible Funding guidelines (Attachment 1).

In addition to the Key Performance Measures as set out in the Activity Description (*Activity 17085*) service providers will be complete a brokerage acquittal template and provide to the department quarterly.

### 2.7.9 Evaluation reporting requirements

DFFH has engaged an evaluation provider to evaluate the Complex Needs Project including the AOS pilot program. The Evaluation Provider has developed data collection tools in collaboration with service providers. It is expected that the data inputs and tools to collect the information will be user friendly and ‘light-touch’ with controls and drop-down menus built into the design. Data collection will include monthly reporting against outcome measures and touch-point interviews with service providers and AOS clients. Support will be available to service providers throughout the pilot period to support consistent and quality data collection.

Data to inform the evaluation will be collected by service providers and de-identified by DFFH prior to disclosure to the Evaluation Provider.

## 2.8 Client care requirements

Service providers are to design and deliver an assertive outreach and case management program that seeks to break down the barriers experienced by the target cohort in accessing services to meet their individual needs, with the aim of reducing their risk of harm to others.

The two key components of the AOS pilot program are delivery of assertive outreach and case management. These services will be delivered by multidisciplinary teams who hold relevant qualifications and have a broad range of experience working across the target cohort.

Service providers are required to:

* confirm receipt of referral from DFFH within 1 business day with the Complex Needs Coordinator
* initiate contact with the referrer within 2 business days
* plan for and initiate contact with the client within 2 business days
* use face-to-face assertive outreach to provide intensive support and pro-social engagement
* work with clients to establish an ISP within six (6) weeks of the individual providing consent for service delivery, focused on meeting the identified risks, needs and goals of these clients. Clients (and their parent or guardian if the client is under 18 years) must receive a copy of their ISP in the format and language they are most likely to understand. A copy of the completed ISP must be provided to the Complex Needs Coordinator.
* where a duty of care referral has been received, and the client has not provided consent for service delivery, an Engagement Plan is required to be established within two (2) weeks. The Engagement Plan will outline strategies to engage with the person to obtain consent for service delivery before an Individual Support Plan is able to be developed. A copy of the completed Engagement plan must be provided to the Complex Needs Coordinator
* refer and connect clients to relevant services to address identified needs, such as area mental health, drug and alcohol services, housing services, and other community services relevant to improving the clients’ ties to their communities, addressing needs, and reducing barriers to accessing services
* engage with the client’s family/partner/support people where appropriate to provide feedback about their engagement with the support service, and to support family connections and positive relationships
* review the individual’s needs, risks, and goals regularly and record progress
* maintain accurate case notes and records
* escalate any concerns to DFFH Complex Needs Coordinators. For example, where engagement has been unsuccessful in obtaining consent within six (6) weeks of service delivery, discuss with the Complex Needs Coordinator and at the Operational Management Group meetings, including the need for and timing of escalation to the Complex Needs Panel. The purpose of escalation is to consider additional strategies that can be applied to form a view for future and ongoing engagement attempts
* attend any Area-based Complex Needs Panels, or other panels, as required
* complete closure reports when a client exits the service and provide a copy to the Complex Needs Coordinator
* discuss the suitability and timing of closing support for the client, in collaboration with the Complex Needs Coordinator
* where the individual still presents a high risk, closure may require endorsement by the Complex Needs Panel.

### 2.8.1 Service planning

Service providers will:

* have processes in place to manage workflow and resources, and measure outcomes
* collect information to monitor changes in service access patterns and use service data to inform planning, ongoing service review and quality improvement
* be required to participate in the evaluation of the pilot program.

## 2.9 Service delivery principles

Service providers are required to deliver the pilot program in line with the below service delivery principles:

#### Human Rights

Services providers must recognise, uphold, and protect human rights as described in the *Victorian Charter of Human Rights and Responsibilities Act 2006*. This includes knowing, understanding, and applying human rights perspectives and protections in their work, [Charter of Human Rights](https://www.humanrights.vic.gov.au/legal-and-policy/victorias-human-rights-laws/the-charter/) <https://www.humanrights.vic.gov.au/legal-and-policy/victorias-human-rights-laws/the-charter/>.

#### Person-centred service provision

Service providers will deliver person-centred services that create an environment that best supports people to achieve their goals and be recovery oriented. Services will align with the [Client voice framework for community services](https://www.dffh.vic.gov.au/publications/client-voice-framework-community-services) <https://www.dffh.vic.gov.au/publications/client-voice-framework-community-services>, [Partnering in healthcare framework](https://www.safercare.vic.gov.au/publications/partnering-in-healthcare%3e) <https://www.safercare.vic.gov.au/publications/partnering-in-healthcare> and [Framework for recovery-oriented practice](https://www.health.vic.gov.au/practice-and-service-quality/recovery-oriented-practice-in-mental-health) <https://www.health.vic.gov.au/practice-and-service-quality/recovery-oriented-practice-in-mental-health> and include people with lived experience in their design and delivery.

#### Trauma-informed approach

Service providers will adopt a trauma-informed approach that recognises many behaviours and responses expressed by people are directly related to traumatic experiences and ensure there is a focus on building therapeutic relationships that are empowering and support individual strengths and learning; and carefully consider the potential for re-traumatisation through inappropriate work practices and/or any continuing trauma in the person’s personal life.

For more information: [trauma-informed care](https://www.health.vic.gov.au/practice-and-service-quality/trauma-informed-care) <https://www.health.vic.gov.au/practice-and-service-quality/trauma-informed-care>.

#### Evidence-based and outcomes-focused

Service providers will deliver evidence-based services that focus on quality, safety and continuous improvement through monitoring and evaluation of outcomes, aligned to the Better, Connected Care outcomes framework.

The effectiveness of different AOS approaches and other Complex Needs Project Initiatives in supporting better outcomes for the target cohort and reducing risk of harm to others will be evaluated over the course of the pilot. This evaluation will inform decisions about the ongoing delivery and potential expansion of the AOS pilot program.

#### Family and carer-inclusive practice

Service providers will recognise, respect and support families and carers as partners in supporting people to access and remain engaged with services, and as the people with the most information about a person’s behaviour in a range of contexts. Families will be able to share the person's strengths, goals, interests, coping strategies and what is important to the person.

#### Responding to diversity

Service providers will recognise, respect, and respond to the diverse needs, values, and circumstances of each person, such as their gender, family circumstances, culture, language, religion, sexual and gender identity, age, and disability. For Aboriginal AOS clients, tailored responses will recognise and respond to their distinct culture and promote Aboriginal self-determination.

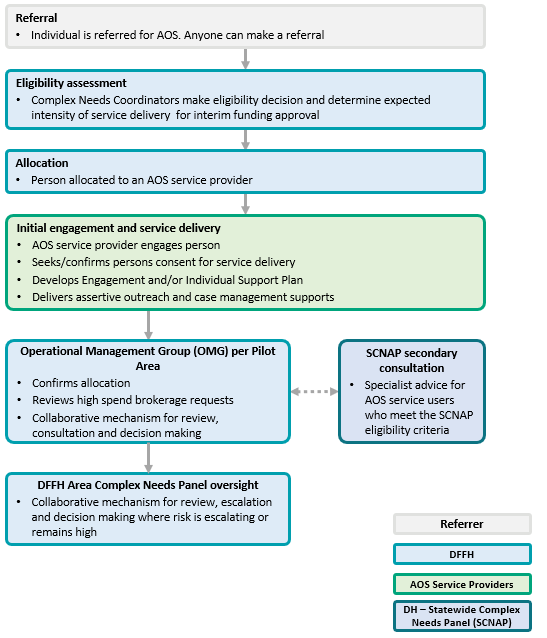
For more information:

* [Aboriginal governance and accountability framework](https://content.health.vic.gov.au/sites/default/files/migrated/files/collections/policies-and-guidelines/a/aboriginal-governance-accountability-framework.pdf)  <https://content.vic.gov.ay/sites/default/files/migrated/files/collections/policies-and-guidelines/a/aboriginal-governance-accountability-framework>
* [Korin Korin Balit-Djack: Aboriginal health, wellbeing and safety strategic plan 2017–2027](https://www.dffh.vic.gov.au/publications/korin-korin-balit-djak) <https://www.dffh.vic.gov.au/publications/korin-korin-balit-djak>
* [Balit Marrup: Aboriginal social and emotional wellbeing framework 2017-2027](https://www.health.vic.gov.au/publications/balit-murrup-aboriginal-social-emotional-wellbeing-framework-2017-2027) <https://www.health.vic.gov.au/publications/balit-murrup-aboriginal-social-emotional-wellbeing-framework-2017-2027>
* [Designing for Diversity](https://dhhsvicgovau.sharepoint.com/sites/ComplexNeedsProject/Shared%20Documents/General/09.%20Assertive%20outreach%20and%20support/02.%20Service%20Agreement%20and%20monitoring/03.%20Approved%20SAMS%20documents%20-%20accessible%20to%20SASO%20and%20AFM/DRAFT%20-%20Program%20Requirements%20and%20Activity%20Description%20-%20June%202024/Designing%20for%20Diversity) <https://www.health.vic.gov.au/populations/designing-for-diversity>.

## 2.10 Practice requirements

The key roles and responsibilities of service providers and government in the referral, allocation, service delivery and oversight of the AOS pilot program are outlined in Figure 1.

Figure 1: Key AOS pilot program roles and responsibilities

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### 2.10.1 Referral

Eligibility for the pilot program will be assessed by the Complex Needs Coordinator in the DFFH area where the person is located. Complex Needs Coordinators are also the referral point for MACNI and SfHRT and will appropriately triage referrals to the program that best meets the person’s needs.

Once an individual has been determined by DFFH to meet the eligibility criteria for participation in the AOS pilot program, the individual will be allocated to the AOS service provider in that geographical area.

### 2.10.2 Eligibility

The target cohort is people aged 16 years and over who meet all of the following criteria:

* appear to have complex functional needs that are causally linked to mental illness, psychological distress, cognitive impairment, neurodiversity, substance use and/or trauma
* appear to pose an unacceptable risk of harm to others
* are experiencing significant service gaps such that the current service system is not addressing their needs or reducing the risk to community safety.

Factors that will be considered in determining if a person meets the eligibility criteria are provided within the AOS Policy Intent.

### 2.10.3 Service response and duration

The AOS pilot program is a client-centred model, intended to be flexible to better meet the individual needs of each client. Service providers are required to demonstrate proactive planning and reflection through key stages, including appropriate allocation of service delivery staff to clients, monitoring ISPs towards outcomes and managing case closure.

The AOS pilot program is a short-to-medium term service response (up to 12 months) based on a person’s needs with the goal to link the person to required supports as soon as possible after referral.

### 2.10.4 Service environment

Service delivery hours will be responsive to the needs of clients and be in line with service agreements. It is expected that some service responses will take place outside the normal business hours of 9am to 5pm, to support contact and engagement with clients.

Service providers will:

* have policies, procedures and/or practice instructions in place to provide guidance on assertive engagement strategies for hard-to-reach and hard-to-engage clients
* have guidelines in place to make the service environment safe for clients, including the use of culturally, developmentally, and age-appropriate resources
* ensure that staff strictly adhere to safety planning processes within their organisation and conduct a risk assessment of the environment they are to attend or enter, in line with organisational policies and procedures
* have options available for where to provide services, including a healthcare setting, another service, in the community, over video, online or the phone, based on the referred person’s needs and preferences
* consider the potential benefits and vulnerabilities posed by different environments, the setting should be one that is the least restrictive and best supports the person’s, worker’s, and community’s safety needs
* support clients to access appropriate services that will assist in meeting their safety and support needs
* support clients to make and maintain supportive connections with people and organisations in their community
* work with clients to develop strategies to assist in managing potential crises that may occur outside of regular working hours.

### 2.10.5 Risk

The Assertive Outreach and Support Pilot Program Risk Assessment and Management Framework (August 2023) has been developed to guide consistent practice amongst service providers. Service providers are required to implement into AOS service delivery.

It is recognised that no single program or intervention will eliminate risk to the safety of others.

People with complex needs who access these services may present with unpredictable and impulsive behaviour and actively avoid engagement.

DFFH Complex Needs Coordinators will use information gained through referral and use of screening tools to assess the level of risk a person presents to others when determining eligibility and funding allocation. The level of risk, and impact of mitigating protective factors, will continue to be measured throughout the duration of a person’s engagement with the AOS pilot program.

Service providers will have organisational systems and processes in place to ensure their staff are engaging safely with AOS clients, and that risks to the client and others are identified, assessed, and managed.

The delivery of AOS services, including the management of risk and safety planning, will be supported through collaborative and multi-disciplinary panels within DFFH and DH. This includes the DFFH Area Complex Needs Panels that provides opportunity for collaboration and shared decision making, and SCNAP that can provide secondary consultation and clinical advice.

### 2.10.6 Interaction with Complex Needs Panels

Each departmental area operates a Complex Needs Panel that meets on a regular schedule (monthly/ bi-monthly or quarterly). Complex Needs Panels provide a collaborative forum for the discussion of service delivery options for clients with complex needs. Complex Needs Panels aim to address the needs of clients who pose significant challenges for the service system and community, and who are likely to require an extraordinary response to meet their needs.

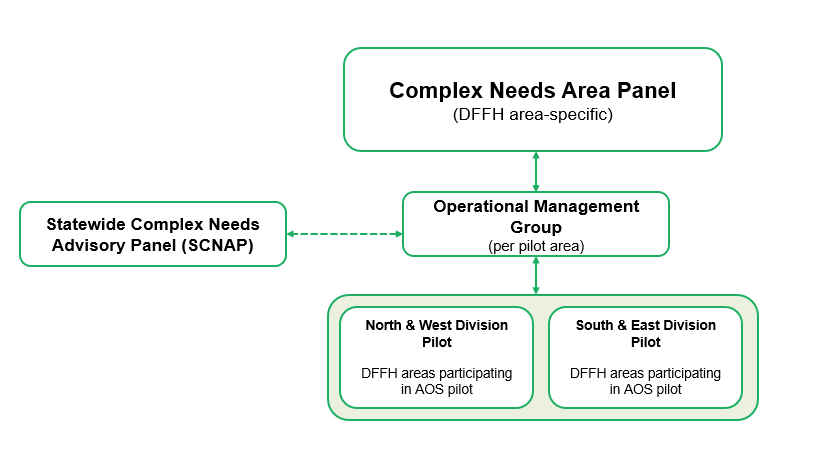
Area Complex Needs Panels will provide a formal mechanism for escalation, review, consultation and decision making for all complex needs’ clients, including AOS clients.

Service providers will attend Complex Needs Panel meetings as required for clients in receipt of AOS services.

Where an individual requires secondary consultation, providers will prepare for the SCNAP in consultation with the Complex Needs Coordinator as required. The SCNAP may provide secondary consultation and advice for individual AOS clients.

Figure 2 illustrates how the AOS pilot program relates to the Complex Needs panels.

Figure 2: AOS operational governance structure



### 2.10.7 Staffing models

Recruiting staff to deliver AOS should be based on a core set of capabilities to provide the required support for clients participating in the pilot program, including experience in engaging with individuals who present with a history of homelessness. A trauma-informed model should be adopted in line with the service delivery requirements described above.

Service delivery staff should be able to develop a trusting professional relationship to provide support to clients, challenge behaviour, and model alternative ways of acting. Service delivery staff should also be able to promote strengths and build on small successes to build the client’s self-esteem and confidence.

Clinical supervision should be provided to service delivery staff working with clients who present with complex trauma.

Management and supervision should facilitate a culture of high commitment and reflection. Given the complexity of the clientele, multiple levels of reflection and planning should be supported for each client.

## 2.11 Flexible funding guidelines

Service providers will be funded through a Service Agreement with DFFH.

Where a service provider identifies a need for brokerage funding, an application for brokerage may be completed in line with the AOS pilot program flexible funding guidelines (**Attachment 1**).

## 2.12 Additional Information

* Assertive Outreach and Support Pilot Program Policy Intent (document can be found by AOS Providers in the Resource Register on the secure Microsoft Teams channel “Assertive Outreach and Support – grp”)
* [Assertive Outreach and Support Activity Description](https://providers.dffh.vic.gov.au/activity-description-assertive-outreach-support-17085) <https://providers.dffh.vic.gov.au/activity-description-assertive-outreach-support-17085>
* Assertive Outreach and Support Pilot Program Risk Assessment and Management Framework (document can be found by AOS Providers in the Resource Register on the secure Microsoft Teams channel “Assertive Outreach and Support – grp”)
* [Service Provision Framework: Complex Needs.](https://www.dffh.vic.gov.au/service-provision-framework-complex-needs) <https://www.dffh.vic.gov.au/service-provision-framework-complex-needs>

# Attachment 1: Assertive Outreach and Support flexible funding guidelines

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Assertive Outreach and Support (AOS) providers will be allocated brokerage through their Service Agreement. AOS providers administer the brokerage and have reporting requirements to monitor performance and ensure that the brokerage is being used in line with these requirements. Brokerage principles The use of brokerage is to provide practical assistance in engaging clients and to support people achieve goals outlined in the persons Individual Support Plan (ISP). Principles relating to the use of brokerage include:   * clearly link to the implementation and achievement of the client’s goals in the Engagement Plan and/or ISP * be focussed on achieving improved client outcomes and enable individuals to make positive and enduring changes, such as increasing meaningful engagement with services * be used for time-limited, practical supports and services aligned to goals that are not readily accessible/timely/available within the existing service system (for example, local, state or Commonwealth government services) or available to other members of the community * aim to reduce the need for more intensive intervention * be prioritised based on an assessment of greatest need, reducing the risk of harm to others, and anticipated positive impacts on the client’s daily life * represent the most cost-effective and relevant option to sufficiently meet the client’s identified needs * be used to support the individual consistent with their cultural identity, including supporting Aboriginal self-determination.  Use of brokerage Brokerage may be used for the following, where there is no other support to access, or the timeliness of availability is prohibitive in plan implementation:   * respite costs for the AOS client * specialist assessments for the individual or specialist interventions where these are not readily accessible, including in a timely way * assistance to meet dental costs or specific medical interventions for the individual that is the gap which is not covered by Medicare * one-off payments to address immediate safety, stability and or wellbeing issues within the client’s home such as assistance with a utilities bill or purchasing material aid * assistance with educational assessments, tutors, training, or educational costs.   In the case of funding a clinical assessment or treatment, the service is to be provided by a professional with appropriate qualifications and registration (such as a clinical psychologist).  Brokerage expenditure exceeding a cumulative total of $5,000.00 for any client will require discussion with the Complex Needs Coordinator (and the Operational Management Group) on the expenditure. Consideration must be given to whether it is a response to a systemic issue whereby the department can provide assistance.  Some examples of how brokerage might be applied are in the table 2.:  **Table 2: examples of brokerage use**   | Activity | Example of brokerage use | | --- | --- | | Engagement Plan | **Scenario**: AOS provider meets the individual, but they have immediate (material) needs that are creating a barrier engaging with the AOS provider. There are no other informal or community supports to assist with this. **Brokerage use**: The AOS provider uses brokerage to purchase material support (such as a small number of groceries) as a once off to support engagement. Support of this nature would be limited and a plan to work with the individual to plan around future needs and possible resolution would be required. | | Engagement Plan | **Scenario**: The individual has no fixed address and is difficult to locate. **Brokerage use**: The AOS provider may use brokerage to purchase a low-cost prepaid phone to contact the individual on to arrange further contact. Support of this nature would be limited and a plan to work with the individual to plan around future needs and possible resolution would be required. | | Individual Support Plan | **Scenario**: ISP is being established but further information is required to identify ISP goals, a specialist assessment or evaluation is required to support future planning, decision making or provide evidence for ongoing support needs - where this service is not available through Medicare via GP referral or any other service system response. **Brokerage use**: The AOS provider may use brokerage to purchase this specialist support. | | Individual Support Plan | **Scenario**: ISP has been established and a need for specialist trauma counselling has been identified as need to assist the individual manage their mental health. **Brokerage use**: Time-limited counselling support is purchased (where this service is not available through Medicare via GP referral or any other service system response) with a plan established to identify ongoing need and how this may be resourced after support period ends. | | Individual Support Plan | **Scenario**: ISP has established a goal to support the individual in obtaining their Driver’s licence. **Brokerage use**: Driving lessons to enable an individual to drive a car to a place of employment/appointments |  Out of scope for brokerage Funding can NOT be used for the following:   * Replacing or duplicating supports that are available through other funding sources, including other local, state and commonwealth government programs, including the National Disability Insurance Scheme (NDIS). * Free or low-cost services readily available within the community * Funding must not be used to meet costs that any other community member would reasonably be expected to pay from their own money unless at least one of the following circumstances applies:   + the individual’s disability prevents them from accessing the service or item in the same way as the rest of the community   + there is a benefit, supported by professional medical evidence, to the individual’s health, wellbeing or fitness that would otherwise be unavailable   + timeliness of service availability is prohibitive in plan implementation   + funding an item or service may prevent a crisis or undesirable outcome for the individual and the individual is experiencing financial hardship, or   + funding a service or item is more cost effective and provides a preferable alternative to a higher cost, more intensive or restrictive support (for example, supported accommodation) that the individual would require if the service or item is not approved. * Use as income for the individual. * Repayment of personal debts – except in exceptional circumstances and with an approval process agreed by the Operational Management Group. This recognises that in many cases it would be more helpful to individuals by working on budgeting or supporting an individual to advocate for a payment plan, or to see a financial advisor. * Costs related to staff forums or events * Prohibited purposes include:   + anything that is illegal   + gambling   + directly employing staff   + setting up or using a legal entity in which they have a financial interest or for the employment of workers, or   + purchasing supports and services from a legal entity in which they have a financial interest (including but not limited to as a director or shareholder).   + smoking related items   + alcohol.   In some situations, service providers can contract specialist positions or services to meet the needs of the target group. For the AOS pilot, approval would be requested at the Operational Management Group – with endorsement required from the Project Control Group. There should be a rationale and purpose for specialist positions, with clear links to the needs of the target group and to the program’s objectives of improving the individual’s wellbeing, functioning, capacity, and safety of others. Allocation and monitoring of brokerage DFFH will allocate brokerage to the AOS providers for administration through their service agreement.  DFFH Disability Services, Policy and Support Branch will coordinate resource allocation across the Complex Needs areas involved in the pilot.  DFFH Agency Performance and Systems Support (APSS) teams will monitor brokerage administration through monthly reporting and quarterly detailed acquittals.  AOS providers can only use brokerage funds within the financial year it has been allocated.  AOS providers will report brokerage expenditure to DFFH, in line with their performance reporting requirements. Brokerage reporting will be a standard agenda item at the OMGs and/or Pilot Area Meetings. This will allow for the tracking of the allocation of funding to assist the OMG and associated teams in ensuring access to priority cohorts. Minimum quote requirements AOS providers should seek at least one detailed quote for goods and services being purchased. If multiple services/items are being quoted, individual costs are required for each activity, not a total without the breakdown of costs.  If the requested service item is more than $5000, a second quote is required. If the higher quote is preferred, a rationale and discussion at the OMG is required.  All brokerage expenditure will be recorded on the brokerage acquittal template provided by DFFH.  Quotes for goods and services are required to include the following information:   * business details – including contact details and ABN * details of qualifications, registration with their respective authorising body and relevant experience * insurance provider – including insurance type and amount of cover * schedule for work * payment details, terms, and conditions * breakdown of costs by item (for example, travel, report writing) – including client items and hourly rates. * variations * registration for GST * total cost * reference number.  Acquittal of Brokerage Brokerage expenditure will be reported to DFFH in line with the AOS key performance indicators. This reporting will inform the pilot around the adequacy of brokerage resourcing for AOS, whether the brokerage guidelines are fit for purpose, that brokerage expenditure is in-line with departmental policies and procedures and ensure all brokerage requests are within budget.  Any organisation holding and administering brokerage will acquit the funds in two ways:   * Monthly, by manual template sent to the APSS contact overseeing AOS funding, copy to DFFH Disability Services, Policy and Support Branch, Complex Needs Team generic inbox [central.complexneeds@dffh.vic.gov.au](mailto:central.complexneeds@dffh.vic.gov.au). AOS providers will acquit the total funds expended in that month. * Quarterly, in the acquittal template. Acquittal templates are maintained by the AOS provider, who will capture brokerage information across the pilot area on one template. APSS will send the template to the AOS provider prior to commencement of service delivery for the year for completion and return by 14 October, 14 January, 14 April, and 14 July each year. |  |

1. [Human Services Standards - DFFH Service Providers](https://providers.dffh.vic.gov.au/human-services-standards) <https://providers.dffh.vic.gov.au/human-services-standards> [↑](#footnote-ref-2)