Consultations to finalise the IDACC Model of Service – Final Report

WA Mental Health Commission

1 July 2022

nous

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Contents

1 Glossary

Term	Acronym
Alcohol and other drug	**AOD**
AOD Crisis Intervention System Service Model consultation process	**AODCISSM**
Central business district	**CBD**
Community Alcohol and Drug Services	**CADS**
Emergency Department	**ED**
Culturally and linguistically diverse	**CaLD**
Family and domestic violence	**FDV**
Immediate Drug Assistance and Coordination Centre	**IDACC**
Lesbian, gay, bisexual, trans, queer, intersex, asexual, plus	**LGBTQIA+**
Mental Health Commission	**MHC**
Methamphetamine Action Plan	**MAP**
Nous Group	**Nous**
Tuna Blue Facilitation	**Tuna Blue**

2 Executive summary

AOD issues continue to be a critical challenge for individuals, carers, families and communities across WA. In 2019, about 17.2 per cent of Western Australians aged 14 and over drank alcohol at levels that risks lifetime harm; and about 15.6 per cent recently used illicit substances.[1] Concurrently, the capacity of the public healthcare system to respond to the needs of those with AOD issues, and those impacted by AOD-related harm, is becoming increasingly constrained.

To address the growing prevalence and complexity of AOD issues in WA, the MHC has committed to funding a model of service to provide immediate assistance for individuals and families experiencing a social crisis in relation to methamphetamine and AOD use, known as the Immediate Drug Assistance Co-ordination Centre (IDACC). The IDACC will bring together five components, two of which are currently operational; Here For You, a support and system navigation telephone line for consumers; and the Drug and Alcohol Clinical Advisory Service (DACAS). To deliver the further three components; a 24/7 Drop in Hub; Short-Term Crisis Beds; and an Assertive Outreach and Care Coordination Team three of the five components of the service, known as the IDACC facility, the MHC will engage a third-party provider through an open tender process. Prior to determining the service provider, the MHC has been refining, with consultation, the model of service which will articulate what the service is, its aims, functions, components, staff, and facility parameters.

The MHC has engaged Nous Group (Nous) to undertake a final and independent review of the proposed IDACC service model. The review considered how components of the model should be implemented to ensure it is aligned to the consultation undertaken to date.. Nous undertook targeted engagements to help develop valuable and actionable recommendations to better meet the needs of individuals in crisis. The engagement process was designed with a strong commitment to incorporating the views of those with lived experience through a series of outreach sessions with consumer, family and carer representatives. This was done alongside a series of sector-wide consultations with service providers, government agencies, peak bodies, and clinicians to finalise the service model. This report outlines:

What stakeholders liked

Overall, consultation feedback reflected the view that service model design is strong, and the IDACC has significant potential to support those in crisis not currently accessing appropriate support. Throughout Nous' consultation, stakeholders voiced a genuine sense of excitement for the role that the IDACC will play in addressing gaps in AOD crisis support. These features are outlined below, and presented further in Section 5 of this report.

FEATURE 1	The IDACC will address a key gap in the wider service system.
FEATURE 2	People in crisis will now be able to access care immediately.
FEATURE 3	The service will offer an integrated suite of five services, not just one or two.
FEATURE 4	The proposed staffing profile and aspirations for the physical layout of the drop-in facility will address known gaps.
FEATURE 5	The service model provides a comprehensive list of practical features as part of the IDACC's facility.

[1] AIHW 2019, National Drug Strategy Household Survey 2019 – Western Australia, Canberra.

Constructive feedback on the model

Broadly, this report finds that there are opportunities to further build out the description of the aims and eligibility, services and supports, staffing and facilities in the model, and describe more specifically what 'cultural safety' looks like in this context. These findings are outlined below and explored in detail throughout Section 6 of this report.

Opportunities to improve the draft IDACC service model	
Service aims, eligibility and target cohort	The service model aims should more clearly emphasise the IDACC's role in connecting people with services, not just its role in treatment.
	The service's current exclusion criteria deny access to some cohorts likely to benefit from the IDACC.
	If the IDACC cannot provide support, staff must clearly state (and advise) where an individual may go instead.
	The target cohort of the IDACC – those experiencing 'social crisis' – requires further clarification, to avoid confusion for consumers, families, and service providers.
Services and supports	Limiting the number of times a consumers must 'tell their story' should be a central design feature of the IDACC service experience
	The IDACC's 'coordination and referral' role should be broad, inclusive, and tailored to individual needs and circumstances.
	Both the Assertive Outreach and Care Coordination Team and Drop-in Hub staff should play an active role in educating the community about the IDACC and other services
	The service model should articulate the key relationships and referral pathways which the IDACC will need to cultivate as core business.
	The IDACC must be underpinned by strong, ongoing working relationships with referral partners.
Staffing	A significant majority of IDACC staff should be non-clinical workers, including AOD workers, counsellors, Aboriginal Health Workers and peer support roles.
	Staff should represent the diversity of those who might access the service, including Aboriginal, LGBTQIA+ and culturally and linguistically diverse (CaLD) groups.
	Soft skills such as non-judgmental support and shared values are critical for all roles within the IDACC.
	Strong medical governance processes and policies need to be embedded across all service components to ensure decisions are clinically safe.
Facilities	While the CBD is a central and logical location, there are several associated risks that must be considered.
	Green space, dim lights, neutral colours, natural lighting and available refreshments will create the right low stimulus, welcoming environment for the IDACC.

Cultural safety	Rooms for other service providers onsite, multi-purpose central spaces and dedicated spaces to 'chill out' should be explicitly called out in the service model.
	'Culturally safe' service provision in the context of the IDACC means non-judgemental support in a culturally welcoming environment.
	Cultural safety can be enabled through specific service, staffing, and facility design features.

Recommendations to finalise the draft service model

To implement stakeholder suggestions, we present 15 recommendations to finalise the draft service model:

1. Recommendation 1: The service aims should be updated to reflect a greater emphasis on the role the IDACC will play in supporting individual recovery, beyond immediate crisis support.
2. Recommendation 2: The current exclusion criteria outlined in the IDACC service should remain substantively as they are[2], however:
    a. The IDACC should have a role in supporting ineligible cohorts through referrals to appropriate services. This role should be more explicitly described in the service model.
    b. The model should articulate greater nuance around the exclusion of people exhibiting violent behaviours. This cohort should not be excluded if a capable IDACC worker can safely de-escalate an individual's current situation to the extent that they can enter the service.
3. Recommendation 3: The model should provide a more fulsome description of the target cohort of the service - those experiencing 'social crisis'. Noting the specific exclusion criteria discussed above, this definition should aim to be as broad and inclusive as possible, although should be limited to those who require immediate support. It should:
    a. Encompass a range of situations which could be considered a 'social crisis' related to AOD from consumer, family, and service provider perspectives.
    b. Be further illustrated in the model through examples and case studies of situations which would be considered a 'social crisis'.
    c. Include escalation and de-escalation from the most acute period of crises, so the IDACC is accessed by not just those as the 'peak' of their social crisis.
4. Recommendation 4: The model should clarify the entry, assessment, and handover processes to embed strong relationship-building and a more personalised approach to meeting the individual's immediate and longer-term needs.
5. Recommendation 5: The coordination and referral role of both the Drop-in Hub and the Assertive Outreach and Care Coordination Team should be broad, inclusive, and flexible depending on consumers, families, and carer needs. To accommodate this, the service model should more specifically describe the broad extent of the IDACC's role in coordination and referral, and an inclusive list of the types of support this could involve.

[2] On balance, Nous heard a mix of views about whether the exclusion criteria should be changed to alter who can and cannot access the IDACC. Ultimately, doing so in the ways suggested by some stakeholders creates safety issues unless there are fundamental changes to the entire scope of services and staff operating at the IDACC.

6. Both the Assertive Outreach and Care Coordination Team's and Drop-in Hub staff's roles should be updated to include an active responsibility in educating others about the IDACC service. This should include:
    a. Outreach to community service providers who may be potential referrers into the IDACC, to build strong relationships and a better understanding of when IDACC might be 'the right place' for individuals.
    b. Education sessions with other potential referrers, such as WA Police and EDs, to clearly communicate the purpose of the IDACC and how WA Police and EDs can play a role in supporting people in AOD crisis to access it.
    c. Development and dissemination of communication materials to promote the IDACC to local community groups, including family and carer support groups.
    d. Ad-hoc community engagement with people who are street-present to inform them of the IDACC as a safe place to go when they are in crisis, as well as information about other nearby services that they can access as well.
7. Recommendation 7: The service model should be updated to include additional detail on expected key referral pathways in and out of the IDACC, and to emphasise the requirement for staff to build ongoing relationships with referral and follow up services through strong sector-wide partnerships.
8. Recommendation 8: Consider whether the benefits of extending the IDACC's scope of services to include the onsite administration of medications are sufficient to outweigh the additional costs and potential safety implications.
9. Recommendation 9: The IDACC model should aim for a predominantly non-clinical staffing profile including AOD workers, counsellors, Aboriginal Health Workers, and peer workers. The number of clinical (nursing) staff should be a limited minority.
10. Recommendation 10: The service model should be updated to explicitly commit to recruiting a workforce that reflects the diversity of people who are accessing the IDACC.
11. Recommendation 11: The service model should be updated to emphasise the importance of IDACC staff members having a range of soft skills and shared values to effectively provide crisis support to individuals accessing the IDACC.
12. Recommendation 12: The service model should embed strong clinical governance policies and processes into the IDACC's operations, to ensure individuals are safe and minimise clinical risk.
13. Recommendation 13: While the broad recommendation to develop the facility in the Perth CBD area should remain in place, there should be considerations in the service model around how the IDACC facility can manage the various risks associated with the facility being in a 'high-risk' area.
14. Recommendation 14: While the facility section should remain largely unchanged due to strong stakeholder support, the IDACC facility could be set up for success by including a small number of changes to design features in the service model to meet the needs of individuals, families and carers, and staff.
15. Recommendation 15: The IDACC should build out its commitment to cultural safety by including the specific service, staff and facility features described above as examples of what cultural safety looks like 'in practice'.

3 Background and context

The section below provides an overview of the background of the development of the draft Immediate Drug Assistance and Coordination Centre (IDACC) service model, outlining:

- the process the MHC is undertaking to design and deliver the IDACC service
- where the IDACC service model sits in the context of broader WA Government reforms
- the establishment of the idea for an alternative AOD crisis response service
- the previous engagement used to inform the development of the draft service model.

3.1 The Mental Health Commission (MHC) is designing a service model for a new alcohol and other drug (AOD) crisis intervention service known as the IDACC

To address the growing prevalence and complexity of AOD issues in WA, the MHC has committed to funding a model of service to provide immediate assistance for individuals and families experiencing a social crisis in relation to methamphetamine and AOD use. To deliver the service, the MHC will engage a third-party provider through an open tender process. Prior to determining the service provider, the MHC has been refining, with consultation, a model of service which will articulate what the service is, its aims, functions, components, staff and facility parameters.

The MHC has engaged Nous Group (Nous) to undertake a final and independent review of three of the five components of the proposed IDACC service model, known as the IDACC facility The review considered how these components of the model should be implemented to ensure that it meets its service objectives in a way that is aligned to the consultation undertaken to date. This required a robust review of the draft model of service, a review of past consultation feedback, and a rigorous and targeted stakeholder engagement process that has informed a series of recommendations to finalise the model of service.

3.2 Development of the IDACC service model sits within the context of broader WA Government reforms to address gaps for those experiencing AOD issues

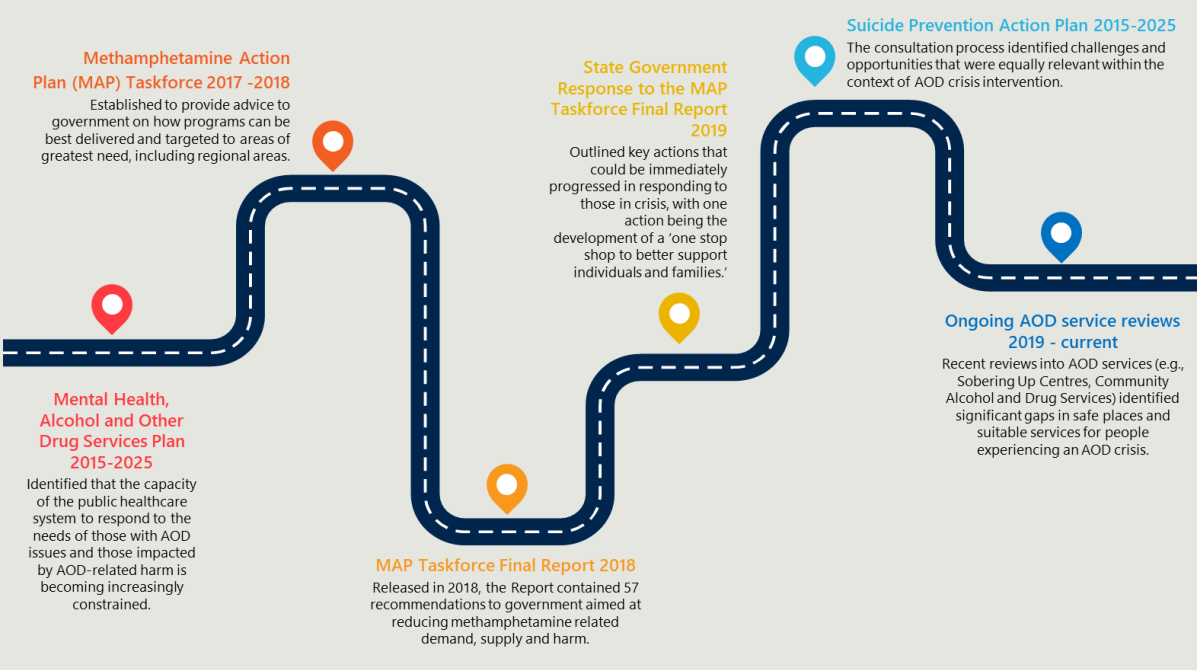
AOD issues continue to be a critical challenge for individuals, carers, families and communities across WA. In 2019, about 17.2 per cent of Western Australians aged 14 and over drank alcohol at levels that risks lifetime harm; and about 15.6 per cent recently used illicit substances.[3] High-levels of AOD use are closely related with AOD crisis. AOD crises are generally short-term and episodic, and may be social i.e. leading to family and domestic violence (FDV); physical i.e. resulting in physical harm; or psychiatric i.e. an individual experiencing psychosis. Concurrently, the capacity of the public healthcare system to respond to the needs of those with AOD issues, and those impacted by AOD-related harm, is becoming increasingly constrained.

[3] AIHW 2019, National Drug Strategy Household Survey 2019 – Western Australia, Canberra.

The Mental Health, Alcohol and Other Drug Services Plan 2015-2025 recognised this, identifying that the capacity of AOD community services will be required to grow by 178 per cent between 2017 and 2025 to meet need. The WA Government has undertaken several reviews into how mental health and AOD services can be better designed and delivered to improve outcomes for individuals; there has been a shift towards investing in new service models that are community designed and driven, and focused on prevention and early intervention. It is recognised that new approaches to providing care for people with AOD issues, and new ways of designing services, are needed.

An overview of key policy reports and reviews driving reforms across the AOD services sector in WA is provided in Figure 1 below.

Figure 1 | WA Government reforms with impact for AOD crisis intervention services



3.3 Development of the IDACC service model was a key MAP Taskforce recommendation

Released in 2018, the MAP Taskforce Final Report contained 57 recommendations to government aimed at reducing methamphetamine related demand, supply, and harm. Recommendation 29 of the MAP Taskforce Final Report stated: "*Within 12 months, the Mental Health Commission, Western Australia Police Force and Department of Health establish an appropriate alternative crisis intervention response that would provide a short-term place for methamphetamine users when they are in crisis that will keep them, their families and the community safe, including in the regions*".

The state government provided an immediate response to the MAP Taskforce Report outlining key actions that could be immediately progressed in responding to those in crisis, with one of these actions being the implementation of a "*one stop shop to better support individual and families*". Here For You, the AOD and mental health support line, was developed as a result and became one of the five components of the IDACC. The IDACC facility was initially recommended as a service for methamphetamine users when they are in crisis, however the scope for the IDACC has now expanded to include individuals who are experiencing an AOD related social crisis.

3.4 Recognising existing gaps in AOD crisis intervention services, a draft IDACC service model has been developed to address gaps for those experiencing AOD issues

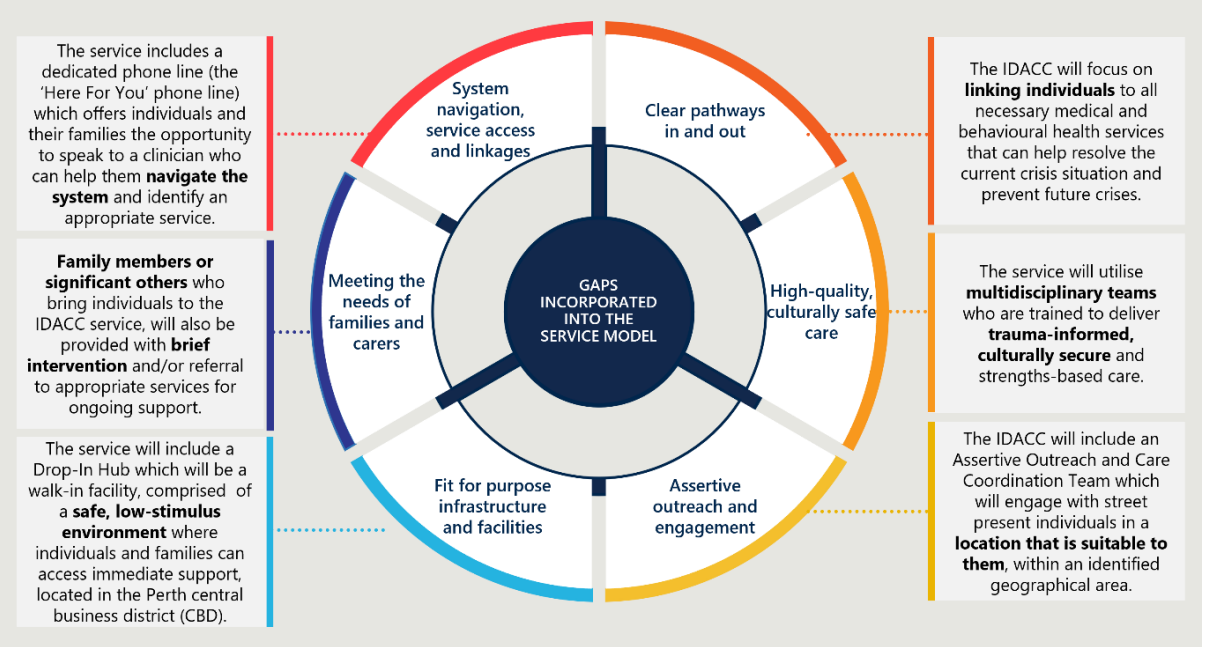
In 2020, the MHC and Tuna Blue Facilitation (Tuna Blue) engaged with consumers, family members, carers and community to identify gaps in short-term AOD crisis intervention services. This informed the development of an AOD Crisis Intervention System Service Model (AODCISSM) that would guide the design of future services such as the IDACC.

The final AODCISSM report identified gaps in the provision of AOD short term critical intervention services, with consumers, family members and carers often left to navigate a system that is complex, unclear and unsafe. For individuals in AOD crisis, themes emerging from this engagement about the current system included:

- **Crisis is crises.** Individuals in the AOD system are, more often than not, dealing with multiple co-occurring social challenges, crises and systems at any one point. Fundamentally, the social support systems in WA are not integrated enough to cater to these co-occurring needs.
- **Confused and desperate.** Whilst services and information exist, for individuals, families and communities, the environment is often complex, disconnected and difficult to navigate. AOD crisis is often characterised by feelings of confusion, helplessness, desperation and agitation.
- **Nowhere to go.** Other than the police or Emergency Department (ED), there is often 'nowhere to go' for individuals in an acute AOD crisis. By this stage, individuals are potentially intoxicated, agitated, and require immediate assessment in a non-judgmental and integrated setting. This is often not available.
- **Nowhere to go again.** The period following an AOD crisis intervention is a critical time for stabilisation, withdrawal, and support. There are currently limited safe places or services for people between initial crisis intervention and preparing themselves for ongoing support.
- **Fragmented and inflexible.** Services are currently geared for the needs of the service itself, rather than the needs of the person. Models of services are incentivising a focus on service activity rather than outcomes, competition rather than collaboration, exclusion rather than inclusion.

The design of the current IDACC service model has been informed by these findings. It incorporates many features identified as critical for all future AOD crisis intervention services, shown in Figure 2 below.

Figure 2 | The draft IDACC service model directly addresses key gaps identified in the current system



3.5 The IDACC will bring together five service components to provide immediate support to those in crisis

The IDACC is comprised of five interrelated service components that together provide a holistic and person-centred response for adult individuals in social crisis related to their AOD use, including support for their families and significant others.

Of the five components of the IDACC, two are currently operational; Here For You, a support and system navigation telephone line for consumers provided by the Alcohol and Drug Support Service; and the Drug and Alcohol Clinical Advisory Service (DACAS) for clinicians that is staffed by the AOD specialists at Next Step.

The further three components will establish an IDACC Facility in the inner city. The three components consist of:

- An immediate access 24/7 Drop In Hub;

  Short-Term Crisis Beds (6); and

- An Assertive Outreach and Care Co-ordination Team.

Given both phoneline components are already operational, the consultation process to finalise the IDACC service model focused on the requirements to design and establish the IDACC Facility and the three components listed above.

4 Our approach and methodology

This section provides an overview of approach and methodology that Nous undertook, outlining:

- the five stages undertaken throughout the project
- the key elements of Nous' conceptual approach
- the stakeholder engagement process
- Nous' key lines of inquiry that informed the stakeholder engagement process.

4.1 This report consolidates findings from Nous' consultation to finalise the service model

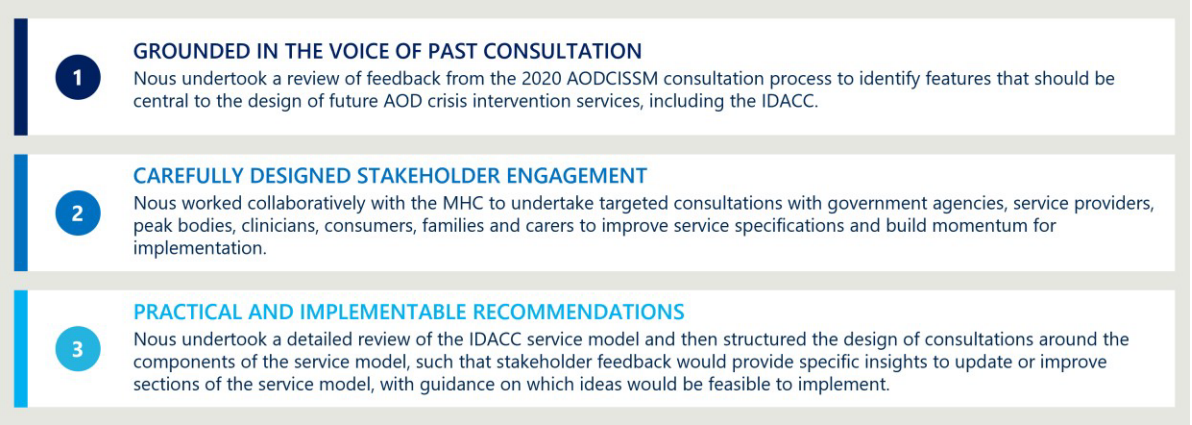
Working closely with the MHC, Nous undertook this project in five stages:

1. **Review.** We undertook an in-depth review of the IDACC service model and past consultation feedback to understand critical features of AOD crisis services and identify key themes which were not directly addressed by the draft service model, to test during our engagements (see Figure 6 below).
2. **Plan.** We developed a stakeholder engagement plan to ensure the final service model would be informed by the insights of all relevant stakeholders (including those with lived experience).
3. **Engage.** We engaged with government agencies, service providers, peak bodies, consumers, families, and carers, presenting the service model and seeking feedback on opportunities for improvements.
4. **Synthesise.** Nous synthesised insights and findings delivered as part of this project into a consultation summary presentation, to inform Nous' recommendations to finalise the service model.
5. **Recommend.** Building on consultation insights, we developed a set of recommendations for specific changes to the draft service model. Some of these represent suggestions made by consultation participants, whilst others translate broader themes into specific suggestions for change.

4.2 Our approach has been grounded in three review principles

Nous' approach to this review has been anchored in a set of review principles, shown in Figure 3 below. These principles overlayed the approach we took to the consultations themselves, and to the development of recommendations, to ensure these met the MHC and other stakeholder requirements and expectations.

Figure 3 | Key elements of Nous' conceptual approach

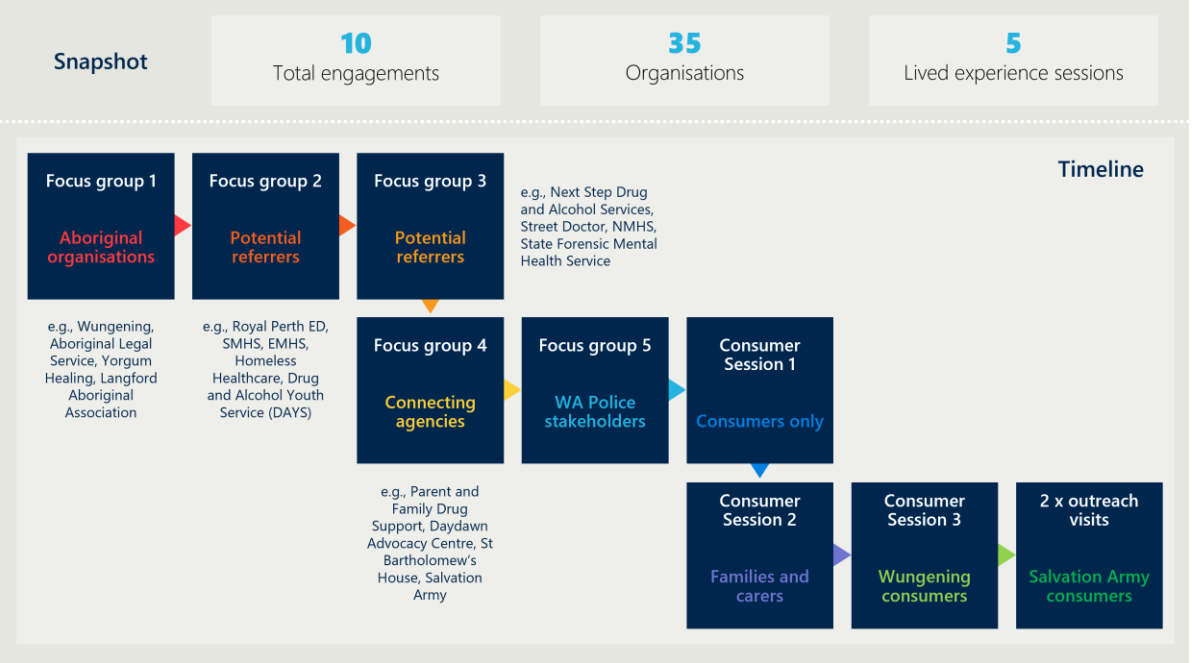


4.3 We engaged with 35 organisations, and facilitated five sessions specifically with consumers, family members and carers

During Stage 3 (Engage) of the project, Nous undertook targeted engagements to help develop valuable and actionable recommendations to better meet the needs of individuals in crisis. The engagement process was designed with a strong commitment to incorporating the views of those with lived experience through a series of outreach sessions with consumer, family and carer representatives. This was done alongside a series of sector-wide consultations with service providers, government agencies, peak bodies, and clinicians to finalise the service model.

Nous engaged over 35 organisations from across the WA mental health and AOD service system, and held several consumer forums and outreach visits with individuals, family members and carers with lived experience of AOD issues. Figure 4 below provides an overview of stakeholder engagements conducted for this review, with a full register of stakeholder organisations engaged in each session contained in Appendix A.

Figure 4 | Snapshot of the engagement process

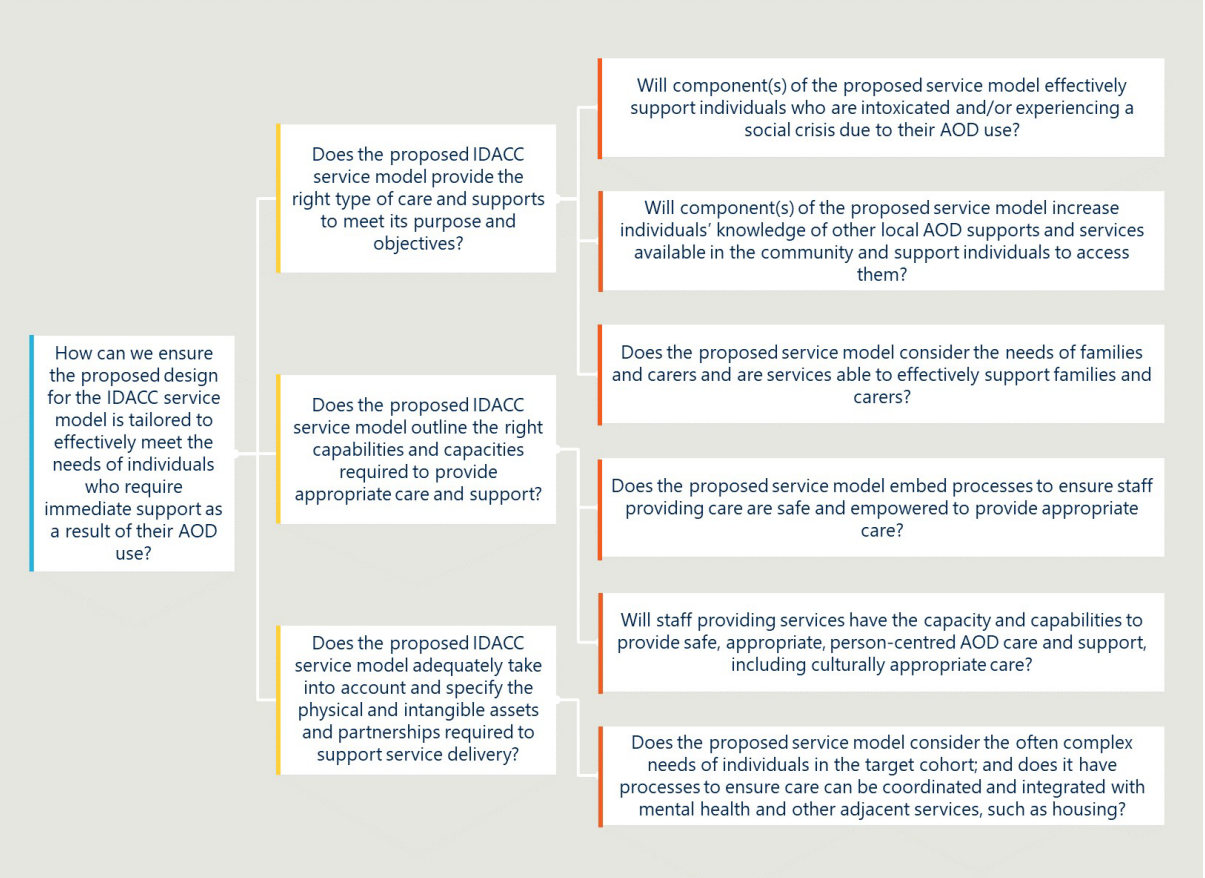


During the stakeholder engagements, Nous took notes on participant's feedback and insights on the IDACC and the wider service system. Nous then synthesised the outputs from the engagements to draw out key themes against each layer of the service model: service aims, eligibility and target cohort; services and supports; staffing; and facilities. Quotes used throughout this report were taken directly from the outputs of the engagements.

4.4 Feedback on the service model was guided by key lines of inquiry, informed by previous consultations

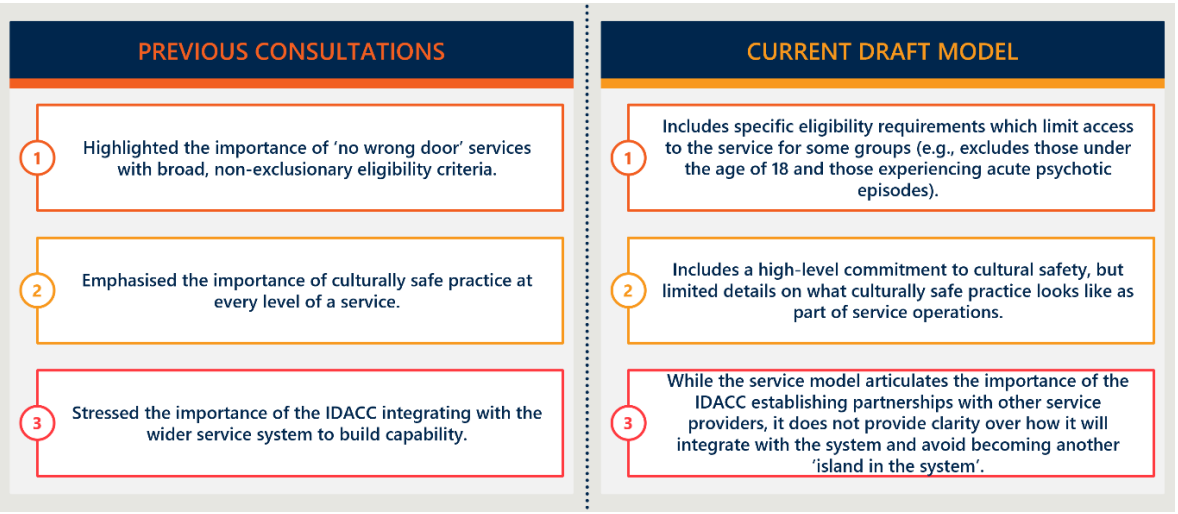
Through the engagements, Nous sought specific feedback on three components of the service model document, guided by a set of key lines of inquiry. Figure 5 below outlines the key lines of enquiry, along with specific lines of questioning around key elements of the draft IDACC service model.

Figure 5 | Nous' key lines of enquiry and specific lines of questioning were aligned to key elements of the IDACC service model



These lines of inquiry were informed by past consultation feedback collected by the MHC and Tuna Blue. While the draft IDACC model appeared to address many of emerging themes from past consultations, there were several where Nous considered the model to diverge from this feedback, shown in Figure 6 below. In response, we re-tested these features of the service model with specific questions relating to each of these areas during our consultations.

Figure 6 | Emerging themes identified in past consultation not addressed in the IDACC service model



5 What stakeholders liked

This section provides an overview of the key insights from Nous' consultations process.

It outlines what stakeholders liked about the model.

Overall, consultation feedback reflected the view that service model design is strong, and the IDACC has significant potential to support those in crisis not currently accessing appropriate support. Throughout Nous' consultation, stakeholders voiced a genuine sense of excitement for the role that the IDACC will play in addressing gaps in AOD crisis support. In particular, the consultation process identified numerous strengths of the service model that should be sustained. In particular, stakeholders noted:

- **The IDACC will address a key gap in the wider service system**. Throughout the consultation period, stakeholders highlighted that the IDACC service will help to address a key gap in the service system and provide an alternative to EDs and the justice system. They noted that individuals in an AOD crisis often have nowhere to go and this service will help address that challenge.
- **People in crisis will now be able to access care immediately.** Stakeholders stressed that within the current service system, individuals often have nowhere to go and often end up interacting with the justice system. With the walk-in hub and Assertive Outreach and Care Coordination Team, stakeholders highlighted the importance that individuals will now have access to immediate care which will help promote their recovery from an AOD crisis.
- **The service will offer an integrated suite of five services, not just one or two**. Stakeholders praised the three core components of the service model, along with the phone lines, and the level of support individuals will receive when they interact with the service. In particular, stakeholders supported the journey an individual will undergo, if they choose to access the service, from being identified by the Assertive Outreach and Care Coordination Team to being offered a short-term crisis bed and referred onto an appropriate service.
- **The proposed staffing profile and aspirations for the physical layout of the drop-in facility will address known gaps.** Upon reviewing the staffing and facilities of the service model, stakeholders identified several key features that will help ensure that the IDACC can meet the needs of its target cohort. The mix of clinical and non-clinical staff, the hub operational 24 hours a day, seven days a week and locating the IDACC close to emergency services were all identified as important during the consultations.
- **The service model provides a comprehensive list of practical features as part of the IDACC's facility**. Stakeholders praised the facility features listed in the service model, noting they were practical and considered the safety of consumers, families, and carers. Located close to a hospital, designated smoking area and the provision of quiet spaces were all features that stakeholders supported during the consultations.

Overall, stakeholders noted that in order to finalise the service model, the focus will likely be building on existing content and concepts, rather than re-visiting the general scope of the service itself.

6 Constructive feedback on the model

This section outlines key constructive feedback on key features of the model (e.g., what needs to change, be explained or built out more).

Broadly, it finds that there are opportunities to further build out the description of the aims and eligibility, services and supports, staffing and facilities in the model, and describe more specifically what 'cultural safety' looks like in this context.

Within each section, we outline the key recommendations to incorporate stakeholder feedback and finalise the draft IDACC service model.

6.1 Service aims, eligibility and target cohort

The insights below are a summary of the feedback provided by stakeholders on the aims, eligibility requirements and the target cohort sections of the IDACC service model. In particular, the findings below seek to address the following questions:

- *Are the aims and objectives of the IDACC consistent with needs of those in AOD crisis?*
- *What cohorts of people of people would benefit most from accessing the service?*
- *How do we ensure the service has broad, non-exclusionary eligibility criteria?*

6.1.1 The service model aims should more clearly emphasise the IDACC's role in connecting people with services, not just its role in treatment

Stakeholders felt that the current framing of the aims and objectives of the IDACC service model focused too heavily on its immediate role in supporting those who present at the drop-in service. They noted a greater focus is needed on the IDACC's role as a helpful 'starting point' or circuit breaker in consumer and carers' longer-term recovery journeys. This will require a greater emphasis on the service's crucial role in connecting and referring clients to other AOD services to ensure the IDACC does not become just a 'drop-in centre' that provides immediate support.

Stakeholders highlighted a risk that people will cycle through the service and not make any progress towards longer-term recovery. Consumers noted that the IDACC needs to provide crisis support *and* put people on a path to recovery through early connection to services, rather than just be a community drop-in centre that is repeatedly used. Consumers noted while these types of centres provide a great service for those at risk, the IDACC must include system navigation and service connection (a gap in the current system). As a result, the IDACC's core service aims must consider an individual's longer-term recovery, not just crisis care. To be a true wraparound service and not just a treatment centre, the service must focus on community engagement, empowering people's recovery journey, and supporting access to other services.

> "It cannot just be a treatment centre! We want to have **hope**, and that comes by getting access to other services and knowing where to go."
>
> **- Consumer**

Recommendation 1: The service aims should be updated to reflect a greater emphasis on the role the IDACC will play in supporting individual recovery, beyond immediate crisis support.

This can be achieved by updating *Section 5. Service Aims (p.5)* of the draft service model to:

- List two overarching aims of the service - to provide immediate support to assist those in a social crisis; and to follow up support to link people with other services that will support their individual recovery journey.
- Emphasise that both aims are equally important elements of the service.
- Organise the existing list of service objectives described in *Section 5* as sub-points underneath these two overarching service aims.

6.1.2 The service's current exclusion criteria deny access to some cohorts likely to benefit from the IDACC

"[With the current criteria]…we are risking creating a marginalised service for a marginalised cohort"

- Service provider

Stakeholders and consumers alike expressed concerns about the current eligibility criteria for the IDACC. There were concerns that these criteria may deny access to the cohorts of people who are likely to need a service like the IDACC. Although largely to manage safety and create specificity around who the service will target, some stakeholders argued that the current eligibility requirements create a narrow definition of those who can access the service and may act as a barrier to access for those who need crisis support the most.

"We have concerns that if we limit the cohort it can target, it's not broad enough for the complicated patients it will see"

- Government organisation

In particular, some stakeholders argued that excluding those under 18 years of age from the service added yet another barrier to access for the significant number of young people in the Perth CBD who need immediate crisis support. Others challenged this perspective, noting that permitting access to people under 18 creates a range of potential safety issues associated with AOD crisis services where both adults and unaccompanied children and young people were present.

6.1.3 If the IDACC cannot provide support, staff must clearly state (and advise) where an individual may go instead

"The IDACC should consider the idea of 'if not here then where?'. Exclusion criteria is fine, but make it clear where we should go instead. Saying that you can't help them is not helpful at all!"

- Family and carer representative

Regardless of its eligibility criteria, stakeholders agreed that the IDACC should play an important role in connecting people in crisis through information and referrals – even for those who don't meet the service's access criteria. This was considered a critical part of providing a wraparound service with a 'no wrong door' approach.

In the situation where an individual does not require crisis support from the IDACC but could benefit from accessing other services, stakeholders felt that the service model could more clearly articulate that IDACC staff would support the individual in identifying and accessing alternative supports and services such as community centres, drop-in hubs, hostels, or social services.

Further to this, individuals who are displaying extremely challenging or violent behaviours are currently excluded from accessing the service. Stakeholders suggested that this be re-framed from a positive perspective to account for individuals who may at first display challenging behaviours due to AOD-related distress but could significantly benefit from access to a highly empathetic peer worker or AOD worker that could de-escalate the individual's current situation safely.

Recommendation 2: The current exclusion criteria outlined in the IDACC service should remain substantively as they are[4], however:

a) **The IDACC should have a role in supporting ineligible cohorts through referrals to appropriate services. This role should be more explicitly described in the service model.**
b) **The model should articulate greater nuance around the exclusion of people exhibiting violent behaviours. This cohort should not be excluded if a capable IDACC worker can safely de-escalate an individual's current situation to the extent that they can enter the service.**

This can be achieved by updating *Section 6.1 Exclusion Criteria (p.6)* of the draft service model to:

- Explicitly call out that individuals who are considered ineligible to access the IDACC will be supported by staff to identify and access alternative services that better reflect their current needs. It should be noted that this is done in later sections of the service model (see *Section 7.2.5* for how the IDACC will support those under the age of 18), but there should be clear commitment from the IDACC to support all ineligible cohorts to find alternative safe places to go.
- Outline that the service provider will be required to develop relevant policies, procedures, and referral pathway partnerships in relation to the engagement and referral of **all** ineligible cohorts, including young people under the age of 18 years, those in a medical or psychiatric crisis, or those who would be better suited to access community support and/or social services, including individuals who are street present.
- Ensure that cohorts considered as ineligible throughout *Section 7* of the draft service model are also called out in *Section 6.1*. Currently, there are a range of cohorts considered ineligible for access in *Section 7* that are not called out in *Section 6.1*, which creates confusion around eligibility.
- Re-frame the paragraph relevant to 'individuals who are actively violent' to better incorporate the capability of IDACC workers to support individuals in crisis. The IDACC looks to target and support 'individuals who may be intoxicated and/or display violent or threatening behaviours', yet this current paragraph suggests that individuals who are displaying violent behaviours will be ineligible from accessing the IDACC. It is recommended that the MHC update this paragraph to articulate that where the IDACC worker is unable to de-escalate the individual's current situation and it remains a safety issue for both staff and other individuals in the hub, then this individual will be referred on to more appropriate services.

[4] On balance, Nous heard a mix of views about whether the exclusion criteria should be changed to alter who can and cannot access the IDACC. Ultimately, doing so in the ways suggested by some stakeholders creates safety issues unless there are fundamental changes to the entire scope of services and staff operating at the IDACC.

6.1.4 The target cohort of the IDACC – those experiencing 'social crisis' – requires further clarification, to avoid confusion for consumers, families, and service providers

The IDACC service overview states that the model has been developed to provide immediate assistance for individuals and families experiencing a 'social crisis'. This is defined as a crisis which relates to methamphetamine and other AOD use, and is "an unstable period, decisive moment or turning point related to an individual's AOD use" which is "not medical or psychiatric crisis".[5]

> "Social crisis can look very different – it just needs to be clear that this is catering to a range of situations. I feel like service providers have a very different understanding of what crisis looks like compared to the individual"
>
> **- Family and carer representative**

While there was support for the target cohort being open to individuals who may be intoxicated, agitated, or displaying challenging behaviours, many stakeholders stressed the need for greater clarity around the term 'social crisis'. In particular, rather than stating what a social crisis is, stakeholders felt that service model currently focuses on articulating what a social crisis is not (i.e. a medical or psychiatric crisis). Many felt that a clearer definition of 'social crisis' would support service providers in making referrals, and consumers, families and carers in knowing whether the service was "for them".

Family and carer representative engagements highlighted that 'social crisis' could take a number of forms, including where a significant other is unable to manage the challenging behaviours of an individual who is severely intoxicated; an individual was displaying violent behaviours towards other family members; or a family member did not know how to support someone who was highly unstable and had become uncontactable. As a result, there should be some degree of flexibility in the definition of 'social crisis' adopted, so to account for the diversity of situations in which individuals are experiencing problematic AOD use.

In addition, some aspects of the service model (e.g., *Section 4: Service Overview*) currently reads as if only those in the midst of a social crisis can access the IDACC. Other sections (e.g., *Section 6: Target Cohort*) implies that any individual who is intoxicated and require support may access the service – not just those immediately 'in crisis'. Stakeholders, including potential referrers such as WA Police, suggested that referrals should still be available into the IDACC after the individual has experienced the 'peak' of their crisis, and so this should be explicitly incorporated into the service model language.

Recommendation 3: The model should provide a more fulsome description of the target cohort of the service - those experiencing 'social crisis'. Noting the specific exclusion criteria discussed above, this definition should aim to be as broad and inclusive as possible, although should be limited to those who require immediate support. It should:

- **Encompass a range of situations which could be considered a 'social crisis' related to AOD from consumer, family, and service provider perspectives.**
- **Be further illustrated in the model through examples and case studies of situations which would be considered a 'social crisis'.**
- **Include escalation and de-escalation from the most acute period of crises, so the IDACC is accessed by not just those as the 'peak' of their social crisis.**

This can be achieved by updating *Section 6 Target Cohort (p.5), Section 7.1.5 Access – Outreach (p.9), and Section 7.2.5 Access - Hub (p.16)* of the draft service model to:

[5] IDACC Draft Service model, Service Overview, p.3

- Explicitly acknowledge that social crisis should be treated as a broad definition with various presentations, and it should not be confined to any particular cohort, situation, acuity level or timepoint in intoxication.
- Provide examples of what an AOD-related crisis might look like to provide further clarity on the diversity of situations in which it may arise and how pathways into the IDACC can become more accessible. Based on the definition provided by the MHC in the draft service model, some examples of a 'social crisis' may include:
    - Someone who is experiencing mental health issues, has engaged in problematic AOD use, and their behaviours have become increasingly erratic due to intoxication and confusion, but has walked into the ED and cannot receive help.
    - A family member who requests help due to a domestic violence situation whereby their significant other is intoxicated, and they are worried they might become threatening or aggressive.
    - An individual who has recently become street-present and has become disoriented in the Perth CBD area due to AOD use, and walks in to the IDACC hub asking for help.
    - An individual who is proximate to a local community support service (e.g., RUAH community drop-in centre), and the Assertive Outreach and Care Coordination Team identifies them as being visibly intoxicated and agitated.
    - Someone in the Perth CBD area who has been engaged with by WA Police when they are intoxicated and at the 'peak' of their crisis, but are now 'coming down' and require non-judgemental support to keep them stable and avoid becoming over-stimulated.
    - A carer who looks after someone with psychosocial issues is concerned that the individual is becoming unstable due to AOD use, but has not yet 'peaked'.
- Articulate that for potential referrers such as WA Police and EDs, individuals can access the IDACC to get immediate support in relation to AOD use either during a period of crisis, or at any point of their intoxication period, and that it need not be at the 'peak' of their heightened state.

6.2 Services and supports

The insights below are a summary of the feedback provided by stakeholders on the Service Components section of the IDACC service model. In particular, the findings below seek to address the following questions:

- *Will the IDACC facility and the Assertive Outreach and Care Coordination Team provide the right type of support for individuals in AOD crisis?*
- *What would you keep or change about the services suggested? Are there any big gaps in terms of social and cultural supports?*
- *How could we make sure that the IDACC considers the needs of families and carers?*
- *What partnerships will need to be formed so that potential referrers can play an active role in supporting people in a social AOD crisis to access this service safely?*

6.2.1 Limiting the number of times a consumers must 'tell their story' should be a central design feature of the IDACC service experience

"It would be ideal if the person who gets you to rest is able to greet you when you wake. You wouldn't have to re-tell your story again and be asked the same questions."

- Consumer

Consumers consistently highlighted the challenge in having to "re-tell their story" when accessing a new service. They emphasised that this process could be 're-traumatising', and raised their frustrations with having to do this over and over again. They felt that, within the IDACC, there must be clear handover processes which ensure the minimum number of 'handover points'. This will reduce the number of times consumers have to re-tell their story and help establish trust and rapport with staff. Consumers reported a lack of trust as a critical reason for not accessing services.

To reduce the number of times a consumer must re-tell their story, the service should adopt a relationship driven model to service delivery which minimises the number of times an individual is handed between service components and staff members. As part of this model, stakeholders highlighted the importance of individuals only being handed over once when transported to the hub, and for the staff member who takes responsibility for them at the hub to take ongoing ownership of their care and journey.

Recommendation 4: The model should clarify the entry, assessment, and handover processes to embed strong relationship-building and a more personalised approach to meeting the individual's immediate and longer-term needs.

This can be achieved by updating *Section 7.2 Drop-in Hub and Short-Term Crisis Beds Target (p.10)* of the draft service model to:

- Better articulate the purpose and benefits of an initial bio-psycho-social assessment in fully
- understanding the individual's immediate and ongoing needs.
- Stipulate that the assessment and entry to the IDACC facility should be undertaken in collaboration with the individual to identify their current situation and immediate support needs, with consideration of recovery goals.
- Explicitly note that the initial conversation with the individual may be impeded by the individual's levels of distress, and so a full bio-psycho-social assessment may not be possible at a moment of crisis where the individual would benefit from rest.
- Once the IDACC worker has an understanding of the individual's biological, psychological, and social factors, the assessment process, as early as possible, the same worker should also include:
    - Set expectations about what will be required of the individual during their stay at the service, including respectful and inclusive behaviour practices, willingness to engage with supports, and policies related to AOD use at the facility.
    - Setting expectations about timeframes for the service, including what the warm transition out of the service will look like. We heard that this is particularly important for consumers who may feel distressed about what their situation will be after they exit the facility.
    - Confirm the level of involvement of family and friends, and other confidentiality considerations based on the preferences of the individual. This may also include a discussion on the level of information that the individual may want to be shared, and with whom. Consumers noted that this is particularly important for mitigating the risk of providing information to unsupportive or hostile family members of LGBTQIA+ individuals, as well as those escaping FDV.

- Include detail on the importance of clear handover processes between IDACC staff in ensuring the comfort and support of the individual in crisis. This should include:
  - A preference for the staff member who undertook the bio-psycho-social assessment of the individual to remain engaged with the individual as much as possible throughout their stay at the IDACC.
  - Where handover to another staff member is required due to shift changeover, this should be communicated in advance with the individual to ensure they are aware of who they can go to for support during their stay.
  - Where handover is required, the staff member who undertook the bio-psycho-social assessment is responsible for communicating these details to all relevant staff members, with consent from the individual.
  - Ideally, the staff member who undertook the bio-psycho-social assessment should be responsible for the coordination and referral of the individual out of the IDACC (see next section for more detail on this). This is to ensure the individual feels safe and supported to access follow-up services through planning and coordination with a staff member that they trust and have built rapport with.

6.2.2 The IDACC's 'coordination and referral' role should be broad, inclusive, and tailored to individual needs and circumstances

Throughout the consultation process, stakeholders stressed the importance of the IDACC providing personal, continued support to help individuals in their long-term recovery after they exit the drop-in hub. Reflecting on past experiences, consumers recalled how difficult it has been to continue long-term recovery after discharge from a service; they often feel as though there was nowhere to go and nobody to support them. Consumers noted the challenge of continued recovery in these situations, with relapse common.

Service providers also emphasised the paramount importance of the connection and referral role which the IDACC will play. Some questioned the extensiveness of the coordination and referral role to be performed by both IDACC Drop-in Hub workers and the Assertive Outreach and Care Coordination Team, including:

- The level and extent of its involvement once an initial crisis has subsided.
- Whether it would provide practical support for individuals (e.g., assistance with transport, helping consumers or carers fill out Centrelink or other forms they need before discharge from the IDACC).
- Whether it would have a role in individualised planning for the suite of services a consumer or carer might need to support their recovery beyond the IDACC (similar to a NDIS Planner role).

"Practical follow-up support will be pretty important in making sure that people don't just leave and go back into the same cycle of using and then entering into a crisis. For some people, this has to be more than just a check-in call."

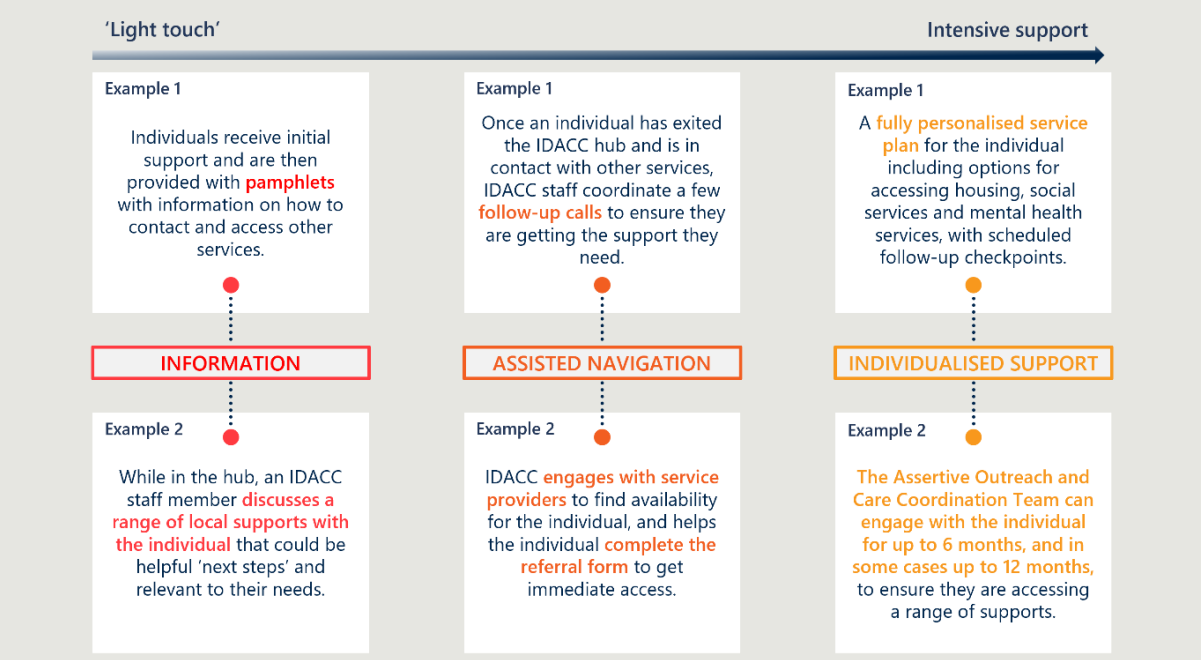
- Consumer

A highly flexible care coordination role was broadly supported by consumer and service providers. It was felt this role should be highly tailored to the individual needs of those who access the service. While some

may only require (or be willing to receive) light touch coordination support (e.g., information about other services available) others will require, and be ready, for a more 'hands on' coordination role – closer to case management. Stakeholders broadly agreed that IDACC workers should be able to perform both roles, and everything in-between.

Examples of the extent of this role identified by stakeholders is outlined in Figure 7 below.

Figure 7 | Types of coordination and referral support that IDACC staff could offer



Recommendation 5: The coordination and referral role of both the Drop-in Hub and the Assertive Outreach and Care Coordination Team should be broad, inclusive, and flexible depending on consumers, families, and carer needs. To accommodate this, the service model should more specifically describe the broad extent of the IDACC's role in coordination and referral, and an inclusive list of the types of support this could involve.

This can be achieved by updating *Section 7 Service Components (p.6)* of the draft service model to:

- Incorporate the concept outlined in Figure 7 of a flexible coordination and referral role into sections that articulate what the IDACC will provide to individuals, placing emphasis on the fact that individuals can have a varying experience of supports while engaging with the IDACC depending on their needs.
- Include specific examples as to how this could look in practice for the individual depending on their needs, ranging from information and awareness provided by the Assertive Outreach and Care Coordination Team, to individualised service planning while the individual is in the IDACC and in contact with an Aboriginal Health Worker.
- Organise the list of supports to demonstrate what are 'foundational' or immediate crisis supports, and then the options for the extent to which individuals can receive service coordination and system navigation support while engaging with the IDACC.

6.2.3 Both the Assertive Outreach and Care Coordination Team and Drop-in Hub staff should play an active role in educating the community about the IDACC and other services

Several stakeholders, including consumers, argued that the Assertive Outreach and Care Coordination Team should play a role in educating the community about the service. This should include the team going out to services in the community and talking about the IDACC, what it does and who it serves. This could be done alongside the immediate intervention, or on its own. Otherwise, there's a risk the service becomes an island. In fact, some stakeholders also suggested that this be an explicit function and role of both the of both the Drop-in Hub and the Assertive Outreach and Care Coordination Team, as educating consumers about services available to them is a critical challenge in knowing 'where to go' in a time of crisis.

"The [Assertive Outreach and Care Coordination] Team must educate the public about the supports the IDACC offers – education is such a crucial component of their role."

- Consumer

Recommendation 6: Both the Assertive Outreach and Care Coordination Team's and Drop-in Hub staff's roles should be updated to include an active responsibility in educating others about the IDACC service. This should include:

- **a) Outreach to community service providers who may be potential referrers into the IDACC, to build strong relationships and a better understanding of when IDACC might be 'the right place' for individuals.**
- **b) Education sessions with other potential referrers, such as WA Police and EDs, to clearly communicate the purpose of the IDACC and how WA Police and EDs can play a role in supporting people in AOD crisis to access it.**
- **c) Development and dissemination of communication materials to promote the IDACC to local community groups, including family and carer support groups.**
- **d) Ad-hoc community engagement with people who are street-present to inform them of the IDACC as a safe place to go when they are in crisis, as well as information about other nearby services that they can access as well.**

This can be achieved by updating *Section 7.1 Assertive Outreach and Care Coordination (p.6), Section 7.2 Drop-in Hub and Section 8.3 Partnerships (p.20)* of the draft service model to:

a) Reflect this required role in the dot point summary of both the Assertive Outreach and Care Coordination Team's and Drop-in Hub's functions to include: Through engagement with service providers, community members and potential referrers, increase awareness of the IDACC, its target cohort and suite of services available to those in AOD-related crisis.

b) In the sections following, articulate the mechanisms through which the Outreach Team and Hub staff can fulfil this function. Points a – d listed above are examples that we heard from stakeholders as to how this could be achieved in practice.

6.2.4 The service model should articulate the key relationships and referral pathways which the IDACC will need to cultivate as core business

Throughout the consultation process, stakeholders noted the need for the service model to clearly state the key relationships and referral pathways the IDACC will need to establish to fulfil its aims and objectives. With many services in the wider system operating as siloes, stakeholders were concerned that if the IDACC does not build strong relationships with existing services within the system, it too risks operating in this way. Relationships with the WA Police, EDs and AOD service providers were identified as the most critical to the success.

WA Police

Stakeholders noted the importance of the service model clearly articulating how it will work with the police, given how closely they will work together. Given the complexity of caring for somebody in an AOD crisis, the IDACC and police will need to establish clear processes and pathways for how the police can best refer and transport consumers to the IDACC, as well as how police could support IDACC staff if their assistance is required. During the consultation with the WA Police, stakeholders also noted the existing database of street-present individuals and its strong community engagement capacity. By leveraging a relationship with the police, the IDACC's Assertive Outreach and Care Coordination Team will be able to work more efficiently to identify street-present individuals and ensure individuals are smoothly transitioned to the IDACC. Service providers noted that the police should aim to keep their distance from the service, where possible, given they may "scare people off" from presenting to the IDACC.

EDs

To ensure the smooth transition of individuals between the IDACC and EDs, stakeholders stressed the need for the service model to clearly articulate how these two services will work together. With the IDACC's current eligibility criteria stating that individuals who are in a psychiatric and medical crisis will not be able to access the IDACC, there will be many individuals who will be referred between these services. Establishing clear referral pathways will allow both the IDACC and EDs to work more efficiently and help meet the needs of individuals, their families and carers.

AOD service providers

As highlighted above, stakeholders expressed their concerns with the IDACC becoming another service that is not integrated into the system and operates on its own. To ensure the IDACC can connect and refer individuals to other services within the system, the IDACC needs to identify how it will work with other service providers – in particular local AOD service providers – to meet their needs in the community. Stakeholders identified the importance of the IDACC acting as a conduit between other services and helping connect individuals to continue their recovery journey.

6.2.5 The IDACC must be underpinned by strong, ongoing working relationships with referral partners

Throughout the consultation period, stakeholders stressed the lack of clear exit pathways that exist within current AOD services. They reported either being unable to access services or nowhere to go once they had been discharged. Stakeholders repeated having nowhere to go and nowhere to go again, highlighting the lack of integration between services and non-existent exit pathways at some services. Consumers also emphasised that without that continued, wraparound support and clear pathways between services, they would often "fall between the cracks" and end up back where they started before they accessed support.

To ensure entry and exit pathways are clear and achievable for both consumers and other services, stakeholders stressed the need for staff within the IDACC to establish genuine relationships early with other services by going out to visit them and also by encouraging other services to visit the IDACC and connect with its staff. Stakeholders recognised that in doing so, this will help support warm referrals to other services to prevent the IDACC becoming a disjointed service in the wider system. To encourage building relationships with services, stakeholders highlighted the importance that it is written into the role description of staff and is not an additional task for staff to do in their down time.

"Pathways in and out of the IDACC really will require a two-way partnership. Some of these services might refer into the IDACC, but connections out to the services is equally as important to leverage the supports they offer. Community services will be important to be connected to the IDACC to support the individual in the next steps of their recovery journey."

- Service provider

Recommendation 7: The service model should be updated to include additional detail on expected key referral pathways in and out of the IDACC, and to emphasise the requirement for staff to build ongoing relationships with referral and follow up services through strong sector-wide partnerships.

This can be achieved by updating *Sections 7.1.5 and 7.2.5 Access, and Section 8.3 Partnerships (p.20)* of the draft service model to:

a) Explicitly call out that strong ongoing partnerships between the IDACC and potential referrers will be required to ensure smooth transition of individuals in AOD-related crisis, which will require the service provider to be responsible for liaising with key stakeholders from WA Police, EDs and AOD service providers to identify ongoing opportunities for improved collaboration and clearer pathways.

b) Include that the service provider will be responsible for engaging with potential referrers on an ongoing basis to inform them of the IDACC, provide clarity on its eligibility requirements, and provide education on situations where people presenting to them with AOD issues would be well suited to attend the Drop-in Hub or be engaged by the Assertive Outreach and Care Coordination Team (see Recommendation 6).

c) When discussing each of these referral pathways, provide more specific examples of situations that are likely to occur. Please refer to the list of sample situations we heard from stakeholders under Recommendation 3 for more detail, which provide a starting point for examples to include.

d) In *Section 7.1*, expand on the ability of police to leverage its existing community outreach functions to inform the Assertive Outreach and Care Coordination Team of individuals who could potentially benefit from accessing the IDACC.

e) Include details as to how the IDACC could liaise with existing community outreach functions, such as Nyoongar Outreach, to identify at-risk individuals who could potentially benefit from accessing the IDACC.

f) Under *Section 7.2*, expand on the 'Referral and follow-up support' heading to articulate the broad range of follow-up support services that the IDACC will need to form strong relationships with across the sector to facilitate referral pathways. The draft service model has already identified withdrawal, residential rehabilitation, outpatient counselling, accommodation, mental health and homelessness, however we also heard from stakeholders that the following partnership areas should be prioritised for:

- government social services (e.g., CentreLink)

- local health services (e.g., general practice, dental, pharmacies)
- education and training providers
- supported employment providers
- financial support services
- advocacy services
- community support groups (see a preliminary list on the MHC's website here).

The service model should also request that the service provider build relationships with and awareness of other local support services that could support the individual's recovery, and could form part of the IDACC workers planning conversations with the individual.

6.2.6 Staff's inability to administer medication limits the IDACC's ability to support those who are intoxicated, detoxing or in withdrawal

During the stakeholder engagements with potential referrers, some participants expressed their surprise at the exclusion of administering medication from the service model's function. They noted that medication can significantly aid individuals in immediate crisis support, preventing acute admissions to EDs, and that the IDACC's ability to administer medication may be contradictory to the IDACC's focus on de-escalation.

While some potential referrers were in support of including medication as part of the service's functions, others noted the risks that this brings. They acknowledged that some individuals may be seeking particular medications, e.g., Benzodiazepine when they access the service and this may "end up doing more harm than good". For the service to successfully administer medication, the importance of strong clinical governance and safety protocols to support clinicians was emphasised.

To ensure the IDACC can administer medication safely, in a way that aids individuals in their recovery from an AOD crisis and supports the IDACC's focus on de-escalation, the potential referrers suggested developing a list of medications that can be administered safely, following the bio-psycho-social assessment. In addition to the safe medications list, they also noted that additional detail around the functions of clinical staff would be required in the service model to ensure clinicians are providing safe, high-quality care.

"The omission of administering medication is quite surprising to me. Medication can often be quite valuable for individuals who require immediate crisis support and can help prevent acute admissions to emergency departments."

- Potential referrers

Recommendation 8: Consider whether the benefits of extending the IDACC's scope of services to include the onsite administration of medications are sufficient to outweigh the additional costs and potential safety implications.

This does not require any changes to the service model until a decision has been made on whether medication administration should form part of the scope of the IDACC. It is noted that including the

administration of medications onsite would likely require significant changes to the IDACC service model, including its staffing and clinical governance.

6.3 Staffing

The insights below are a summary of the feedback provided by stakeholders on the staffing sections of the IDACC service model. In particular, the findings below seek to address the following questions:

- *What roles should form part of the Assertive Outreach and Care Coordination Team and IDACC facility multidisciplinary teams?*
- *What's the right ratio of the different roles for each of these teams?*
- *What skillsets, experiences and other capabilities should the teams have?*

6.3.1 A significant majority of IDACC staff should be non-clinical workers, including AOD workers, counsellors, Aboriginal Health Workers and peer support roles

The IDACC should be delivered and supported by primarily non-clinical staff and peer workers who have demonstratable experience of working with people with complex AOD issues. Although understanding of the importance of the IDACC employing an appropriate number of clinical staff to undertake assessments, deliver interventions and ensure clinical governance, stakeholders stressed the importance of the IDACC employing a greater proportion of non-clinical workers, including AOD workers, peer support workers and Aboriginal Health Workers, to engage and support individuals who require non-judgemental support. The current scope of services provided by the IDACC under the service model require strong relationship-building between staff and individuals, rather than focusing heavily on clinical procedures, as individuals are accessing the IDACC to feel safe and promote recovery from distressing social situations, not medical crises. Therefore, the staff profile should reflect a focus on emotional trust and rapport, rather than reflecting a clinical facility such as a hospital or other institution.

> "You only need a handful of nursing staff. The main focus should be the AOD and social support roles"
>
> **- Service provider**

Stakeholders noted that it is individuals with lived experienced and those from similar backgrounds who are most able to relate and build rapport with individuals struggling with AOD. They also highlighted that in their past experiences of engaging with services, they often do not employ enough non-clinical staff which deters individuals from presenting to these services as they can use non-inclusive practices and experience stigma from clinicians. If the IDACC does not employ an appropriate proportion of non-clinical staff, it risks individuals avoiding the service due to a lack of trust and confidence in the service that it can meet their needs.

> "Our [drop in] service has only one nurse. The rest of the staff are non-clinical"
>
> **- Service provider, comparative service**

To ensure the service has the right balance of clinical and non-clinical staff, peer support workers need to be formalised in the service model. The service model currently states, "*Peer support workers may also be engaged to complement the roles of clinical and counselling*". Viewed by some stakeholders as the most important staff member at the service given their ability to build relationships, the decision to include peer support workers in the service should not be left to the service provider and instead, formalised in the service model.

"Peer workers are excellent and can provide support in a way that clinical staff cannot."

- Consumer

Recommendation 9: The IDACC model should aim for a predominantly non-clinical staffing profile including AOD workers, counsellors, Aboriginal Health Workers, and peer workers. The number of clinical (nursing) staff should be a limited minority.

This can be achieved by updating *Section 7.2.2 Staffing (p.14)* of the draft service model to state a target ratio of clinical to non-clinical staff. This ratio should reflect that a significant majority of the IDACC's core staff should be non-clinical roles, noting that clinical staff will play a critical role in overseeing clinical governance.

Ultimately, the specific ratio of clinical to non-clinical roles possible at the IDACC will be restricted by the nurse-to-bed ratio required for the facility to operate consistently with clinical safety requirements, and the overall funding available for the service (e.g., remaining funding available for non-clinical roles, after the minimum nursing staff per bed requirements are met).

6.3.2 Staff should represent the diversity of those who might access the service, including Aboriginal and Torres Strait Islander, LGBTQIA+ and CaLD groups

Stakeholders raised the need for IDACC staff to reflect the diversity of individuals, families and carers accessing the service. Throughout the consultation process, stakeholders highlighted the barriers to accessing services, including discrimination and ineffective communication mechanisms. Consumers felt that when they were able to access these services, they often experienced stigma from clinicians and staff, leaving them feeling isolated and unwilling to access similar services again.

"Not everybody is Aboriginal and not everybody is white. The service needs staff members from all backgrounds."

- Consumer

To ensure the IDACC is delivered and supported by clinical and non-clinical staff who can meet the needs of consumers, families and carers, the service needs to employ a workforce that reflects the diversity of the community it serves. The service, where possible, needs to employ a diverse range of people including those who are LGBTQIA+, Aboriginal and Torres Strait Islander, and CaLD. Consumers who can see themselves reflected in the staff of the service will be much more likely to engage and trust the service with their recovery and be willing to access the service.

Recommendation 10: The service model should be updated to explicitly commit to recruiting a workforce that reflects the diversity of people who are accessing the IDACC.

This can be achieved by updating *Sections 7.1.2 and 7.2.2 Staffing* of the draft service model to:

- Provide an explicit commitment to recruiting a high proportion of workers who identify as Aboriginal or Torres Strait Islander, CaLD, and LGBTQIA+.
- Articulate the benefits of having a diverse workforce that can communicate effectively and build relationships with the diverse cohorts of people who might access the IDACC.
- Reflect that recruitment processes will provide strong encouragement for applications from people from these backgrounds to ensure that the workforce is accessible and can build trusting relationships with its clientele.
- Articulate that all staff members will be responsible for demonstrating inclusive practices and culturally secure ways of working, regardless of background.

6.3.3 Soft skills such as non-judgmental support and shared values are critical for all roles within the IDACC

"Staff need to do it with love and not just treat it as a job"

- Consumer

Throughout the consultations, stakeholder stressed the importance of the IDACC's staff having the soft skills required to effectively support individuals, families and carers. Reflecting on their past experiences of accessing services, stakeholders reported, at times, "feeling like a number" and did not believe that they were committed to helping each individual in their recovery journey, particularly EDs at hospitals. As a result, stakeholders often chose not to access support, as they were unable to trust and build rapport with staff members. The current draft service model articulates that IDACC workers should have strong rapport building and relationship development skills, and work from a recovery and strengths-based approach. Stakeholders also identified the following soft skills as critical for IDACC workers to demonstrate they:

- Are able to provide **non-judgemental support** when interacting with individuals whose behaviour is or has been impaired due to AOD use.
- Can **actively listen** to and support individuals in a vulnerable state to identify what their most critical and immediate needs are (which are often basic needs like human comfort, hygiene, a place to relax), rather than being in 'solution mode'.
- The ability to **remain calm** when interacting with highly erratic individuals who are displaying challenging behaviours.
- Are **resilient** and **client-focussed**, that is, they are willing to go the extra mile to ensure the individual is supported to access follow up supports that best meet their needs.

By recruiting a workforce who possess soft skills and share similar values with individuals, families and carers who access the IDACC, the service will be able to establish a reputation within the community as a trusted and approachable provider of AOD crisis support, increasing the number of people who access support and kickstart their recovery journey.

The IDACC must ensure that staff delivering clinical and non-clinical supports are open-minded, inclusive, empathetic and have demonstratable experience working with diverse people including those who are neurodiverse, LGBTQIA+, Aboriginal and Torres Strait Islander, and CaLD. Recruitment within the IDACC should be focussed on employing a workforce who can meet all the needs of consumers, families, and carers, not just the clinical capabilities they possess.

Recommendation 11: The service model should be updated to emphasise the importance of IDACC staff members having a range of soft skills and shared values to effectively provide crisis support to individuals accessing the IDACC.

This can be achieved by updating *Sections 7.1.2* and *7.2.2 Staffing* of the draft service model to:

- Explicitly call out that soft skills and shared values of staff will be as important as technical capabilities in providing inclusive care that is non-threatening and makes individuals in crisis feel safe and supported.
- Expand on the current list of soft skills identified to include those outlined in the findings above.
- Indicate that recruitment processes should be considerate of these skills to ensure the 'right people' are providing care and support.

6.3.4 Strong medical governance processes and policies need to be embedded across all service components to ensure decisions are clinically safe

Stakeholders highlighted that the service model lacks clarity on its medical governance and raised concerns with the risks this may bring for staff, consumers, families, and carers. With staff members having to assess consumers on their presentation to the service, there is the need for strong medical governance policies and processes to be embedded across the service to ensure staff are safe and supported when making decisions about accessibility. This sentiment was also echoed by stakeholders for the need for the clinical oversight within the IDACC once an individual is under the care of the service.

With individuals having to undergo a bio-psycho-social assessment upon presentation to the Drop-In Hub, this presents risks for both staff and individuals, and their families and carers. Providing additional information in the service model around who is making decisions on access and eligibility will help reduce the clinical risk and ensure consistency for all who try to access the service.

To ensure decisions across the service are clinically safe, stakeholders stressed the need for the service model to establish clearer eligibility requirements for individuals trying to access the service and additional detail around the processes for accessing, including who will conduct the assessment, to ensure consistency. They also noted that it is vital that the facility staff have access to clinical advice through the DACAS and other mechanisms where possible, ensuring the decisions made by the IDACC's staff are clinically safe. This includes the need for robust risk management policies, as well as a shared understanding amongst staff of escalation procedures if clinical assistance or advice is required.

"Who makes the determination as to where people should go in a medical situation?"

- Potential referrer

Recommendation 12: The service model should embed strong clinical governance policies and processes into the IDACC's operations, to ensure individuals are safe and minimise clinical risk.

This can be achieved by updating *Sections 7.1.3 and 7.2.3 Safety and Security* of the draft service model to ensure the model explicitly includes various considerations and mechanisms to embed clinical governance, including the following components:

a) **Processes.** Such as requirements for ongoing staff training in de-escalation and other crisis management techniques (including first aid and intoxication/overdose responses), a comprehensive suite of policies and procedures designed to ensure safety of staff working in outreach environments with unknown clients who may be intoxicated. This has been addressed by the current draft service model.
b) **Structures.** In the event of a clinical incident, there should be clear lines of escalation for all staff, which includes but should not be limited to ensured access to the DACAS phone line.
c) **Responsibilities.** Staff JDFs and/or capability statements should include reference to the responsibilities of staff pertaining to client safety, health and wellbeing, managing clinical risks and patient oversight. This should include explicit guidelines on what decisions non-clinical staff can and cannot make.
d) **Complaints.** The IDACC should ensure that there are transparent complaints processes. Individuals, family members and carers should receive a clear explanation of the complaints process, including how to raise concerns and issues, as well as escalation pathways and who will be responsible for taking these complaints forward.

e) **Clinical risk management.** This has largely been addressed by the current draft service model in stating what service safety risks will need to be accounted for by the service provider under *Section 7.2.3*.

f) **Staff management.** This has largely been addressed by the current draft service model, and includes duress features and safety training for staff.

It is suggested that the MHC look to similar AOD service models, such as the integrated Community Alcohol and Drug Services (CADS) approach to clinical governance. This may support alignment of service governance, as well as assist the service provider in understanding what governance requirements must be set in place.

6.4 Facilities

The insights below are a summary of the feedback provided by stakeholders on the facilities sections of the IDACC service model. In particular, the findings below seek to address the following questions:

- *What does a 'low-stimulus environment' look like in practice?*
- *What other design features would be needed to make the facility welcoming, culturally and physically safe, private, and inclusive?*
- *What considerations should be given when deciding the location of the IDACC facility?*

6.4.1 While the CBD is a central and logical location, there are several associated risks that must be considered

Throughout the consultations, stakeholders stressed the number of associated risks with a CBD location for the IDACC. Although they acknowledged that the CBD is a logical location, participants were concerned with the AOD use associated with the CBD and feared that individuals may be walking "straight into trouble" when they left the service. In addition, they also highlighted the likelihood that there will be some individuals who are unwilling to access the service in a central location given the associated risks. To address these key risks, stakeholders emphasised the importance of exit pathways (see Section 6.2.3) and the need for the service model to clearly articulate how the Assertive Outreach and Care Coordination Team will engage and continue to engage with individuals who are not willing to access the IDACC facility.

As highlighted in Section 6.3.2, stakeholders stressed the lack of clear exit pathways that exist within current AOD services. They reported that if the IDACC is unable to establish clear exit pathways, street-present individuals are likely to return to areas of heightened AOD use jeopardising their longer-term recovery. Similarly, as highlighted in Section 6.3.5, if the Assertive Outreach and Care Coordination Team does not have consistent processes for how it provides ongoing support for individuals, they may not be able to provide the ongoing support required to support individual's long-term recovery who will not engage with the service.

To ensure the IDACC can mitigate the risks by locating the IDACC facility in the CBD, stakeholders again stressed the need for staff within the IDACC to establish genuine relationships early with other services in

"The CBD can be a trap – there needs to be support so individuals are either returned home or referred to an appropriate service."

- WA Police

the wider system. Establishing linkages with other services will ensure that individuals do not fall through the cracks and will help ensure that the IDACC is the beginning of an individual's recovery journey. Stakeholders also emphasised the need for the Assertive Outreach and Care Coordination Team to provide greater clarity around how it plans to provide ongoing support to individuals and the processes behind this.

Recommendation 13: While the broad recommendation to develop the facility in the Perth CBD area should remain in place, there should be considerations in the service model around how the IDACC facility can manage the various risks associated with the facility being in a 'high-risk' area.

This can be achieved by updating *Sections 7.2.1 Location and Facility (p.13) of* the draft service model to ensure the model explicitly addresses and acknowledges the risks associated with a CBD-based Drop-in Hub, including:

- Acknowledge the risks associated with an AOD crisis hub being located in the Perth CBD including individuals in crisis not viewing the hub as accessible due to the need to travel into the CBD, as well as the risks of individuals becoming involved with anti-social behaviour in the Perth CBD area following their stay at the IDACC.
- State that the service provider should ensure it is actively engaging with people in a broad range of suburban communities to avoid the Drop-in Hub becoming inaccessible due to reluctance for individuals in a heightened state to travel into the CBD.
- Minimising instances in which individuals exit the IDACC service by 'walking out' into the Perth CBD area, ensuring they are connected back to a safe place of residence or community/housing service for safety and recovery reasons.

6.4.2 Green space, dim lights, neutral colours, natural lighting and available refreshments will create the right low stimulus, welcoming environment for the IDACC

Stakeholders were highly supportive of the list of design features currently outlined in the draft service model, noting that the extensive list included both safety considerations as well as practical low-stimulus design features. This included the private and separate safe rooms to provide support, the central outdoor area for people to relax in, and amenities for people to access including showers. However, there was some caution from stakeholders that it will be critical for the IDACC facility to find the balance between being a home away from home and meeting health and safety requirements. For example, one stakeholder noted that although, in theory, lounge cushions may seem like an avenue to create a welcome and home-like environment, they can also be used in a threatening manner which may jeopardise the safety of the service.

> "For all design features, the service must consider the associated health and safety risks"
>
> **- Potential referrer**

By finding the balance to ensure the space is both welcoming and in line with occupational health and safety requirements, the IDACC will be able to build trust within the community while ensuring the safety of individuals, families and carers who present to the service. With consumers repeatedly noting that serval other facilities look too hospital-like, stakeholders noted that the IDACC has the opportunity to provide an environment that consumers are comfortable attending.

Throughout the consultation process, stakeholders presented a number of ideas to ensure that the IDACC is a safe and welcoming space, including:

- natural lighting throughout the facility
- no plain white walls
- plants and trees
- artwork (and other cultural artefacts)
- available refreshments – stakeholders noted that these facilities might not necessarily be accessible by individuals, that staff should be able to provide refreshments such as tea and coffee where requested.

6.4.3 Rooms for other service providers onsite, multi-purpose central spaces and dedicated spaces to 'chill out' should be explicitly called out in the service model

Stakeholders broadly supported the concept of a central living room, but also suggested that considerations should be made for other rooms, as they felt that the current service model focuses on specific design features rather than the functionality of the delivery environment. If the service model were to provide greater detail and clarity on the functionality of rooms and spaces within the IDACC, stakeholders felt that the service would be better placed to not only improve the supports offered to individuals but better engage with other service providers to improve collaboration and integration with the wider service system. For example, the current service model indicates that the service may also consider incorporating the provision of mobile services from the IDACC facility (e.g., medical, dental, social/welfare etc.) depending on the needs of the cohort accessing the service, and will need to develop the appropriate partnerships to enable this to occur. This will require specific rooms within the built environment to enable external service providers to come in and engage with individuals at the facility.

> "If there is enough space for other service providers on site, it would make that handover a lot easier"
>
> **- Service provider**

To ensure the IDACC can balance individual support, community engagement, and capacity to host other providers, stakeholders voiced that there should be rooms for service providers or consumer groups to use and engage with consumers to promote services. Some stakeholders also noted that the central living room should be multi-purpose, with places to 'chill out', as well as enough space to have community or family groups to come together, so long as there is sufficient separation.

Recommendation 14: While the facility section should remain largely unchanged due to strong stakeholder support, the IDACC facility could be set up for success by including a small number of changes to design features in the service model to meet the needs of individuals, families and carers, and staff.

This can be achieved by updating *Sections 7.2.1 Location and Facility (p.13) of* the draft service model to incorporate design features suggested by stakeholders during recent consultations. This includes:

- Including the list of design features outlined above in Section 6.4.2 onto the existing list.
- Aligned to the services provided by the Drop-in Hub, re-considering the design of the space to include both multi-purpose common rooms where stimulating activities can be undertaken, as well as designated 'chill-out spaces'.
- Extend the consideration of having mobile health services on site to stipulate that the Drop-in Hub should have rooms for external service providers to come in and either provide supports to individuals, or engage with them due to existing relationships.

6.5 Cultural safety

The insights below are a summary of the feedback provided by stakeholders on the importance of embedding culturally safe practices across the IDACC service model, particularly the service delivery interface, staffing model and physical environment.

6.5.1 'Culturally safe' service provision in the context of the IDACC means non-judgemental support in a culturally welcoming environment

Stakeholders stressed the need for the service to adopt practical ways of embedding cultural safety to ensure everybody who access the services feels safe and supported. They noted that in their past experiences with the system, services were not always inclusive and culturally competent, resulting in a lack of trust and unwillingness to access support by key cohorts including but not limited to Aboriginal and Torres Strait Islander people.

By delivering a service that is culturally competent, non-discriminatory and inclusive, the IDACC will be able to build trust and support individuals from all backgrounds, helping them to begin their recovery journey. If the IDACC is unable provide a culturally safe environment, stakeholders feared that it would be cutting off several key target cohorts who are in need of the support the most.

6.5.2 Culturally safe crisis care can be enabled through specific service, staffing, and facility design features

To ensure the IDACC service is culturally secure and fosters an environment for everybody to feel safe and included, stakeholders identified several service features recommended for the model.

Service interface and staff

- There should be a high proportion of Aboriginal staff, and both male and female, available.
- All staff should receive cultural security training, including staff in security and administrative roles.
- There should be access to interpreter services for those who need them.
- The IDACC should have a role in building relationships with Aboriginal-led community service providers who have outreach teams or community services to leverage their experience and embed culturally safe practices, including but not limited to Wungening Aboriginal Corporation (and the associated Boorloo Bidee Mia hostel), Nyoongar Outreach Services, Derbarl Yerrigan Health Service and Moorditj Koort Aboriginal Corporation.

Facilities:

- Aboriginal, LGBTQIA+ and CaLD people should be involved in the facility design process.
- An Acknowledgement of Country should be featured above the entrance to the facility.
- Aboriginal art should feature throughout the facility.
- There should be access to a 'green area', with plants and trees.
- There should be an abundance of Aboriginal signage around the facility, such as pamphlets that use Noongar language, or rooms that can be named after important Aboriginal places in the Perth CBD (e.g. Derbarl Yerrigan, Kaarta Koomba).

Recommendation 15: The IDACC should build out its commitment to cultural safety by including the specific service, staff and facility features described above as examples of what cultural safety looks like 'in practice'.

This can be achieved by updating *various sections of* the draft service model to build out its commitment to cultural safety and ensure the IDACC is welcoming and inclusive for people of all backgrounds. This includes:

- **Section 5 – Service aims.** Amend the bullet point list of service aims by building out what 'providing a safe environment' looks like in practice i.e. culturally safe, inclusive practices from a diverse workforce.
- **Section 7 – Service Components.** Include the capability for the Drop-in Hub to provide cultural services to individuals when they are receiving care, including interpreter services and access to staff of similar backgrounds where possible.
- **Sections 7.1.3 and 7.2.3 – Staffing.** Include a specific commitment to recruiting a high proportion of Aboriginal and Torres Strait Islander people as IDACC workers.
- **Section 7.2.1 – Location and Facility.** Include the list of cultural facility considerations outlined above to the list of design features required in the Drop-in Hub.
- **Section 8.3 – Partnerships.** Specifically call out the need for the IDACC service provider to have a role in building relationships with Aboriginal-led community service providers who have outreach teams or community services to leverage their experience and embed culturally safe practices.

Appendix A Consultation register (organisations)

Focus Group 1 Aboriginal Organisations	**Focus Group 2** Potential referrers	**Focus Group 3** Potential referrers	**Focus Group 4** Connecting agencies	**Focus Group 1** WA Police only
12 pax	**17 pax**	**8 pax**	**6 pax**	**15 pax**
Aboriginal Legal Service	Royal Perth Hospital	Next Step Drug and Alcohol Services	North Metro Community Alcohol and Drug Services	WA Police
Mental Health Royal Perth Bentley Group	Street Friends WA	Street Doctor WA	Parent and Family Drug Support	
Yorgum Healing	Mission Australia (DAYS)	State Forensic Mental Health Service	Daydawn Advocacy Centre	
Langford Aboriginal Association	Next Step Drug and Alcohol Services	North Metropolitan Health Service	St Bartholomew's	
Wungening Aboriginal Corporation	South Metropolitan Health Service		Salvation Army	
Aboriginal Health Council of WA	East Metropolitan Health Service			
	Homeless Healthcare			

Appendix B IDACC Briefings

Overview

To ensure the final IDACC Service Model is comprehensive, clear and will meet the needs of the target cohort, the MHC provided a summary of the draft Service Model and this consultation report for final feedback to the MHC's expert advisory groups as key stakeholders. This included:

- **Alcohol and Other Drug Advisory Board (AODAB).** The AODAB is a key advisory body that provides advice to the Mental Health Commissioner (the Commissioner) about matters relevant to AOD policies, practices, programs, and initiatives, and works to achieve a coordinated focus on alcohol and other drug use issues and mental illness.[1]
- **Mental Health Advisory Council (MHAC).** The MHAC is a key advisory body that provides strategic advice and guidance to the Commissioner regarding major issues affecting people with mental health problems, their families and service providers.[2]

Furthermore, to ensure the final IDACC Service Model is genuine to the consultation which occurred before Nous' engagement, Nous sought written feedback on the draft Service Model and this report from select stakeholder groups that were involved in the 2020 AOD Crisis Intervention System Service Model (AODCISSM) process, facilitated by the MHC and Tuna Blue. This included:

- **Previously engaged stakeholders.** This comprised key providers of similar services, including organisations such as RUAH Community Services, WANADA, WAAMH, Palmerston, Mission Australia, Cyrenian House, and Anglicare.
- **Community Advisory Group (CAG).** The CAG membership comprised of a diverse mix of individuals including consumers, family members, carers, and peer workers.

All cohorts referenced above were provided with a presentation that included an overview of the Draft IDACC Service Model and a summary of the key insights arising from the IDACC Service Model review process that informed Nous' Final Report. Please note that insights provided to these stakeholder groups were high-level only, as these engagements were only seeking reflections on the findings of this consultation process, as well as any other feedback about the finalisation or implementation of the IDACC Service Model.

Overleaf is a synthesis of the feedback from these groups on the service model itself and the findings of the consultation process, with the following section outlining some of the considerations for implementation that were raised during these engagements.

[1] Western Australian Mental Health Commission (2021). Alcohol and Other Drug Advisory Board. Access here.
[2] Western Australian Mental Health Commission (2021). Mental Health Advisory Council. Access here.

Feedback on the service model

Collectively, stakeholders who participated in the briefing sessions provided a range of reflections on the service model design for the IDACC.

Finding 1	**The service model design is strong, and has leveraged many key features of good practice, making it an exciting proposition for the AOD sector.**

On the whole, stakeholders were appreciative of the aims and objectives of the IDACC, as well as how specific components of the service model had been articulated to best meet the needs of individuals in crisis. In particular, previously engaged stakeholders noted that the service model aligns well with some of the key features of good practice AOD Crisis Intervention Services that were identified during 2020 consultations, including but not limited to:

- Providing support for family members and carers was a really positive inclusion, as this is often overlooked in the service design phase.
- Embedding cultural safety throughout the service model, rather than an afterthought, received overwhelming support. Stakeholders noted that this is often a component of services that is challenging to articulate and prioritise, and so many were pleased with this being such a clear consideration in the model.
- The specificity of required inclusive and low-stimulus design features in the facility was comprehensive and clear, with many stakeholders commenting that these will be critical to creating a positive service experience for people in crisis.

Finding 2	**The current target cohort is still unclear, with mixed views on whether it has become too restrictive.**

The Overview of the IDACC service model outlined that the IDACC aims to "Help individuals experiencing a crisis, to gain relief quickly." This detail raised some level of confusion amongst stakeholders, who sought further guidance about what a 'crisis' entails and who would be excluded from the service. Some stakeholders expressed concern that those in active withdrawal, and those experiencing an episode of psychosis but were not an active danger to themselves or others, would be excluded from the service. They argued that assuming clinical intervention would be best in these circumstances represented an overly medicalised view of AOD and mental health issues: in fact, a service like the IDACC would be well placed to support these groups.

While stakeholders appreciated the need for some exclusion criteria, they called for the model to provide a more fulsome description of the target cohort of the service - those experiencing 'social crisis'. This definition should aim to be as broad and inclusive as possible and should not unwittingly exclude those for whom the IDACC would be well suited. The service should continue to be limited to those who require immediate support.

Separately, some stakeholders were disappointed that in the Overview of the IDACC, the target cohort, excludes those under eighteen years old. Again, stakeholders noted that this excludes a key cohort who are in clear need of AOD crisis support, but were conscious of the safety risks associated with expanding the age eligibility for the IDACC.

Finding 3	**Stakeholders voiced concerns about whether the IDACC Service Model will effectively support those with acute mental health issues, particularly those in a drug-induced psychiatric crisis.**

The service model currently attempts to articulate that if someone presents to the IDACC experiencing a

psychiatric crisis and is showing high risk behaviours (e.g., suicidal or homicidal), there needs to be a robust and safe initial assessment process of that individual's mental state when they enter the IDACC, to ensure:

- Those who are in real danger – to themselves or to others – are immediately referred to the right emergency service (e.g. Emergency Departments).
- Those who are agitated but can be de-escalated through immediate intervention from qualified staff at the Drop-in Hub can still access the service and are not turned away, as this immediate support is likely to the be the safest place for this individual.

Stakeholders were appreciative of the bio-psycho-social assessment being included in the service model, but were heavily in favour of there being clarity over how this assessment should be applied to support people with acute mental health issues or those in a drug-induced psychiatric crisis. Many stakeholders commented for many individuals with mental health issues, AOD-induced psychosis is a real possibility, and although this cohort would benefit substantially from the IDACC, the current wording is too restrictive and will likely see these people end up in Emergency Departments in all cases.

Finding 4	**The non-clinical workforce will need clinical and personal support to maximise their effectiveness.**

While there was broad support for a non-clinical workforce focused on building relationships and trust, stakeholders emphasised that they must be supported both professionally and emotionally to ensure the safety of consumers and staff. In particular, stakeholders wanted to ensure that although the Hub would have a predominantly non-clinical workforce, assessments such as bio-psycho-social assessments would only be undertaken by clinically qualified staff. Moreover, stakeholders mentioned that peer support workers will need supervision and guidance, as the peer support worker may be having individual challenges as well, and may require flexibility in working hours or out-of-shift support.

Finding 5	**The IDACC will likely target similar cohorts to existing central engagement hub services, and so a collaborative approach will be critical to success.**

Stakeholders sought greater clarity on how the IDACC will integrate with and connect to existing engagement services operating in the Perth CBD area. For example, some stakeholders referenced the RUAH Community Drop-in Hub, which runs an engagement hub in the Perth CBD area alongside Tranby Uniting Care and Vinnies' Passages Youth Engagement Hub. Given there is likely to be significant overlap between the cohorts that may access these services, stakeholders believed that it will be critical for the IDACC Drop-in Hub to work closely with these nearby similar services through ongoing partnership and collaboration. As an extension to this, some stakeholders saw this as an opportunity to ensure the provision of enhanced service provision, given that many of these existing services are not adequately funded to provide services 24/7. Similarly, stakeholders called for the IDACC's Outreach Team to work closely with existing services (e.g. Street to Home, HEART), as there is a risk that there are too many services providing assertive outreach, and not enough case workers to provide follow-up support.

Considerations for implementation

- **Availability of suitable locations.** Many stakeholders raised concerns around the fact that the current IDACC Service Model plans to have the facility/Drop-in Hub located in the Perth CBD, but with no current location confirmed. An issue that similar service providers have experienced is getting a suitable facility in City of Perth which is centrally located, and has appropriate design features to enable quality care and support in line with consumer needs. For example, Mission Australia currently

runs a youth service called YouthBeat, and has a facility in Northbridge, but noted that the current facility is not ideal and has functional restrictions in place. In the context of the IDACC, some stakeholders see this as a considerable risk to successful delivery, as trouble finding a suitable location, and/or building and construction issues, may lead to significant delays.

- **Workforce shortages.** While all stakeholders reflected positively on the composition of the proposed team structures and skillsets outlined in the IDACC service model, they noted that the successful provider may face challenges to recruit sufficient staff with the appropriate capabilities upon implementation, particularly within a mental health and AOD sector that already faces significant workforce capacity challenges. For example, some stakeholders showed concern that if the expectation that the clinical team would need to be available 24/7, that this model would be extremely difficult to staff due to competition between community services and the public health system, as well as extremely costly. Further, current providers of outreach services noted that the seven-day outreach team at double staffing is a very costly model and may be unfeasible.
- **Contract expectations.** Some stakeholders noted that it is unclear from the information provided as to whether the IDACC will form part of the integrated service models, whereby clinical support (e.g., the nursing component within the Drop-in Hub) will be provided by a clinical specialist organisation (such as Next Step) or if an NGO will be expected to provide all services. Stakeholders implied that the integrated service model through the MHC and the selected NGO seems to be the preferred model but suggested that this delineation of responsibility be made very clear in any service request.