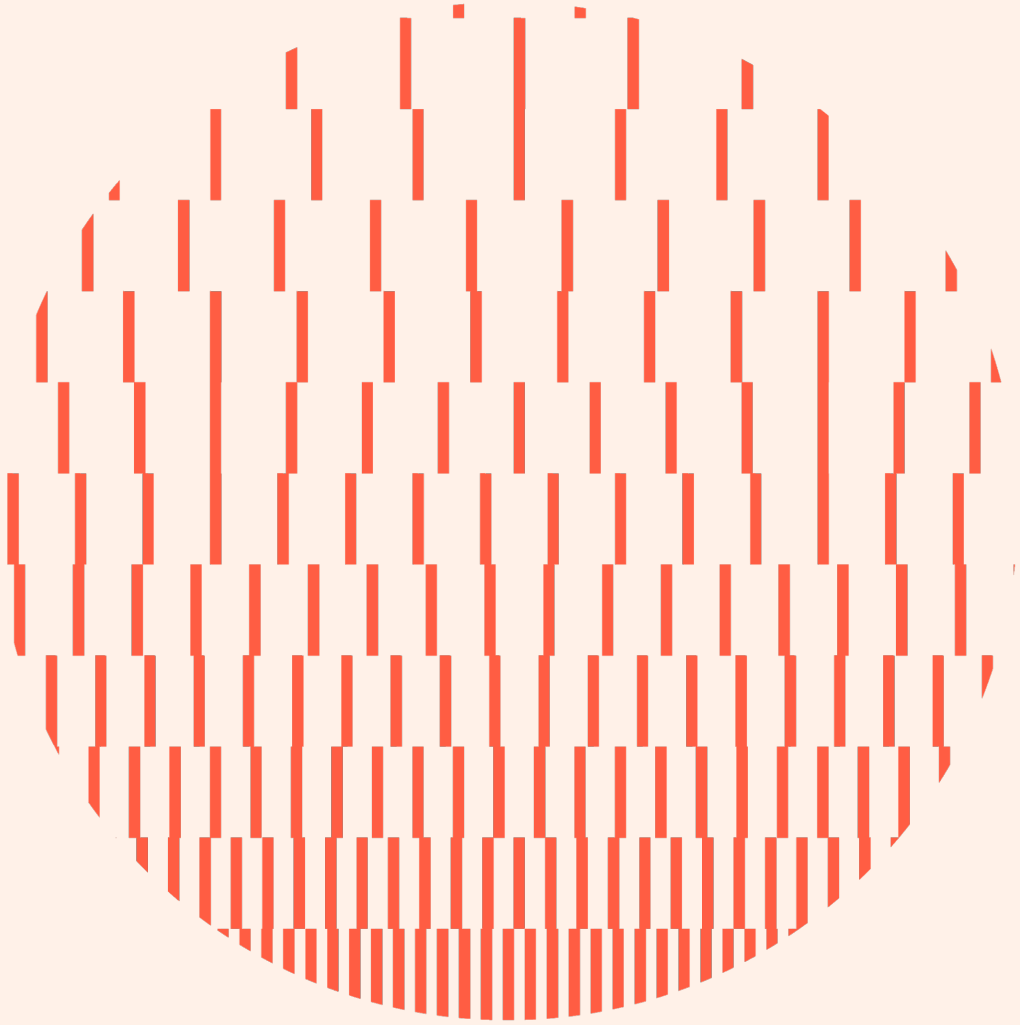
CLIENT
Department of Health Victoria

DATE
August 2025

Design of mental health and wellbeing crisis and emergency responses

System & Service Design
Sector Engagement Overview



IMPACT CO. lively.

Acknowledgement of Country

We would like to acknowledge the traditional custodians of the land on which our offices stand, and pay our respects to Elders past, present and emerging. We acknowledge their continuing relationship to this land, its waterways and seas and the ongoing living cultures of Aboriginal and Torres Strait Islander peoples across Australia.

Finally, we would like to acknowledge that sovereignty has never been ceded.

This land always was and always will be the land of Aboriginal and Torres Strait Islander peoples.

Recognition of Lived and Living Experience

We recognise the individual and collective contributions of people with a lived and/or living experience of mental health issues, their families, carers and supporters.

Through listening to and acting on the voices of people with lived experience, those who provide services, those who fund services, and most importantly, those who use services, we will find the information we need to move towards the mental health system that Australia needs.

Every person's story we hear, and every experience shared, helps to develop our understanding of the system that is required to best meet the needs of Australians living with mental health issues, their families, carers and supporters.

ABOUT THIS DOCUMENT

The Royal Commission into Victoria's Mental Health System (RCVHMS) made several recommendations to deliver a mental health system that better responds to people in mental health crisis. This includes new and redesigned services that are connected across the broader system to support enhanced experiences and outcomes for those in crisis, along with their families, carers and supporters. This project focuses on developing a high-level design for a networked system of mental health and wellbeing crisis supports as well as detailed service designs for new or redesigned services.

Background

Over the period 19th May to 27th June, Impact Co. and Lively Collective facilitated a range of diverse engagement activities to support project phase 3 (service design) including:

- 3 x workshops with sector-wide stakeholders - average 28 Stakeholders per session;
- 35 x consultations with service providers and peak bodies - total of 91 Stakeholders.

These sessions focused on capturing insights from those directly involved in delivering, coordinating and supporting mental health crisis responses across the state.

This builds on phase 2 (system design) engagement which included a focus on the broad system design and the objectives and target cohort for the five in-scope services.

About this Document

This document provides a high-level summary of key themes that emerged from the service design workshops and consultations. This includes system and service design concepts raised throughout the engagement phase.
The findings in this report will be further considered by Government in the finalisation of the service designs.

Note: This is not intended to be an exhaustive list of diverse perspectives and insights elicited through engagement activities.

Engagement Objectives

These sessions sought to:

- Develop a shared understanding of the current state of the crisis system, drawing on diverse perspectives and experiences to identify key strengths and challenges;
- Define the ideal future state where anyone can access the right crisis support, at the right time, delivered by a well-supported workforce; and
- Explore proposed new/redesigned services in detail to understand how they can each contribute to improved experiences and outcomes and be integrated within the future service system. These services are:
  - Enhanced Clinical Assistance for First Responders
  - Enhanced Crisis Telehealth
  - Enhanced Crisis Outreach
  - New Crisis Stabilisation
  - New Drop-in Safe Spaces.

Who We Heard From

- Acute health organisations
- Alcohol & Other Drug (AOD) service providers
- Community health organisations
- First Nations organisations
- Lived/living experience led organisations
- Government Department/Agencies
- Emergency responders
- Infant, child & youth mental health service providers
- Disability service providers
- Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual (LGBTQIA+) organisations
- Peak bodies.

The list of organisations reflects a diversity of perspectives, with considerations of intersectionality through the inclusion of service supporting people impacted by family violence, AOD, youth mental health, LGBTQIA+ communities,
First Nations and culturally and linguistically diverse populations.

BACKGROUND: THE PROPOSED NEW/REDESIGNED SERVICES

Core to the crisis reforms is the intent to provide greater options for consumers, families, carers and supporters to enable access to treatment, care and support in the most appropriate setting – this may include having someone to talk to, someone to respond, and somewhere to go. Each of the new/redesigned services seeks to respond to identified needs and/or current service gaps. A description of the service and its intended outcomes are outlined below. It is recognised that each new/redesigned service has significant impacts for consumers, their families, carers and supporters, and the performance of the system.

	Someone to Talk To		Someone to Respond		Somewhere to Go	
	Virtual Clinical Assistance for First Responders	**Crisis Telehealth**	**Onsite Clinical Assistance for First Responders**	**Crisis Outreach***	**Crisis Stabilisation***	**Drop-in Safe Spaces**
What is the purpose of the service?	***First responder access only*** 24/7phone and video support connecting paramedics and police with mental health professionals when they're helping someone in crisis, so they can make better decisions about what help is needed and where to go next.	***Public/provider access*** A 24/7 phone and video service that connects people experiencing a mental health crisis—along with their families, carers, and support people—directly with a team of mental health professionals for immediate help and guidance.	***Primary response*** Access to mental health professionals who can come on-site during busy times and in high-need areas to work alongside ambulance and police teams when responding to mental health emergencies.	***Secondary response*** Early intervention support from a team of mental health professionals who can respond quickly in community settings to help de-escalate situations and support recovery. This service is activated through referrals from crisis phone lines or other assessment services.	***Moderate/High acuity response*** Access to a short-term intensive care in a supportive, healing environment where people can receive focused help from a team of professionals to stabilize their situation and connect them with ongoing support.	***Low acuity response*** Access to peer support in a comfortable, non-medical setting where people can connect with others who have lived experience of mental health challenges.
What does the service do?	The service assists first responders with assessment, de-escalation and mobilisation support. The service will provide access to mental health clinicians and specialist secondary consultation (clinician to clinician) to meet individual needs. *Note: this service is for first responders – it is not a service available for the general public.*	Crisis Telehealth provides consumers and families, carers, and supporters with targeted, multidisciplinary support and services provider with navigation support and advice. *Note: this is a separate function from Area Service Telephone Triage which focusses on intake and assessment.*	The service involves mental health clinicians leading an on-site response with paramedics to provide assessment and treatment, care and support. The service will provide specialist advice in-field through mobile co-response teams. *Note: this is a co-response with a paramedic in attendance to enable a physical health response and/or police in attendance to provide a safety response.*	The service will support people of all ages experiencing mental health crisis or acute emotional distress and who can be appropriately supported in community settings. It may be activated by consumers, their families, carers and supporters or service providers. A multidisciplinary team will provide targeted therapeutic support, including intensive single session treatment and strategies to support de-escalation and recovery.	A Crisis Stabilisation service will offer a therapeutic environment, staffed by a trauma-informed multidisciplinary team (including clinical mental health, clinical AOD, and lived experience workers), to provide up to 24 hours of short-term intensive treatment, care and support, and connection to ongoing care.	Safe Spaces will enable guests to engage with a peer worker and/or receive support navigating other services, with an option for clinical involvement if required.

De-escalation involves verbal and non-verbal communication, environmental modification and is the combination of strategies, techniques and methods to reduce a person's distress and work with the person to find solutions. The aim is to support the person to regain control.

Secondary response refers to access for the mental health clinician to additional expertise from a person with specialist knowledge to enhance decision-making.

** Support for families, carers and supporters may include engagement in care planning, psychoeducation, and other direct supports (e.g., family therapy, peer support).*

SYSTEM DESIGN: KEY INSIGHTS

KEY INSIGHTS

The Royal Commission into Victoria's Mental Health System (RCVMHS) set out a vision for transforming the state's mental health system: "*A future mental health and wellbeing system that is compassionate, responsive, and provides holistic care for all Victorians.*" To achieve this, service and system design must consider both the potential drivers of mental health crisis, and the health, mental health and other community services required to support an appropriate response. Opportunities to enhance connection and integration between services was a key consideration for future system design.

An intersectional lens to system and service design seeks to ensure that is strong connections between mental health and other health and social services.

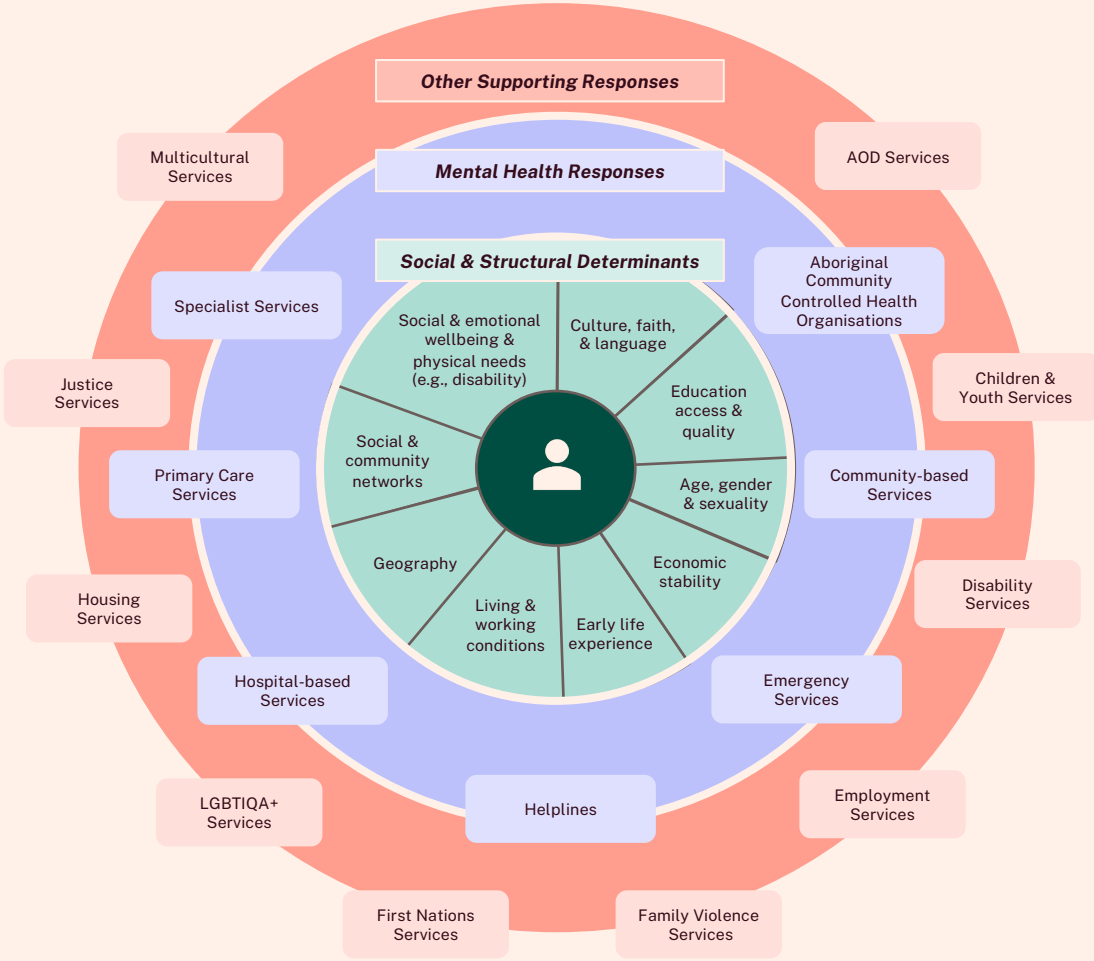
People's mental health and wellbeing needs are shaped by the ways intersecting systems of power and oppression, such as racism, colonialism, sexism, capitalism, and ableism, intersect and compound. These structural forces create unequal conditions across housing, employment, healthcare, and social connection, which in turn influence how people experience mental health crises and how they access or are excluded from care. These intersecting systems do not reside within the individual but operate around them.

It is within this broader context that the diagram should be understood - each layer is interconnected and reciprocal. An individual's mental health journey does not move through these layers in a linear fashion; rather, people navigate support systems in dynamic and overlapping ways, shaped by their lived experience and the structural conditions that influence access, inclusion, and quality of care.

The future state should embed the necessary workforce capabilities and referral pathways to support access to the range of services required to support recovery and wellbeing. An intersectional lens is increasingly being applied across the service system, with enhanced efforts to meet the needs of people experiencing overlapping needs. There is a clear opportunity to deepen service integration and strengthen pathways to embed more holistic and coordinated care.

Key considerations relating to the potential drivers of mental health crisis, together with the targeted mental health and broader service system responses required, include the following inter-related components:

- **Social and structural determinants** that shape a person's individual wellbeing needs and influence how they access and experience support;
- **Targeted mental health response**, including access to treatment, care and support for acute mental health needs; and
- **Broader wellbeing services** that provide preventive, ongoing and/or specialist support to address social determinants.



KEY INSIGHTS

A responsive, integrated crisis service system requires person-centred service pathways and access to a range of capabilities delivered by a diverse workforce mix.

Improving experiences and outcomes requires enhanced knowledge of, and access to, a range of services and supports

People need to know who to call or where to go.

Any new or redesigned services must be accessible for those who need them, with clear entry pathways when people are experiencing mental health crisis. These individuals may seek access to early treatment, care and support in a variety of settings, including via virtual support, community services, and hospital services when appropriate.

Crisis responses should be available via multiple modalities.

Multiple assistance options — digital, telephone, and in-person — tailored to different situations and individual preferences is key to providing more choice. This is especially important for rural and remote communities.

Improved referrals and service transitions will support enhanced outcomes.

Warm referrals with confirmed follow-up may prevent consumers from falling through gaps in the system. Continuity of care can be enhanced through access to care plans, advanced statements of preferences, care coordination and integrated services.

Whilst an optimal workforce model varies across services, the system requires a workforce with a mix of capabilities, backgrounds and experiences

Crisis services require multidisciplinary teams with diverse capabilities.

The core service functions includes: assessment, de-escalation, treatment, care and support; response mobilisation; and/or referral and navigation support. Depending on the setting, these functions may be delivered by a range of disciplines, including mental health clinicians and peer workers, with secondary support from specialist expertise (e.g., age-based responses, support for co-occuring AOD use, and/or social and emotional wellbeing).

Trauma-informed approaches are essential to reducing ongoing harm to consumers.

Trauma-informed care* is foundational to effective health-led responses to people experiencing mental health crisis.

** Trauma-informed care promotes awareness and impact of trauma, rebuilds individual control, encourage self-empowerment & promotes connection for those who have experienced trauma.*

Workforce development will continue to strengthen crisis system.

The system faces significant workforce issues, including recruitment, burnout and retention challenges. Ongoing access to training and supervision, in addition to clear career pathways are critical components to support workforce retention.

KEY INSIGHTS

Stakeholders emphasised the importance of coordinated support that can meet the complex and intersecting needs of people experiencing mental health crisis, and their carers, families or supporters.

Enhanced service integration is the foundation of a clear, cohesive and collaborative system

Information-sharing between services supports system integration.

Each services involved in responding those experiencing mental health crisis must "talk to the other" so that people seeking support are not having to repeat information. Stakeholders noted the need for optional anonymity in certain settings, such as telehealth services and safe spaces, and the need for consent to share information.

System navigation supports enhanced care pathways.

Navigation support, supported handovers (e.g., between community and hospital-based care teams), and warm referrals (e.g., between mental health services and other services) can reduce fragmentation and support timely access to ongoing care.

Stronger cross-sector collaboration can improve service access and outcomes.

Strengthened partnerships between community and tertiary services may avoid duplicated assessment and intake process and reduce barriers to shared/integrated care.

Inclusive design is required to provide safe responses for diverse community needs

Services must be responsive to diverse needs and preferences.

Access to person-centred treatment, care and support requires enhanced mainstream services, and access to specialist services where required.

The current service system can present significant barriers for people with intersectional needs, including but not limited to First Nations peoples, people from culturally and linguistically diverse communities, people with a physical, mental, intellectual or sensory disability, people with complex mental health needs, and/or people from LGBTQIA+ communities.

Service must meet the needs of people with co-occurring mental health and AOD needs.

People with substance use and/or addiction needs who are experiencing mental health crisis are disproportionately impacted by siloed services and exclusionary access criteria, leading to service refusal or enhanced risk of harm.

System and service design must align workforce capability, and service models that enable access to treatment, care and support for multiple needs at the same time.

Crisis responses are not one-size fit all. An intersectional lens should underpin all services.

Recognition of, and response to, the drivers that shape a person's crisis presentation must be factored into service responses and workforce capability.

SERVICE DESIGN: KEY INSIGHTS

VIRTUAL & ONSITE CLINICAL ASSISTANCE

Both virtual and onsite clinical assistance services aim to provide first responders, by enabling access to timely clinical assessment; advice on options to access treatment, care and support; and mobilisation of an appropriate response, when required.

	VIRTUAL CLINICAL ASSISTANCE FOR FIRST RESPONDERS	ONSITE CLINICAL ASSISTANCE FOR FIRST RESPONDERS
Core Functions	**The service assists first responders with assessment, de-escalation and mobilisation support when they are attending to someone experiencing a mental health crisis.** This could look like: • Timely mental health assessment of consumer, involving families, carers and supporters where appropriate; • Access to specialized support, as required (e.g., infant, child and youth expertise); • Identifying if further medical or mental health in-person treatment, care and support is required; • Identifying if it safe to stay in-place or which service is most appropriate for treatment, care and support; and • A warm handover to telehealth, community and hospital supports, where appropriate.	**In addition to the services provided through the virtual service, onsite clinical assistance includes providing treatment, care and support in the community.** This looks like: • Real-time access to specialist clinicians.; • Medication administration; • Direct linkage to community-based support, including AOD and/or mental health services; • Wraparound care initiated with warm handovers; and • Support for consumers, families, carers and supporters onsite.
Workforce	**The service should be staffed by mental health clinicians** • A central pool of mental health clinicians could provide support across locations, with ability to triage, escalate and refer as needed.	**The service should involve a multidisciplinary team,** consisting of: • Mental health clinician; • Peer workers; and • Emergency Services (Ambulance Victoria paramedics to support physical health needs, and/or Victoria Police to support safety response when needed).
System Integration	**It is proposed that virtual Clinical Assistance be delivered as a centralised service, closely integrated with Area Service telephone triage and future Crisis Telehealth services.** • The intended functions of Virtual Clinical Assistance are distinct from the Crisis Telehealth service and the broader functions of Area Services Telephone Triage. • It would provide emergency services responding to a mental health crisis with 24/7 virtual access to mental health experts, to support in-field assessment and enable timely health-led decision-making and escalation. In contrast Crisis Telehealth provides consumers, families and carers direct access to a multidisciplinary team to support initial assessment and navigation to an immediate response. • Virtual Clinical Assistance will require integration will other elements of the reformed service system to enable consumers to step up/down their care based on their needs.	**It is proposed that onsite Clinical Assistance should be integrated with Crisis Outreach.** • Onsite Clinical Assistance will require integration with Virtual Clinical Assistance, Area Service Telephone Triage, Crisis Telehealth, and Crisis Outreach . • It is intended that onsite clinical assistance would only be implemented in high-volume areas and at time periods.

CRISIS TELEHEALTH & CRISIS OUTREACH

Crisis Telehealth and Outreach will support consumers experiencing a mental health crisis, their families, carers and supporters, and service providers through more timely access to multidisciplinary mental health expertise.

	CRISIS TELEHEALTH	CRISIS OUTREACH
Core Functions	**The core functions of an enhanced crisis telehealth response include: assessment; treatment and care, and support; referral and navigation support.** This could look like: • Clinical assessment at the point of call to support consumer-led decision-making; • Brief intervention and single-session response to support de-escalation, emotional regulation and stabilisation; • Care and safety planning; • Mobilisation of secondary response; • Advice and information; and • System navigation support.	**The core functions of an enhanced crisis outreach service include: in-person crisis attendance, assessment, treatment, care, and support.** This could look like: • Comprehensive assessment such as clinical risk evaluations, consideration of psychosocial supports, and mental state observations; • Development and/or updating of care and safety plans, which may involve families, carers and supporters where appropriate; • Delivery of onsite therapeutic support to support rapid de-escalation of crises; • Direct service referrals to follow-up care and/or linkages to community supports; and • Provide families, carers and supporters with information/warm referrals to other supports for both themselves and the consumer.
Workforce	**The service should be staffed by a multidisciplinary team.** This may include: • Mental health clinician; • Peer workers; and • Specialist disciplines (including infant, child and youth, AOD, social and emotional wellbeing).	**The service should involve a multidisciplinary team that inclusive of clinical, peer and specialist roles.** This may include: • Mental health clinician; • Peer workers; and • Specialist disciplines (including infant, child and youth, AOD, social and emotional wellbeing).
System Integration	**Integration options include:** • Enhancing the existing Area Service Telehealth function (for example by enabling access to the local functions vis a statewide number), or • A statewide service Under either model • The service could be integrated with Area Service Telephone Triage for response mobilisation (inclusive of relevant hospital and community supports); and • The service could provide warm referrals to a range of services, across mental health wellbeing, physical health, and social and emotional supports.	**It is proposed that an enhanced Crisis Outreach is integrated as part of an enhanced Crisis Assessment and Treatment Team (CATT)** **This could look like:** • Embedding rotating staff arrangements to enable Area Service staff to work across Crisis Outreach, Continuing Care Teams, Triage, and other service functions; and • Enabling Crisis Outreach teams to provide surge support in other catchments within the same Local Health Service Network, where appropriate. **As noted on slide 11, it is proposed that Onsite Clinical Assistance for First Responders could also be Integtated as part of the enhanced crisis outreach model in area of high demand.**

CRISIS STABILISATION & DROP IN SAFE SPACES

Crisis Stabilisation seeks to provide short-term, clinically supported mental health care in a therapeutic setting, through a multidisciplinary workforce.
Drop-in Safe spaces seek to deliver flexible, peer-led support focused on wellbeing, connection, and navigation, in a consumer-led service environment.

	CRISIS STABLISATION	DROP-IN SAFE SPACES
Core Functions	**The core functions of a crisis stabilisation service include: delivering intensive, multidisciplinary mental health support in a therapeutic environment, with the potential for intensive short stays.** This could look like: • Rapid assessment, including medication management; • Immediate therapeutic support from a multidisciplinary team; • Access to short-term (<24 hour) intensive support; and • Navigation, advocacy and warm referral to follow-on supports.	**The core functions of drop in safe spaces include: flexible, peer-led support and consumer-led service use.** This could look like: • No formal or clinical assessment; • Peer-led support in a range of forms, including talking support, co-engagement, or simple welcome and guidance on the space; • Supported safety and care planning; • Advice, warm referrals and tailored navigation support to other services; and • Linkage to a range of services to address social determinants of health.
Workforce	**The service should be staffed by a multidisciplinary workforce, with both clinical and peer expertise.** Emphasis is placed on the value of a warm, supportive entry and exit through peer support, highlighting the importance of navigational guidance at key transition points. The composition of multidisciplinary teams may include: • Mental health clinicians; • Consumer and carer peer workers; • AOD clinicians; • AOD peer workers; • Social and emotional wellbeing practitioners; and • Other psycho-social-related workers, such as Family Violence specialists and social workers.	**Drop in Safe Spaces should be primarily staffed and governed by a peer workforce.** The peer workforce should have a diverse range of capabilities and be representative of the communities it serves. While the service should be peer-led, access to clinical support may be required– either onsite or virtual – as well as secondary input from allied health, social work, and Nurse Practitioners.
System integration	**Crisis stabilisation services would be established in locations of greatest demand with, or within proximity to, an existing hospital campus, or a standalone community service.** Emphasis should be placed on the importance of creating a therapeutic environment that does not replicate the sensory experience of the Emergency Department and consideration of rapid escalation pathways and transport, where required.	**It is proposed that Drop in Safe Space services are integrated with existing and relevant community-based health services.** This may involve co-location within established infrastructure to leverage community familiarity and access to the service environment. Consideration of appropriate escalation pathways for those who require a more acute servivce response will be critical

ACRONYMS

Term	Description
AOD	Alcohol and Other Drugs
AV	Ambulance Victoria
ED	Emergency Department
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual
MH	Mental Health
MHaP	Mental Health and Police
PACER	Police, Ambulance and Clinician Early Response
PROMPT	Prehospital Response of Mental Health and Paramedic Team
RCVMHS	Royal Commission into Victoria's Mental Health System
TelePROMPT	Telehealth Pre-hospital Response of Mental Health and Paramedic Team

THANK YOU

For more information regarding the Victorian Department of Health's redesign of the mental health and wellbeing crisis and emergency response system., please refer to the Impact Co. Online Engagement Platform.

IMPACT CO.

impactco.com.au