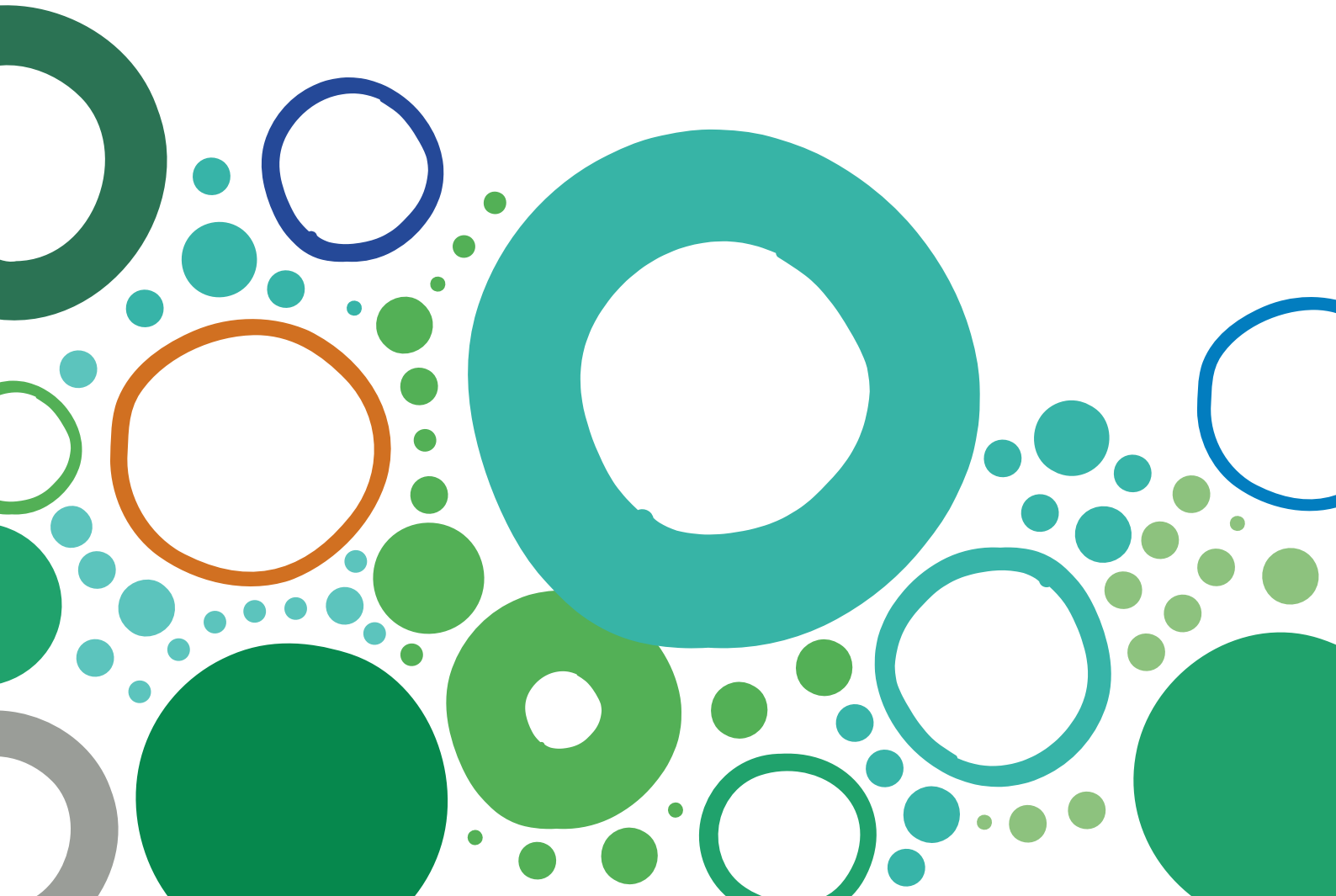
GOVERNMENT OF WESTERN AUSTRALIA

Mental Health Commission

Youth Transitional Housing & Support Packages Program

Guidelines



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1. Program Outline

These guidelines expand on the Mental Health Commission's (Commission) pilot Youth Transitional Housing & Support Program (YTH&SP) (Program) model of service and provide an outline of the processes of the YTH&SP service model.

The Commission in collaboration with the Program Coordinator and Psychosocial Support Package Providers (Provider) have developed these guidelines with the intention of guiding stakeholders in the parameters of the Program, providing clarity on what the YTH&SP can provide and informing individuals, families and carers on what to expect when participating in the Program.

The Program is recovery focussed and transitional for young people aged 16-24 for up to three years, or less if the young person reaches the age of 25 before they have been in the program for three years. As individuals become increasingly independent and build their capacity, the various stakeholders, (e.g., Health Service Providers (where relevant), service providers, family, carer, significant others) will work together to support the individual to source alternative supports where appropriate.

2. Background

The YTH&SP program was established in 2023 after the State Government committed funding for the pilot program as part of the 2021 State Election.

The valuable role of psychosocial supports is recognised in optimising individual recovery outcomes as highlighted in the Productivity Commission Inquiry Report into Mental Health 2020 (Productivity Commission Report). Productivity Commission Report Recommendation 17 is that all Australian governments make it a priority to improve the availability of psychosocial supports. The Productivity Commission Report expresses the effectiveness of psychosocial supports when they are available early in a person's experience of mental health issues, highlighting that young people experiencing mental health issues may respond favourably to the provision of psychosocial supports.

The Program is included as a 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.

In recognition of the required investment in community bed-based and community support services, the 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) in 2020. Young people with mental health and AOD issues are recognised within A Safe Place as a particularly vulnerable cohort.

This was further reflected in the Mental Health Inpatient Snapshot Survey 2021[1] which reported approximately 10% of 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.

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*.

The Program is an innovative and collaborative partnership approach between the Commission, Program Coordinator[2], Providers, and the Department of Communities (Communities) to provide psychosocial supports linked to transitional psychosocial support and housing, concurrent with clinical supports and services for the young person to maximise their success in recovery and living in the community.

1 Mental Health Inpatient Snapshot Survey (mhc.wa.gov.au)
2 The Program Coordinator is expected to re-commence in mid-2025. The Commission is undertaking limited roles and responsibilities of the Program Coordinator until this time.

3. What is the YTH&SP

3.1 Purpose and Aim

The Program will provide young people with moderate to severe mental health issues with or without co-occurring AOD issues access to personalised supports linked to transitional housing for up to three years. This includes coordinated clinical and psychosocial supports to improve their wellbeing and capacity to live independently[3]. The Program will support young people to increasingly participate in, and contribute to community, social, and economic life. A young person accessing the Program can expect to:

1. Have an increasing ability to fully participate in their ongoing psychosocial (and clinical where relevant) support needs.
2. Receive psychosocial support to effectively manage day to day living, including tenancy support;
3. Develop and sustain meaningful social connections and relationships.
4. Participate and contribute to their community and relationships in personally meaningful ways.
5. Have an increased ability to participate in educational, vocational and/or employment activities.
6. Develop their skills to self-manage their lifestyle and well-being.
7. Gain confidence and independence in life skills, Including maintaining a tenancy.
8. Improve their quality of life.

The Providers will work with participants to identify goals and provide recovery focussed support in areas such as:

- Daily living skills such as how to manage finances, prepare meals or use public transport.
- Accessing mental and physical health services.
- Participating in social, leisure or sporting activities.
- Establishing, building and maintaining relationships with family, friends, and local communities.
- Learning new skills, accessing education or help gain meaningful work.
- Securing accommodation.
- Accessing other supports such as the National Disability Insurance Scheme (NDIS)[4].

3.2 Target Group

The Program will provide support to young people aged 16 to 24 years for up to three years, or less if the young person reaches the age of 25 before they have been in the program for three years. The Program is available for those who:

- Have signs and symptoms of moderate to severe mental health issues, with or without co-occurring AOD issues; and
- Require access to stable accommodation.

The Program will operate in the Perth Metropolitan area but is not restricted to metropolitan residents as long as the individual is willing and able to move to a metropolitan location.

The target group includes individuals that have a range of complexities and challenges and there will be a mix of individuals requiring low, medium and high levels of support.

Priority population groups for the service include:

- Aboriginal young people.
- Young people from Culturally and Linguistically Diverse (CaLD) backgrounds;
- Young people who identify as Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual and other sexually or gender diverse (LGBTQIA+).
- Young people in care/care leavers.
- Young people with co-occurring mental health and AOD issues.
- Young people with co-occurring disability (including those with cognitive and neurodevelopmental disability).

3 Participants are required to transition to a public mental health service on entrance to the YTH&SP program to ensure maintenance of partnership relationships. Participants under the care coordination of Youth Link prior to entrance to YTH&SP may remain under Youth Link care coordination until discharged to the public mental health service catchment. Youth Link will provide all clinical roles and responsibilities required under the YTH&SP Guidelin

4 If people are eligible for both YTH&SP and NDIS, the NDIS supports should be complementary to and not duplicative of those provided through YTH&SP.

3.3 Individualised Supports

Individualised supports are the various paid and unpaid supports that are identified through a personalised planning process to meet the unique circumstances of individuals, and where relevant, their families and carers.

Individualised supports can be created from a vast array of possible sources including personal networks, peers, community and generic supports and services within the mental health sector.

3.4 National Disability Insurance Scheme (NDIS)

- Participants with NDIS plans are not excluded if the NDIS supports are for their physical and/or medical support.
- If a participant is already receiving NDIS supports for their psychosocial needs, they are not automatically excluded from the service, however;
    - If a participant is receiving NDIS supports, the additional supports provided through this service should be complementary, not duplicative.
- It is important to ensure a cohesive eco-system of supports and that transition is integrated with NDIS, noting the Program is a transitional recovery program. As a result, there is an obligation and expectation for all NDIS plan content to be shared with YTH&SP stakeholders. The Agreement to Share must be signed by the participant or their legal guardian.

3.5 Privacy and Confidentiality

The privacy and confidentiality of participant information is strictly upheld.

All nominees into the YTH&SP are required to sign a Consent to Share Information form prior to being assessed for the Program. All sections of this form must be completed to consent to the sharing of information required for assessment into the program.

The Providers and Program Coordinator are required to develop and maintain policies and processes regarding confidentiality, privacy, and consent to share information that uphold individuals' rights to privacy and confidentiality, considering relevant privacy and other legislative requirements.

4. Accessing YTH&SP

4.1 Eligibility

To be eligible for support through the YTH&SP program, individuals will[5]:

4.1.1 Have moderate to severe mental health issues, with or without co-occurring AOD issues.

4.1.2 Be aged 16 to 24 years.

4.1.3 Be an Australian citizen or permanent resident.

4.1.4 Be willing and able to reside in the Perth metropolitan area.

4.1.5 Not exceed the community housing income and asset limits for a person with a disability at both the time of application and while occupying a Community Disability Housing Program (CDHP) property.

4.1.6 Does not own or part-own property or land or exceed the community housing income and assets limits as defined in the Department of Communities Community Housing Rent Setting Policy.

4.1.7 If they owe any money or have debts related to a previous tenancy with the Department of Communities, they must make arrangements to repay the money owing or debts[6].

4.1.8 Is eligible under and compliant with the Department of Communities Community Disability Housing Program Policy[7].

4.1.9 Have the capacity to live independently with drop-in supports (24/7 support is not available through the YTH&SP).

4.1.10 Agree to fully participate in a recovery-oriented support initiative to work towards achieving personally identified goals.

4.1.11 Be able to provide informed consent or have a formally appointed guardian to provide consent to share relevant information and participate in all aspects of the Program.

4.1.12 Be ready and voluntarily willing to commit to engage in support from the chosen Provider.

4.1.13 Agree to and participate in a range of assessments to confirm eligibility and identify the level of support needed.

4.1.14 Understand the program is recovery focused and transitional in nature and that the duration of support for housing is for a period of up to three years[8].

4.1.15 Agree to the sharing of NDIS plan content and transparency of supports (if a NDIS participant).

4.2 Entry to the YTH&SP

Refer to **Appendix A** for a flowchart of the referral process.

The Program Coordinator will oversee the referral process and the convening of an assessment panel for the assessment of referrals[9]. A call for nominations will be sent out to a Nomination Distribution List made up of mental health services from across Western Australia. Young people can also self-refer.

An assessment panel will be formed by the Program Coordinator. The Program Coordinator will chair the assessment panel which will consist of stakeholder representatives from a community mental health clinical team, a community support provider and a Peer Worker.

5 It is noted that individuals continuing to receive funded psychosocial supports through alterative programs funded by the Commission are not eligible for the YTH&SP program.

6 A participant who has a poor tenancy history and or evictions may still be eligible for the Program and will be assessed on a case-by-case basis. More intensive tenancy supports, safeguarding and risk management practices will be put in place by the Provider.

7 The criterion for housing is as per Department of Communities Community Disability Housing Program policy community_disability_housing_program_policy.pdf (www.wa.gov.au).

8 Or less if the young person reaches the age of 25 before they have been in the program for three years.

9 See Providers Roles and responsibilities section for further detail.

The Panel will review the applications based on the following:

- The required mental health assessments such as a Treatment Support Discharge Plan or Risk Assessment and Management Plan.
- The level of support and care required to assist in the transition into YTH&SP supports.
- Alignment of support needs with the parameters of the Program.
- Willingness to engage in clinical/non-clinical recovery focussed supports.
- Readiness to engage.
- Relevant risks.
- Current living arrangements and past tenancy history if applicable.

The Panel will shortlist applicants to a 'meet and greet' panel to further assess suitability and eligibility, and to ensure the individual understands the requirements including the transitional nature of the Program. Prior to meeting with prospective young people, their details are sent via the Commission to Communities to check against the CDHP and assessment of tenancy history.

The Panel will recommend successful applicant(s) and the Program Coordinator will advise all referrers of the outcome of their application.

Where a referral is not accepted, the referrer will be informed in writing and provided the opportunity to discuss the declined referral. Where possible, the Program Coordinator will work with the young person to direct them to the most appropriate service to effectively meet their needs and provide a warm referral to alternative services.

The decision not to accept a referral does not preclude future referrals being made for the young person.

If successful, the Program Coordinator will inform the referrer and provide them with the Providers' profiles as well as information for the Peer Worker should the individual request independent support to choose their Provider.

Once a signed Choice of Service Provider form has been completed and sent back to the YTH&SP Program Coordinator, the Provider will be informed that the individual wishes to access their services and request acceptance of the referral.

Once the Provider has accepted the referral, the Commission will process the initial funding for the Provider to commence working with the individual to develop an individualised funding plan.

If successful, the Provider will support them to engage with the Community Housing Provider (CHO) who manages the YTH&SP program property to ensure a smooth transition into their YTH&SP property. Where a young person does not have their own essential white goods and furniture, one off funding will be provided to the Provider to assist in the purchasing of essential white goods and furniture. This will be assessed on a case-by-case basis[10].

When there are limited vacancies available in the Program, priority will be given to people based on:

- Meeting the eligibility requirements.
- Readiness and willingness of the young person to engage in supports.
- The young person's needs and risk factors, including the safety of the young person, staff and the community.
- Being homeless or at risk of becoming homeless.
- Whether the young person will be required to remain in hospital as they require additional supports on discharge.

The Panel will assess each referral against available properties to ensure appropriate allocation. Considerations include but are not limited to:

- Size of the property.
- Disability access.
- Pet friendly status[11].
- Location.
- Previous property history.

10 The Provider will facilitate and support the purchase of these items.
11 Property conditions vary and there may be limits on or exclusions to pets in some properties.

5. Roles and Responsibilities of all Stakeholders

It is the role and responsibility of all stakeholders to:

- Respect the health, safety and welfare of themselves and others.
- Respect the rights of the individual, families, carers and others.
- Respect the parameters and requirements of the program.
- From the commencement of the first funding plan engage in and commence transition planning.
- Recognise the expertise of the community clinical teams.

5.1 Individual's Role and Responsibilities

5.1.1 Engage with transitional, recovery focused clinical and psychosocial supports.

5.1.2 Recognise the Program is a transitional recovery focused program and work towards goals and transition planning to transition from the Program as independence and capacity increases over the period of engagement in the program[12].

5.1.3 Be a good neighbour, pay rent on time and look after the property, take responsibility for damage to the property, not injure anyone, abide by CDHP policy and housing requirements.

5.1.4 Advise the CHO and the Provider when maintenance and repairs are required.

5.1.5 Advise the CHO and the Provider when circumstances change, including:

5.1.5.1 Income changes.

5.1.5.2 Change in the number of people who regularly stay in the property[13].

5.1.5.3 Other circumstances that might affect the tenancy.

5.1.6 Work with the Provider and the Clinician to transition to alternative accommodation.

5.2 Family and Carer Role and Responsibilities

5.2.1 Consider the opinions and skills of professional and other staff who provide assessment, individualised care planning, support, care, treatment, recovery, and rehabilitation services to individuals.

5.2.2 Engage, as far as is possible, with programs of assessment, individualised care planning, support, care, treatment, recovery, and rehabilitation.

12 The program is up to three years or less if the young person reaches the age of 25 before they have been in the program for three years.
13 Changes to the number of people regularly staying at the property may impact lease agreements.

5.3 Program Coordinator Role and Responsibilities

5.3.1 Provide oversight and management of the referral process and convene a Panel to assess referrals to ensure program packages operate in line with the allocated budget.

5.3.2 Provide information and support to prospective and current participants throughout the referral and assessment process.

5.3.3 Allocate the bandwidth of support and the maximum amount of funding available for participants.

5.3.4 Notify the Commission of successful referrals.

5.3.5 Through a Peer Worker, support young people to choose a Provider from the panel of Providers.

5.3.6 Once a choice of Provider has been made by a participant, inform the Provider and the Commission.

5.3.7 Assist the successful participant to connect with the CHO and support the participant with signing the lease.

5.3.8 Provide warm on-referrals to alternative services for unsuccessful referrals.

5.3.9 Remind Providers of submission dates for individualised funding plans and acquittals.

5.3.10 Receive and review individualised funding plans from Providers to ensure they are correct, activities and strategies are appropriate, and recovery focused, individualised funding is relevant, necessary and costed correctly. Discretionary funding will also be checked to ensure it meets requirements as outlined in **Appendix B**. Individualised Funding Plans are then to be submitted to the Commission for consideration and approval no later than four weeks prior to the end of the previous plan[14] or between three to six weeks after acceptance into the Program[15].

5.3.11 If the individualised funding plan is not correct, the Program Coordinator will liaise with the Provider to revise the plan.

5.3.12 Receive and review the Outcome Measurement Tools for consideration when reviewing the updated individualised funding plans. This is then to be submitted to the Commission along with the individualised funding plan and at the time of the participant's transition out.

5.3.13 Receive and review acquittals to ensure they are correct, ensuring discretionary funding was approved in the plan and appropriate and within guidelines. Acquittals are then submitted to the Commission for consideration and approval, no later than four weeks after the end date of the plan.

5.3.14 Work in collaboration with the Commission, Providers and other stakeholders as required to support referrals, engagement and service delivery and continuous improvement of the program.

5.3.15 Undertake regular check-ins with each participant at least every six-months including at the point of participants transitioning from the program to ensure their needs are being met, assess and report on participant satisfaction with service and transition planning.

5.3.16 Notify the Commission of any changes that may impact participant's tenancy or support funding arrangements.

5.3.17 Working in collaboration with the Provider, Clinician and CHO to ensure the participant transitions safely to alternative support and/or accommodation.

5.3.18 Provide support to participants to change Provider if required.

5.3.19 Provide a letter to the participant on transition out of the program with a copy to be provided to the Commission, Provider and clinician (where relevant).

5.3.20 Provide information and support on individual advocacy agencies to assist participants and their family or carer in complaint resolution.

5.3.21 Maintain effective communication and working relationships with Providers, Commission, Clinicians, Communities and CHOs, including the facilitation and participation in forums to enhance service delivery and continuous improvement of the Program.

5.3.22 Promote the Program including information sessions about the Program to Clinicians,

14 The Commission will not backdate funding without prior notification, reason, and approval from the Commission. The Commission may request the individual funding plans are submitted earlier should circumstances require.

15 The set-up funding covers approximately three - six weeks dependant on the time of onboarding to the first day of the following month.

Providers, and other relevant stakeholders.

5.4 Psychosocial Support Package Providers (Provider) Role and Responsibilities

5.4.1 Work in collaboration with the participant, their family, carers[16], Clinician and other appropriate stakeholders in planning processes to identify support needs and aims and develop a plan of recovery focused supports.

5.4.2 Ensure individualised funding plans are submitted to the Program Coordinator in a timely manner to ensure they are provided to the Commission no later than four weeks prior to the end of the previous plan[17] or three to six weeks after acceptance into the Program[18].

5.4.3 Develop and maintain processes to support participants to work towards their goals in a planned and gradual manner.

5.4.4 Provide flexible recovery focused supports and maintain overall management and coordination of supports and activities identified in the individualised funding plan.

5.4.5 Review individualised funding plans every three months.

5.4.6 Provide support to YTH&SP participants to enable them to live independently in the community, including assisting individuals to comply with their tenancy obligations.

5.4.7 Develop and maintain formal and effective partnerships with all relevant CHOs.

5.4.8 Support a participant's family and carers where consented to.

5.4.9 Have a planned approach, strategies, and safeguards for the participant to manage their mental health, including collaboration with community mental health services where relevant.

5.4.10 Develop and maintain formal and effective partnerships with specialist mental health services.

5.4.11 Advise the CHO and the Program Coordinator[19] of any changes to the individual that may affect their tenancy or support funding arrangements.

5.4.12 Participate in joint problem solving, at an individual and/or program level.

5.4.13 Utilise existing available community-based services and add additional value through supports and services provided.

5.4.14 In consultation with other key stakeholder's support participants to test their eligibility for the NDIS if they wish to do so.

5.4.15 In consultation with the participant's community clinical team, the Provider should advise the Program Coordinator of any participant no longer considered appropriate to remain within the Program, and therefore recommending they be withdrawn.

5.4.16 Advise the Program Coordinator if the participant no longer requires the support of the Program and wishes to successfully exit the Program.

5.4.17 In consultation with other stakeholders, develop a transition plan and assist the transition to alternative accommodation and supports.

5.4.18 Investigate all complaints in accordance with Provider's established complaints management policy.

5.4.19 Develop necessary operational policies regarding AOD use by participants whilst receiving services in order to ensure a fair, equitable and transparent approach is provided in supporting participant's recovery; and staff supervision and training in order to ensure staff have the opportunity to access development opportunities.

5.4.20 Support evaluation of the service.

16 The involvement of family and carers should be encouraged however the individual has the right to refuse the involvement of family. Where a person is recognised as a carer under the Carers Recognition Act 2010, the following applies:
- The role of carers must be recognised by including carers in the assessment, planning, delivery and review of services that impact on them and the role of carers.
- The views and needs of carers must be taken into account along with the views, needs and best interests of people receiving care when decisions are made that impact on carers and the role of carers. Complaints made by carers in relation to services that impact on them and the role of carers must be given due attention and consideration.

17 The Commission may request the individual funding plans are submitted earlier should circumstances require.

18 The set-up funding covers approximately 3 weeks – 6 weeks dependant on the time of onboarding to the first day of the following month

19 Program Coordinator to advise the Commission of any changes to the individual that may affect their tenancy or support funding arrangements.

5.5 Community Housing Organisation (CHO) Role and Responsibilities

5.5.1 Manage the property and tenancy, including undertaking maintenance and collecting rent, in accordance with the *Residential Tenancies Act* and ensure appropriate CDHP policy is applied.

5.5.2 Ensure any tenancy related decisions are taken in consultation with all relevant stakeholders.

5.5.3 Develop and maintain formal and effective partnerships with all relevant Providers in relation to a participant's tenancy.

5.5.4 Recognise the Program is transitional for up to three years[20] and provide consistent messaging to participants around this. YTH&SP properties are not houses for life and a housing first approach is not applicable to the Program.

5.5.6 In consultation with other stakeholders, participate in transition planning to explore and support participants to secure alternative accommodation, such as housing 'swaps' etc.

5.5.7 Notify the Program Coordinator and the Commission when the YTH&SP CDHP vacant property is ready for a new participant.

5.5.8 Develop and maintain formal and effective partnerships with the Program Coordinator, Provider and Commission.

5.5.9 Comply with their contractual agreements with the Department of Communities.

5.6 Health Service Providers (HSP) Role and Responsibilities[21]

5.6.1 Recognise the Program is transitional and provide consistent messaging to Program participants around the transitional nature of the program.

5.6.2 Provide assertive clinical supports for each participant that is tailored to their individual needs.

5.6.3 Manage the provision of agreed clinical services in a timely manner.

5.6.4 Inform the Program Coordinator and the Provider of critical participant issues (such as but not limited to disengagement from clinical management, increased support needs beyond the scope of the Program) in a timely manner.

5.6.5 Ensure a care coordinator or single point of contact is available and has a replacement, which is familiar with the participant if on leave or away, and to ensure the Provider is made aware of any changes to the participant's primary clinical contact. This is to enable Providers to easily make contact as appropriate in relation to participants they are supporting.

5.6.6 Allocate each participant a dedicated clinical care coordinator. The clinical care coordinator is responsible for:

5.6.6.1 Referrals and management of the participant (where relevant) including the discharge of a participant from clinical care to management by a General Practitioner.

5.6.6.2 Notify the Provider and Program Coordinator[22] should the participant be discharged from clinical care to management by a General Practitioner.

5.6.6.3 Work collaboratively with the Provider to provide input into the development of a participants funding plan and sign off on the plan.

5.6.6.4 In consultation with other stakeholders, participate in transition planning to explore and support participants to transition from the Program including seeking alternate accommodation. Provide consistent messaging to participants around this.

5.6.6.5 Work collaboratively with the Provider to provide input into the development and review of a participant's safeguarding plan.

5.6.6.6 Work collaboratively with the Provider and the participant to develop strategies for the management of limited engagement or non-engagement.

5.6.6.7 Be point of contact for the Commission and the Provider for the participant's clinical care and participate in joint problem solving at an individual and/or program level.

20 Or less if the young person reaches the age of 25 before they have been in the program for three years.
21 Please refer to Appendix D for additional information on clinical roles and responsibilities.
22 The Program Coordinator to notify the Commission.

5.6.6.8 Consult and collaborate with the Provider in the support of participants.

5.6.6.9 In consultation with other key stakeholders, support a participant to test their eligibility for the NDIS if they wish to do so including advocating for home and living supports within the NDIS plan.

5.6.6.10 Following regular review and assessment, advise the Program Coordinator if a participant is no longer considered clinically appropriate to remain within the Program, and therefore recommending they be withdrawn.

5.6.6.11 Work with participants to achieve their goals to reduce supports to transition out of the Program over a period of three years.

5.7 Department of Communities' Role and Responsibilities

5.7.1 Assess eligibility for CDHP and liaise with the Commission regarding potential Program participant's housing history and requirements.

5.7.2 Purchase housing for lease to CHOs through the CDHP.

5.7.3 Identify and contract manage a suitable CHO.

5.7.4 Recognise the program is transitional and the Program properties are not houses for life, a Housing First approach is not applicable to the program and work with stakeholders to consider transition planning options.

5.7.5 Ensure all Communities housing managers and regional staff across the State are aware of the policy approving participants to simultaneously be in the Program and on the Public Housing Waitlist if they so wish.

5.7.6 If the Commission requires additional Program CDHP properties to be purchased by Communities they will communicate, liaise and confirm with the Commission regularly and acquire the properties in a timely manner.

5.7.7 Annually cross check Program properties with the Commission to ensure accurate records.

5.7.8 Act as a point of escalation for grievances between the Commission and CHOs.

5.8 Mental Health Commission's Role and Responsibilities[23]

5.8.1 Contract management of Program Coordinator and Providers including negotiating, reviewing, supporting, monitoring and evaluating Service Agreements in line with outcomes and outputs.

5.8.2 Upon receipt from the Program Coordinator, review and approve individualised funding plans, Outcome Measurement Tool and acquittals.

5.8.3 Notify the CHO and Communities of successful allocations to properties.

5.8.4 Provide overarching administration of the Program, including budget, maintenance of a database of participants accessing Program, State and Commonwealth reporting, the release of funding to Providers and Clinicians.

5.8.5 Annually cross check Program properties with Communities to ensure accurate records.

5.8.6 Support service delivery through the provision of policy, guidelines, templates and other resources for the Program in collaboration with relevant stakeholders.

5.8.7 Maintain effective communication and working relationships with Providers, Program Coordinator, Clinicians, Communities and CHOs, including the participation in forums to enhance service delivery and continuous improvement of the Program.

5.8.8 Identify and provide information on training and development opportunities for Providers.

5.8.9 Recognise the Program is transitional, and properties are not houses for life and a Housing First approach is not applicable to the program.

5.8.10 Act as a point of escalation (for example plan content etc) should Provider, CHO and Program Coordinator resolution processes be exhausted.

5.8.11 Evaluation of the Program.

23 The Commission does not hold a direct relationship with program participants. This ensures participants receive assistance from the stakeholder best equipped to address their needs.

6. Service Delivery Guidelines

6.1 Recovery Oriented Mental Health Service Provision

The term recovery-oriented practice is widely recognised as a core concept that underpins contemporary mental health service delivery. The focus of recovery-oriented practice is that support is individualised and centred on the aims of the person and the role of stakeholders is to support a person's recovery journey.

The Commonwealth Government's *National Framework for Recovery-oriented Mental Health Services – Guide for Practitioners and Providers and The Principles of Recovery Oriented Mental Health Practice (National Framework)* provide guidance to Providers on the way that mental health services can encapsulate recovery based mental health care and support.

The principles of mental health recovery practice are:

6.1.1 Uniqueness of the individual – service providers acknowledge that recovery is a personal journey and is about living a meaningful life with or without the symptoms of mental illness.

6.1.2 Real choices – service providers recognise that for a person to exercise 'real choice' they are supported to creatively explore choices to enable them to define their recovery goals.

6.1.3 Attitudes and rights – service providers promote an individual's legal, citizen and human rights; this includes commitment to supporting a person.

6.1.4 Dignity and respect – service providers treat individuals with compassion and respect regardless of presenting behaviour and are culturally sensitive at all times.

6.1.5 Partnership and communication – service providers believe in a person's recovery and work in partnership with them and their support network to help them realise their hopes, goals and aspirations.

6.1.6 Evaluating recovery – service providers support individuals to track their own progress and use consumer and carer feedback to inform quality improvement activities.

6.2 Culturally Appropriate Practice

All stakeholders are required to adopt cultural awareness and cultural sensitivity in all aspects of service delivery and be culturally responsive to the unique needs of Aboriginal people.

Stakeholders should apply sensitive and respectful practices when working with people from culturally and linguistically diverse backgrounds and provide services that respect and respond to the health beliefs, practices, needs and preferences of diverse people.

Stakeholders should apply non-discriminatory entry criteria with respect to gender, sexual orientation, race, culture, religion and disability. Service provision and individualised funding plans should appropriately respond to the individual's cultural background, preferences, and specific needs.

6.3 Individualised Planning

In order to access funding and supports through the YTH&SP the following planning process and approval of individualised funding plans needs to occur:

6.3.1 Prior to service commencing, the Provider must complete a planning process including safeguarding, limited engagement/non-engagement planning and transition planning with the individual and any other relevant parties[24] (the planning process used should be based on person-centred planning principles and can be any tool the Provider chooses). This planning process should continue to be built on and reviewed over time as the Provider develops their relationship with the participant and should include a non-engagement plan which has been designed and consented to by the participant.

24 Relevant parties that may be involved are the individual's family/carers, guardian and clinician.

6.3.2 The information gathered through the Provider's planning process must then be used to populate the Program's individualised funding plan and determine the appropriate level of weekly support which is submitted to the Program Coordinator.

6.3.3 The individualised funding plan will be reviewed by the Program Coordinator[25] to ensure that the support strategies are appropriate, activities and strategies are appropriate, and recovery focussed, individualised funding is relevant, necessary and costed correctly within the participant's allocated bandwidth, funding is individualised and meets the funding parameters. Discretionary funding will also be checked to ensure it meets requirements as outlined in Appendix B.

6.3.4 Following approval of the individual funding plan by the Commission, an engagement letter will be issued to release funding through a Recipient Created Tax Invoice (RCTI).

6.3.5 If the individualised funding plan is not approved, the Program Coordinator will liaise with the Provider to revise the plan based on the recommendations/feedback received and resubmit the plan.

6.3.6 Once an individual funding plan has been approved, Providers will be required to review plans against the identified individual outcomes in partnership with the participant and any other relevant parties. Plan reviews will occur every three months and formally at the end of the plan period.

6.3.7 At the end of each plan period the Provider's will complete the Outcome Measurement Tool template and submit to the Program Coordinator alongside the new individualised funding plan for review. Once reviewed, the Program Coordinator will submit this to the Commission. The information gathered through these reviews inform the next individualised funding plan. The Outcome Measurement Tool and Plan are to be submitted for approval and funding allocation[26] no later than four weeks prior to the end of the previous plan[27]. The steps outlined above for the review and approval process will then occur for the renewed individualised funding plan.

6.4 Funding parameters

Funding provided to support young people who are participating in the YTH&SP Program is intended to be recovery focussed, transitional and flexible to optimise the individuals' opportunity to live successfully in the community. The level of support must be individualised to each participant's needs[28].

The YTH&SP funds reasonable and necessary supports that assist the participant to reach their recovery aims and aspirations. Funding provided through the Program must purchase supports that are clearly linked to the achievement of outcomes related to the personal support needs identified in the participant's plan these may include:

6.4.1 Supporting the participant to build their capacity and skills to live independently (such as how to manage finances, prepare meals or use public transport).

6.4.2 Supporting the participant with opportunities to develop social relationships and to engage in active community participation.

6.4.3 Supporting the participant to build on their skills to further their opportunities to participate in educational/vocational and/or volunteer work or employment.

6.4.4 Provide opportunities for participants to make choices about and access a range of mental and physical health services.

6.4.5 Assist participants in developing safeguarding, prevention, harm minimisation and crisis resolution strategies that support their mental health and AOD use.

6.4.6 If emergency brokerage funding has been agreed in the individual plan, it will be assessed by the Provider on a case-by-case basis for essentials only (i.e., medication, public transport fares to get to a medical appointment, essential groceries).

25 The Commission will also review individual funding plans once submitted by the Program Coordinator.
26 Funding requested through the individual funding plan should be reflective of the individual's current support needs and may be reduced in line with their support needs (refer to Duration and Level of Support for further details).
27 The Commission may request the individual funding plans are submitted earlier should circumstances require.
28 This means that participants may not require the maximum support of their allocated bandwidth and therefore funding is individualised.

There are circumstances where supports will not be funded through this initiative.

A support will not be funded if it:

- Is not related to the participant's recovery goals as documented in their individualised funding plan or not related to their mental illness.
- Duplicates other supports already funded by another government department or agency.
- Relates to day-to-day living costs (for example, rent or other household bills)[29].
- Relates to the provision of services for daily personal self-care (for example, bathing, showering, dressing, eating).
- Relates to the provision of services for ensuring medication compliance, particularly if a participant is on a community treatment order[30].
- Is likely to cause harm to the individual or pose a risk to others.
- Is for illegal activities or gambling.
- Is considered an income supplement for the participant, family members or carers.

It is recognised participants may wish to change some of the goals and activities stipulated in their individualised funding plan. Stakeholders are encouraged to work flexibly with participants to meet their changing needs, working within the above parameters. It is expected that the Provider and Clinician will contact the Program Coordinator for advice when significant changes to a participant's individualised funding plan is warranted.

6.5 Duration and Level of Support

The duration and level of support a participant receives will be different for everyone based on their individual needs. The intention of the Program is to be transitional, for up to three years or less if the young person reaches the age of 25 before they have been in the program for three years.

Supports for the individual should be as flexible as possible to support goals by working in partnership with the participant, their family/carer and any other appropriate formal/informal support. The level of support must be individualised to each participant's needs (i.e., participants may not require the maximum support of their allocated bandwidth).

For example, a participant may have a reduction in support needs due to successful recovery and transition into community life. This should be discussed with all stakeholders when reviewing their individualised funding plan so that a reduced level of support reflective of the participant's needs is outlined in the revised individualised funding plan. Reducing the level of support provided can occur at any time based on the participant's needs. The Provider will discuss any significant reduction in supports with the Program Coordinator who will notify the Commission when a reduction of services should be reflected in a new plan.

Alternatively, a participant may experience increased support needs that require a more intensive level of support than is within the provision of their current funding bandwidth allocation. If this occurs, it is essential the Program Coordinator is notified as soon as practicable, so they can work in partnership with all stakeholders to determine the best solution for all parties involved.

If the circumstances warrant an increase in supports and funding bandwidth to meet the participant's changed needs, there will be a requirement for the Commission to provide approval of a temporary increase to services funding plan (Top-Up Plan). The Commission will not back date any increased funding levels without prior notification and agreement of the participant's changed circumstances.

Where a participant does not engage with support that is offered through the Program, but clearly requires some form of assistance to live independently in the community, the Program Coordinator, Provider, Clinical team and, where relevant, the Commission will work with all stakeholders to review the participant's needs and their suitability for ongoing access to the Program. The Program Coordinator must be notified if it is recommended the participant be withdrawn from the Program.

29 Emergency brokerage funding is available, assessed on a case-by-case basis for essentials only (i.e., medication, public transport fares to get to a medical appointment, essential groceries).

30 This is a clinical responsibility.

6.6 Accommodation and Tenancy

Having a stable form of accommodation is widely recognised as one of the most significant factors in achieving recovery for a person with mental health difficulties. Safe, secure, stable housing helps people keep in touch with family and friends and form new relationships with neighbours and local communities. It provides a basis for other areas of a person's life to fall into place, such as engaging in employment, education, recreational or other activities.

Individuals that access housing through the YTH&SP program are required to meet all relevant Communities' policies and guidelines in addition to the terms and conditions set out in the lease agreement between the individual and the CHO.

Communities reserves the right to refuse assistance to any applicant with substantiated breaches of their tenancy agreement or the *Residential Tenancies Act, 1987*. This means that:

- The Commission may not be able to offer a property within the Program for individuals identified with outstanding arrears, debts, significant events such as property damage or violence or significant past evictions related to a previous tenancy.
- The Commission may not be able to offer an alternative property for individuals whose tenancy is terminated while in the Program or has had significant tenancy issues[31] while in the Program.

Additionally, due to the limited number of houses available and the high demand for housing, alternative properties are unlikely to be available. The responsibilities of participants are described in the responsibilities section. Ongoing engagement with supports provided through the Provider and Clinician is important to assist with understanding and meeting these responsibilities.

As the program is transitional for up to three years, or less if the young person reaches the age of 25 before they have been in the program for three years, in collaboration with all stakeholders, each participant will be supported by stakeholders with a transition plan to explore and work towards securing alternative accommodation.

6.7 Housemates and Live in Supports

The Commission recognises the potential benefits a supportive housemate may provide for some individuals experiencing severe mental illness, living independently in the community. A supportive housemate can assist individuals to develop independent living skills, maintain their tenancy and develop community connectedness. For some individuals, having a supportive housemate may reduce (though not necessarily replace) the necessity of more formal supports.

Where appropriate, Program funds may be used to assist the implementation of a supportive housemate model and Providers are asked to discuss individual proposals with the Program Coordinator prior to submission of a formal funding request (if there is a guardian involved with an individual, the guardian would need to be involved in this process). The Provider must inform the Program Coordinator and CHO of their intention to explore the possibility of a housemate or live-in support before any further action is taken.

Though the individual circumstances will govern the specific model employed, the following aims to provide Providers with information on some of the logistics in implementing a supportive housemate model.

6.8 Clarifying the role of a supportive housemate

The Provider should assist the individual and their supporters to identify the specific types of support they require from a housemate. Clarifying the proposed role of the housemate along with the desirable competencies and qualities of an ideal candidate will assist the individual to develop a set of selection criteria.

The Participant's Clinical Care Coordinator should be consulted to ensure collaboration.

6.8.1 Selection of a housemate

There are numerous avenues for sourcing potential housemates. Examples include:

- Online community classified websites.
- Posting housemates wanted notices on community billboards in public locations.
- Via recommendations from friends, family members or other contacts.
- An existing friend to take on the role of supportive housemate.
- Another Program participant.

31 Significant tenancy issues may include antisocial behaviour or violence, outstanding arrears or debts, property damage etc.

The Providers are encouraged to work closely with the individual to implement staged interview processes with potential housemates. This may include phone interviews and initial face to face meetings in the community, prior to inviting potential candidates to view the property. A supportive housemate should be subject to a successful police clearance along with any other formal requirements of the CHO.

6.8.2 Supporting the co-tenancy

Following the selection of an appropriate housemate, participants may require assistance to work with the supportive housemate to establish, clearly outline and formally agree to by all parties[32] (with input from Provider and CHO):

- House rules.
- Roles and responsibilities.
- Grievance processes.
- In some existing co-tenancy arrangements, a regular house-meeting is convened. Depending on the specific situation, the Provider may participate in these meetings.

6.8.3 Rent

The supportive housemate will be subject to standard tenancy requirements as outlined in the *WA Residential Tenancy Act, 1987*. This includes the payment of rent. The Commission encourages Providers to discuss the proposed logistics of a particular housemate model with both the allocated CHO managing the tenancy and with the Program Coordinator, prior to implementation.

6.8.4 Lease

The specifics of the supportive housemate's lease will need to be determined prior to the commencement of tenancy, in line with the WA Residential Tenancy Act, 1987 and subject to approval of the CHO. The Providers and individuals are encouraged to be cognisant of the various rights, responsibilities and legal ramifications of tenancy contracting arrangements prior to implementing a supportive housemate model.[33]

6.9 Safeguarding

Safeguards are precautions and measures that are put in place to ensure a participant has the best possible chance of succeeding in their recovery. Safeguards may protect a person from exploitation and harm, and foreseeable unintended events. Importantly, safeguards should enhance and protect a person's human rights, and enable a person to make choices and decisions, take considered risks, and live a life as an active and equal citizen in the community.

The identification and establishment of appropriate safeguards is viewed as a fundamental component of person-centred planning and practice. When safeguards are understood in this way, there is a need to develop an appreciation of what safeguards are, and how they can be implemented to have maximum positive impact on the lives of individuals.

One perspective in looking at safeguards is to consider the extent of 'citizen capital' that each person has in order to identify areas of strength, possible areas of vulnerability, potential threats and hazards, and level of risk.

This concept provides a way of understanding the range of resources that everyone needs in their lives to enable them to live safely and well in their communities. The key aspects of citizen capital are:

6.9.1 Personal capital (who I am) – for example a person's ability to assert themselves, their resilience, self-esteem and a person's key roles;

6.9.2 Knowledge capital (what I know) – for example, a person's skills, knowledge, education experiences;

6.9.3 Social capital (who I know and who knows me) – for example a person's relationships and connections, membership to groups, sources of support, informal and formal advocates; and

6.9.4 Material capital (what I have) – a person's income and investments, employment/ occupation, safe and stable home and other community resources that a person can readily access.

Providers are expected to utilise a holistic approach to developing multiple safeguarding strategies to support a participant to succeed in their recovery on their own terms.

32 Housemates are required to meet the requirements outlined in the CDHP guidelines and abide by all lease requirements.
33 The housemate may be included as a household member and not added to or required to sign the lease agreement.

Providers are required to work with the Clinician to develop a safeguarding plan for each participant at the engagement of the program and review the safeguarding plan with each individualised funding plan. Completed safeguarding plans must be stored by the Provider in accordance with their record keeping policies and procedures. Advice of the safeguarding plan being in place must be provided to the Program Coordinator who will advise the Commission as part of the plan submission process.

6.10 Cancellations

During the initial engagement period, prior to rapport being well developed, where the non-engagement plan has not been developed, or during times when young people are experiencing significant stress or there are competing needs, non-attendance at organised support sessions can occur.

The below guide has been developed to account for these times:

6.10.1 If 48 hours or more (two full business days) notification is provided by the participant – no hours are claimed.

6.10.2 If 24 hours or more (one full business day) notification is provided by the participant, Providers can claim one hour against the participant's package.

6.10.3 If less than 24 hours (one full business day) notice is provided by the participant, Providers can claim two hours against the participant's package.

6.10.4 If it is a 'no show', with no notification by the participant and no travel is involved (e.g., online meeting) – two hours of contact time is claimed against the participant's package. This must include administrative work to attempt to contact and reschedule.

6.10.5 If it is a 'no show', with no notification by the participant and travel is involved – three hours of contact time is claimed against the participant's package. This must include administrative work to attempt to contact and reschedule.

Any time additional to the above hours must be approved by the Program Coordinator in consultation with the Commission.

6.11 Longer periods of non-engagement

Where the participant is unable to participate in the Program for three months (due to reasons such as incarceration, moving outside of region, entering residential care, being admitted to hospital or support needs are out of scope of the Program etc.), this may indicate the participant may no longer be suitable for the Program. This is to be discussed with the Provider, clinical supports and the Program Coordinator. The Program Coordinator will notify the Commission of the outcome of the discussion if it is a withdrawal.

Where participants are not engaging for periods of time, to encourage participation, reduce barriers and provide accessibility and flexibility, the below steps should be taken.

Individualised Recovery Plan	The Provider will inform the participant of the likely steps the worker will take to re-engage them in the Program.
Non-attendance of one appointment	Worker to call and send text to attempt to arrange another appointment.
Non-attendance of two appointments	Worker to call and send text with a timeframe for participant. Highlight with participant any opportunities for engagement, e.g., activity planned/steps toward goal attainment.
Non-attendance of three appointments	Worker to call, send text and email for participant, inform that the Provider will attempt to get in contact with their support people, e.g., parent/other workers as well as the Program Coordinator (where consent is provided). Contact support people to find out any reasons for non-attendance and request their assistance in re-engagement. Highlight with participant and support people any opportunities for engagement, e.g., activity planned/steps toward goal attainment. Address any barriers to attendance, e.g., suggest a different location, reduce concerns, suggest other ways to assist them. If concerns with worker, Program Coordinator to make contact and discuss.
Non-attendance / limited contact for a month period	Record monthly any young people who have not engaged in appointments and had limited contact. The Program Coordinator is to be informed of this, using the limited or non-engagement form. Reasons, steps taken and an engagement plan are to be included.
Non-attendance and concerns for safety	Attempt to call and text, include a short timeframe for response (within the same day), inform them you are concerned for their wellbeing and may need to get others involved, e.g., police if no response, plan with Coordinator regarding who to contact should participant not respond. If no response within timeframe, contact will be made usually with parents/carers/support people/Mental Health crisis response service or police to complete a welfare check, in agreement with Coordinator. Where appropriate a notifiable incident is to be submitted to the Commission via the Notifiable Incident Management System.

6.12 Grievances and Complaints

The Commission is committed to purchasing high quality services and recognises that complaints and feedback provide information to improve the quality of services.

Providers and the Program Coordinator should ensure that participants supported through the Program are advised of their organisation's complaints procedure. Many complaints can be resolved quickly and effectively at a local level. Complaints should be dealt with in a confidential manner and will only be discussed with the people directly involved. Where a complaint cannot be satisfactorily resolved with the Provider and Program Coordinator the issue can be raised with the Commission or alternatively by contacting the Health and Disability Services Complaints Office (HaDSCO).

The Provider and the Program Coordinator will document all complaints in accordance with the organisation's formal procedures.

In instances where individual advocacy support is required to assist an individual and their family or carer in resolving a complaint, information about services will be provided by the Program Coordinator.

Should the Provider or the Program Coordinator wish to raise a complaint in relation to a stakeholder of the Program, the issue can be raised with the Commission or alternatively by contacting HaDSCO.

6.13 Portability of funding

Participants choose their Provider and can transfer/move between Providers subject to the following conditions:

6.13.1 A reasonable time[34] accessing a particular Provider is required before the participant changes Providers. This is to allow a plan to be developed and implemented effectively. The timeframe is negotiable based on the circumstances surrounding the request.

6.13.2 If a participant requests a change of Provider, the Program Coordinator will meet with the participant to explore whether the issue can be resolved.

6.13.3 If it is found the issue is unable to be resolved, a negotiated timeframe will be agreed prior to the implementation of a transfer. Where a transfer is requested, the Program Coordinator will ensure the timeframe is mutually acceptable to all parties to ensure appropriate administration tasks have been undertaken and allow for a smooth transition with minimal disruption to the participant. The principle of choice for participants is paramount and every effort will be made to accommodate a participant's choice and resolve any issues quickly.

6.13.4 The Program Coordinator will support the participant to choose another Provider through the services of their Peer Worker.

6.13.5 Services transferred during the course of a year will involve a pro-rata transfer (or based on an acquittal of funds to date) of the allocated funding for that year and the full allocation thereafter, unless otherwise negotiated between the Commission and the Provider.

6.13.6 Where services are being terminated by the Provider, three months written notice is required to the Program Coordinator and to the participant(s) who is/are receiving the service, to enable appropriate transition arrangements[35].

6.13.7 Additional costs will not be incurred due to individuals transferring between Providers.

34 In most cases, a reasonable time is three (3) months; however, each case must be discussed with the Commission

35 Where it is unsafe for a Provider to continue to provide services to a participant, this must be discussed with the Program Coordinator to ensure suitable alternative support is investigated prior to, or urgently after supports cease.

6.14 Transitioning from the Program

Participants will transition from the Program for a variety of reasons including:

6.14.1 Achieves their recovery goals[36] and no longer requires support of the program in a planned and agreed upon manner.

6.14.2 No longer wishes to participate in the program or has support needs which are outside the scope of the Program.

6.14.3 Has moved outside the Perth metropolitan area for an indefinite period.

6.14.4 Support is insufficient to meet their needs.

6.14.5 Is admitted to inpatient care, hospital or alternative supported residence (e.g. Rehabilitation centre), for an extended period of time[37].

6.14.6 Is incarcerated for an extended period. In most cases, an extended period is three months; however, each case must be discussed with the Program Coordinator.

6.14.7 Has transitioned to the NDIS for all psychosocial support needs.

6.14.8 Reaches the age of 25.

Transition from the Program must be in consultation with all key stakeholders.

If a participant is linked to a Clinician, the Clinician is required to formerly notify the Program Coordinator, in writing, that they support the participant's transition from the Program. The Clinician must discuss this recommendation with the participant in consultation with other key stakeholders. If appropriate, the Clinician must ensure a transfer of care to another mental health service or General Practitioner has occurred before the participant transitions from the Program. Once this is received the Program Coordinator will send a formal letter of transition to the participant and inform key stakeholders.

If a participant is not linked to a Clinician, the Provider is required to formerly notify the Program Coordinator, in writing, that they support the participant's transition from the Program. Once this is received the Program Coordinator will send a formal letter of withdrawal to the participant and inform key stakeholders.

To ensure that the participant transitions from the program safely, each participant is supported by the Provider and Clinician (where relevant) to engage in and continually review a transition plan. The transition plan must include steps for securing alternative supports (if required) and accommodation[38].

In addition, the Provider and Clinician is required to ensure that participants have adequate support from other sources when they transition from the Program.

36 Should an individual's circumstances change and supports are needed to be reintroduced, this will be possible by a new referral into the Program.

37 If individuals are in hospital or alternative supported accommodation for an extended period, their personal circumstances no longer align with the strategic intent of the program which is to support individuals to live independently in the community. In most cases, an extended period of time is three months. However, each case must be discussed with the Program Coordinator.

38 The Commission does not support termination into homelessness and all participants are supported by the Provider and Clinician through a transition plan to source suitable alternative accommodation prior to transitioning from the Program. Should a participant remain in a Program property without Program supports, the individual must independently actively seek alternative accommodation while continuing to abide by all requirements of the Lease and as stipulated by the CHO. The individual will be required to continue meeting the Department of Communities eligibility criteria.

7. Relevant Policies and Strategies

The Program is guided by the following polices and strategies:

- *Delivering Community Services in Partnership Policy 2023*
- *National Safety and Quality Health Service Standards 2021*
- National Standards for Mental Health Services 2010[39]
- Australian Government 2013 A *National Framework for Recovery-Oriented Mental Health Services – Guide for Practitioners and Providers*
- Australian Government 2010 Principles of Recovery Oriented Mental Health Practice
- Australian Government *Carers Recognition Act 2010*
- Community Disability Housing Program
- Community Managed Organisations Mental Health Standards

The following the Commission documents also provide guidance:

- Mental Health 2020: Making It Personal and Everybody's Business
- The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025
- Safeguards Framework for Individualised Support and Funding
- Notifiable Incident Reporting Policy
- Quality Assurance Framework
- Youth Transitional Housing and Support Program Model of Service

39 Mental Health Service Providers contracted by the Commission will be transitioning to the National Safety and Quality Mental Health Standards for Community Managed Organisations. Timelines have not been confirmed as yet.

8. Glossary

This Glossary contains terms that are common to some of the related documents, such as the Individualised Support Policy Framework.

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.

Carer

In line with the *Carers Recognition Act 2010*[40], a carer is an individual who provides personal care, support and assistance to another individual who needs it because that other individual:

(a) Has a disability; or
(b) Has a medical condition (including a terminal or chronic Illness); or
(c) Has a mental illness; or
(d) Is frail and aged.

Clinician

Refers to the clinical care coordinator allocated through the public health service provider for the region for the participant. Clinicians work in collaboration for the delivery of supports within the YTH&SP. The clinical supports are provided by experienced clinicians.

Community Housing Organisation

Refers to the organisation contracted by the Department of Communities to manage the YTH&SP properties and tenancies, including undertaking maintenance and collecting rent. The Community Housing Organisation works in partnership with all YTH&SP stakeholders.

Co-occurring

Refers to a person who has AOD issues and a mental health illness(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, an appropriate treatment plan is essential in the management of co-occurring issues.

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.

Cultural Safety

Cultural safety (or cultural responsiveness) 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.

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.

40 The explanation of the word 'carer' is adapted from Section 5 of the Act.

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

A funding mechanism that promotes 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. This means that participants may not require the maximum support of their allocated bandwidth and therefore funding is individualised.

Individualised funding plan

Developed in partnership with the participant, the Support Provider, Clinician (where relevant), and any other key stakeholders important to the participant. The individualised funding plan outlines the participant's goals and detail how psychosocial supports will be provided to assist the participant to achieve their goals. The individualised funding plan is submitted to the Commission to release allocated funding to the Support Provider to deliver the psychosocial supports.

Individualised supports

Are the supports that have been identified to meeting the support needs and solutions of individuals with mental health and/or co-occurring 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.

Mental health

A state of wellbeing in which the individual realises their 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 or the International Classification of Diseases.

Notifiable Incident

Notifiable incidents are incidents that need to be reported to the Commission as part of the *General Provisions for the Purchase of Community Services 2018*.

Peer Worker

A Peer 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 Workers use a combination of their lived experience plus training and professional development in their practice.

The person-centred approach

Puts individuals with mental health problems and/or mental illness at the centre of planning and decision making on how they would like to see their lives unfold. Supports and services provided to individuals are based on their unique wishes, interests, strengths, goals and needs.

Person-centred approach to planning

Puts individuals with mental health problems and/or mental illness at the centre of planning and decision making on how they would like to see their lives unfold. Supports and services provided to individuals are based on their unique wishes, interests, strengths, goals and needs.

Personalised Plan

Refers to the individual support plan completed by the Provider in conjunction with the individual and any other related parties.

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.

Program Coordinator

Refers to an NGO contracted by the Commission to manage the referral and assessment process for people nominated for the YTH&SP and support eligible participants to choose their support provider under the program and throughout the term of the individual's Individualised Plan as required.

Provider

Refers to the NGOs contracted by the Commission to deliver psychosocial supports to participants of the YTH&SP. Providers work in collaboration for the delivery of supports within the YTH&SP.

Recovery

Recovery is a personally defined process. A common definition is being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues. Regarding AOD use, recovery may or may not involve goals related to abstinence. Increasingly, recovery is seen not only as a psychological process but also as a social and relational process. This development recognises that change occurs through relationships and opportunities that consumers want, and that result in healing and empowering experiences. Recovery is about transforming relationships in community life, especially around employment, education, and other areas of social participation.

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.

Safeguarding Plan

Refers to the document that captures the safeguards for each participant. Safeguarding plans are developed for each participant at the engagement of the Program and reviewed with each individualised funding plan. Safeguarding plans are developed in collaboration with the Clinician (where relevant).

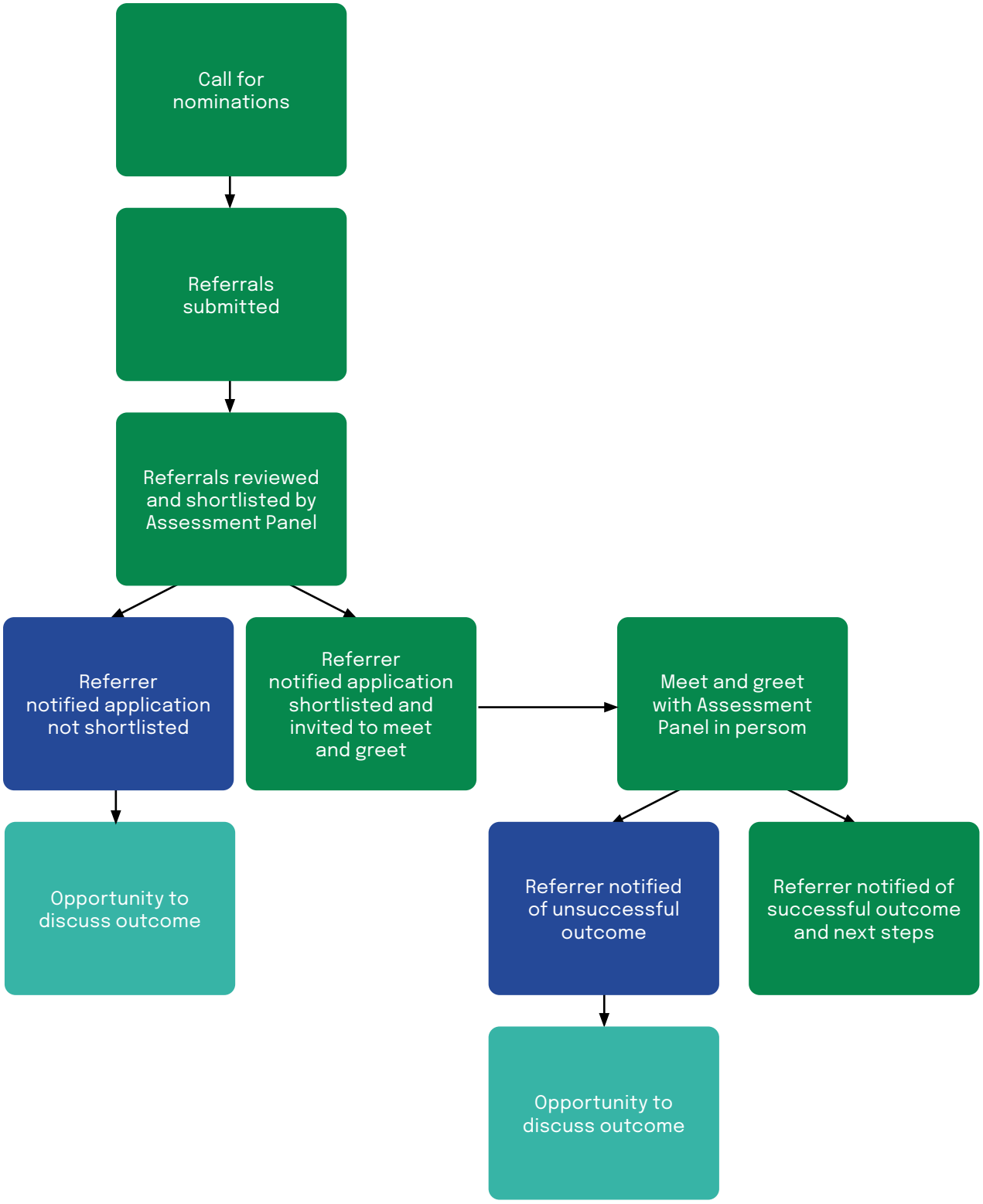
Social Inclusion

Is a sense of belonging, sharing responsibility, contributing, having one's differences respected, and being seen to be of value regardless of one's circumstance. Social inclusion also refers to policies and practices which lead to the experience of being socially included for people who may otherwise be excluded because of disability, mental illness or disadvantage.

Warm referral

Warm referral involves contacting another service on a participant's behalf (with the participant's consent and where possible, with the participant present). It may include following up with the participant to ensure successful engagement with the referral service.

Appendix A – Referral Process Flowchart



Referral Process Flowchart

Appendix B – Use of Funding

Each participant of the Program is provided with an allocated maximum amount of funding for each 12-month plan period[41]. The amount of funding relates to the recommended bandwidths of support ranging from Low, Medium and High.

The bandwidth of support and the maximum amount of funding available is determined by the assessment panel when the young person is successful in their referral to the Program. The Provider can request an increase or decrease in the bandwidth of support if after meeting with the participant it is recommended that more or less supports are required.

The information gathered through the planning process should be used to determine the appropriate level of weekly support in the individualised funding plan up to the maximum amount of funding available in the allocated bandwidth.

There are three funding plan templates available depending on the participant's needs at the time of submission. They are:

Full Year Funding Plan

- Full Year Funding plans cover 12 months and are developed in consultation with the individual, families/carers, Guardian, community clinical team, Provider and any other relevant stakeholders.
- The individual, families/carers and guardian must sign the Full Year Funding Plan.
- The Provider and Clinician must sign the Full Year Funding plan.
- Full year funding plans are to commence 1 July or 1 January.

Interim Funding Plan

- Interim plans are plans longer than four months, less than 12 months and developed in consultation with the individual, families/carers, guardian, Clinician and Provider.
- The Interim Funding Plan should be utilised when a Provider has received a new referral and they need to align the Full Year Plan with either a 1 July or 1 January start date which exceeds three months. Alternatively in consultation with the Program Coordinator when it is determined an interim plan is more appropriate for an individual than a full year plan (examples include transitioning to alternative supports, transitioning out of the program, or periods of severe instability for the participant).
- It is preferred the participant, families/carers and guardian sign the Interim plan however is not a requirement.
- The Provider and Clinician must sign the Interim Funding Plan.

Provisional Funding Plan

- A Provisional Plan should be utilised when a Provider has received a new referral and they need to align the Full Year Plan with either a 1 July or 1 January start date which is three months or less.
- It is preferred for the individual to sign the Provisional Plans, however, is not a requirement. The Provider and Clinician must sign the Provisional Plan.

41 For plans length less than 12 months, the funding may be pro-rater and the combination of funding across the 12-month period must not exceed the allocated maximum amount of funding for each 12-month plan period.

Temporary Increase to Services Funding Plan

- A Temporary Increase to Services Funding Plan (top-up plan) is developed if the Provider requires a temporary increase in funding through to the end of the participant's plan. The temporary funding must be within the individuals allocated bandwidth.
- It is preferred for the individual, families/carers and guardian sign the Temporary Increase to Services Funding Plan however is not a requirement.
- The Provider and Clinician must sign the Temporary Increase to Services Funding Plan.

Developing and Submitting a Funding Plan

In developing and submitting a funding plan, Providers must:

1. Use the Commission provided Plan templates (Full Year Funding Plan, Interim Funding Plan, Provisional Funding Plan, or Temporary Increase to Services Funding Plan templates).
2. This initial plan should be submitted to the Program Coordinator who will provide it to the Commission three to six weeks after acceptance into the Program[42] or for the first day of the following month. An initial plan payment is paid to the Provider for of the first 12-month plan. The Commission estimates the initial plan payment for plan development, depending on the individual's needs, which usually equates to approximately one months' worth of supports[43]. During this time the Provider should begin meeting the participant, building rapport with the community clinical team and CHO, arranging tenancy, supporting participant to buy furnishings and move into their home.
3. The hours of direct support and subsequent funding must be entered on the costing sheet of the individualised funding plan on a weekly basis (not annually) and the total costings (not hours) for the year entered.
4. The individualised funding plan should have the input of all relevant stakeholders. The Clinician (where engaged) needs to contribute to the plan and to safeguarding and transition planning.
5. The start date of all individualised funding plans should be clearly stated on each plan document.
6. An update on the participant's progress, against the previous year's aims as well as a report on any brokered services, is captured within the Outcome Measurement Tool template. This is to be submitted on an annual basis with the new individualised funding plan as well as at the time of the participant's transition from the Program.

Discretionary Funding

1. Discretionary funding is to be utilised for recovery focussed supports in the community that will aid the participant to connect to their community, gain employment or learn relevant skills. Discretionary funding is not to be used to acquire items including consumables[44].
2. If discretionary funding is requested, it must be clearly stated what the funding will be used for, relating it to recovery focussed supports in the participant's individualised funding plan. In addition, a summary of discretionary funding and a description is required on the costing sheet of the participant's individualised funding plan.
3. The discretionary funding is not an automatic payment. It should be relevant to the participant's identified recovery aims.
4. For costs associated with training courses the participant is to be encouraged to contribute 50% of the fees, to motivate them to save money towards their recovery aims.
5. For costs associated with driving lessons, the participant is to be encouraged to contribute 50% of the fees, noting discretionary funding to cover driving lessons will be limited to a 12-month period only. Discretionary funding is not able to cover fees associated with driving tests (such as the practical driving assessment), hire vehicles, or other payments.
6. Funding cannot be utilised for: activities or items that can be funded through other sources, to acquire items, 1:1 personal training, home gym training, transport costs[45], gambling or illegal activities, holiday costs, utilities, as an income supplement etc[46].

42 The set-up funding covers approximately three - six weeks dependant on the time of onboarding to the 1st of the following month.
43 Approximately 3 weeks - 6 weeks dependant on the time of onboarding to the 1st of the following month. The Commission will not backdate funding without prior notification, reason, and approval from the Commission.
44 Emergency brokerage funding is available, assessed on a case-by-case basis for essentials only (i.e., medication, public transport fares to get to a medical appointment, essential groceries).
45 Emergency brokerage funding is available, assessed on a case-by-case basis for essentials only (i.e., medication, public transport fares to get to a medical appointment, essential groceries).
46 Program funding is to be used to support community and social participation such as accessing group classes, groups, or community sessions.

7. Please discuss with the Program Coordinator if there is uncertainty around the appropriateness of how discretionary funding can be utilised before including it in the individualised funding plan.
8. If uncertainty continues, please discuss with the Commission.

Acquittals

1. When a new funding plan is submitted, the Provider must provide a preliminary acquittal, showing funding spent to date for the previous plan period for the participant.
2. The total of all funding provided by the Commission must be acquitted at the end of the funding cycle through a Final Acquittal form.
3. Final acquittals must be submitted by the Provider to the Program Coordinator for review and submitted to the Commission no later than four weeks after the end date of the participant's individualised funding plan.
4. Funds for direct support, brokered supports, discretionary, temporary increase to services funding and the initial start-up funding for plan development must be included in the Final Acquittal.
5. Funding should be reconciled and acquitted monthly by the Provider and may be requested at contract management meetings.
6. There is an acceptable 5% 'slippage' in acquittals on each individual's funding plan.
7. Funds that are surplus (i.e. over and above 5%) at the end of a funding period will be offset against funds to be paid by the Commission to the Provider for another Program participant. Details of offsets are described in the Payment Summary for each participant when payments are released.
8. The Commission will notify each Provider of their current surplus position twice a year in May and November through a reconciliation.

Change in needs (including accommodation)

- If a participant is supported to temporarily access other funded accommodation/ residential services, e.g. Step Up/Step Down (excluding hospital admissions), the Provider is required to communicate with the Program Coordinator as early as possible to ensure flexibility and accountability of the Commission funds and resources can be maintained. It is anticipated that Program funds will not be stopped during this period, rather reduced to maintain relationships and continuity of service provision.
- Any change to the level of funding (e.g., an interim increase for a specific period due to need for more intensive supports; an increase in bandwidth whether temporary or permanent) will need to be requested to the Program Coordinator and will be supported if found reasonable and necessary.
- The Program Coordinator, Provider or the Commission can recommend a reduction or increase in bandwidth.
- If an individual has consistently decreased their supports during the life of the plan, the expectation is that a reduction in bandwidth will be reflected in subsequent plans.

Appendix C – Communication and Information Sharing by the Provider

To support and maintain effective communication and working relationships with Provider's, the following notifications must be submitted to the Program Coordinator who will notify the Commission:

a) An individual is admitted to hospital due to their mental health or physical health via a '**Hospital Admission Form**[47]' within three business days.

b) The Provider is concerned that an individual has been/or is going to be discharged via a '**Discharge Hospital Form**'.

c) An individual does not engage with their supports via a '**Limited or Non-Engagement Form**' – when there have been three consecutive unsuccessful scheduled engagements[48].

d) The individual is not in their home for any length of time longer than four weeks, i.e. if they are admitted to hospital, if they go on holiday, if they go to a residential rehab.

- The Provider must ensure the house is secure and visit it from time to time to ensure it remains safe.
- The Provider must support the individual to maintain their tenancy to an acceptable standard including communicating with the CHO of any concerns or changes to supports. Please note, support does not include using supports for physical assistance such as for cleaning, tidying, gardening etc.
- If the property is at risk of inappropriate and uninvited guests, the Provider must notify the CHO as soon as is practicable as well as the Program Coordinator.

If there is a Notifiable Incident[49] (NI) relating to an individual in the Program, notification is required via the Commission general submission of NI forms – please see Commission website for further details and to access the NI system.

47 Hospital Admission Forms should be submitted when a Program participant is admitted to hospital. This form should be utilised when a serious or notifiable incident has not preceded the admission, i.e. a planned admission by the clinical team due to a decline in wellness or change in medication – even if the police are called to escort the individual to the hospital.

48 If an individual is not engaging in the program this does not mean that the participant will be withdrawn from the program. People disengage for a variety of reasons and early notification of this allows the Commission to provide support to the Provider as appropriate, and to ensure that the clinician is also aware so that appropriate strategies can be developed to ensure the participant's needs are met.

49 Notifiable Incident Forms should only be submitted if a serious or notifiable incident has occurred (and/or resulted in a hospital admission) as outlined in the General Provisions (examples are also available on the Commission website).

Appendix D – Clinical Team Responsibilities

When necessary, each individual in the Program receives dedicated clinical support from the relevant community clinical team.

The community clinical team should provide assertive community clinical outreach to individuals in the relevant area in the Program. In addition to the roles and responsibilities outlined in section 5.6:

(a) Provide clinical input into each individualised funding plan with particular emphasis on relapse prevention, safeguarding and discharge planning strategies.

(b) If appropriate and the individual indicates, support all newly nominated individuals entering the Program to contact the Program Coordinator to choose a Provider.

(c) If appropriate and the individual indicates their interest, support existing participants who would like to change Provider, to utilise the support of the Program Coordinator.

(d) Provide written endorsement (via email) to the Program Coordinator if a request is made for an increase in support and an increase in bandwidth, whether permanently or as an interim funding package.

(e) Meet with all identified stakeholders at least quarterly for participants on a Low/ Medium bandwidth and at least monthly for participants on a High bandwidth;

(f) In collaboration with the chosen Provider, support each participant to be linked with a General Practitioner (GP) in the community for their general health needs and encourage them to attend the GP at least three times per year.

(g) Ensure a care coordinator or single point of contact is available and has a replacement, which is familiar with the participant if on leave or away, for each individual and to ensure the Provider is made aware of any changes to the individual's primary clinical contact. This is to enable Providers to easily make contact as appropriate in relation to participants they are supporting.

(h) In consultation with other stakeholders, explore and support participants to secure alternative accommodation.

(i) Provide a referral back into clinical care coordination if needed after deactivation.

(j) Ensure integration of care between clinical and Provider services reflect the Program Guidelines.

(k) Attend meetings with the Provider and Program Coordinator[50] as agreed.

(l) Notify the Program Coordinator who will notify the Commission when an individual is deactivated from clinical care coordination.

(m) Provide detailed reporting every six months in line with the current year's Commission Service Agreement.

(n) Participate in nomination panels for new referrals into the Program where appropriate.

50 The Commission may be involved in meetings with the Provider, Program Coordinator and/or Clinical as required and agreed.

Appendix E - Suite of Reporting Forms

1. Hospital Admission Form
2. Hospital Discharge Form
3. Limited or Non-Engagement Form

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Hospital Admission Form

This form is used to notify your Program Coordinator of hospital admissions. Please complete and email to your contact.

A Hospital Discharge Form is to be used when a participant has been discharged.

Please continue to use the Notifiable Incident Form when appropriate.

Date of Submission:	
Participant's Name:	
Psychosocial Support Provider:	
Date of Hospital Admission:	
Name of Hospital:	
Anticipated Length of Stay:	
Referral Type: I.e. Police, MHERL, Self, Other	
Reason for Referral:	

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Hospital Discharge Form

This form is used to notify the Program Coordinator of hospital discharges. Please complete and email to your contact.

Please continue to use the Notifiable Incident Form when appropriate.

Date of Submission:	
Individual's Name:	
Psychosocial Support Provider:	
Date of Hospital Discharge:	
Name of Hospital:	
Length of Stay:	
Plan on Discharge:	

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Limited or Non-Engagement

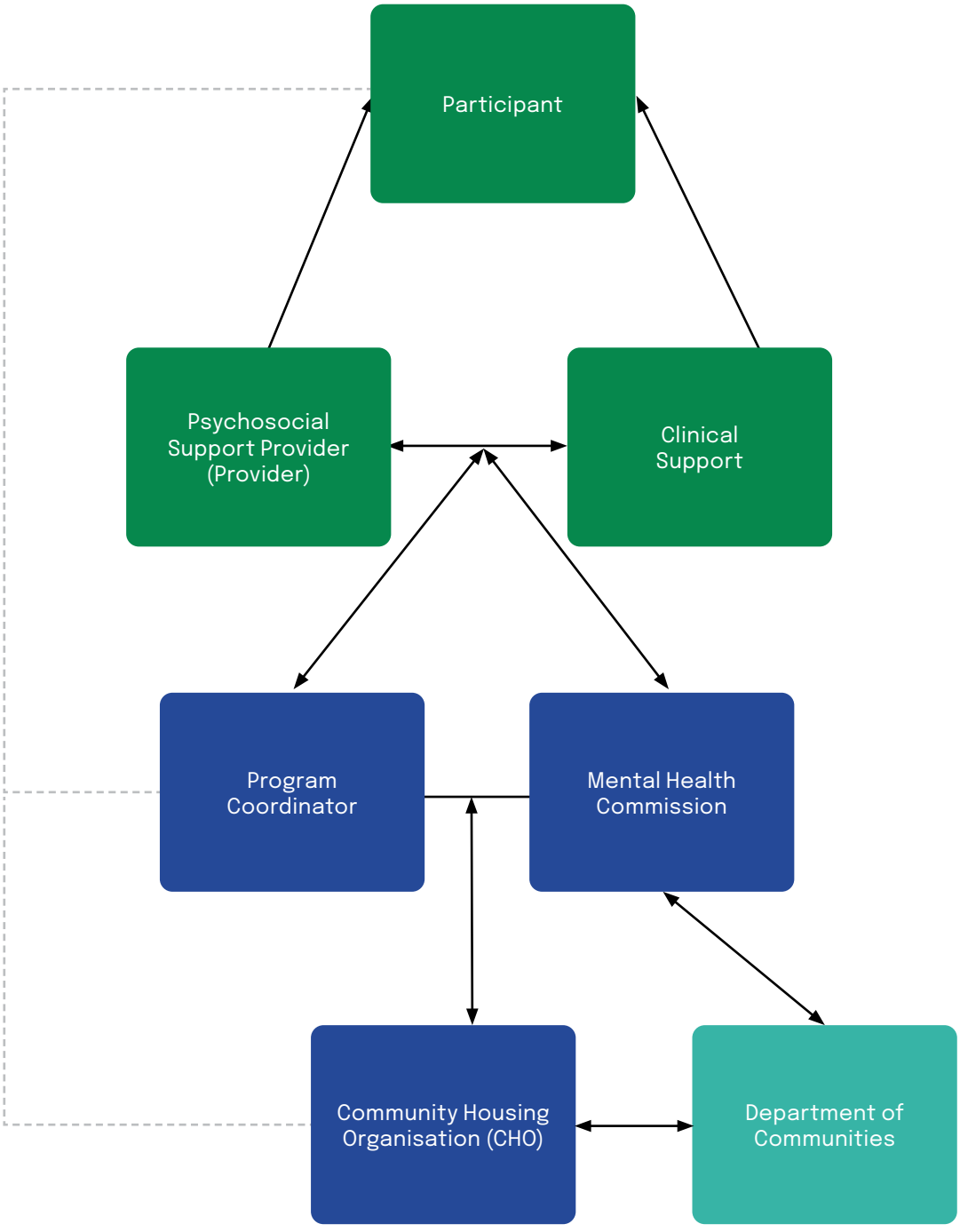
This form is to be used to notify the Program Coordinator of concerns[51] relating to limited or non-engagement[52].

Date of Submission:	
Participant's Name:	
Bandwidth:	
Psychosocial Support Provider:	
Date Organisation Last had Contact with the Participant:	
Details of Issues/ Barriers to Engagement Experienced (include details on timelines, events and actions leading to disengagement):	
Strategies for Engagement and Proposed Next Steps:	

51 Please note this form is not required for participants who are living well in the community and no longer require the previous level of support. This can be captured at the end of plan reporting.

52 Limited or non-engagement is considered when there have been three consecutive scheduled appointments missed.

Appendix F – Collaborative Partnerships Flowchart



Collaborative Partnerships Flowchart

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