



Government of **Western Australia**
Mental Health Commission

Western Australian Community Mental Health Step Up/Step Down Services

Model of Service
June 2017



Background

Central to current mental health, alcohol and other drug (AOD) reforms is the delivery of better care options for people with mental illness and alcohol and other drug problems, closer to where they live, while also reducing the pressure on hospital inpatient beds. This is consistent with the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025: Better Choices. Better Lives (the Plan) that aims to achieve a more balanced mental health system through investment in community based treatment and support services.

To meet these aims, a range of services are required including providing individuals experiencing mental health problems with the support to transition from inpatient settings into the community, as well as providing alternative community based options when individuals require additional support to maintain their usual way of life and reduce their need for admission in an inpatient setting.

The provision of Community Mental Health Step Up/Step Down services (step up/step down services) provides individuals an additional choice regarding the service options they can access when developing their personal recovery plans at different stages of their recovery¹ journey across their lifespan.

Western Australia's first contemporary step up/step down service opened in Joondalup in May 2013, with the second service in Rockingham commencing operations in October 2016.

¹Personal recovery is defined within the National Framework for Recovery-oriented Mental Health Services as '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'. It is acknowledged recovery is personal and means different things to different people.

Future step up/step down services are being planned and developed throughout the State.

A copy of the Plan can be downloaded from the Mental Health Commission's (MHC) website: www.mhc.wa.gov.au

Service Overview

Step up/step down services provide:

Step up services, which allow people to step up from the community, and provide additional support for a person to manage a deterioration in their mental health, but where an admission to an inpatient facility is not warranted; and

Step down services, which allow people to step-down from a stay in an inpatient facility, and provide additional support to a person who no longer requires acute inpatient care but does require assistance in re-establishing themselves in the community.

The overall aims of step up/step down services are to:

- provide short-term mental health care in a residential setting
- promote recovery
- reduce the stigma associated with mental illness.

Services operate within a framework of recovery and rehabilitation delivered by a combination of psychosocial and clinical interventions and activities.

Providers

Step up/step down services provide a balanced combination of psychosocial and clinical support programs within a residential style setting.

The psychosocial support is generally provided by a community based organisation.

The clinical support to step up/step down services are provided by an appointed clinical service provider (usually the local public mental health service).

The providers work in collaboration for the delivery of services and programs within the service.

Aims

The overall aims of step up/step down services are to:

- Improve recovery outcomes for people with a mental illness
- Reduce avoidable admissions and re-admissions to hospital for people living with a mental illness
- Facilitate appropriate and earlier discharge from inpatient care
- Assist individuals in developing prevention and crisis resolution strategies
- Contribute to reducing the burden of care experienced by carers in supporting consumers who are unwell but do not require acute inpatient treatment
- Reduce over-reliance on crisis and emergency services for the provision of services more appropriately delivered in the community
- Ensure that the day-to-day management of services provides a safe and secure environment for service users, staff, visitors and the community.

It is important to note that step up/step down services:

- are not an alternative for acute inpatient care where individuals require significant clinical intervention and monitoring
- do not provide emergency or crisis accommodation services
- are not alcohol and other drug rehabilitation centres
- are not used as temporary accommodation/respite care whilst permanent accommodation is sought.

Target Groups

Step up/step down services provide assistance to individuals living with a mental illness who are aged 18 years and above and who:

- no longer require acute inpatient level mental health intervention and treatment, but would benefit from short-term, intensive treatment and psychosocial support; or
- are living in the community and require additional specialist mental health psychosocial support and interventions to prevent the risk of further deterioration or relapse, which in the absence of this option, may lead to admission to an acute mental health inpatient unit.

It is accepted that step up/step down services may accept young people aged 16 to 17 years on a case-by-case basis, where assessed as clinically appropriate.

Service Outcomes

Step up/step down services will be managed in line with the following features that are outlined in more detail below:

- Readily accessible
- Recovery focused
- Self-directed care
- Person centred
- Collaborative relationships and partnerships.

Readily accessible

The service will:

- Have psychosocial support services available on-site for 24 hours a day, seven days a week
- Provide *short-term* residential programs and activities that offer daily living and practical assistance that builds the person's skills, resilience and confidence

- Deliver programs and activities which promote an individual's capacity to develop and use recovery strategies to assist them meet their personal recovery goals
- Establish, with the provider of clinical services, policies and procedures that maintain the ongoing treatment of the person using the service
- Ensure referral pathways enable prompt access to the service for people who experience an exacerbation of their mental illness
- Undertake an initial assessment in partnership with the provider of clinical support services with all individuals seeking support, to establish if they can benefit from the service
- Have staff on site 24 hours a day, seven days a week to ensure safety for both consumers and the community
- Provide regular and ongoing risk assessments and interventions
- Ensure, in partnership with the provider of clinical support services, that individuals requiring urgent psychiatric assessment are directed to the appropriate clinical service provider.

Recovery focused

The service will:

- Assist the individual in their recovery care planning and its implementation in a way that meets their requirements to live and participate in the community
- Offer a range of types and levels of specialist psychosocial support interventions that aim to reduce the impact of a person's symptoms and prevent the relapse of illness
- Assist residents in crisis support planning where necessary
- Focus on providing better outcomes for people, including a sense of personal wellbeing and living a satisfying life.

Self-directed care

The service will:

- Ensure that individual service users are supported in the development and/or implementation of their personal recovery plan
- Support the active involvement of people including family members, where appropriate, in their own treatment
- Encourage and support each individual to articulate the types of intervention they require to assist with their recovery
- Ensure decisions regarding recovery and treatment outcomes are led by the individual and family members/carers where appropriate
- Ensure the person living with a mental illness has the opportunity to make choices about the range of services they require at different stages of their recovery journey.

Person centred

The service will:

- Provide comprehensive assessment processes that identify the needs of each individual and that support the development of an individual's personal recovery plan
- Offer a balanced range of psychosocial supports and other activities that meet the individual's self-directed recovery plan
- Ensure the programs and activities provided are consistent with the clinical recovery plans developed by the clinical service provider
- Provide services within the context of the individual's family, friends, culture and community and encompass all health and support services
- Ensure the service increases opportunities for individuals to determine when they need additional supports, and to seek assistance as necessary through contacting the service provider

- Include in their plans how the service provider can meet the individual’s cultural and language needs.

Collaborative relationships and partnerships

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

- Agreed shared goals and values
- An understanding of the individual’s circumstances
- Develop and maintain strong and effective relationships with local general practitioners, community based public mental health services, community sector recovery support providers and other key stakeholders
- Develop and maintain strong and effective relationships to facilitate access with other primary care and community sector services, such as general practice or community health, alcohol and other drug services, housing, employment and education.

The psychosocial support provider and clinical service provider will jointly develop a Memorandum of Understanding (MOU) that establishes the working relationships of the partner organisations that ensures an awareness of processes and procedures in place to enable the ongoing relationship for the benefit of the individuals receiving the step up/step down service.

The MOU should include, but is not limited to:

- Clinical governance
- Roles and responsibilities
- Communication and information sharing
- Dispute resolution
- Safety and critical incident management
- Assessing service effectiveness.

Length of Stay

Step up/step down services are delivered focusing on short-term programs. Services are expected to ensure:

- the service maintains a maximum length of stay of 30 days (indications from similar service models suggest that stays of between seven and 14 days can be anticipated); and
- that individuals who are referred to the service have a permanent place of residence to which they can return to.

Referral & Exit Processes

Generally, referrals will be initiated by the person’s clinical treating team as part of the agreed recovery plan. However, in some instances, a person who has a recovery plan that includes the option of using the step up/step down service, can refer themselves. In this latter circumstance the person’s treating team will be informed and their support for the referral sought.

Following a meeting with the person concerned and their treating team, the step up/step down service provider will review the referral and the outcomes of the meeting, in collaboration with the clinical services provider.

The decision to accept the referral is based on a number of factors including:

- the person meeting the eligibility requirements;
- the individual’s willingness to participate;
- the capacity of the service to meet the referred person’s needs; and
- any risk factors that the service feels they would not be able to adequately manage, including the safety of the individual, staff and the community.

Where a referral is not accepted, the person concerned and the team will be informed of the reasons. The decision not to accept a particular referral does not preclude future referrals being made.

Access to step up/step down services is time limited to 30 days; however each person will develop a plan for their stay at the facility. This plan includes the areas they wish to work on and can identify an anticipated end date that may be shorter than the maximum length of stay.

For a range of reasons individuals may not be able to complete a program and are free to leave at any time. In all cases, whether as a 'planned' or 'unplanned' exit, the treating team are informed and provided with a summary of the person's stay including any response that may be required.

In some instances the mental health of a person staying at the step up/step down service changes to an extent that the service is no longer able to meet their needs and they require the more intensive environment found in an inpatient unit. This admission will be managed in collaboration with the person's treating team and the clinical services provider.

Catchment Areas

Step up/step down services will be available to eligible individuals with a mental illness who usually reside in or have strong connections within the catchment areas of the local public mental health service(s).

In some instances where step up/step down services are not available in neighbouring regions, a broader catchment will be accepted.

Building Description

Step up/step down buildings are designed and purpose built to meet the accommodation and program needs of service users and operators, and the local conditions. Currently, the buildings are being designed and constructed by contractors on behalf of the Housing Authority (HA). The HA will be undertaking this work in consultation with the MHC and, when appointed, the successful service operator. The HA will retain ownership of these facilities.

Step up/step down sites need to be located within suitable proximity to the amenities that any general member of the community could expect. This would include access to suitable public transport, shopping and recreational precincts, so that people can engage within the community and develop their skills with activities of daily living.

The residential nature of the building design means that they should sit quietly within their respective neighbourhood.

Property and Tenancy Management Services

In line with the HA's Community Housing Registration Policy, the Property and Tenancy management is undertaken by a Registered Community Housing Organisation (CHO).

The appointed service provider of step up/step down services is responsible for providing the day-to-day management of the service. Where they do not meet the policy requirements, the service provider will enter into a Memorandum of Understanding with a CHO who will be responsible for meeting the Property and Tenancy Management service specifications.

Service Procurement

The MHC is the responsible agency for establishing the step up/step down services and as such purchases the services to be provided.

To identify suitable organisations to deliver the on-site psychosocial programs and activities, and manage the day-to-day operations, the MHC undertakes an open tender process that meets the Government's Delivering Community Services in Partnership Policy. This process commences with a request for tenders being advertised on Tenders WA that invites organisations to submit offers. A panel of people who understand the program and are able to assess the suitability of the responses against the criteria, as well as a value for money criteria. Following this process, the MHC will finalise the negotiations and enter into an agreement to deliver the services.

The process used to engage the clinical service generally starts with an invitation to the Director of the Health Service to deliver the clinical service. Once accepted, a service specific agreement is developed with the local mental health service. This is undertaken in collaboration with the appointed provider of psychosocial support programs to ensure there is clarity and shared understanding of their respective responsibilities. If not accepted, an alternative clinical provider will be identified.

Service Evaluation

The service agreements with both psychosocial support and clinical service providers will stipulate the processes to be undertaken to evaluate the service. In general terms, they are required to provide both quantitative and qualitative measures based on the outputs and outcomes identified in the agreements.

More Information

The MHC welcomes feedback from anyone interested in the step up/step down services. You can provide feedback or request further information by emailing the MHC: communitystepupstepdown@mhc.wa.gov.au