



Government of **Western Australia**
Mental Health Commission

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Western Australia.*

Youth Long-term Housing and Support Program

Model of Service August 2022



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Background

The Youth Long-term Housing and Support Program (the Program) 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 of the existing adult inpatient services currently providing services for this vulnerable cohort.

Accommodation services, and related mental health and AOD supports in the community, enable people to recover in a safe and appropriate environment. Therefore, ensuring people have a safe place to live is essential to enabling their recovery or managing their mental illness or AOD problems. In recognition of the required investment in community bed-based and community support services, the Mental Health Commission (MHC) 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) in 2020. A Safe Place aims to improve accommodation and support options in the community and will guide future investment in community-based mental health and AOD accommodation and support services. It 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.

Young people with mental health and AOD issues are recognised within A Safe Place as a particularly vulnerable cohort. The failure to provide appropriate mental health and AOD support to young people can impact their ability to access and maintain safe housing, placing them at a higher risk of experiencing homelessness. It can also result in young people accessing acute care and remaining in hospital for long periods of time. This was reflected in the [Mental Health Inpatient Snapshot Survey 2021](#) which reported approximately 10% of the inpatients in Western Australia's publicly-funded mental health facilities who could be discharged if appropriate accommodation, treatment and/or support services were available were aged 24 years or younger.

Additionally, transitions are a critical stage of a young person's life and if not provided with adequate supports, young people transitioning out of institutionalised settings, particularly hospital services, the juvenile justice system, and child protection, are at significant risk¹. Failure to provide appropriate accommodation and supports to young people during transitional periods can entrench disadvantage resulting in poor physical and mental health outcomes, homelessness and reoffending. Therefore, it is

¹ Youth Affairs Council of Western Australia. (2019). *The Western Australian strategy to end homelessness: Youth Homelessness Action Plan*. Retrieved from <https://apo.org.au/sites/default/files/resource-files/2019-11/apo-nid268766.pdf>

important that the right supports are available in the community to assist young people in their recovery, and to avoid entering or re-entering inappropriate settings.

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. It also articulates that while the development of a dedicated youth stream as outlined in the Plan has commenced, without a fully operational youth stream, young people, particularly those aged between 16 and 17 years, are falling through the gaps. This issue was recognised by young people, families, carers and sector stakeholders at the YPPA consultations who identified the need to increase community-based options, including options for young people to access stable and appropriate accommodation. Accordingly, the YPPA includes a specific priority of establishing a housing and support program, with coordinated clinical and psychosocial support, for young people with mental health and AOD issues in Western Australia.

In 2021, extensive consultation was undertaken to inform the development of the Program Model of Service (noting consultations also included the Youth Psychosocial Support Packages and Youth Step Up/Step Down). 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 Program should be designed and delivered to best meet the needs of young people. Findings outlined in the Final Consultation Report have been drawn upon to develop this Model of Service.

Service Overview

The Program will provide young people with moderate to severe mental health issues access to personalised supports linked to housing for up to three years. This includes coordinated clinical and psychosocial supports to improve their wellbeing and capacity to live independently. The Program will support young people to increasingly participate in, and contribute to community, social, and economic life.

A range of recovery orientated supports will be provided through the Program, including support to keep on top of day to day living, tenancy support, support to navigate access to other services and support to socialise and build a young person's confidence and experience to start or return to education or meaningful employment. Through access to stable accommodation alongside coordinated supports, young people with mental health and AOD issues will be assisted to achieve their recovery goals, improve their mental health, increase confidence in their ability to reduce, cease or manage their AOD use (if appropriate) and live well in the community.

The psychosocial and clinical staff will work in collaboration for the delivery of supports within the Program. The psychosocial support will be provided by a panel of non-government organisations (NGOs) with experience in delivering recovery-based programs to young people experiencing mental health and AOD issues. The clinical supports will be provided by experienced clinical staff).

The Program will be similar to the existing MHC model for adults, known as the Individualised Community Living Strategy (ICLS). Learnings from operation of the ICLS, and other youth specific services, have helped inform this Model of Service.

The Program will:

- provide personalised supports linked to housing for young people with moderate to severe mental health issues, with or without co-occurring AOD issues;
- offer cultural safety;
- be trauma-informed;
- improve well-being and promote personal recovery;
- optimise independent functioning;
- focus on whole of life and quality of life needs;
- be person-centred and meet the diverse needs of young people²
- provide services that will be delivered by a combination of psychosocial and clinical activities and interventions; and
- support transition to suitable, stable and safe accommodation.

Where applicable, the Program will provide support to the young person's family and carers. Providing support to family members and carers may better equip them to understand and respond to the needs of the young person, and, in some instances, enable family unification or reunification, and strengthen safety in the family home.

The Program will be available to young people (aged 16 to 24 years) who have moderate to severe mental health issues, with or without co-occurring AOD issues and who reside in the Perth metropolitan area or are willing to relocate to the Perth metropolitan area.

Each young person will receive an individualised package of recovery orientated supports with an allocated maximum amount of funding for each plan period, up to 12-months. At the end of a plan period, the young person's needs will be reviewed and if they are not ready to transition out of the Program, a new plan (for up to 12-months) will be established. Funding will be individualised and will relate to the recommended bandwidth of support³. The bandwidth of support and the maximum funding amount will be determined by the Support Coordination Provider, in partnership with the clinical team, when the young person is successful in their referral to the Program. The duration and level of support a young person receives will be reviewed regularly and adjusted based on the changing needs of the young person.

It is important to note that the Program:

- is not an alternative for acute inpatient care where significant clinical intervention and monitoring is required;
- does not provide emergency or crisis accommodation services;
- does not provide in-reach services to detention centres and prisons; and
- does not provide AOD withdrawal management services.

² Including Aboriginal young people, young people from ethnoculturally and linguistically diverse (ELD) backgrounds, young people from the lesbian, gay, bisexual, transgender, gender diverse, intersex, queer, asexual and questioning (LGBTIQA+) communities, and young people with co-occurring disability.

³ Bandwidth of support include "Low, Medium and High", each contains a different level of support.

Target Cohort

The Program will provide support to young people aged 16 to 24 years who:

- have signs and symptoms of moderate to severe mental health issues⁴, with or without co-occurring AOD issues;
- reside in the Perth metropolitan area or be willing to relocate to the Perth metropolitan area; and
- require access to accommodation.

Priority should be given to young people who are currently not accessing the National Disability Insurance Scheme (NDIS), however young people with NDIS plans are not excluded⁵.

Access and Referral

A young person can be referred to the Program by:

- General Practitioners (GP);
- Private and public mental health services (including mental health observation areas, inpatient and outpatient);
- Community mental health services delivered by other NGOs;
- AOD public and private services;
- Department of Communities (Child Protection), for those under the age of 18;
- Mental Health Co-Response teams;
- Community based services including homelessness services, family and domestic violence and disability services;
- Youth services;
- School psychologists, nurses, social workers, youth workers and chaplains;
- The Criminal Justice System⁶; and
- Self-referral⁷.

The decision to accept the referral is based on several factors including:

- meeting the eligibility requirements⁸;
- readiness and willingness of the young person to engage in supports⁹;
- the young person's needs and risk factors, including the safety of the young person, staff, and the community; and
- the intake process should ensure that young people with the highest needs for this Program are able to access it¹⁰.

⁴ A formal mental health diagnosis is not required to access the Program. The Support Coordination Provider will use an assessment tool, such as the K10 test, to assist the referral process

⁵ If a young person is receiving NDIS supports, the additional supports provided through this Program should be complementary, not duplicative.

⁶ 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.

⁷ Self-referral may also be initiated through engagement with families and carers.

⁸ Refer to 'Target Groups' section for further information regarding eligibility.

⁹ Young people must consent to entering the Program; this is not an involuntary program.

¹⁰ Priority should be given to young people who do not already have access to funding for psychosocial and other supports through the National Disability Insurance Scheme (NDIS), although NDIS participants should not be excluded altogether. If a young person is receiving NDIS supports, the additional supports provided through this Program should be complementary, not duplicative.

An independent service provider will be appointed by the MHC to provide a support coordination role including oversight of the referral process and the convening of a panel for the assessment of referrals (see Providers section for further detail). Where a referral is not accepted, the young person(s) concerned and the referring team will be informed in writing and provided the opportunity to discuss the declined referral via phone. Where possible, the Support Coordination Provider 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 concerned.

Catchment Areas

The Program will be available to all young people (16 to 24 years) in Western Australia who meet the eligibility criteria¹¹, regardless of the catchment area in which they reside. Although properties will be located in the Perth Metropolitan area, the Program is available for young people from regional areas across the state to access, if they are willing to relocate.

Service Description

The Program will:

- Undertake assessment processes, including:
 - an initial assessment (clinical and psychosocial) with each young person, to establish if they can benefit from the program (including consideration of any risk factors and/or vulnerabilities);
 - comprehensive assessment processes that identify the needs of each young person and that support the development of a young person's individualised recovery plan based on the young person's goals, their individual treatment needs and the accommodation they wish to transition to;
 - identification of any other formal / informal supports in place for the young person, (including NDIS supports), to avoid duplication;
 - identification and establishment of appropriate safeguards. Comprehensive safeguarding is viewed as 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
 - assessments should be regular and ongoing during the young person's journey in the Program.
- Be flexible to support the changing needs of the young person and their family/carers (as appropriate). The duration and level of support a young person receives will vary based on their individual needs. The young person can transition between bandwidths of support should their support needs increase or decrease over the course of their journey in the Program¹².

¹¹ Refer to 'Target Groups' section for further information regarding eligibility.

¹² Assessment of the young person's needs will be undertaken every three months (or as needed) by the Support Coordination Provider in partnership with the Clinical Provider, Psychosocial Support Package Provider and the young person.

- There will be three bandwidths of support for the service - Low, Medium and High. Each bandwidth contains different levels of support and will be accessed based on the young person's needs. The funding amount will relate to the recommended bandwidth of support.
 - Low: a young person who can live independently within the community with low-level or periodic assistance, up to eight hours per week.
 - Medium: a young person who can live in the community but requires moderate supports on a frequent basis, between eight to 15 hours per week.
 - High: a young person that requires a high level of regular supports on a frequent basis, up to 24 hours per week.
- Provide psychosocial and clinical support linked to housing for up to 3 years¹³ that is not permanent but rather transitional in nature.
- Provide recovery orientated psychosocial supports and clinical services within the context of the young person's family, friends, culture and community.
 - Each young person will receive an individualised package of recovery orientated supports with an allocated maximum amount of funding for each plan period (up to 12-months).
- Provide a variety of individual and group programs and activities that:
 - increase a young person's capacity to develop and use strategies to meet their recovery goals;
 - promote independent daily living and practical assistance that builds the young person's skills, resilience and confidence (for example cooking, budgeting, maintaining tenancies, seeking 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 and access the range of services they require at different stages of their personal recovery (for example, these could include counselling; 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); and
 - assist young people in developing prevention and crisis resolution strategies that support their mental health and AOD use.
- Support the young person to access education, training and employment services.
- Support young people likely to be eligible for the NDIS to apply for access to the Scheme¹⁴.
- Support the young person to identify additional supports they need to maintain their physical, sexual and mental health that are not offered through the service and provide navigation support (including warm referrals) to access services that offer these supports. For example, additional services may include GPs, dental and eye care, AOD outpatient and withdrawal management, disability support services and sexual health services.
- Provide emergency brokerage funding, assessed on a case by case basis for essentials only (i.e. medication, public transport fares to get to a medical appointment, essential groceries).

¹³ where required, length of stay can be extended on a case by case basis if agreed by all service providers.

¹⁴ If a young person is receiving NDIS supports, the additional supports provided through this Program should be complementary, not duplicative.

- Where a young person does not have their own essential white goods and furniture, one off funding will be provided to assist in the purchasing of essential white goods and furniture¹⁵. This will be assessed on a case-by-case basis.
- Assist the young people to access funding sources that they need to access other services.
 - Where a young person is not able/eligible to access other funding sources, provide discretionary funding for recovery related activities (e.g. health club passes, art and community classes), assessed on a case by case basis.
- Assist the young person (and family / carers where appropriate), in their recovery planning (this includes planning for, facilitating, and supporting transition out of the Program) and its implementation in a way that meets their goals. This includes:
 - encouraging the young person to articulate the types of support they require to assist with their recovery;
 - assisting in crisis support planning where necessary;
 - strategies to meet additional access and support needs, including cultural, diversity, language and disability needs; and
 - ensuring decisions regarding recovery and support outcomes are led by the young person.
- Ensure the Program is accessible for, and meets the needs of, Aboriginal people, young people from ethnoculturally and linguistically diverse (ELD) backgrounds, 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).
- Transition plans are developed for young people entering and exiting the Program with all relevant stakeholders, this includes planning for, facilitating, and supporting transition out of the Program, specifically in regard to seeking, and preparing the young person to maintain suitable, safe accommodation that meets their individual needs.

Staffing

Psychosocial Supports

Psychosocial supports will be provided by experienced mental health and AOD support workers¹⁶ (Support Workers), which must include peer workers, with skills and experience in supporting wellbeing and recovery and in working with young people. Support Workers 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. All Support Workers must work from a holistic, person-centred, culturally safety, recovery-focused, trauma-informed, strengths-based approach to promote the best outcomes for young people. Where possible, the service should include a diverse staffing profile to reflect the diversity of young people that may access the service¹⁷.

¹⁵ The Psychosocial Support Provider will facilitate and support the purchase of these items.

¹⁶ At minimum, Support Workers must demonstrate two to three years' experience in working with young people. A university qualification will not be an essential requirement however, a certificate III or IV in a relevant field such as community services, AOD, mental health, youth work or peer work is desirable.

¹⁷ 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.

The 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 will also play an important role in ensuring the young person is able to 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 other services that offer these supports.

The Psychosocial Support Providers will be responsible for ensuring Support Workers have access to training and workforce development opportunities, including supervision. This will ensure a high quality of support is provided for young people, the Support Workers themselves are supported and have the opportunity to debrief and seek guidance.

Clinical Supports

Clinical supports will be provided by experienced clinicians, including social workers and occupational therapists, with skills and experiencing in working with young people with mental health and AOD issues. Clinicians 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 work from a holistic, person-centred, culturally safety, recovery-focused, trauma-informed, strengths-based approach to promote the best outcomes for young people.

Clinical staff will provide ongoing counselling and support, including personalised mental health and AOD services for example psychology, psychiatry, cognitive behavioural therapy, gender transitional and diversity therapy and assertive community outreach. Clinical staff will work in partnership with the young person's Support Worker and the young person, to develop recovery plans and to ensure the young person is able to identify additional supports they need to maintain their physical, sexual, and mental health that are not offered through the Program.

The support coordination provider will be responsible for ensuring clinical staff have access to training and workforce development opportunities, including supervision. This will ensure a high quality of support is provided for young people, the clinical staff themselves are supported and have the opportunity to debrief and seek guidance.

Transition from the Program

With the support of their Support Worker and clinical team, the young person will be an active participant in planning for their transition out of the Program. This will be undertaken as a part of the individual recovery plan developed when supports commence. This will also include assistance in sourcing other accommodation and supports (if applicable). Transition will be supported by the service provider and clinical team and occur through a planned process in stages achievable for the young person.

If one or more of the following occurs, transition out of the Program will be initiated:

- The young person has met their goals as agreed with their Support Worker and clinical team and they are 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 can be offered through the Program. In this case the young person should be transitioned to alternative support/care services 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 Program 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, and the community becomes unmanageable by the Program;
- The young person is successful in their application for access to the NDIS, and the supports provided through their NDIS package will be duplicative of those provided by the Program; and/or
- The young person is unwilling to engage adequately with the service/programs in line with their individual recovery plan.

In circumstances where a young person enters a mental health facility, is admitted to hospital or enters custody, their package may be put on hold for up to three months (to be assessed on a case-by-case basis). After three months the young person will be transitioned out of the Program.

Upon transitioning out of the Program, the young person will not be precluded from accessing the Program in the future and can re-commence the referral process (this may include going on the waitlist if one exists).

Building Description

The design and location of the properties within the Program will be critical to reflecting a community environment that is focused on recovery and independence. Properties will be located within suitable proximity to amenities that any general member of the community could expect. This includes access to suitable public transport, shopping and recreational precincts, so that young people can engage within the community, maintain personal supports from family and friends, and develop their skills with activities of daily living.

The property options will:

- include a hybrid of different configurations e.g. one- or two-bedroom private units/villas/houses;
- have a low maintenance outdoor area or courtyard space; and
- not be too large and overwhelming for a young person (i.e., a single young person in a large four-bedroom family home).

Providers

The MHC will have a contractual relationship with the Support Coordination Provider, and each of the Psychosocial Support Providers on the panel. This contractual relationship will include mandatory reporting requirements and evaluation of the outcomes of each package to be assessed. The MHC contract manager will be responsible for managing the performance of all service providers during the life of the service agreement.

All service providers will develop policies and procedures for the safe operation of the Program. This will include the development of relevant frameworks, policies and documentation to:

- Support a young person's participation in the Program, as well as family member, carer and support network participation; and
- Support evaluation of the Program. It is important that the service providers involve young people in continuous improvement processes. Young people accessing the Program should be supported in understanding how they can be engaged in Program 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 receiving services in order to ensure a fair, equitable and transparent approach is provided 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.

Clinical Support Providers

The clinical support will be a range of services including personalised mental health and AOD services provided by staff with experience working with young people with mental health and AOD issues.

Psychosocial Support Providers

Psychosocial support will be provided by a panel of NGO service providers with experience in delivering recovery-based programs to young people experiencing mental health and AOD issues. This will provide young people with choice of provider and ensure flexibility to meet their recovery goals.

Support Coordination Provider

An independent service provider¹⁸ will:

- Provide oversight of the referral process and convene a panel, including a young person with lived experience and a clinician, to assess referrals;
- Review individual support packages to ensure activities, strategies and safeguards are appropriate, that funding requested is within the young person's allocated bandwidth and meets the funding parameters;
- Through a peer worker, support young people to choose a Psychosocial Support Provider from the panel. Once a choice has been made, the Support Coordination Provider will inform the chosen NGO that the young person wishes to access their service¹⁹; and
- Undertake regular check ins with each young person to ensure their needs are being met.

¹⁸ The Support Coordination Provider cannot be one of the service providers delivering psychosocial supports.

¹⁹ A young person will have the option to request a change of their Psychosocial Support Provider if they feel that their needs are not being adequately met. In this instance, the Support Coordination Provider will undertake a review of the services being provided and assist the young person to choose a new service provider. A change of service provider cannot be requested within the first six weeks of the service commencing.

Partnerships

The Support Coordinator Provider, Psychosocial Support Providers and the clinical team must work in partnership with each other and the young person, to support the young person to reach their recovery goals.

Partnerships with other services will also 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 other 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 partnership with specialist AOD organisations, sexual health organisations, GPs, housing organisations etc to provide the specialist supports that the NGO and clinical team cannot provide themselves.

Collaborative Relationships

The Support Coordinator Provider, Psychosocial Support Providers and the clinical staff will develop and maintain effective partnerships that are 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;
- Develop and maintain 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
- Develop and maintain strong and effective relationships to facilitate access with other primary care and community sector services, such as community health, housing, financial, employment and education.

The Support Coordinator Provider and Psychosocial Support Providers will jointly develop formal agreements that establish the working relationship. This will ensure that all providers have a shared understanding of roles and responsibilities, to enable their ongoing relationship for the benefit of the young people in the Program.

The formal agreement should include, but is not limited to:

- clinical governance;
- roles and responsibilities;
- case management;
- communication and information sharing;
- dispute resolution;
- safety and critical incident management;
- assessing Program effectiveness;
- partnership with the clinical service on the assessment tools that can be used to regularly assess the mental health / AOD clinical acuity and level of support needs of the resident;
- referral process including a referral intake and exit panel; and
- initial assessment (clinical and psychosocial) and comprehensive assessment processes that support development of a young person's individualised recovery plan.

Procurement

The MHC is the responsible agency for establishing the Program, and as such will engage suitable service providers to deliver the Program via a formal service agreement.

To identify suitable organisations to deliver the Support Coordination Provider and Psychosocial Support Provider roles, the MHC will undertake an open tender process that meets the State Government's Delivering Community Services in Partnership Policy.

The successful Support Coordination Provider is responsible for contracting the clinical services.

Property and Tenancy Management Services

The Department of Communities (Housing) will own the asset on behalf of the MHC.

The Property and Tenancy management will be undertaken by a Registered Community Housing Organisation (CHO) as per Housing's Community Housing Registration Policy. The Support Coordination Provider is responsible for providing the day-to-day management of the Program and will enter into a formal agreement with the CHO who will be responsible for meeting the Property and Tenancy Management service specifications.

Service Monitoring and Governance

The service providers will be required to: comply with any statutory obligations that apply to the specific service; comply with all appropriate legislative, statutory and health standards including the revised National Standards for Mental Health Services; and have the appropriate type and level of insurance in relation to the provision of the service.

The key standards for monitoring service performance include:

- National Standards for Mental Health Services (2010);
- The standards within the National Quality Framework for Drug and Alcohol Treatment Services (2019); and
- The Child Safe Standards

Evidence Based and Informed Practice

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

- The MHC's Counselling Guidelines: Alcohol and Other Drug issues, 2019²⁰;
- Working Together: Mental Health and Alcohol and Other Drug Engagement Framework 2018 – 2025; and
- Australian Commission on Safety and Quality in Health Care. National Model Clinical Governance Framework 2017.

²⁰ Although Support Workers will not provide specialist counselling services, AOD Support must be consistent with these guidelines.

Service Evaluation

The service agreements will stipulate the timeframe and processes to be undertaken to evaluate the Program. In general terms, the service providers are required to provide quantitative measures based on the outputs and outcomes identified in the agreements. 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.

There will be an opportunity to include feedback from consumers before, during, and after interaction with the Program, to understand how stable accommodation and the supports provided to them has enabled them to improve their mental health, and understand/manage their AOD use (where relevant and appropriate), and achieve their life goals in both the short and long-term.

Community Outcomes

The aim of the Program is to support young people with mental health issues, with or without co-occurring AOD issues, to improve their functioning and reduce difficulties that limit their independence, so they can increasingly participate in, and contribute to community, social, and economic life.

The Program will assist young people in their recovery and improve their individual wellbeing, optimise independent functioning, and improve quality of life while assisting them to obtain suitable, safe and stable accommodation.

Service-level Outcomes

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

- young people demonstrate an improvement in skills and/or confidence required for independent daily living;
- young people demonstrate an improvement in their mental health and confidence in their ability to reduce, cease or manage their AOD use (if appropriate);
- young people transition to suitable, stable and safe accommodation that is appropriate for their needs; and
- time spent at the Program is appropriate for a medium to long-term accommodation service.

Glossary

Aboriginal:

The use of term “Aboriginal” has been 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 colleagues and community.

Acute mental health services:

Acute mental health services provide specialist psychiatric care for people who present with acute episodes of mental illness. These episodes are characterised by severe clinical symptoms of mental illness that have potential for prolonged dysfunction or risk to self and/or others. The treatment effort is focused upon symptom reduction with a reasonable expectation of substantial improvement. In general, acute services provide relatively short-term treatment.

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, comorbidity or dual diagnosis:

Refers to a person who has a substance use problem(s) and a mental health problem(s) (e.g. depression or anxiety) 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, adult and older people sectors.

Consumer:

A person who uses or has used a mental health service or who has experienced/is recovering from a mental illness.

Court diversion:

Court diversion or intervention programs recognise that a person has reached a crisis point when they appear in court charged with an offence. In partnership with community-based services, court intervention programs

aim to address the issues that underpin a person's offending behaviour in order to reduce the likelihood of reoffending.

Culturally Competent:

Culturally competent (or cultural competency) is a philosophy and a way of operating that ensures all individuals and groups are treated with regard to their unique cultural needs and differences. It assumes the right to difference and calls for interactions that do not diminish, demean or disempower individuals on the basis of any perceived or actual difference.

Cultural Safety:

Cultural safety (or cultural 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.

Discretionary funding:

Is intended to address short term needs that pose impediments to personal skills development, community engagement and mental health gains. It should not be seen as an income supplement or an alternative to other free or low-cost goods or services available within the community. Similarly, discretionary funding is not intended for use to provide welfare support where other appropriate welfare services are identifiable and accessible.

Ethnoculturally 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 peoples.

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 funding:

Are both funding mechanisms that promote person-centred approaches where the funding is based on the support needs and identified solutions for individuals, families and carers. It is based on the principle that individuals and families are best placed to determine their own needs and solutions to those needs, and therefore have control over the purchasing of services and supports that they require.

Individualised supports:

Are the supports that have been identified to meeting the support needs and solutions of individuals 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 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 classification systems of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD).

Peer support and peer support workers:

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.

Person centred:

An approach to service which embraces a philosophy of respect for, and a partnership with people receiving services. A collaborative effort consisting of patients, patients' 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. In regard to 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 a mental health and/or AOD issue from exploitation and harm, and provide protection against foreseeable unintended events, while at the same time 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.

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 conditions 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.

Young Carer:

The definition of a 'young carer' means a young person or child aged 25 years and under, 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. This includes a caring relationship in which the child is the primary carer and the adult is the care recipient.



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