Western Australia Youth Mental Health, Alcohol and Other Drug Homelessness Service: Consultation report

Mental Health Commission

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nous

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1 Executive Summary

Young people experiencing co-occurring mental health and alcohol and other drug (AOD) issues are a particularly vulnerable cohort and require dedicated, age-appropriate services. Western Australia (WA) is still developing a dedicated stream of youth community services and has largely relied on adult services to fill the gaps in the service system. Over the last few years, the Mental Health Commission (MHC) and the State Government have invested significantly in reform of the mental health and AOD system to try to address the needs of people with co-occurring issues – including youth – but this is an ongoing reform and there is still much to do. After an extensive co-design process, the State Government published *A Safe Place – A Western Australian strategy to provide safe and stable accommodation, and support to people experiencing mental health, alcohol and other drug issues 2020-2025* (A Safe Place - 2020)[1] which outlined a series of key focus areas to address the housing and support needs of people with mental health, AOD issues and those who are homeless or at risk of becoming homeless.

Following the publication of '*A Safe Place*' in early 2020, the Government announced that $25 million had been allocated for the establishment and construction of a new youth mental health and AOD homelessness service (the Service) in the North Metropolitan area. This includes the establishment of an interim option while the new facility is being built. The Service aims to enhance individual wellbeing, optimise independent functioning, and improve quality of life for young people who are homeless and have a mental health issue, with or without a co-occurring AOD issue. Through the provision of recovery programs in a residential setting, young people using this service will be supported to transition from homelessness or being at risk of homelessness, to suitable, stable, and safe accommodation.

The MHC developed a Model of Service (MoS) for the interim service based upon the current Ngatti House service in Fremantle. This draft MoS will be the basis from which the long-term MoS will be developed.

Nous Group (Nous) was engaged to support the MHC in a series of consultations to refine the MoS and facility requirements. This support included:

- the consolidation of written submissions that the MHC received on the draft MoS
- the design and facilitation of two key stakeholder workshops with consumers, carers, families, government, and non-government stakeholders.

The objective of the workshops was to seek further input into the design of the service components, to ensure the service is fit-for-purpose, inclusive and appropriate for those eligible. This report provides an overview of each core component of the MoS, the feedback from participants in the written submissions and the workshops; and recommendations to inform the future long-term service, organised by the service components below. The recommendations are summarised on the following page.

[1] The Mental Health Commission, 2020, *A Safe Place.* Access here.

2 Summary of recommendations

Target groups

1. The Service should be focused on supporting those with moderate to severe mental health issues, with or without co-occurring AOD issues.
2. The Service should assess each individual on a case-by-case basis and engage with other agencies in assessing an individual's history and access to safe and stable accommodation.
3. The MoS should align with established definitions of mental health and homelessness.
4. Allowance needs to be built into the KPIs and therefore contract management of this Service so individuals can leave temporarily for other treatment (such as withdrawal management) – without this penalising the service provider.

Catchment area

5. The final MoS should provide a definition of catchment area that allows for the different circumstances of the target group (e.g., transient).

Service description

6. The Service should be planned around a maximum stay of 12 months, but with built-in flexibility into the duration of stay so this can be adjusted on a case-by-case basis.
7. Staff should work with the young person to create individualised support plans based on the goals of the young person, their individual treatment needs and identify where they wish to transition to after the Service.

Access and referral

8. A formal diagnosis should not be made mandatory for this service. An individual treatment plan should be developed when entering the Service, based on the presenting signs and symptoms.
9. The Service should develop a comprehensive and accessible list or 'handbook' of who can refer young people to the service and implement a waitlist mechanism based on priority of need.
10. The Service – with the support of the MHC – should establish mechanisms to raise awareness of the eligibility criteria and how people can access the service.

Transition

11. A transition plan should be developed and tailored to each individual need and include a structured follow up plan utilising peer workers/lived experience mentors to support the young person after they exit the Service.

Staffing

12. The MHC to work with the service provider to agree the right staffing model for the Service – including peer workers/lived experience mentors.
13. The MHC to evaluate the workforce model during the interim service and update the long-term MoS with any findings from this evaluation.

Building and facility design

14. The facility should include a combination of individual bedrooms and shared living areas and bathrooms of differing configurations.
15. Young people should be involved in the design of, and choice of amenities, individual areas and 'comforts' within the facility.

Providers

16. The MoS should define the minimum key partnerships that should be in place to ensure young people have access to a range of supports.

Service monitoring and governance

17. The MHC should explore the opportunity to establish a youth advisory reference group that provides advice on the design, delivery, and implementation of this Service (and could be applicable to other relevant initiatives and services).

3 Background and overview of the Service

The MHC mental health and AOD sector is undergoing reform

As the lead commissioner for mental health and AOD services in WA, the MHC is implementing a ten-year plan that will see the fundamental reform of mental health and AOD services across WA. These reforms will see the establishment of a contemporary mental health and AOD service system that is integrated with adjacent service systems – notably Health, Justice, Disability Service, Child and Family Support, and Housing. The need to better integrate service systems recognises that any one individual's physical and mental health is influenced by a range of factors outside of one service system's ability to support.

This is especially true with regards to young people aged between 16 and 24. Over half of all mental health conditions will have started by this age[2], and the consequences of not addressing adolescent mental health and AOD conditions extend to adulthood, impairing both physical and mental health and limiting opportunities to lead fulfilling lives as adults. In WA, there is a critical need for dedicated, age-appropriate youth services which can provide a combination of clinical and psychosocial supports that can address more than one presenting condition.

Following an extensive research and co-design process, the Service was developed to meet the needs of a vulnerable youth cohort

Extensive consultation and research were undertaken into the needs of youth with complex needs and informed the development of *A Safe Place*, the state-wide accommodation and support strategy. This strategy highlighted the significant vulnerabilities of the youth cohort, in particular those who are experiencing co-occurring mental health and AOD issues. Following the publication of this strategy in early 2020, the government announced that $25.1 million had been allocated for the establishment and construction of a new youth mental health, AOD homelessness service in the North Metropolitan area. The Service is based on the Ngatti House service model, a youth mental health, homelessness services which operates in Fremantle – however, unlike Ngatti House, the Service will include a formal AOD component.

The Service aims to enhance individual wellbeing, optimise independent functioning, and improve quality of life for young people who are homeless and have a mental health issue, with or without a co-occurring AOD issue. Through the provision of recovery programs in a residential setting, young people using this service will be supported to transition from homelessness or being at risk of homelessness, to suitable, stable, and safe accommodation. A summary of the service is below.

It is intended that the youth mental health and AOD homelessness service will:

- Provide **care and support** for young people with mental health (with or without co-occurring AOD) issues within a **residential setting**
- Offer **cultural security**
- Be **trauma-informed**
- Promote **personal recovery**
- Focus on **whole of life** and **quality of life** needs
- Provide services that will be delivered by a combination of **psychosocial** and **clinical activities** and **interventions**
- Support **transition** to **suitable, stable,** and **safe accommodation.**

[2] World Health Organisation, 2020, *Adolescent Mental Health.* Access here.

There are nine core components of the service model

The MoS is comprised of nine components. Feedback has been sought on all components through written submissions and stakeholder workshops. This report is structured according to each of the components of this service model as outlined in Table 1 below.

Table 1 | An overview of the core components of the Service

Target groups
The Service is proposed to be for young people aged 16-24 who have signs of mental health issues, are homeless, or are at-risk of homelessness, with or without co-occurring AOD issues (if with, then have detoxed prior to accessing the Service).
Catchment areas
This service is proposed to be available to young people who reside or have strong connections with the North Metropolitan area or surrounding areas.
Service description
The Service is proposed to provide access to psychosocial supports, mental health and AOD specialists, and facilitate individual and group activities aimed to increase a young person's capacity to effectively live independently. It is proposed that the Service will provide supported residential accommodation for up to 12 months.
Access and Referral
It is proposed that referrals into the Service are made by a general practitioner (GP), AOD service, homelessness service or self-referral. Referrals will be reviewed by the psychosocial service provider and clinical service provider and will be accepted based on willingness of the individual to participate, the capacity of the Service.
Transition from the Service
The Service is proposed to provide young people with support and assistance to effectively transition away from the Service when the young person has either effectively met their goals, suitable accommodation has been identified or a higher level of support is required. The Service will provide access to suitable accommodation and will follow up with the young person 60 days post discharge.

Staffing

The Service is proposed to be staffed by a skilled, multidisciplinary team to ensure that there is a holistic and comprehensive view of the issues experienced by young people accessing the Service. They will be on site 24 hours a day, seven days a week.

Building description and facility design

The facility is proposed to provide a home-like environment with a maximum of 16 beds and will be in proximity to amenities such as public transport, shopping centres, and recreational precincts, so that young people can develop their skills with activities of daily living.

Providers

Psychosocial support is proposed to be provided by a community managed organisation (CMO) with experience in delivering recovery-based programs to young people experiencing mental health and AOD issues. The clinical support to the Service will be provided by an appointed Health Service Provider (HSP).

Service monitoring and governance

It is proposed the Service will be monitored and evaluated based on the identified community outcomes and service-level outcomes, including the ability of consumers to demonstrate improvement in their mental health, the ability of consumers to demonstrate an improvement in skills and confidence for independent daily living.

4 Stakeholder feedback on the service model components

The following section outlines the stakeholder feedback from the written submissions and workshops and is aligned to each of the components of the service model. Based on the feedback received, some of the service components have more feedback than others – in particular, there were some service components that were not discussed in the workshops, given the unanimous support from stakeholders through the written submission process.

4.1 Target groups

The Service is proposed to be for young people aged 16-24 who have signs of mental health issues, are homeless, or are at-risk of homelessness, with or without co-occurring AOD issues (if with, then have detoxed prior to accessing the Service).

Feedback from the written submissions

Further definition is required over the eligibility criteria for the target groups of this service.

Further definition is needed on what the signs/symptoms of mental health issues are; what 'at risk of being homeless' means; and the requirements related to AOD issues, including where a detox would be necessary.

Clear strategies need to be implemented to account for the large range of ages eligible; and the cultural, psychological, and social backgrounds of the young people.

The Child Safe Standards[1] must be embedded into the planning, delivery and evaluation of the Service to ensure children and young people of different ages are protected from harm and abuse. There needs to be clear, flexible, and practical inclusivity strategies for young people of Aboriginal identity, LGBTQIA+, and those with disabilities, including neurodevelopmental disabilities.

There was support for the range of target groups eligible for the Service to be expanded- although some stakeholders expressed concerns over the safety for young people under 18.

Young people with co-occurring mental health conditions including intellectual or neurological disabilities should not be excluded from eligibility to this service, particularly Autism Spectrum Disorder – and consideration should be given to circumstances such as young people within the justice system or people younger than 16, so no one is turned away. However, some stakeholders did express concerns over the risk of safety for young people under the age of 18.

Feedback from the workshops

This Service should cater to young people with moderate to severe and complex mental health issues with or without co-occurring AOD issues.

There were discussions around the wider availability of community services for youth with mild to moderate mental health conditions. These services are not often appropriate for those young people presenting with severe conditions or those who require multiple supports, including co-occurring AOD issues. Given the vulnerability of this cohort, stakeholders felt that the Service should focus on young people who have moderate to severe, and complex mental health, with or without co-occurring AOD issues. There was widespread support for a diagnosis not being required for admission to the Service.

The eligibility criteria needs to be flexible and consider wider circumstances, in particular for those who are 'at risk of homelessness.'

The eligibility criteria for the Service needs to be flexible when considering those that might be 'at risk of homelessness' as this may not be evident in the presenting details. Individuals might have access to accommodation when they are referred or apply, but the wider complexities of their circumstances may not be evident through their application. There were discussions around the need for risk to be considered in terms of access to safe and stable accommodation. Young people might have accommodation, so are not seen as being homeless, but their accommodation might not be safe (e.g., experiencing family and domestic violence) or might not be stable (e.g., couch surfing). It was proposed that the MHC should align the definition of homelessness with the State Government's Homelessness Strategy (see below) so that there is no ambiguity about definitions and that individuals do not fall through the gaps between the service systems.

Homelessness definition[3]

The State Government's Homelessness Strategy adopts the definition used by the Australian Bureau of Statistics (ABS) to produce official statistics including the Census of Population and Housing. Under the ABS definition a person is considered homeless if they do not have suitable accommodation alternatives and their current living arrangement:

- Is in a dwelling that is inadequate
- Has no tenure, or if their initial tenure is short and not extendable
- Does not allow them to have control of space for social relations.

A complex history with AOD use should not be a barrier for eligibility – and individuals should be able to step away from the service temporarily if they need to undergo withdrawal management.

Stakeholders largely agreed that an individual's history for AOD use should not be a barrier to eligibility for this service. Further, it was agreed that individuals should be able to step away from the service temporarily without losing their 'bed' if they need to go to an acute or residential service to receive other treatment such as withdrawal management. It was suggested that this could be supported through partnerships with AOD services. The MHC contract management model would need to avoid penalising the provider of the Service if a bed were temporarily unoccupied in these circumstances and where this impacts the KPIs for the service (e.g., occupancy/utilisation KPIs).

Recommendations

1. The Service should be focused on supporting those with moderate to severe mental health issues, with or without co-occurring AOD issues.
2. The Service should assess each individual on a case-by-case basis and engage with other agencies in assessing an individual's history and access to safe and stable accommodation.
3. The MoS should align with established definitions of mental health and homelessness.
4. Allowance needs to be built into the KPIs and therefore contract management of this Service so individuals can leave temporarily for other treatment (such as withdrawal management) – without this penalising the service provider.

[3] Department of Communities, 2020, *All Paths Lead to a Home: Western Australia's 10-year Strategy on Homelessness 2020-2030.* Available here.

4.2 Catchment areas

This service is proposed to be available to young people who reside or have strong connections with the North Metropolitan area or surrounding areas.

The feedback from the written submissions

A designated catchment area does not account for young people who are transient or at risk of homelessness.

A designated catchment area seems contradictory, given the target population of young people who are homeless – or at risk of homelessness – and are characteristically transient across the regions. Further, the designated catchment area could create further barriers for those trying to access the Service who have been characteristically transient for a while.

There is a need for further clarification for certain terms used in the MoS.

Further clarification is required on the terminology used in the MoS, specifically what 'strong connections within the catchment areas of North Metropolitan Health Service' refers to, and how this term will be used when assessing a young person's eligibility.

Feedback from the workshops

The catchment area service component was not discussed in the workshops, as this is a core parameter of both the interim and future service. The Interim Service will operate in the East Metropolitan area – and the future service will operate in the North Metropolitan area, which has been specified through the funding agreement. Stakeholders were largely supportive of the idea of this Service being a replicated model both throughout the metropolitan and regional areas of WA.

Recommendations

5. The final MoS should provide a definition of catchment area that allows for the different circumstances of the target group (e.g., transient).

4.3 Service description

The Service is proposed to provide access to psychosocial supports, mental health and AOD specialists, and facilitate individual and group activities aimed to increase a young person's capacity to effectively live independently. It is proposed that the Service will provide supported residential accommodation for up to 12 months.

The feedback from the written submissions

Further definition around the intent of the Service is required.

There was confusion around whether this service is a homeless youth hostel, a youth homeless program with a focus on psychosocial intervention, or a mental health accommodation service. Stakeholders also wished to seek clarity about how the Service would respond to ongoing mental health and AOD conditions, as well as those that emerge throughout a young person's stay.

Stakeholders were supportive of the Service providing practical supports, in particular those that focus on developing independent living skills.

Provision for support programs such as employment assistance, help maintaining tenancy, providing assistance to improve economic and social participation, and education for daily living were considered to be critical for the Service.

Suggestions were made to expand the type of support services provided, in particular taking a more holistic lens to psychological and AOD service provision.

The Service could include enhanced mental health services, to include specific activities for psychological fitness and mental health maintenance, for example, emotion regulation and conflict resolution.

Providing supported residential accommodation for up to 12 months was not considered to be 'stable accommodation' and is likely to be inadequate for achieving lasting positive outcomes.

Stakeholders felt that 12 months would not be long enough to achieve the goals of the program and was not long enough time for young people to transition into the highly competitive private rental market. Stakeholders believed there should be consideration to extend the Service to 18 or 24 months, as a longer timeframe would be more consistent with the goals of the program.

Feedback from the workshops

The Service should provide supports for up to 12-months, with flexibility for extension based on the need of the young person.

The duration of supports for young people should be provided on a case-by-case basis, with a view that 12-months should be established as a 'soft deadline.' Workshop participants believed that the Service needs to be clear in its communication to young people that it is not a permanent housing facility. There was consensus that the aim of the service is to successfully transition young people to stable long-term accommodation or independent living by 12 months, or at a minimum, ensure that by 12 months the young person is in a position to effectively transition out of the Service in the coming months. In this case, the Service should continue to provide supports to the young person past the 12-month mark to ensure this transition effectively occurs. Some stakeholders suggested that the establishment of a 'step-down facility' within this Service could be an effective mechanism to educate young people to learn independence in a safe environment.

The Service needs to cater for, and be responsive to a range of individual support and treatment needs.

Young people with co-occurring mental health and AOD issues, who have, or who are experiencing homelessness, are going to present with a range of complex needs. This is not going to be a 'one size fits

all approach' and there is a need for flexibility (within pragmatic reason) for the service to cater to the many needs of the individuals who present to the Service. It was suggested that there should be no 'hard and fast rules' about what a young person can and cannot bring into the facility, for example, emotional support animals. Young people need to be trusted and empowered to be independent, therefore, should be able to use their judgment to make these decisions. However, many stakeholders suggested that young people bringing their children into the Service would not be appropriate given the complexity of the needs of the individuals entering this Service.

The Service should focus on the individual goals of the young person and where appropriate, engage the chosen network to support the young person's journey through the Service.

It is critical that the Service initially engages with the young person to determine their individual goals, support, and treatment needs. This should include identifying what they are hoping to achieve from the Service, and their plan for where they would like to be living once, they transition out of the Service. The Service should provide a tailored and individualised support and treatment plan accordingly. Stakeholders expressed the importance of bringing all relevant family members, carers, and other members of the young person's support network along the journey by keeping them frequently updated on the young person's progress. In a case where a young person may want to transition to living with family members, or friends, the Service should keep this network engaged, and work with them to build their capacity so that the young person is set up for success. However, stakeholders unanimously agreed that consent needs to be a critical and underpinning element and it is therefore, up to the young person to select the family members or friends that are to be engaged and communicated with whilst the young person is a part of the Service.

The Service should focus on providing supports that ensure the young person is set up for independent living.

Stakeholders unanimously agreed that the Service should provide the necessary tools and education for young people to ensure they will be able to live independently. The Service should provide opportunities to learn about all the elements that intersect with traditional independence, such as how to navigate Centrelink and Medicare, budgeting support and career and education pathways. In particular, stakeholders were in firm agreeance about setting up the education and employment pathways for young people as they look to transition out of the Service.

Recommendations

6. The Service should be planned around a maximum stay of 12 months, but with built-in flexibility into the duration of stay so this can be adjusted on a case-by-case basis.
7. Staff should work with the young person to create individualised support plans based on the goals of the young person, their individual treatment needs and identify where they wish to transition to after the Service.

4.4 Access and referral

It is proposed that referrals into the Service are made by a GP, AOD service, homelessness service or self-referral. Referrals will be reviewed by the psychosocial service provider and clinical service provider and will be accepted based on willingness of the individual to participate, the capacity of the Service.

The feedback from the written submissions

It is critical that young people are provided with support when transitioning into the facility.

The Service needs to account for the fear from past experience that some young people may have when engaging with residential services. It was the view of some, that young people should also receive a comprehensive assessment when entering the Service in order to identify any other formal or informal supports in place for the young person, (including National Disability Insurance Scheme (NDIS) supports).

The MoS is unclear in certain areas, such as whether formal diagnosis are required to access the Service, or if waitlists will be used to cater for the likely demand.

Further clarity is needed around whether a formal diagnosis is required to access the Service, the pathways that will be available to a young person when their referral is not accepted, and whether waitlists will be used, given the likely demand for the Service.

The outcome of a referral should be communicated in a timely way to the young person and should keep the families and carers engaged throughout the process.

Protracted referral processes and/or time taken to advise of the outcome of a referral, without discussion with families and carers, has been described by people with lived experience as being a source of considerable distress.

Feedback from the workshops

The referral process should be clear, accessible, and come from a multitude of sources.

Stakeholders strongly expressed the need to mitigate any possibility of referrals being a barrier to accessing the Service. The referral process should be made as simple as possible to enable young people to receive the support they need. It was widely agreed that referrals should be able to come from GPs, service providers, close friends, family members and carers, in addition to self-referrals. Hospitals, prisons, school psychologists and inpatient mental health services were also suggested as being possible referral pathways for a young person to enter the Service. However, some stakeholders noted there should be a limited number of services able to refer the individuals to ensure appropriate and targeted referrals. The collective view held by stakeholders at both workshops was that if a referral was not accepted, the Service should apply a 'no wrong door' approach – meaning staff members would work closely with the young person to direct them to the most appropriate service which would effectively address their needs.

A formal diagnosis should not be part of the eligibility criteria as it can create stigma and confusion and ultimately be a barrier for entry into the system.

A formal diagnosis is a system barrier that can cause confusion and stigma for young people. The Service should work with the individuals to identify the supports and services they need for presenting conditions e.g., disability support services required; but through the duration of their stay in the Service, there would be value in helping the individual to better understand their condition – including where appropriate, securing a diagnosis. Some stakeholders felt that a provisional diagnosis should be a requirement from a clinical perspective; however, other stakeholders noted that this can be exclusionary and similar to Ngatti House, should not be made mandatory for this Service.

Hospitals, GPs, schools, and local service providers should be a conduit for building awareness of the Service.

The Service should seek to gain exposure through hospitals, GPs, schools, and local service providers. It was suggested that the Service could partner with these organisations to provide them with service information in the form of brochures and posters, which could be passed along to young people and family members wishing to learn more.

There needs to be strategies in place to support young people when entering into the Service.

Support to transition into the Service will vary for each young person, depending on the situation they are in and their distinctive needs. Stakeholders highlighted the potential need for supports around advocacy, transportation, communication, and for people living with disabilities, when entering into the Service. Additionally, stakeholders noted that the Service may have to consider providing support to young people who wish to access the Service but are currently unable to do so due to AOD issues. In these cases, the Service could direct the young person to the appropriate detox service or provide guidance on the appropriate next steps the young person could take to gain access to the Service.

Recommendations

8. A formal diagnosis should not be made mandatory for this service. An individual treatment plan should be developed when entering the Service, based on the presenting signs and symptoms.
9. The Service should develop a comprehensive and accessible list or 'handbook' of who can refer young people to the service and implement a waitlist mechanism based on priority of need.
10. The Service – with the support of the MHC – should establish mechanisms to raise awareness of the eligibility criteria and how people can access the service.

4.5 Transition

The Service is proposed to provide young people with support and assistance to effectively transition away from the Service when the young person has either effectively met their goals, suitable accommodation has been identified or a higher level of support is required. The Service will provide access to suitable accommodation and will follow up with the young person 60 days post discharge.

The feedback from the written submissions

A more regular and structured follow-up mechanism should be established which includes following up with the young person prior to 60 days post-discharge.

The Service should follow up prior to 60 days post-discharge and transition should include a 'warm exit' which includes a robust follow up and the ability for the consumer to call the Service and check in as required. There was also support for the individual being able to re-enter the Service if required in the future.

The MoS needs to further clarify the support that will be provided to source suitable accommodation, and the provisions for circumstances in which alternative options are required.

It is currently unclear about what provisions will be made if suitable accommodation cannot be located, and how long a young person can stay in the Service after they have been assessed that they can move on. Further, the transition options that might be available for a young person who has 'consistently demonstrated that they require a higher level of support than what can be offered through the Service' is unclear.

Feedback from the workshops

Regular follow-up post-discharge should occur until the young person has successfully connected with another Service or transitioned to independent living.

A regular and structured follow-up mechanism should be implemented post-discharge until the young person has successfully connected with or transitioned to stable long-term accommodation or independent living. Stakeholders suggested that the frequency of these follow-ups should be tailored to the individual depending on their level of need. It was suggested that when a young person is transitioning out of the Service, a peer worker/lived experience mentor could engage with the young person to establish a structured follow-up plan that works best for the young person. Some stakeholders noted that the follow-up mechanism for young people aged 16 to 18 may differ, as this cohort may need support for a longer period of time and more regular follow-ups post-discharge from the Service.

Support should be provided to the young person's chosen support group including family members

It was widely agreed that during the transition from the Service, support should be provided to family members or friends, especially if the young person is transitioning back to living in their household. Stakeholders believed the Service could work with these relevant families or support network to build their capability and establish the foundations for successful living with the young person.

Recommendations

11. A transition plan should be developed and tailored to each individual need and include a structured follow up plan utilising peer workers/lived experience mentors to support the young person after they exit the Service.

4.6 Staffing

The Service is proposed to be staffed by a skilled, multidisciplinary team to ensure that there is a holistic and comprehensive view of the issues experienced by young people accessing the Service. They will be on site 24 hours a day, seven days a week.

The feedback from the written submissions

Stakeholders reinforced the need for the Service to deploy a skilled, multi-disciplinary team, who are consistently supported in delivering a holistic service for all target cohorts.

The workforce needs to be experienced in working across multiple 'issues', in particular, supporting individuals with a disability. A capacity building approach for clinicians and support workers can ensure staff are culturally competent and understand and work effectively with all young people; particularly those with neurodevelopmental conditions such as ADHD, autism spectrum disorders and intellectual disability.

The inclusion of a peer workforce, as well as family inclusive practices are critical, and should be explicitly stated in the MoS.

Consumers, families, carers, and peer workers/lived experience mentors would provide invaluable input to a multi-disciplinary team. This should be explicitly stated within the MoS; and that organisational readiness is assessed to ensure a robust peer workforce can operate effectively.

The staffing profile should be reflective of the diversity of young people accessing the Service.

The Service needs to have a diverse staffing profile to ensure it is reflective of young people from different communities and groups who could be accessing the Service.

Feedback from the workshops

Peer workers/lived experience mentors were considered crucial to the Service.

Stakeholders strongly expressed the importance of using peer workers/lived experience mentors in the Service. It was noted that 'having lived experience' should be considered its own qualification, and the invaluable support that could be provided by peer workers/lived experience mentors in effectively achieving better outcomes for young people. It was the collective view that peer workers/lived experience mentors could play a role in:

- Providing social and emotional support to ensure young people felt included and 'at home' whilst in the Service
- Educating young people on life skills, and how to navigate services such as Medicare, Centrelink and providing information or access to career pathways
- Providing support and advocacy to young people when they are transitioning out of the Service
- Ensuring that the socialisation between young people of different ages in the Service is safe and appropriate.

A number of essential staff attributes and competencies were identified for the Service.

Stakeholders reinforced the importance of staffing a skilled, multi-disciplinary team. Further, stakeholders identified, and agreed upon the key attributes that they believed were essential for all staff to have. These include:

- Having a compassionate, approachable, and understanding nature whilst still maintaining professionalism
- Possessing the ability to listen without judgement
- Focusing on recovery
- Having a solid understanding of working with diverse populations, which includes being culturally competent, having the knowledge of working with people living with disabilities and having the knowledge of LGBTQIA+ needs and issues
- Being trauma-informed
- Possessing the knowledge of related issues for young people e.g., eating disorders.

Recommendations

12. The MHC to work with the service provider to agree the right staffing model for the Service – including peer workers/lived experience mentors.
13. The MHC to evaluate the workforce model during the interim service and update the long-term MoS with any findings from this evaluation.

4.7 Building and facility design

The facility is proposed to provide a home-like environment with a maximum of 16 beds and will be in proximity to amenities such as public transport, shopping centres, and recreational precincts, so that young people can develop their skills with activities of daily living.

The feedback from the written submissions

The Service will need to ensure it provides a 'home-like' environment to young people and overcome any possibility of creating an institutionalised setting.

A 16-bed facility may be considered a large facility for vulnerable young people. Careful planning, monitoring and review of this facility will be essential to ensure it is fit for purpose and does not feel like a mental health facility.

Allowing for some shared facilities, such as shared bathrooms and kitchens, would be beneficial as this would emulate daily living in a share-house.

Stakeholders noted that a shared bathroom between two to three residents is more like a home situation and would foster responsibility and consideration for others in keeping with sharing a home. However, there was support for a mix of individual and shared living arrangements.

Certain terms in the MoS may need to be rephrased to avoid stigmatisation.

The Service is described as needing to 'sit quietly within their respective neighbourhood.' This phrasing is potentially stigmatising and does not refer to the need for the organisation to establish community connection, local support, or social license to operate.

Feedback from the workshops

The facility should include both shared and individual living spaces for young people.

Stakeholders highlighted the benefits of providing both shared and individual spaces within the Service facility. Having shared facilities and amenities, such as kitchens and bathrooms, may be beneficial, particularly as a young person progresses in their recovery, so they get used to the responsibility, negotiation and tolerance needed to live with others. However, stakeholders expressed the importance in providing young people with their own individual space, such as their own bedroom, so that they have their own safe space to go to whenever they need. Most stakeholders held the belief that shared bedrooms should not be considered as an option, however, there were varying opinions on whether bathrooms should be shared, with some stakeholders expressing the need for individualised bathrooms to ensure sexual and cultural safety, particularly for LGBTQIA+ young people. The service provider for Ngatti House noted that having one communal kitchen in Ngatti House was the one flaw in the design and advocated for multiple kitchen areas.

The facility needs to be designed to mitigate any possibility of feeling like an institution and should focus on creating a warm, inclusive and 'home-like' environment.

The facility must avoid any possibility of feeling like an institutionalised setting. It was suggested that this could be achieved through having certain comforts that enable young people to feel 'at home,' and strengthen their sense of self-identity and connection to culture. Such comforts highlighted, and agreed upon by stakeholders were:

- The provision of board games, WIFI, and exercise, art, and music equipment

- The inclusion of a gardening area, recreation room, open living spaces, religious spaces, meditation zones and parking spaces in the facility design
- The provision of a space for visitors to stay overnight
- The establishment of strategies to empower young people, such as promoting self-responsibility, working together to design the rules of the facility, and allowing young people to request the Service to provide other amenities and equipment that they may desire and/or require.

The facility layout should be subject to ongoing feedback from the young people once the service is operational and should inform the design of future services.

Stakeholders believed that the facility design should be consistently refined and adapted to address the needs of the young people living in the facility at that time, particularly at the beginning of the Service. Some stakeholders suggested before the Service is operational that further architectural consultation could be undertaken with priority groups, such as LGBTQIA+, people living with disability and people with CaLD backgrounds, to ensure the building has taken into account the specific needs of these cohorts.

Recommendations

14. The facility should include a combination of individual bedrooms and shared living areas and bathrooms of differing configurations.
15. Young people should be involved in the design of, and choice of amenities, individual areas and 'comforts' within the facility.

4.8 Providers

Psychosocial support is proposed to be provided by a CMO with experience in delivering recovery-based programs to young people experiencing mental health and AOD issues. The clinical support to the Service will be provided by an appointed HSP.

The feedback from the written submissions

The Service should allow for collaborations and partnerships with other service providers, GPs, and Aboriginal healers, to provide access to an abundance of supports.

It was recognised and recommended that memorandum of understandings (MOU's) be developed with other services in the youth, mental health and AOD sectors; and that young people have access to GPs to receive physical health support. It is also critical for the Service to have links with Aboriginal healers so that Aboriginal (and non-Aboriginal young people) have access to culturally secure and broader approaches to healing.

The roles of the HSP and CMO need to be clearly articulated and communicated.

The roles of the HSPs and CMO need to be very clearly delineated with clear boundaries around assessment and management of risk, and a level of therapeutic/treatment intervention of each.

Feedback from the workshops

The Service should partner with local service providers to enable the provision of in-reach supports for young people.

Stakeholders reinforced the importance of collaborating with service providers and other key stakeholders to ensure that the young people are part of the Service and have access to a variety of in-reach supports. Suggestions included:

- Primary health care services, such as general practitioners, physiotherapists, and dental services
- Youth, mental health and AOD services
- Education services, such as school tutoring and life-skills education
- NGO organisations, to provide employment and volunteering opportunities
- Housing-related services, so that the Service is able to swiftly and successfully transition young people into accommodation when leaving the Service (if required)
- Aboriginal healers, so that Aboriginal (and non-Aboriginal people) have access to culturally secure approaches to healing
- Alternative groups, such as Hearing Voices groups, and Discharged – currently run by Trans Folk of WA – to provide further support services.

Recommendations

16. The MoS should define the minimum key partnerships that should be in place to ensure young people have access to a range of supports.

4.9 Service monitoring and governance

It is proposed the Service will be monitored and evaluated based on the identified community outcomes and service-level outcomes, including the ability of consumers to demonstrate improvement in their mental health, and the ability of consumers to demonstrate an improvement in skills and confidence for independent daily living.

The feedback from the written submissions

It is critical that the voices and views of young people are heard for service development and improvement throughout the life of the Service.

Young people should be involved and participate in all aspects of decision making within the organisation – this includes the individual planning for their care, as well as in the design, delivery, and evaluation of the Service. Qualitative measures should be included as part of the evaluation requirements, and young people should be involved in the development of these outcomes and benchmarks.

A lived experience advisory group could be established to provide advice on implementation and monitoring of the Service throughout.

An ongoing interagency and lived experience advisory or reference group should be established to monitor and provide advice on implementation. This group could include representatives from young people and families, NGOs, primary care, and clinical services. This reference group may have further utility for the MHC beyond this specific service.

There was a recommendation to include youth work and homelessness key standards for monitoring service performance, in addition to mental health.

Other key standards are needed beyond mental health/AOD standards to ensure a more holistic approach to service performance, rather than just a clinical outcome focus.

Feedback from workshops

The service monitoring and governance service component was not discussed in the workshops, as the feedback provided through written submissions was comprehensive and non-contentious. Our recommendation is aligned to the feedback from the written submissions.

Recommendations

17. The MHC should explore the opportunity to establish a youth advisory reference group that provides advice on the design, delivery, and implementation of this Service (and could be applicable to other relevant initiatives and services).

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