Government of **Western Australia**
Mental Health Commission

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Youth Step Up/Step Down

Scope of Service

January 2024

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Background

The Youth Step Up/Step Down Service (the Service) is a State Government 2021 Election Commitment and is included as an immediate priority in the WA State Priorities Mental Health, Alcohol and Other Drugs 2020-2024 (State Priorities). The State Priorities outline the Government's immediate priorities to reform and improve the Western Australian mental health and alcohol and other drugs (AOD) service system by providing focus to the large number of actions in the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (the Plan). The Plan responds to gaps in services, identifies areas where future investment and reform should be prioritised and indicates that a lack of community-based services has resulted in a heavy reliance on costly hospital-based services. The Plan also specifies that young people with co-occurring mental health and AOD issues are particularly at risk of poor outcomes. The Plan Update 2018 further highlights a lack of adequate community-based accommodation and support services for young people, with many adult inpatient services currently providing services for this vulnerable cohort.

In recognition of the required investment in community bed-based and community support services, the Mental Health Commission (Commission) released A Safe Place – A Western Australian Strategy to Provide Safe and Stable Accommodation, and Support to People Experiencing Mental Health, Alcohol, And Other Drug Issues 2020-2025 (A Safe Place). A Safe Place acknowledges that community support services are an essential element of an effective and balanced mental health system and play a vital role in facilitating recovery and enabling individuals to progress toward independent living.

The need for targeted efforts to improve access to services and supports for young people with mental health and AOD issues is further emphasised in the Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025 (YPPA). The YPPA was launched in December 2020 and recognises that in responding to the needs of young people with mental health and AOD issues, the right services need to be available when and where they are needed. Young people, families, carers and sector stakeholders at YPPA consultations identified the need to increase community-based options, including Youth Step Up/Step Down services, to address the needs of young people in the missing middle[1]. YPPA stakeholders also identified the need to integrate mental health and AOD services so young people can access a single service to support their co-occurring issues.

Following the launch of A Safe Place and the YPPA, the Commission initiated planning to implement several initiatives, including the Service, aimed at addressing existing gaps to build a cohesive youth mental health and AOD service system. The provision of the Service will provide young people with an innovative and accessible short-term service option that will offer them a safe place to stay well in the community, out of hospital and connected to their family, friends and community. It will also provide support to assist with the transition from hospital to home, prevent relapse and promote good overall health and wellbeing. While recovery is a unique personal journey that belongs to the individual, mental health professionals and services can work in ways that encourage and support young people's recovery journey and improve their experiences of mental health care. The Service will be similar to the existing adult Step Up/Step Down services operating in Western Australia[2].

[1] The 'missing middle' refers to a gap in services for people who are not unwell enough to access public mental health services but are too unwell to access or benefit from entry-level counselling and primary care.

[2] Step Up/Step Down services are operating in the following locations:

In 2021, extensive consultation was undertaken to inform the development of the Scope of Service (noting consultations also included the Youth Psychosocial Support Packages and Youth Transitional Housing and Support Program). Consultations involved young people, carers and family members, service providers, peak bodies, government agencies, and organisations who were invited to share their views on how the Service should be designed and delivered to best meet the needs of young people. Along with findings outlined in the 2021 Final Consultation Report, learnings from the existing adult Step Up/Step Down services in Western Australia and Youth Step Up/Step Down services in other Australian States have informed this Scope of Service. Moving forward it is important that the Service be informed by identification of contemporary best practice, continuous improvement, occupational health and safety requirements, and staff and lived experience feedback and evaluation.

Service Overview

The Service is a short-term, residential service provided in a recovery focussed environment and is part of an evidence-based, early interventionist approach aimed at providing appropriate support for young people experiencing mental health deterioration and/or young people who are in the early stages of recovery from an acute mental illness, with or without co-occurring AOD issues. It will provide an integrated service pathway for young people who are exhibiting early warning signs of a deteriorating mental state and/or impaired psychosocial functioning. The Service will aim to intensively support the young person's recovery journey, which is recognised as an ongoing, continued journey for the young person after their exit from the Service.

The length of stay will be a maximum of 28 days, however in recognition of the complex support needs and specific vulnerabilities of young people, this may be extended on a case-by-case basis, as agreed by all service providers and the Commission. The Service will be staffed 24 hours a day, seven days a week to provide around the clock support for young people in a safe and supportive setting.

The Service will provide psychosocial, clinical and AOD interventions and treatment, including a range of individual and group peer support programs, to actively support the young person to achieve their individual recovery goals and engage or re-engage with social and educational/vocational activities within their community.

The Service will:

- provide short-term support in a residential setting for young people with moderate to severe mental health issues, with or without co-occurring AOD issues;
- provide psychosocial and AOD supports, including support with daily living and AOD counselling if applicable and appropriate;
- provide active and appropriate clinical care and treatment with Individual Recovery Plans;

- Joondalup, 22 beds, opened May 2013
- Rockingham, 10 beds, opened October 2016
- Albany, six beds, opened November 2018
- Bunbury, 10 beds, opened March 2020
- Geraldton, 10 beds, opened January 2021
- Kalgoorlie, 10 beds, opened January 2021

- have a youth specific focus and provide appropriate treatment and support to young people that meets their age and developmental needs;
- have low-access barriers and be responsive to young people with complex histories and needs;
- offer cultural safety;
- be trauma informed;
- improve wellbeing and promote personal recovery;
- optimise independent functioning;
- focus on whole of life and quality of life needs;
- if appropriate and with consent of the young person, actively identify and support family members and/or carers in the ongoing care and support of the young person; and
- be person-centred and meet the diverse needs of young people[3].

It is important to note that the Service:

- is not an alternative for acute inpatient care where significant clinical intervention and monitoring is required;
- does not provide emergency or crisis services;
- is not a homelessness service and does not provide temporary accommodation/respite care whilst permanent accommodation is sought; and
- does not provide AOD detoxification/ withdrawal /rehabilitation management services.

Target Cohort

The Service will provide support to young people aged 16 to 24 years who have signs and symptoms of moderate to severe mental health issues[4], with or without co-occurring AOD issues, who:

- are living in the community and require additional support to manage a deterioration in their mental health, but where an admission to an inpatient facility is not warranted (**Step Up**); or
- no longer require acute mental health inpatient care but require a short period of additional support to consolidate their recovery goals and re-establish themselves in the community (**Step Down**).

[3] Including Aboriginal young people, young people from culturally and linguistically diverse (CALD) backgrounds, young people in care/ care leavers, young people from the lesbian, gay, bisexual, transgender, gender diverse, intersex, queer, asexual and questioning (LGBTIQA+) communities, and young people with co-occurring disability (including those with cognitive and neurodevelopmental disability).

[4] While a formal mental health diagnosis is not required to be referred to the Service, an assessment tool such as the Kessler 10 test or other suitable assessment tools can be used to assist the assessment process.

Suitability Criteria

In addition to the target cohort considerations, the following suitability criteria will apply:

- With consultation and agreement from all service providers, on a case-by-case basis, young people aged 15 years may be considered and accepted into the Service. If the young person is less than 16 years, they will require parent or guardian consent. Where no suitable parent or guardian is available, a young person may be deemed a mature minor. The decision around mature minor status will be made by a health care provider and the relevant paperwork will be completed prior to their entry;
- Young people will need to provide a discharge address to access the Service. This does not need to be their permanent address; however, they need to have a place to which they can be discharged when they exit the Service. If their identified accommodation is no longer a viable option at the time of discharge, the provider will work with the young person to secure safe and stable ongoing accommodation;
- As this is a short-stay service, National Disability Insurance Scheme (NDIS) participants will be eligible for this Service and will be encouraged to continue engaging with their current NDIS service provider/s to maintain continuity of supports and facilitate transition and next steps after they exit the Service; and
- Young people on Community Treatment Orders may be admitted to the Service if they voluntarily agree. The Service will ensure the young person provides informed consent for admission and this is appropriately documented.

Catchment Areas

The Service will be available to all young people (16 to 24 years) in Western Australia who meet target cohort and suitability criteria[5] regardless of the catchment area in which they reside. The Program operates in the metropolitan area but is not restricted to metropolitan residents.

Service Description

Assessments

- An assessment team comprising of all relevant service providers will undertake referral and intake assessments to evaluate the complexity, acuity and risk connected to the young person and their suitability for the Service; and
- Once accepted into the Service, a comprehensive assessment process will be undertaken to identify the young person's support needs. This will include identifying other formal/informal supports already in place for the young person (e.g., NDIS supports). It is expected that supports provided through the Service will not replace supports already in place. Strategies will be implemented to ensure a cohesive and coordinated approach when delivering psychosocial supports across different funding streams. Comprehensive assessments will identify the risk levels of each young person, and

[5] Refer to 'Target Cohort' and 'Suitability Criteria' sections for further information.

support the development of their Individualised Recovery Plan[6] based on their goals, individual treatment needs and the accommodation they wish to transition to.

Supports

- The Service will regard young people as partners in decisions about their mental health care, ensure that they are fully informed about their rights and will provide the necessary information that will enable them to make informed decisions. Young people will also be actively supported to engage and maintain links with existing/natural supports (e.g., family and friends) and their participation in community life (e.g., study or work);
- The Service will look to provide additional support options (i.e., a day program or virtual support) for young people deemed to be eligible but who are not able to reside at the service (e.g., young people on the waitlist to enter the Service);
- The Service will provide access to recovery orientated psychosocial support services, clinical mental health services and AOD support services[7]. These supports and services will be provided within the context of the young person's developmental needs, family, friends, culture and community;
- The Service will be accessible for, and meet the needs of, Aboriginal people, young people from culturally and linguistically diverse (CALD) backgrounds, young people in care/care leavers, young people from the lesbian, gay, bisexual, transgender, gender diverse, intersex, queer, asexual and questioning (LGBTIQA+) community, and young people with co-occurring disability (including those with cognitive and neurodevelopmental disability); and
- The Service will offer a holistic approach, including warm referrals to appropriate services for all aspects of a young person's needs (including but not limited to AOD; mental health; vocational support, family and domestic violence services), which allows for greater success and better long-term outcomes.

Psychosocial supports include but are not limited to:

- A variety of individual and group programs and activities (including offsite activities) that:
    - Increase a young person's capacity to develop and use strategies to meet their recovery goals;
    - Support to access meaningful education, training and employment services;
    - Promote independent daily living and practical assistance that build the young person's skills, resilience and confidence (e.g., cooking, budgeting, maintaining tenancies, seeking and maintaining employment, education and other day-to-day tasks);
    - Promote engagement and connection with family members, friends and other support networks identified by the young person (where appropriate/possible);
    - Provide opportunities for the young person to make choices about the range of services they require at different stages of their personal recovery[8;]

[6] See Recovery Planning section below.

[7] Services could be accessed onsite, offsite or via in-reach, as needed.

[8] For example, these could include counselling, case management and support; mental health and AOD education; recreation and relaxation activities; alternative therapies such as music and art; and culturally secure activities that promote healing and connection to country.

- Assist the young person in developing prevention and crisis resolution strategies that support their mental health; and
- Support access to other services that promote general wellbeing.
- Support to access psychosocial supports in the community, including submitting an application to access NDIS funding, if eligible and requested by the young person;
- Support to continue accessing any existing psychosocial supports provided through the NDIS or other local government or Commonwealth programs. This includes in-reach of NDIS services where appropriate;
- Support to review existing psychosocial supports provided through the NDIS, and liaise with NDIS to request a Plan Review if necessary; and
- Support to access suitable housing and homelessness services as needed.

AOD supports include but are not limited to:

- Education regarding harmful AOD use and harm reduction/minimisation;
- Daily support and strategies to address and manage AOD issues, and increase their confidence to reduce or cease problematic AOD use; and
- Support to access appropriate AOD services like Next Step Drug and Alcohol Services (Next Step) or the Drug And Alcohol Youth Service (DAYS), if required.

Clinical supports include but are not limited to:

- Clinical assessments and formulations, as required, using a consumer centred, recovery focused and interdisciplinary approach to guide all clinical interventions; and
- A range of integrated, therapeutic and rehabilitative interventions to reduce the severity of symptoms and increase resilience to cope with mental health issues. Efficacy of treatment and progress will be reviewed regularly throughout the episode of care.

Intensive, timely and recovery-oriented clinical interventions and treatment will reduce vulnerability to mental health distress or illness relapse for the young person. The clinical support provider must ensure that young people requiring urgent psychiatric assessment or withdrawal management support are directed to the appropriate service. It is anticipated that clinical supports will generally be provided on-site and via in-reach.

Management of mental health crises

- All relevant service providers and agencies will work collaboratively, in partnership with the young person, to complete mental health risk assessments including the development of risk management plans;
- Risk management plans will be maintained and updated, and outcomes of mental health risk assessments will be communicated to all Service staff as appropriate; and
- Risk management plans will include psychoeducation, safety planning, medication management, psychological therapies (individual and group), occupational therapy interventions and

referral/facilitated access to appropriate services e.g., AOD services, general health services including general practitioners.

Recovery planning

- All relevant service providers and agencies will work collaboratively, in partnership with the young person, to develop an Individualised Recovery Plan. This plan will assist in exploring and identifying the young person's recovery goals and will include a shared understanding of the presenting challenges, specific support, treatment and interventions occurring during their stay with corresponding outcomes and timelines. This plan will include and integrate clinical treatment and care goals. In partnership with the young person, the Individualised Recovery Plan will be reviewed and updated by all the relevant service providers as frequently as required;
- The young person (and family / carers where appropriate), will be assisted in their recovery planning and its implementation in a way that meets their goals. This includes:
    - encouraging the young person to articulate the types of supports and interventions they require to assist with their recovery;
    - assisting in crisis support planning where necessary;
    - identifying strategies to meet additional access and support needs, including cultural, diversity, language and disability needs; and
    - ensuring decisions regarding recovery and treatment outcomes are led by the young person; and
- The Individualised Recovery Plan will include transition planning[9].

Safeguarding

- Identification and establishment of appropriate safeguards is a fundamental component of person-centred planning and practice and is required to ensure the young person has the best possible chance of succeeding in their recovery;
- Service providers will utilise a holistic, creative approach to develop multiple safeguarding strategies to support a young person to succeed in their recovery on their own terms; and
- The Service will be child safe and operate in line with child safe practices.

Access and Referral

A young person can be referred to the Service (noting this is a voluntary service) by:

- General Practitioners (GP);
- Private and public mental health services (including mental health observation areas, inpatient and outpatient);
- Community mental health services delivered by non-government organisations (NGOs);

[9] Refer to Transition from the Service section for further information on transition planning

- Clinical AOD Services (i.e., Next Step and DAYS) which provide outpatient and medical support specifically for young people;
- Other AOD public and private services;
- Department of Communities (Child Protection);
- Mental Health Co-Response teams;
- Community based services including homelessness, family and domestic violence and disability Services;
- School psychologists, nurses, social workers, youth workers and chaplains;
- Personnel within the Criminal Justice System[10]; and
- Self-referral[11].

The decision to accept the referral is based on the target cohort considerations including:

- meeting the suitability criteria[12];
- readiness and willingness of the young person to engage in clinical treatment and psychosocial supports[13];
- the young person's needs and risk factors, including the safety of the young person, staff, other young people in the Service and the community; and
- ensuring that young people with the greatest need for the Service can access it.

Referrals will be reviewed by the assessment team comprised of all relevant service providers, with all decisions made in partnership. The assessment team will complete an initial assessment of all referrals to establish if the young person can benefit from the Service (including consideration of acuity, risk factors, complexities, vulnerabilities and the young person's suitability to the service). This initial assessment should occur in consultation with the referring area. The resolution of issues around potential disagreement on referrals should be clearly addressed in the Model of Care (MoC) or Memorandum of Understanding (MoU)[14].

Generally, after completion of the program, repeat admissions will be deferred for 28 days. However, this can be considered on a case-by-case basis. Where a referral is not accepted, the young person and the referring team will be informed in writing. An appeal mechanism and/or an opportunity to discuss the decision must be provided. Where possible, the Service will work with the young person to direct them to the most appropriate service to effectively meet their needs. The decision not to accept a referral does not preclude future referrals being made for the young person.

[10] Including referral from the Western Australian Police Force, Department of Justice (Courts, Corrections and Office of the Public Advocate) at all points of the justice continuum from pre-charge through to post release from custody.

[11] Self-referral may also be initiated through engagement with families and carers.

[12] Refer to Target Cohort section for further information regarding suitability.

[13] Young people must consent to receiving supports; this is not an involuntary service.

[14] Refer to Providers, Collaborative Relationships and Partnerships section for further information regarding the MoC and MoU.

Transition from the Service

The Service is part of the continuum of community care and should be integrated with the young person's usual community supports where possible. With the support of the Service, the young person will be an active participant in planning for their transition out of the Service. Transition planning needs to commence early in the young person's stay to ensure that the discharge and transition processes are as smooth as possible.

Transition planning will occur as a part of the Individualised Recovery Plan developed when the young person commences their stay at the Service. This includes planning for, facilitating, and supporting transition out of the service and should include identifying the required outbound referrals and ongoing support arrangements with mental health and AOD support services that will be put in place for the young person after they exit the Service. Transition planning should include housing and accommodation needs for young people who are at risk of homelessness or in the care of the State. If the discharge address provided at the time of entry is no longer a viable option at the time of discharge, the provider will work with the young person to secure safe and stable ongoing accommodation.

If any of the following occur, transition will be initiated from the Service:

- The young person chooses to leave the Service earlier than originally planned;
- The young person has met the goals identified in their Individualised Recovery Plan and is ready to move on to the next phase of their personal recovery;
- The young person has consistently demonstrated that they require a higher level of support than what can be offered through the Service. In these cases, the young person should be transitioned to an alternative service that can meet their higher level of need;
- The mental health and/or AOD needs of a young person change to an extent that the Service is no longer appropriate for their needs. In this case, the young person will be supported to access more or less intensive support services;
- The level of risk to the safety of the young person, staff, other young people residing in the Service and the community becomes unmanageable; and
- The young person is unwilling to engage adequately with the Service supports in line with their Individualised Recovery Plan.

Where a young person's condition deteriorates, or where it becomes clear that the young person requires more intensive clinical intervention or treatment support, provisions should be made to transfer them to an inpatient facility or acute care setting as indicated. The Service will develop protocols to ensure prompt and seamless access to inpatient care when required.

Whilst the Service aims to address the needs of young people with co-occurring mental health and AOD issues, AOD use will not be permitted within the facility. In cases where this occurs, the service provider will assess the appropriateness of the young person continuing to access the Service. Where it is decided that the young person should no longer be using the Service, they will be supported to access other appropriate services and provided with a referral where necessary.

Post Discharge care

The Service will ensure that young people exiting the Service have access to ongoing support to ensure continuity of care. Follow up contact[15] with the young person must be made no later than seven days post discharge from the Service. This will enable the Service to proactively provide any assistance and advice required to support the young person to achieve or maintain their recovery goals within the community. Follow up support should be provided for up to 28 days post discharge.

Transition Pathways

Transition from the Service is generally a planned process, designed to ensure appropriate continuum of care and maximise outcomes for young people. The Service will develop strong partnerships and work collaboratively with a range of community services, including NDIS providers, to maximise integration into the continuum of care, as well as providing and promoting pathways to successfully navigate back into the community. Where necessary and based on individual needs, young people who exit the Service may be provided with referral to longer-term accommodation and support programs and services designed specifically for young people experiencing mental health issues, with or without AOD issues. This may include, but is not limited to, the Youth Psychosocial Support Packages, Youth Mental Health and AOD Homelessness Service or Youth Transitional Housing and Support Program.

Building Description

The Service facility will need to meet the needs of young people and service providers, and the local conditions. The facility will provide a home-like environment with 10 beds, including amenities such as:

- Single bedrooms with ensuites;
- Single bedrooms and ensuites that are compliant with disability support requirements;
- Large communal spaces including common kitchen, living, dining and laundry areas;
- Outdoor areas suitable for physical exercise and outdoor activities;
- Dedicated spaces/rooms for group and individual activities/therapy etc;
- Dedicated spaces/rooms for clinical activities;
- Designated office space and staff amenities;
- Onsite parking;
- Dedicated spaces for visitors;
- Inclusive and safe spaces and amenities that incorporate the needs of young people from diverse backgrounds[16]; and
- Adequate soundproofing (especially in intake and assessment rooms) to ensure resident privacy and confidentiality.

[15] The frequency, duration and nature (i.e., face-to-face or telephone) of follow ups will be tailored to the individual needs and preferences of each young person and will be captured in their Individualised Recovery Plan.

[16] Including Aboriginal young people, CALD young people, young people from the LGBTIQA+ community, and young people with co-occurring disability.

The design and location of the Service will be critical to reflecting a community environment that is focussed on recovery and independence. The Service site will be located within suitable proximity to the amenities that any general member of the community could expect. This includes access to public transport, shopping, and recreational precincts.

The residential nature of the building design means that the service provider should establish community connections and local networks to help build community support for the Service.

Providers

It is anticipated that the NGO and clinical provider will develop policies and procedures in partnership for the safe operation of the service. This should include the development of relevant frameworks, policies and documentation to:

- Support a young person's participation in the Service, as well as family members, carer and support network participation as applicable; and
- Support evaluation of the Service. It is important that the service providers involve young people in continuous improvement processes. Young people accessing the Service should be supported in understanding how they can be engaged in Service evaluation and improvement (i.e., ongoing consultation with the young people).

In addition, the service providers will develop necessary operational policies regarding:

- AOD use by young people whilst residing at the service in order to ensure a fair, equitable and transparent approach is taken in supporting young people's recovery; and
- Staff supervision and training in order to ensure staff have the opportunity to access development opportunities to ensure they provide contemporary best practice care and support.

All providers will work in a way that:

- offers cultural security;
- is driven by a harm reduction approach;
- is trauma informed;
- promotes personal recovery;
- recognises co-occurring AOD use and mental health issues;
- focuses on whole of life and quality life needs; and
- is accessible for, and meet the needs of, young people from diverse backgrounds[17].

Psychosocial Support Provider

Psychosocial and AOD supports will be delivered by an NGO service provider/s with experience in delivering short term, evidence based, recovery-focussed programs to young people experiencing

[17] Including Aboriginal young people, young people from culturally and linguistically diverse (CALD) backgrounds, young people in care/care leavers, young people from the lesbian, gay, bisexual, transgender, gender diverse, intersex, queer, asexual and questioning (LGBTIQA+) communities, and young people with co-occurring disability.

mental health and AOD issues. Where required, the psychosocial support provider/s will also facilitate in-reach and work collaboratively with NDIS providers and services to coordinate delivery of care to young people.

Clinical Support Provider

It is anticipated the clinical support provider will be a Health Service Provider (HSP). The clinical support provider will be responsible for the day-to-day management of the clinical supports provided to young people.

Collaborative relationships and partnerships – Service Providers

All service providers will develop and maintain an effective partnership that is founded on key principles including:

- Agreed shared goals, values and outcomes that focus on delivering person-centred care;
- An understanding of the young person's circumstances, including culture, diversity and past trauma;
- Strong and effective relationships with local general practitioners, community based public mental health and AOD services, community sector recovery support providers and other key stakeholders; and
- Strong and effective relationships to facilitate access with other primary care and community sector services, such as community health, housing, financial, employment and education.

To foster a collaborative and supportive partnership, all relevant providers will jointly develop and agree to a MoU, and a MoC before the Service is operational to ensure a shared, clear understanding of roles and responsibilities for the Service. This will ensure that all operational decision making, from intake to exit (and after), is transparent and accountable to all stakeholders and the established procedures support integrated and continued care across all settings and between services. This will also serve to establish a cooperative working relationship from the onset and will ensure an ongoing synergistic dynamic between the service providers for the benefit of the young people residing at the Service. Measures should be taken to ensure that there are opportunities for shared learning and development to minimise ideological differences in the appropriate application of the recovery model in a residential setting.

The MOU should include, but is not limited to:

- Clear delineation of roles and responsibilities;
- Clinical governance;
- Communication and information sharing between the psychosocial support and clinical service providers;
- Dispute resolution;
- Safety and critical/notifiable incident management;
- Risk management;
- Assessing service effectiveness; and

- Practical elements of the partnership between the parties[18].

The MoC establishes best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition. It aims to ensure people get the right care, at the right time, by the right team and in the right place. The psychosocial support and clinical providers will jointly develop a MoC that should include, but is not limited to:

- Delivery of psychosocial and clinical care;
- Development and delivery of the Individualised Recovery Plan;
- Case management;
- Referral processes including suitability guidelines, intake, triage and exit procedures;
- Initial assessment (clinical and psychosocial) and comprehensive assessment processes that support development of a young person's Individualised Recovery Plan, including clarity around the final decision maker and governance for these processes;
- Care coordination;
- Data sharing protocols;
- Transfer of care;
- Evaluation of the service; and
- Governance.

Community Partnerships

Partnerships with other services will be essential for informing individual assessments and recovery planning to reflect a holistic approach to supporting a young person's recovery. Partnerships are required to ensure that young people receive seamless, wraparound supports that are integrated and coordinated. The service providers will form partnerships with NGOs, public and private services to provide young people with a choice of options for the types of supports they may require. This may include partnerships with specialist AOD organisations, Aboriginal Medical Services (AMS), sexual health organisations, GPs, housing/accommodation providers and NDIS partners/NDIS community connectors to provide the specialist supports that the Service cannot provide.

Procurement

The NGO service provider will be engaged to deliver the Service via a formal Service Agreement. To identify suitable organisations/s to deliver the Service, an open tender process will be undertaken. If a consortium approach to service delivery is adopted, clear governance arrangements must be in place prior to service commencement.

The process used to engage the HSP will commence with an invitation to the relevant metropolitan HSP to deliver the clinical service. Once accepted, a service specific agreement will be developed with the local mental health service for the provision of clinical governance and supports to the Service.

[18] Including the assessment tools that can be used to regularly assess the mental health/AOD clinical acuity and level of support needs of the young people. This could also include the nature and specifics of clinical service provision.

Staffing

The staffing structure should be developed by service providers to attain best practice and be responsive to local requirements to ensure optimal support, treatment and care for young people. The staffing model will include a combination of experienced psychosocial and clinical staff to deliver the different service components and interventions.

The Service will have an experienced multidisciplinary team with skills in supporting the wellbeing and recovery of young people. Staffing for the Service will include peer workers and a mix of trained mental health and AOD support workers, clinical mental health and AOD workers, and those with skills and experience in therapeutic activities and in working with young people.

All staff must be appropriately trained in understanding and/or addressing complex trauma and providing trauma-informed care, de-escalation techniques, suicide prevention, youth appropriate interventions and working with diverse populations. To promote the best outcomes for young people, all staff must work from a holistic, person-centred, culturally secure, recovery-focused, trauma-informed, strengths-based approach. Where possible, the Service must include a diverse staffing profile to reflect the diversity of young people that may access the Service [19].

The psychosocial and clinical service providers will be responsible for ensuring all staff have access to relevant training and workforce development opportunities, including supervision. This will ensure a high quality of support is provided for young people, the clinical and non-clinical staff are supported and have the opportunity to debrief and seek guidance.

Psychosocial Support Staff

Mental Health Support workers will provide ongoing recovery orientated support, as well as advice and education around managing one's wellbeing, developing coping strategies, achieving goals, and building daily living skills. They must have appropriate knowledge and experience in providing support to young people who have experienced trauma, and be competent in de-escalation techniques, suicide prevention, and youth appropriate interventions. They will play an important role in ensuring young people can identify additional supports they need to maintain their physical, sexual, and mental health that are not offered through the Service and will provide navigation support (including warm referrals) to access services that offer these supports.

AOD support workers will provide support for young people including AOD education, strategies and expertise to manage their AOD issues, reduce or cease problematic AOD use and work on harm reduction/minimisation. They must have appropriate knowledge and experience in delivering AOD education and support to young people experiencing AOD issues, working with complex and high-risk individuals and knowledge of mental health co-occurring conditions and trauma informed practices.

Clinical Staff

Clinical staff will provide counselling, medication management and support, including personalised mental health and AOD services such as psychology, psychiatry, cognitive behavioural therapy, gender transitional and diversity therapy. The clinical staffing profile will be comprised of a mix of

[19] Services should consider employing an Aboriginal Liaison Officer, or engaging an Aboriginal Liaison officer from another provider, to assist young Aboriginal people to ensure cultural safety is achieved.

multi-disciplinary, clinical mental health professionals including nurses and allied health staff (e.g., social workers) to provide clinical coverage as required. A mental health clinician will act as a clinical case manager/care coordinator to oversee the clinical interventions and treatment required to improve the young person's mental and physical health.

Clinical staff will maintain regular and clear communication with all providers, will participate and contribute to development of recovery and transition plans, will participate in regular service reviews for the young person and will convene/attend all case conferences to ensure a person-centred, integrated system of care.

Service Monitoring and Governance

Service providers will be required to comply with all relevant state and national legislative, statutory requirements; and have the appropriate types and levels of insurance in relation to the provision of the Service.

Mental Health Services

Providers of mental health services will need to demonstrate accreditation against:

NGOs providing psychosocial supports:

- National Safety and Quality Mental Health Standards for Community Managed Organisations (2022); and
- National Safety and Quality Digital Mental Health Standards (2020), where the NGO is providing online services.

Clinical mental health services:

- Accreditation against the National Safety and Quality Health Service Standards; and
- Compliance with the Chief Psychiatrist's Standards for Clinical Care.

Alcohol and other Drug Services

Providers of mental health services will need to demonstrate accreditation against one of the agreed standards identified in the National Quality Framework for Drug and Alcohol Treatment Services.

All child-related services

All services that comprise or involve "child-related work"[20-21] must understand their obligations in relation to:

- The National Principles for Child Safe Organisations;
- Minimum Practice Standards: Specialist and Community Support Services Responding to Child Sexual Abuse; and
- The Reportable Conduct Scheme through the WA Ombudsman.

[20] As defined in the Working with Children (Criminal Record Checking) Act 2004 (WA), a child refers to any person who is under 18 years of age.

[21] "Child-related work" as defined under section six of the Working with Children (Criminal Record Checking) Act 2004 (WA).

Evidence Based and Informed Practice

The Service will operate as an evidence-based service. The Service will capture and monitor resident feedback, complaints and incidents and examine data from scheduled quality improvement operational and clinical audits

The service providers will ensure that services rendered are consistent with current best practice and undertake evidence based and informed support strategies. Support provided must be consistent with:

- The Commission's Counselling Guidelines: Alcohol and Other Drug issues (2019)[22];
- Working Together: Mental Health, Alcohol and Other Drug Engagement Framework 2021-2025; and
- National Model Clinical Governance Framework (2017).

Service Evaluation

The Service Agreement/s will stipulate the timeframe and processes to be undertaken to evaluate the Service. In general terms, the service providers are required to provide quantitative measures based on the outputs and outcomes identified in the agreement. The service providers should also ensure that qualitative input from young people and their families/carers is used as a measure to support evaluation, where appropriate.

Community Outcomes

The Service will provide a community bed-based facility specifically catering to young people who have complex and acute support needs. The Service will improve wellbeing and recovery support and reduce AOD related harms (if applicable) for young people with mental health issues, with or without AOD issues. This may reduce unplanned admissions to acute hospital care.

The Western Australian Council of Social Services and the Department of Premier and Cabinet have developed an Outcomes Measurement Framework[23] that provides a framework to support the assessment of outcomes in the delivery of community services.

The relevant Domain Outcomes for the Service are:

- **Safe:** We are safe and free from harm;
- **Healthy:** We are healthy and well; and
- **Equipped:** We have the skills, experiences and resources to contribute to our community and economy.

Service Level outcomes

The Service will provide a safe and supportive environment where young people can stabilise and focus on their recovery and wellbeing with 'Step-Up' and 'Step-Down' options based on the type and level of care they need.

The Service will primarily have an impact upon the individual and will be required to demonstrate this impact through achievement of the following service level outcomes:

[22] Although Support Workers will not provide specialist counselling services, AOD Support must be consistent with these guidelines.
[23] https://wacoss.org.au/wp-content/uploads/2019/11/OMFW-illustrative-framework-FINAL.pdf

- Young people demonstrate an improvement in their mental health and increased confidence in their ability to reduce, cease or manage their AOD use (if appropriate);
- Reduce avoidable admissions and re-admissions to hospital for young people living with mental health issues;
- Facilitate appropriate and earlier discharge of young people from inpatient care;
- Assist young people in developing prevention and crisis resolution strategies;
- Contribute to reducing the burden of care experienced by carers in supporting young people who are unwell but do not require acute inpatient treatment;
- Reduce over-reliance on crisis and emergency services for the provision of services more appropriately delivered in the community; and
- Time spent at the Service is appropriate for a short-stay service.

Glossary

For the purposes of this Scope of Service, the key terms below have the following meanings.

Aboriginal:

The use of term "Aboriginal" is used throughout this document to include both Aboriginal and Torres Strait Islander people**.** The term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. Aboriginal and Torres Strait Islander may be referred to in the national context and Indigenous may be referred to in the international context. No disrespect is intended to our Torres Strait Islander community.

Carer:

The definition of a 'carer' is a person who provides unpaid, informal and ongoing care and assistance to a person with disability, a chronic illness (which includes mental illness), or who is frail. The care they provide is not given under any formal paid work or volunteer arrangement. A carer may be caring for more than one person, be a young person or child (young carer), a family member, friend or neighbour, or other acquaintance of the person receiving care. It is acknowledged that a large proportion of support persons are carers as defined in the Western Australian Carers Recognition Act 2004, the Australian Carer Recognition Act 2010 and the Western Australian Mental Health Act 2014. In the Mental and Alcohol and other drug Engagement Framework, and Toolkit the term "support persons" includes families, carers, friends and significant others.

Co-occurring:

Refers to the existence of more than one health related issue at the same time. For example, co-occurring AOD issues refers to the existence of substance use problem(s) and a mental health problem(s) (e.g., depression or anxiety) at the same time. Co-occurring disability refers to the existence of a disability (including cognitive and neurodevelopmental disability) and mental health problems at the same time. Interaction between the two can have serious consequences for a person's health and wellbeing; therefore, appropriate diagnosis is essential. Co-occurring problems generally require long-term management approaches and an integrated approach with other services.

Community mental health services:

Those services and teams that are delivering care outside of inpatient settings across the child and adolescent, youth, adult and older people sectors.

Cultural safety:

Cultural safety (or culturally responsive) has the same meaning as culturally competent, however, specific to Aboriginal people. Cultural safety seeks to ensure that the construct and delivery of services occurs within a framework that sensitively unites Aboriginal cultural rights, views and values with the science of human Services.

Culturally and linguistically diverse:

Is a broad term used to describe communities with diverse languages, ethnic backgrounds, nationalities, traditions, societal structures and religions.

Evidence based and informed practice:

Support strategies based on identified needs of the young person and informed by the best available evidence on effectiveness through research and evaluation.

Family:

Family is not limited to immediate family members, rather what constitutes family should be decided by the young person. This recognises that family can look different for young people, especially for young Aboriginal people.

Holistic:

Recovery envelops all aspects of a person, including physical, emotional, mental, social and community. Areas of life that may be addressed include self-care, family, housing, employment, transport, education, clinical treatment, faith, spirituality, social networks, and community participation.

Individualised supports:

The supports identified in an Individual Recovery Plan that are required to meet the specific support needs and solutions of an individual with mental health and/or AOD issues, and their families and carers. Individualised supports include paid supports, as well as freely given supports through organisations and members of the community.

Interventions:

A set of sequenced and planned actions designed to reduce risky behaviours in society. Intervention often targets a specific group (risk group) in order to reduce the adoption of potentially harmful behaviours (such as drug use). In the GP setting interventions are synonymous with treatment plan activities, which are negotiated with the patient.

Mental health:

A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

Mental health issue:

A health issue that has a diminished effect on an individual's cognitive, emotional or social abilities. Mental health issues could occur in varying degrees of severity and signs of a mental health issue include changes in a person's thoughts, moods or behaviour. A person may have trouble functioning at school or work or in normal activities due to a mental health issue. As a clinical diagnosis is not required to be eligible for this Service, mental health issues will be referred throughout this document.

Mental health services:

Refers to services in which the primary function is specifically to provide clinical treatment, rehabilitation or community support targeted towards people affected by mental illness or psychiatric disability, and/or their families and carers. Mental health services are provided by organisations operating in both the government and non-government sectors, where such organisations may exclusively focus their efforts on mental health Service provision or provide such activities as part of a broader range of health or human Services.

Mental illness:

A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. The diagnosis of mental illness is generally made according to the International Classification of Diseases (ICD).

Moderate mental health issues:

Refers to people who have a mental health issue that has a moderate impact on their day-to-day lives. They may experience problems with psychosocial functioning that impede their ability to attend school or work, carry out household responsibilities or maintain healthy relationships.

Outreach services:

An outreach service refers to a program or initiative that provides AOD and mental health services in a location removed from a central management site.

Peer support:

Social and emotional support, frequently coupled with practical support, provided by people who have experienced mental health and/or AOD issues to others experiencing a similar issue. Peer support aims to bring about a desired social or personal change.

Peer support worker:

A peer support worker is an individual who has had a personal, life-changing experience of mental health, alcohol and other drug challenges and or suicidal crisis (including thoughts, feelings or actions) or a family member or significant other who has or is caring for or about someone with these experiences or who has been bereaved by suicide. Peer support workers use a combination of their lived experience plus training and professional development in their practice.

Person centred:

An approach to service delivery which embraces a philosophy of respect for, and a partnership with people receiving services. A collaborative effort consisting of individuals, their families, friends and mental health professionals.

Prevention:

Strategies to maintain positive mental health through pre-emptively addressing factors which may lead to mental health problems or illnesses. These strategies can be aimed at increasing protective factors, decreasing risk factors or both, as long as the ultimate goal is to maintain or enhance mental health and wellbeing. Interventions that are designed to stop or delay the uptake of drugs or reduce further problems among those using drugs. Interventions can be categorised as primary, secondary or tertiary.

Recovery:

A personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life. It is acknowledged recovery is personal and means different things to different people. Regarding AOD use, it may or may not involve goals related to abstinence.

Safeguards:

Are individualised precautions and safety measures that are put in place to protect the person with mental health and/or AOD issues from exploitation and harm, and provide protection against foreseeable unintended events, while also enabling the person to make choices, take considered risks and live a life that reflects their personal preferences. An important safeguard is the building and supporting of relationships in a person's life as this increases the number of people who care about the safety and wellbeing of the person.

Service Providers:

Refers to all organisations delivering services and supports as part of the Service. This includes the clinical and psychosocial service providers and any consortium partners associated with the Service.

Severe mental health issues:

Refers to people who have mental health issues[24] that have a high impact on their day-to-day lives. They experience a severe level of symptoms and often some degree of disruption to social, personal, family and occupational functioning. They have severe, persistent or episodic mental health issues or conditions and many experience significant social and environmental stressors.

Trauma informed:

A trauma-informed approach is underpinned by the recognition and acknowledgement of the prevalence and impact of trauma amongst workers and an understanding of the relationship between AOD issues, mental health issues and trauma. The principles of trauma-informed care and practice are safety, trustworthiness, choice, collaboration, empowerment and an understanding of cultural, historical and gender issues.

Warm referral:

Warm referral involves contacting another service on a client's behalf (with the client's consent and if possible, with the client present) and may involve writing a report or case history on the client for the service and/or attending the service with the client. It may also include following up with the client to ensure successful engagement with the referral service.

Wraparound:

An approach that envelops a person with mental health and/or AOD issues (usually someone with complex and multiple challenges), and where relevant their family and carers, with an array of integrated supports and services to build and maintain the person's (and their family's) strengths and address holistic and specific needs.

[24] Young people may be experiencing severe mental health issues however might not have a formal diagnosis. While a formal mental health diagnosis is not required to be referred to the Service, an assessment tool such as the Kessler 10 test or other suitable assessment tools can be used to assist the assessment process.

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