

# Western Australian Youth Mental Health, Alcohol and Other Drug Homelessness Service

# Model of Service

# Draft for Consultation

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# Background

Central to current mental health, alcohol and other drug (AOD) reforms is the delivery of better service options for people with mental health and AOD issues, within their community, while also reducing the pressure on inpatient beds. This is consistent with the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025 (the Plan) and subsequent Plan Update 2018, which aim to achieve a balanced mental health and AOD system through investment in community-based support and accommodation.

The Plan and Plan Update 2018 also acknowledges the need for age appropriate services. This includes for youth[[1]](#footnote-1) with co-occurring mental health and AOD issues, who face increased risk because of their age and stage of development. With a dedicated youth stream not yet fully developed in Western Australia, requiring existing adult services to fill this gap, it is important to increase community services dedicated to youth.

Increases in community bed-based and community support services specifically in respect to youth with co‑occurring mental health and AOD issues, also aligns with the recently developed state-wide accommodation and support strategy, *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* (A Safe Place) which highlights youth as a vulnerable cohort requiring dedicated services who are able to respond to more than one presenting condition.

In Western Australia, over 3,000 children and young people under the age of 25 were counted as homeless[[2]](#footnote-2) on Census night in 2016, which equates to 21% of Western Australia’s entire homeless population. The most common reasons for young people accessing specialist homeless services were: housing crisis (21%), family or domestic violence (15%), and relationship or family breakdown (12%)[[3]](#footnote-3).

Homelessness includes rough sleeping on the streets, parks and in cars, couch surfing and reliance on temporary lodging. The Western Australian Strategy to End Homelessness – Youth Homelessness Action Plan 2019 states that the main drivers of homelessness for young people include:

* family violence;
* mental health issues (including co-occurring AOD issues);
* lack of affordable housing; and
* transitioning out of institutionalised care.

In particular, transitions are a critical stage of a young person’s life so a young person transitioning out of an institutionalised setting is especially vulnerable to homelessness if not provided with adequate support. Young people leaving the juvenile justice system, acute mental health services and child protection are at significant risk. Failure to provide appropriate support can lead to entrenched disadvantage, leading into homelessness, poor health outcomes and recidivism.

Research by Reconnect Australia, a youth program focused on community early intervention, indicates that intervening early with intensive case management and stable accommodation can result in: considerably improved outcomes for young people across a range of areas; and preventing entrenched homelessness and the over-burdening of crisis services by addressing the main drivers of disadvantage. Measured outcomes from Reconnect sites in Western Australia included improvements in individual wellbeing, sense of control and support, housing permanency, family cohesion and financial condition of the family[[4]](#footnote-4).

Having access to a safe place to live is critical to a young person’s recovery, or management of mental health and/or AOD issues. It provides the feeling of safety that comes with security of housing and tenure.

# Service Overview

The interim youth mental health and AOD homelessness service is expected to be located in the North Metropolitan region, or surrounding suburbs, and is similar to the service currently operating in the South Metropolitan region located in Fremantle.

The interim youth mental health and AOD homelessness service aims to enhance individual wellbeing, optimise independent functioning and improve quality of life for young people who are homeless and have a mental health issue, with or without a co-occurring AOD issue.

Through the provision of recovery programs in a residential setting, young people using this service will be supported to transition from homelessness or being at risk of homelessness, to suitable, stable and safe accommodation.

The interim youth mental health and AOD homelessness service will include a combination of psychosocial and clinical support within a residential style setting. The psychosocial and clinical service providers will work in collaboration for the delivery of services and programs within the service.

The psychosocial support will be provided by a community managed organisation with experience in delivering recovery-based programs to young people experiencing mental health and AOD issues. The clinical support to the service will be provided by an appointed Health Service Provider (HSP).

The youth mental health and AOD homelessness service will:

* provide care and support for young people with mental health (with or without co-occurring AOD) issues within a residential setting;
* offer cultural security;
* be trauma-informed;
* promote personal recovery;
* focus on whole of life and quality of life needs;
* provide services that will be delivered by a combination of psychosocial and clinical activities and interventions; and
* support transition to suitable, stable and safe accommodation.

The interim youth mental health and AOD homelessness service will have up to 16 beds and focuses on delivering residential, recovery programs. The service can be offered to young people aged 16-24 years, for up to 12 months.

It is important to note that the youth mental health and AOD homelessness service:

* is not an alternative for acute inpatient care where significant clinical intervention and monitoring is required;
* does not provide emergency or crisis accommodation services; and
* does not provide AOD detoxification or withdrawal services.

# Target Groups

The interim youth mental health and AOD homelessness service provides assistance to young people aged 16 to 24 years who:

* have signs and symptoms of mental health issues(s) with or without co-occurring AOD issues;
* are homeless or at risk of being homeless; and
* in respect to young people who have co-occurring AOD issues, will have undertaken a detoxification prior to accessing this service, if necessary.

# Catchment Areas

The interim youth mental health and AOD homelessness service will be available to eligible young people who usually reside in or have strong connections within the catchment areas of North Metropolitan Health Service. In some instances, a broader catchment area will be accepted given that some Health areas do not currently have a dedicated youth homelessness service.

# Service Description

The interim youth mental health and AOD homelessness service will have the following service components:

* Provide supported residential accommodation for up to 12 months.
* Have staff on site 24 hours a day, seven days a week to ensure psychosocial support services are available and to ensure safety for individuals, staff and the community.
* Access to on-site specialist mental health, AOD and psychosocial support services.
* Provide services within the context of the young person’s family, friends, culture and community which encompass all health, mental health, AOD and social support services.
* Undertake assessment processes, including:
	+ an initial assessment (clinical and psychosocial) with each young person, to establish if they can benefit from the service (including consideration of any risk factors and/or vulnerabilities);
	+ comprehensive assessment processes that identify the needs of each young person and that support the development of a young person’s individualised care plan;
	+ identification of any other formal / informal supports in place for the young person, (including National Disability Insurance Scheme (NDIS) supports), to avoid duplication; and
	+ provide regular and ongoing risk assessments and interventions.
* Provide a variety of individual and group programs and activities that:
	+ increase a young person’s capacity to develop and use strategies to meet their recovery goals;
	+ promote independent daily living and practical assistance that builds the young person’s skills, resilience and confidence (for example cooking, budgeting, maintaining tenancies, seeking employment, education and other day-to-day tasks);
	+ promote engagement and connection with family members (where appropriate/possible);
	+ provide opportunities for the young person to make choices about the range of services they require at different stages of their personal recovery (for example, these could include counselling, case management and support; mental health and AOD education; recreation and relaxation activities; alternative therapies such as music and art; and culturally secure activities that promote healing and connection to country); and
	+ assist young people in developing prevention and crisis resolution strategies that support their mental health and problematic AOD use.
* Assist the young person (and family / carers where appropriate), in their recovery care planning and its implementation in a way that meets their goals. This includes:
	+ encouraging the young person to articulate the types of intervention they require to assist with their recovery;
	+ assisting in crisis support planning where necessary;
	+ strategies to meet additional access and support needs, including cultural, diversity, language and disability needs; and
	+ ensuring decisions regarding recovery and treatment outcomes are led by the young person.
* Transition plans are developed for individuals entering and exiting the service with all relevant stakeholders, this includes planning for, facilitating, and supporting transition out of the service, specifically in regard to seeking, and preparing the young person to maintain suitable accommodation that meets their individual needs.
* Support the person to access the NDIS if not already engaged in the Scheme (where appropriate).
* Support the young person to identify and access additional services they need to maintain their physical, sexual and mental health, and ensure referral pathways enable prompt access to the service for people who experience an exacerbation of their mental illness and any co-occurring AOD issues.
* Ensure, in partnership with the provider of clinical services, that young people requiring urgent psychiatric assessment, detoxification or withdrawal are directed to the appropriate service.
* The service is accessible for, and meets the needs of, Aboriginal people, people from Culturally and Linguistically Diverse (CaLD) backgrounds, the LGBTIQ+ community, and people with co-occurring disability.
* The service is considered child safe and operates in line with child safe practices.

# Access and Referral

A young person can be referred to the service by:

* General Practitioner
* Private mental health services
* Public mental health services (mental health observation areas, inpatient and outpatient)
* Community mental health services delivered by other non-government organisations
* Alcohol and other Drug public and private services
* Department of Communities (Child Protection), for those under the age of 18
* Mental Health Co-Response teams
* Homelessness services
* Self-referral[[5]](#footnote-5)

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

* meeting the eligibility requirements[[6]](#footnote-6);
* willingness of the individual to participate;
* the mental health clinical acuity and the level of support needs of current young people at the service;
* capacity of the service to meet the referred young person’s needs; and
* the young person’s presentation and risk factors, including the safety of the young person, other residents, staff and the community.

Referrals will be reviewed by both the psychosocial service provider and the clinical service provider, with referral decisions made in partnership. Where a referral is not accepted, the person(s) concerned and referring team will be informed in writing. The decision not to accept a particular referral does not preclude future referrals being made for the individual concerned.

# Transition from the service

With the support of the Service Provider, the young person will be an active participant in planning for their transition out of the residential service. This will be undertaken as a part of the individual care plan developed in conjunction with other service providers when they commence their stay at the service. This will also include assistance in sourcing suitable accommodation and support noting that the service will not discharge a young person into homelessness. Transition will occur through a planned process in stages achievable for the young person.

At 60 days post discharge, there will be a follow up contact[[7]](#footnote-7) from the service. This will enable the service to check in with the young person and provide any assistance and advice to access or maintain appropriate accommodation and supports (where required) and live more independently within the community.

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

* The young person has met the goals as agreed with their case manager and clinician and they are ready to move on to the next phase of their personal recovery.
* The young person has a suitable, stable and safe accommodation to move to with appropriate support.
* The young person has demonstrated the skills, over time (how long is determined as part of the individual care plan), to live independently. This includes having sufficient skills to enable them to cope effectively in their family, social and other environments and existence of a support network from friends, family and the wider community.
* The young person has consistently demonstrated that they require a higher level of support than what can be offered through the service. In these cases, the young person should be transitioned to alternative supported accommodation or support/care service that can meet their higher level of need.
* Another support system/organisation/service is better suited and available to support the young person and facilitated referrals to this alternative support is provided.
* Any risk factors that the service feels they would not be able to adequately manage, including the safety of the young person, staff and the community.
* The young person is unwilling to engage adequately with the service/programs in line with their individual care plan.

People who exit this service will not be excluded from accessing the service again in the future, if required.

Whilst this service aims to address the needs of young people with co-occurring mental health and AOD issues, AOD use will not be permitted within the facility. In cases where this occurs, the service provider will assess the appropriateness for the young person to continue to access the service, and where it is decided that the young person should no longer be using the service, they will be supported to access other appropriate AOD services and provided with a referral where deemed necessary. The service provider will develop necessary operational policies regarding AOD usage of the clients whilst a resident of the service in order to ensure a fair, equitable and transparent approach is provided in supporting young people’s recovery. Upon transitioning out of the service, the young person will not be precluded from accessing the service in the future, and can re-commence the referral and admission process (this may include going on the waitlist if one exists).

For a range of reasons, a young person 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 mental health treating team are informed and provided with a summary of the young person’s stay including any response that may be required.

If the mental health and/or AOD needs of a young person changes to an extent that the service is no longer able to meet their needs, the individual will be supported to access more or less intensive support within a different environment (for example, an inpatient unit, withdrawal unit, or different accommodation).

# Staffing

The youth mental health and AOD homelessness service will be staffed by a skilled, multidisciplinary team to ensure that there is a holistic and comprehensive view of the issues experienced by young people accessing the service. This is especially important given the presence of co-occurring mental health, health, AOD, LGBTIQ+ and social-related issues experienced by those who are homeless, or at risk of homelessness. The staffing mix should include staff skilled in addressing and responding to these issues.

The youth mental health and AOD homelessness service may include a staffing mix of trained mental health and AOD support workers, clinical mental health and AOD workers, and those with skills and experience in therapeutic activities and in working with young people.

Staff must be appropriately skilled in addressing trauma and providing trauma-informed care, de‑escalation techniques, suicide prevention, and youth appropriate interventions. All staff must work from a person‑centred, culturally secure, recovery-focused, trauma-informed, strengths-based approach in order to promote the best outcomes for consumers.

# Building Description

The youth mental health and AOD homelessness service facility will need to meet the accommodation and program needs of consumers and operators, and the local conditions. For example, the facility will provide a home-like environment with a maximum of 16 beds, which include amenities such as:

* Single bedrooms with ensuites (where possible)
* Common living, dining and laundry areas
* Cooking facilities
* Outdoor areas suitable for physical exercise and outdoor activities
* Dedicated spaces/rooms for group and individual activities/therapy etc
* Where possible, the service facility should incorporate the needs of LGBTIQ+ young people in providing inclusive and safe spaces and amenities.

The youth mental health and AOD homelessness service site needs to be located within suitable proximity to the amenities that any general member of the community could expect. This would include access to 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.

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

# Providers

The youth mental health and AOD homelessness service will include a combination of psychosocial and clinical support within a residential style setting. The psychosocial and clinical service providers work in collaboration for the delivery of services and programs within the service.

The psychosocial support will be provided by a community managed organisation with experience in delivering recovery-based programs to young people experiencing mental health and AOD issues. The clinical support to the service will be provided by an appointed Health Service Provider.

## Collaborative relationships and partnerships

The community based organisation and relevant local HSP will develop and maintain an effective partnership that is founded on key principles including:

* Agreed shared goals, values and outcomes;
* An understanding of the young person’s circumstances, including culture, diversity and past trauma;
* Develop and maintain strong and effective relationships with local general practitioners, community‑based public mental health and AOD services, community sector recovery support providers and other key stakeholders; and
* Develop and maintain strong and effective relationships to facilitate access with other primary care and community sector services, such as community health, housing, financial, employment and education.

The community managed organisation and HSP will jointly develop a Memorandum of Understanding (MOU) that establishes the working relationship. This will ensure that the partners have a shared understanding of roles and responsibilities, to enable their ongoing relationship for the benefit of the young people receiving the youth mental health and AOD homelessness service.

The MOU should include, but is not limited to:

* Clinical governance
* Roles and responsibilities
* Case management
* Communication and information sharing
* Dispute resolution
* Safety and critical incident management
* Assessing service effectiveness
* Partnership with the clinical service on the assessment tools that can be used to regularly assess the mental health / AOD clinical acuity and level of support needs of the resident
* Referral process including a referral intake and exit panel
* Initial assessment (clinical and psychosocial) and comprehensive assessment processes that support development of a young person’s individualised care plan.

In partnership, the community managed organisation and clinical service provider will develop policies and procedures for the safe operation of the service. This should include the development of relevant frameworks, policies and documentation to support a young person’s participation in the service, as well as family/carer participation, and to support evaluation of the service. It is important that the service providers involve the participants in continuous improvement processes. Young people accessing the service should be supported in understanding how they can be engaged in service development and improvement (i.e. ongoing consultation with the young people).

## Service Procurement

The MHC is the responsible agency for establishing the youth mental health and AOD homelessness service services and as such purchases the services to be provided.

To identify suitable organisations to deliver the psychosocial programs and activities, and manage the day‑to‑day operations, the MHC undertakes an open tender process that meets the State Government’s Delivering Community Services in Partnership Policy.

The process used to engage the clinical service generally starts with an invitation to the Health Service Provider 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.

## Property and Tenancy Management Services

Should the property be sourced from Department of Communities (Housing), the Property and Tenancy management is undertaken by a Registered Community Housing Organisation (CHO) as per Housing’s Community Housing Registration Policy. The appointed service provider of youth mental health and AOD homelessness services is responsible for providing the day-to-day management of the service and will enter into a Memorandum of Understanding with a CHO who will be responsible for meeting the Property and Tenancy Management service specifications.

# Service Monitoring and Governance

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

The key standards for monitoring service performance include:

* Service Standards for Non-Government Providers of Community Mental Health Services 2004 Office of Mental Health, Department of Health;
* Licensing Standards for the Arrangements of Management, Staffing and Equipment Private Psychiatric Hostels 2003 Licensing Standards & Review Unit, Department of Health;
* Standards in Care Outcomes in Licensed Psychiatric Hostels for People with A Psychiatric Disability May 2003 Office of the Chief Psychiatrist, Department of Health; and
* National Mental Health Standards 2010.

## 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 quantitative measures based on the outputs and outcomes identified in the agreements. Qualitative measures can also be provided to support evaluation where appropriate and accessible.

## Community outcomes

The aim of the youth mental health and AOD homelessness service is to support young people to transition from homelessness and move to more independent living, by working with them to improve functioning and reduce difficulties that limit their independence. The service will assist young people in their recovery and to obtain suitable, safe and stable accommodation in the community.

## Service-level outcomes

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

* consumers demonstrate an improvement in skills and/or confidence required for independent daily living;
* consumers demonstrate an improvement in their mental health and confidence in their ability to reduce, cease or manage their AOD use (if appropriate); and
* consumers transition to suitable stable accommodation appropriate to their needs.

The service will also be expected to demonstrate the following outcomes:

* time spent at the service is appropriate for a long-term support service; and
* occupancy is maintained at high levels to ensure an efficient service.



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1. In line with the Plan, in respect to mental health, youth refers to people aged between 16 and 24 years and is the age cohort relevant to this Model of Service. The term ‘young people’ is also used within this document interchangeably with ‘youth’. [↑](#footnote-ref-1)
2. A person is defined as being homeless when they do not have adequate access to safe and secure housing. These people may be further classified as suffering:

Primary: Homelessness or sleeping rough: People without conventional accommodation, such as people living on the streets, in parks, squatting in vacant buildings or using cars or makeshift dwellings.

Secondary: Homelessness or stop gap accommodation: People who move frequently from one form of transitional shelter to another.

Tertiary: Homelessness or insecure tenure/marginally housed: People whose living arrangements do not provide them with security of tenure as provided by a lease, or who are living in accommodation that is unsafe or harmful to their health. [↑](#footnote-ref-2)
3. Australian Institute of Health and Welfare. (2016). Young people presenting alone. Retrieved from http://www.aihw.gov.au/homelessness/specialisthomelessness-services2014-15/presenting-alone/ [↑](#footnote-ref-3)
4. Youth Affairs Council of WA and WA Alliance to End Homelessness (2018). The Western Australian Strategy to End Homelessness: Youth Homelessness Action Plan. Retrieved from: https://apo.org.au/sites/default/files/resource-files/2019-11/apo-nid268766.pdf [↑](#footnote-ref-4)
5. Self-referral may also be initiated through engagement with families and carers. [↑](#footnote-ref-5)
6. Refer to ‘Target Groups’ section for further information regarding eligibility. [↑](#footnote-ref-6)
7. It is anticipated that follow up contact will predominantly be via phone, however face-to-face follow up may also occur where the service provider feels it is necessary. [↑](#footnote-ref-7)