The Kimberley Youth Alcohol and Other Drug Service

SERVICE MODEL

Mental Health Commission (WA)

30 November 2020

nous

Nous Group is privileged to have supported this project on behalf of the Mental Health Commission (WA)

Nous would like to acknowledge and thank the many committed, passionate and skilled professionals, young people, community members and leaders in the Kimberley. We are humbled by your resilience and determination and inspired by your future goals. Thank you to those who travelled to participate in the co-design engagements, dedicated a substantial amount of time, and offered valuable perspectives.

Disclaimer:

*Nous Group (**Nous**) has prepared this report for the benefit of the Mental Health Commission (the **Client**).*

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Contents

1 Overview

This report outlines the service model of Kimberley Youth Alcohol and Drug Service ('the Service').

The Service is the culmination of more than three years of work by the Mental Health Commission (WA) (MHC) in partnership with community leaders, community members and service providers across the Kimberley to address the profound need for a region-wide response to alcohol and other drug (AOD) and co-occurring mental health issues among Kimberley young people.

The Service was born from Kimberley-wide consultations undertaken as part of the development of the Western Australian (WA) Methamphetamine Action Plan (MAP), which aimed to identify gaps in the AOD service system in the region. The most acute and profound gap which emerged from these consultations related to the lack of dedicated AOD and co-occurring mental health services for young people in the Kimberley. This finding informed the 2019-20 Budget Process, where the WA Government allocated $9.2 million of funding over three years for the design and commissioning of an AOD and co-occurring mental health service for young people with complex needs and their families in the Kimberley

In November 2019, Nous Group (Nous) was engaged by the MHC to support the co-design of the service model for the Service.

1.1 This report sets out the parameters and requirements of the Service

This report sets out the parameters and requirements of the model for the Service, which has been developed to inform the commissioning process for the Service and to be a tool for the service provider(s) that will ultimately deliver the Service.

This report is the product of a 12-month co-design process and has been informed by:

- A **literature review** into best practice service models for young people, particularly Aboriginal young people, with AOD and/or co-occurring mental health issues.
- **Engagement** with 311 individuals, including 116 young people, 40 families and community leaders, and 155 individuals working across a range of organisations across the Kimberley.

The findings from the co-design process have been captured in a detailed **co-design summary.** It is highly recommended that this report be read in conjunction with the literature review and co-design summary. Both reports provide the evidence base for the design of the model for the Service.

1.2 The co-design process was guided by a principles-based approach and tailored service model framework

To guide the co-design of the Service, Nous' approach was guided by five core principles of co-design, and a tailored service model framework.

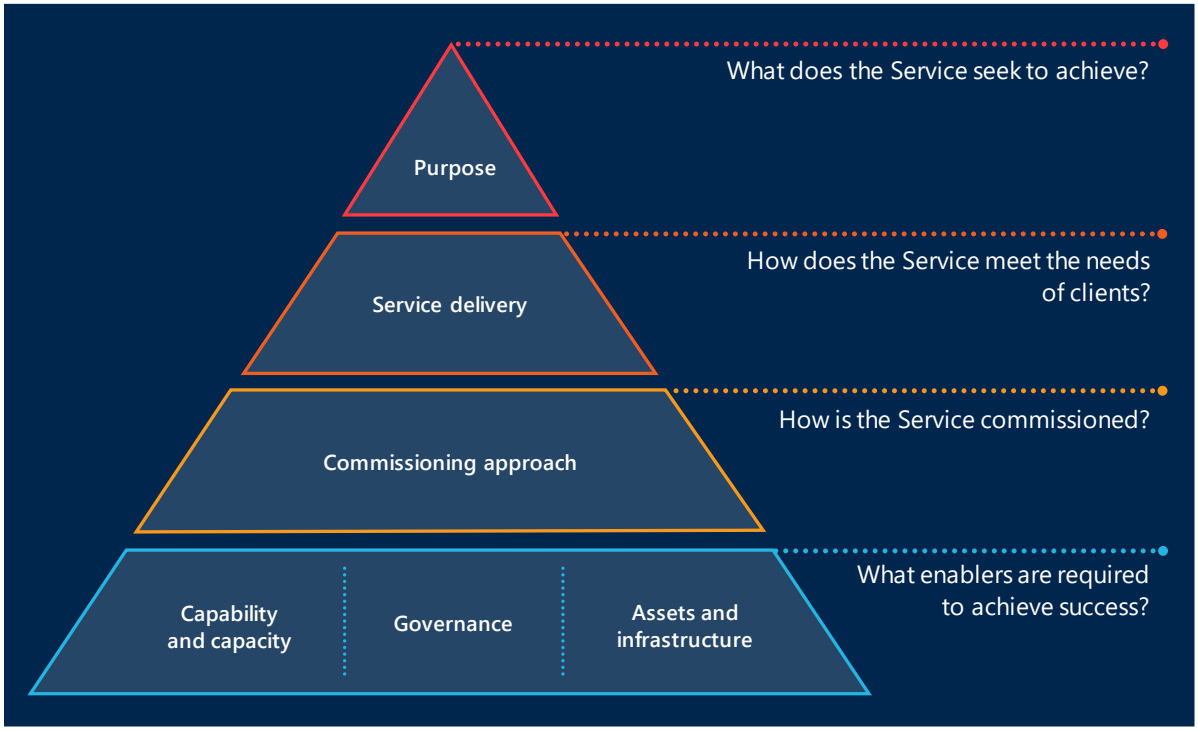
The five core principles of co-design are underpinned by the findings of previous consultations, and years of advocacy by community and regional leaders for consumers to be involved as equal partners in the design and delivery of new programs and services. It is in this context that Nous sought to partner with young people, families, and community and regional leaders to co-design the Service. The five principles of co-design are set out in Table 1.

Table 1 | Five principles of co-design

Co-design is inclusive	The process was inclusive of, and provided equal weighting to, stakeholders' diverse ideas and views on what the Service could be.
Co-design is iterative	Our process involved developing an emerging service model for the Service based on stakeholders' ideas and insights, then testing and building on it with them, to ensure that the end-product genuinely meets their needs.
Co-design is outcomes-focused	The process was specifically designed to achieve the outcome of designing a Service to address a key gap in AOD and co-occurring mental health services for young people in the Kimberley.
Co-design is participatory	Nous sought the involvement and participation of a wide range of stakeholders in the co-design of the Service, including young people, families, community and regional leaders, and service providers.
Co-design is respectful	Nous sought to be respectful of cultural protocols and governance structures in the community and work through them, wherever possible. Nous also sought to work in partnership with other agencies and providers to minimise consultation fatigue and duplication.

The co-design process has been guided by a tailored service model framework, which details all the core components of a service model – from its 'purpose' through to the assets and infrastructure required to support delivery. The framework (set out in Figure 1) provided a clear and structured approach for the co-design process. The chapters of this report align with all seven components of the framework.

Figure 1 | Service model framework



1.3 The Service will support young people aged 10-18 to address their AOD issues and strengthen their social and emotional wellbeing

The Service will aim to prevent and intervene in young people's AOD use and support them to achieve meaningful and sustained improvements in their social and emotional wellbeing. Acknowledging that AOD use is commencing earlier in the Kimberley than in other regions in WA, the target cohort for the Service will be young people aged 10-18 years of age, with discretion and flexibility to support younger children (under 10 years of age), and older young people (aged between 19 and 25 years of age), as necessary. The Service will be grounded in a whole-of-family approach, and work with a young person's family, carers and community, where possible and appropriate.

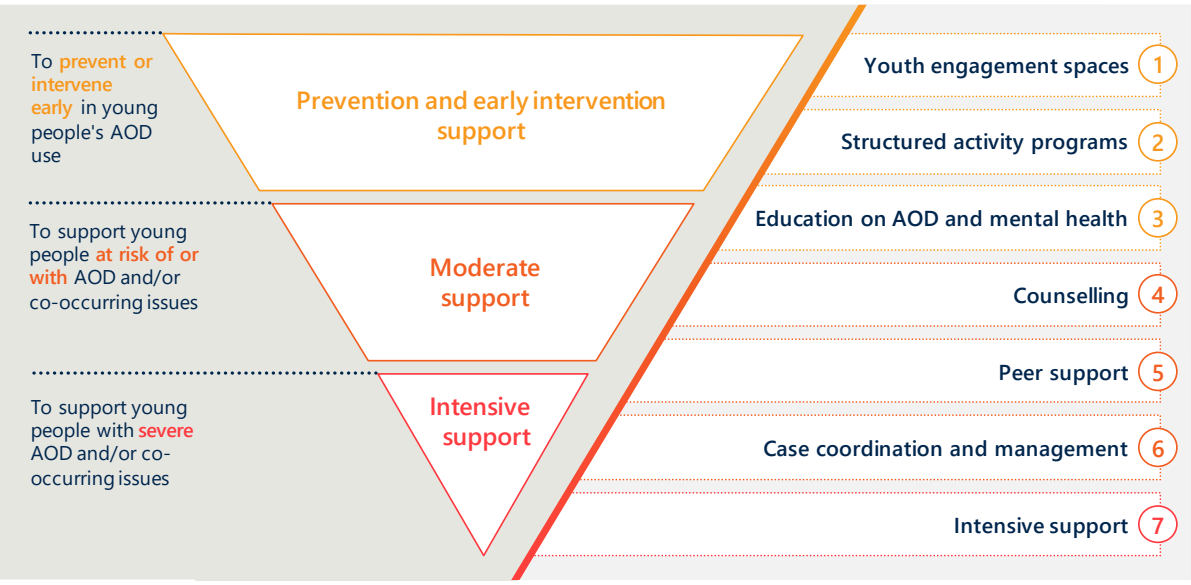
The Service has been designed to be place-based. It will be tailored in each town or community – based on the needs and aspirations of young people, families and community, and the gaps in the local service system. It aims to build on and empower – rather than duplicate – the services already being delivered in each town or community.

Though there is great need across the entire Kimberley, it is acknowledged that there are limited resources available to invest in the delivery of the Service. Therefore, it is critical that an appropriate balance is found between addressing service gaps in each town and community and making the best use of existing community assets. Thus, it is recommended that the smaller and more remote towns across the Kimberley – **Derby**, **Fitzroy Crossing**, **Halls Creek** and **Wyndham** – are the **priority locations** for the Service.

1.4 The Service comprises of seven coordinated and integrated components, delivered through a consortium approach

To realise the Service's aim of supporting young people with AOD and co-occurring mental health issues, strengthening their social and emotional wellbeing, and building the resilience of families, it will deliver seven components spanning three increasingly intensive tiers of support – from prevention and early intervention through to intensive support. These components are set out in Figure 2.

Figure 2 | Three increasingly intensive tiers of support



- ***Youth engagement spaces:*** The Service will support the provision of safe, engaging spaces for young people to drop-in, participate in activities and programs, and access support for their AOD and mental health issues.
- ***Structured activity programs:*** The Service will provide a structured program of activities to young people aged 10-18 years old that allows them to explore their interests and aspirations and build their resilience and skills for life.
- ***Education on AOD and mental health:*** The Service will deliver education on AOD and mental health to young people, families and the broader community through a combination of formal sessions and brief interventions.
- ***Counselling:*** The Service will provide counselling to young people who are at risk, or have AOD issues, who can access this support through self-referrals, and referrals from families and carers, and other service providers.
- ***Peer support:*** The Service will facilitate the provision of formal and informal peer supports to young people through structured activity programs and counselling.
- ***Case coordination and management:*** The Service will provide wraparound case coordination and management to young people and their families, that supports their journey through each service they are engaged in at the same time.
- ***Intensive support:*** The Service will provide young people with moderate to severe AOD issues, and their families (where appropriate), with options for intensive support in their home, in an alternative housing arrangement, and on County.

All components should be delivered in a coordinated and integrated manner, to provide young people and their families with seamless, wraparound support.

In recognition that the Service will need to deliver or facilitate several components in an integrated and coordinated manner, a consortium approach to commissioning and delivery is recommended. This approach will involve one organisation adopting the role of 'lead agency' and entering into formal arrangements with consortium partners in each location of the Service. **To balance efficiency, model integrity and place-based considerations, it is recommended that separate commissioning processes are progressed for the East Kimberley (Wyndham and Halls Creek) and West Kimberley (Derby and Fitzroy Crossing).**

The lead agency (or agencies) and consortium partners for the East and West Kimberley should meet three requirements: they should be **local Aboriginal community-controlled organisations (ACCOs**), they will need to have **experience in youth specific AOD and mental health service** delivery, and they must have a track record of **partnering with other services**.

1.5 The Service will be enabled by the right mix of local and capable staff and effective governance arrangements

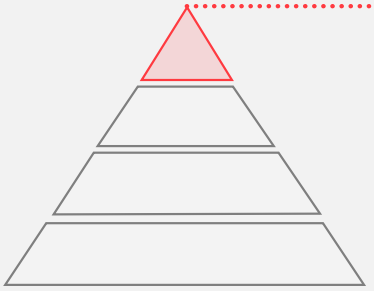
To deliver the Service in line with its purpose and underpinning principles, a wide range of staff will be required. Some of the staff required to deliver the Service will be already be in place (e.g. youth workers staffing youth engagement spaces or delivering structured activity programs). However, other staff will need to be recruited or drawn from the existing workforces of the lead agency and consortium partners. Staff roles – which may be part or full-time – to be filled include: regional coordinators, clinical leads, community leads, case managers, case support workers, AOD counsellors, community navigators and peer support workers.

To ensure the Service meets the needs of the community, employing local Aboriginal people should be a priority. Local Aboriginal people will not only understand first-hand the challenges experienced by young people in the community, but also help to build the credibility and legitimacy of the Service and create a culturally safe and secure environment for young people and their families. An additional benefit of local employment is increased sustainability, given that staff will be permanently located in the community.

The lead agency and consortium partners will be responsible for implementing governance arrangements to provide assurance and accountability to young people, the community, and the MHC, that the Service is being delivered in accordance with its purpose and reflects the needs and aspirations of the community. The governance arrangements should be tailored to the unique context of each community, and leverage existing formal and informal governance structures and processes, where possible. Formal and informal governance mechanisms that could be implemented include working through existing governance bodies, establishing community steering or advisory groups, engaging with community and cultural leaders, and seeking ongoing feedback from young people.

2 Purpose

This chapter outlines the aims and objectives of the Service.



SUMMARY

- The aim of the Service will be to address young people's AOD use to support them to enhance their social and emotional wellbeing
- The target cohort will be young people aged 10-18 years of age and their families
- The Service will adopt a place-based approach
- Five principles will underpin the delivery of the Service: youth-led, family-centred, community-informed, anchored in culture, and consistent, committed and structured

2.1 The Service will support young people to address their AOD issues and strengthen their social and emotional wellbeing

The purpose of the Service will be to prevent and intervene in young people's AOD use, and support them to achieve meaningful and sustained improvements in their social and emotional wellbeing. To do this, the Service will adopt a holistic approach to addressing young people's AOD issues, which acknowledges that there are a broad range of complex drivers underlying these issues, including intergenerational and other complex trauma, poverty, poor environmental and physical health, overcrowding and housing instability, disengagement from education, and a lack of employment and recreational opportunities.

2.2 The target cohort for the Service will be young people aged 10-18 years of age and their families

AOD use is commencing at earlier ages in the Kimberley than in other regions in WA – with children and young people as young as 10 years old, if not younger, beginning to experiment with and use AOD. For this reason, the Service will support young people aged 10 to 18 years old. However, although this is the target age group, the Service will need to be flexible, and work with children and young people on a case-by-case basis, who may be as young as seven to eight years old, and at-risk of or already engaging in AOD use.

The Service will, where possible and appropriate, work with the young person's family and carers alongside the young person. Family and carer involvement should be encouraged, as it can contribute significantly to the young person's wellbeing. For example, by working closely with the young person's family and carers, the Service can support them to develop new skill and strategies to support the young person and ensure the home environment is conducive to their recovery.

However, family and carer involvement will not be a pre-condition for a young person to be supported by the Service. There are a range of reasons why young people may not want their family or carers involved in their journey. It will be up to the young person to decide *whether* their family or carers should be involved, and if so, *which* of their family or carers should be involved.

2.3 The Service will adopt a place-based approach to delivery

The Kimberley is characterised by a vast geographical area, a dispersed, diverse and young population, and an uneven spread of services across each town and community. Additionally, it encompasses around 221 remote Aboriginal communities – each with its own cultural beliefs, norms and values, and home to several family and language groups. As such, it is recognised that a 'one-size-fits-all' approach to service

delivery will not work. The Service will be tailored in each town or community – according to the needs of young people and families, and gaps in the local service system.

In addition to being tailored to meet the specific needs and gaps in each location, the Service will build on – rather than duplicate – what is already being delivered. The focus of the Service will be on filling gaps in the local service system, facilitating coordination, and providing support to existing service providers. The commissioned service provider(s) will need to map the service landscape in each location, and determine what implications this has for how the Service should be delivered.

Additionally, to enable a genuinely place-based approach, the Service will – to the extent possible – have a permanent physical presence in each location it serves and be delivered in-person. This will be essential to building trusting relationships between young people and their families or carers and the Service.

2.4 Priority locations for the Service are smaller, more remote towns – with outreach to remote communities

It is recognised that youth specific AOD and mental health services are an urgent priority across the entire Kimberley. However, the most significant gaps in services for young people appear to be in the smaller and more remote towns, and remote communities. The Service will need to strike the right balance between addressing these gaps, and making the best use of existing community assets. **It is therefore recommended that the smaller and more remote towns across the Kimberley – Derby, Fitzroy Crossing, Halls Creek and Wyndham – are priority locations for the Service.**

While the Service would be based in Derby, Fitzroy Crossing, Halls Creek and Wyndham, it should provide outreach to surrounding remote communities. The commissioned service provider(s) will need to develop an understanding of the needs of the surrounding communities and identify whether and how the Service could meet these needs.

Based on the co-design process, Derby, Fitzroy Crossing, Halls Creek and Wyndham should be prioritised for the Service. However, if additional funding for the Service were to become available, priority should be given to counselling and intensive support in Broome and Kununurra, which are critical gaps in their local service systems.

2.5 Five key principles will underpin the delivery of the Service

There are five key principles which should underpin the delivery of the Service, as summarised in Figure 3 below.

Figure 3 | Five principles underpinning the Service

Youth-led

The Service should be led by the young person – from design through to delivery. It is key that the voice of young people is reflected in all aspects of the Service. To contribute to this, young people from across the Kimberley were engaged in the co-design process, and their insights and aspirations have informed the service model outlined in this document. Following the implementation of the Service, young people should have a clear role in the delivery of components of the Service (as peer support workers) (see Section 5.2), the design of physical spaces for the Service (for any refurbishments that may need to be made), governance of the Service (see Chapter 6), and in the design of future components of the Service. Further, young people should be empowered to direct their journey through the Service – this will include setting their own goals, determining how the Service can best help them to achieve these goals and deciding who will be involved in their journey through the Service.

Family-centred

The Service should be underpinned by a whole-of-family approach. This acknowledges the central role of family in young people's lives – in particular, Aboriginal young people, given the importance of Aboriginal family and kinship.[1] Further, this acknowledges that it will be challenging – if not impossible – for young people engaged in the Service to achieve meaningful and sustained outcomes unless the family unit and home environment are able to support their recovery once they have left the Service. The Service will work with young people's families and carers to build their capability and capacity to support the young person, where possible and appropriate. Additionally, the Service will coordinate and integrate with other services that young people and their families or carers are engaged in, to ensure they receive wraparound care.

Community-informed

The Service should enable genuine community-level participation and develop partnerships with other services in the local service system. This will be critical to ensuring that the Service is not only tailored to the specific needs and service gaps in the community, but also reflective of local culture, beliefs, norms and values. The service model outlined in this document was informed by deep engagement by service providers, community leaders and other community members during the co-design process. To ensure that the Service continues to be community-informed, community leaders and members should have a role in the delivery of the Service – as community navigators, employed by the Service to identify and build relationships with young people and their families, work with Service staff to strengthen the cultural safety and security of the Service, and contribute to the delivery of the Service, as needed (see Section 5.2). Additionally, they should play a role in the governance of the Service (see Chapter 6), and in the design of future components of the Service.

Anchored in culture

Embedding culture in the Service will be key to engaging the community and achieving positive outcomes for young people. To achieve this, the Service should integrate cultural practices such as traditional healing

[1] Encompass Family and Community, Learning From Each Other: Working with Aboriginal and Torres Strait Islander Young People, Dovetail, 2014.

– where safe and appropriate to do so – with effective clinical practice, particularly trauma-informed approaches to care. The inclusion of cultural practices will need to be driven and supported by community and cultural leaders – they should play a central role in designing the integration of cultural practices into the Service. In addition, community and cultural leaders could play a key role in the delivery of the Service, providing young people with guidance and mentorship – in particular, those who are disconnected from culture. They should also contribute to the governance of the Service (see Chapter 6). To recognise how valuable their participation would be, there should be brokerage funding to remunerate these leaders for their expertise and time.

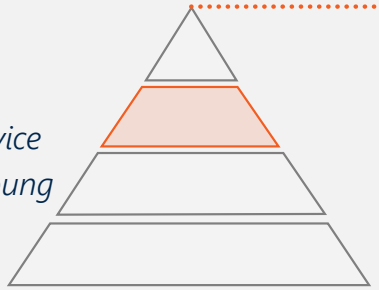
Furthermore, the Service should explore, assess and implement existing cultural competency standards and frameworks. This will help to ensure that the Service is delivered in a culturally safe and secure manner and is respectful of and responsive to local cultural beliefs, norms and values.

Consistent and structured

Building and retaining the trust of young people and their families in the Kimberley requires a consistent and structured approach to service delivery. The Service should be underpinned by the principles of consistency and structure. This means it should ensure that, to the extent possible, the same staff are available at the same place, at the same times. Staff should be flexible in their approach and be willing and able to work around the needs of young people and their families. For example, staff should meet with young people wherever they feel most comfortable and safe (e.g. at home, at school or at the park) or meet young people outside regular working hours. In addition, staff will need to demonstrate a genuine commitment to supporting young people. They will need to be persistent, acknowledging that it may require repeated attempts to engage with young people and their families. To provide structure, the Service should dedicate time and effort toward building the profile of the Service in each priority location, and toward ensuring that young people, their families and the broader community understand what types of supports are available, where and when.

3 Service delivery

This chapter outlines what the Service will deliver to meet the needs of young people.

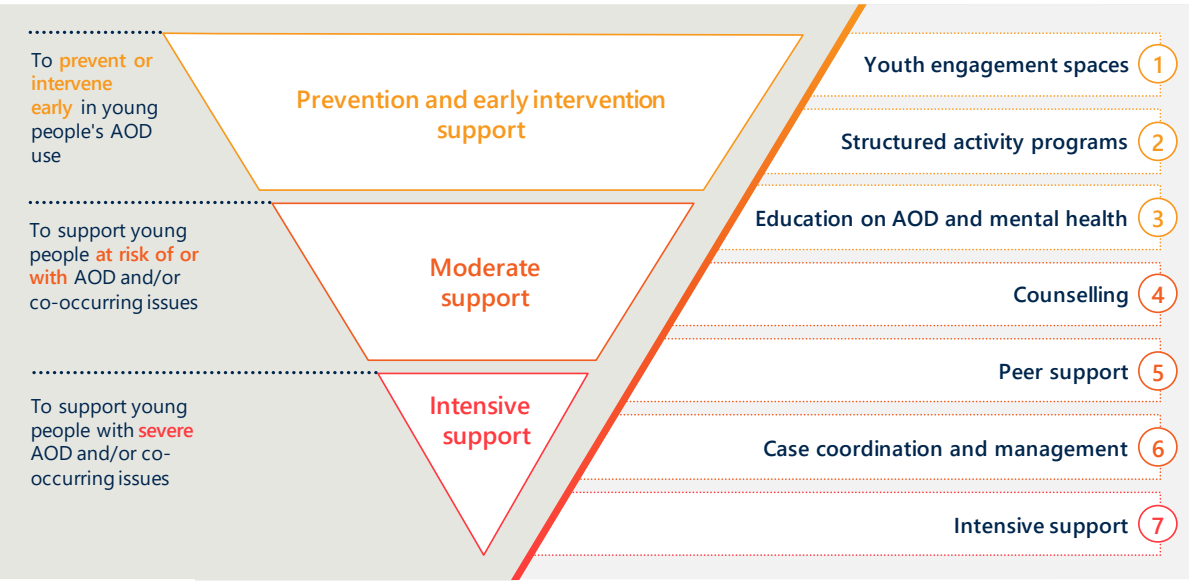


SUMMARY

- The Service will comprise of seven increasingly intensive components which address young people's AOD and co-occurring mental health issues at various stages of severity
- The seven components are youth engagement spaces, structured activity programs, education on AOD and mental health, counselling, peer support, case coordination and management, and intensive support
- The seven components will be delivered in a coordinated and integrated manner

There is great need across the entire continuum of AOD services among young people in the Kimberley – from prevention and early intervention, to intensive treatment. For this reason, the Service will comprise of seven components[2] which address young people's AOD and co-occurring mental health issues at various stages of severity. As illustrated in Figure 4 below, the seven components span three increasingly intensive tiers of support – from prevention and early intervention through to intensive support.

Figure 4 | Three increasingly intensive tiers of support[3]



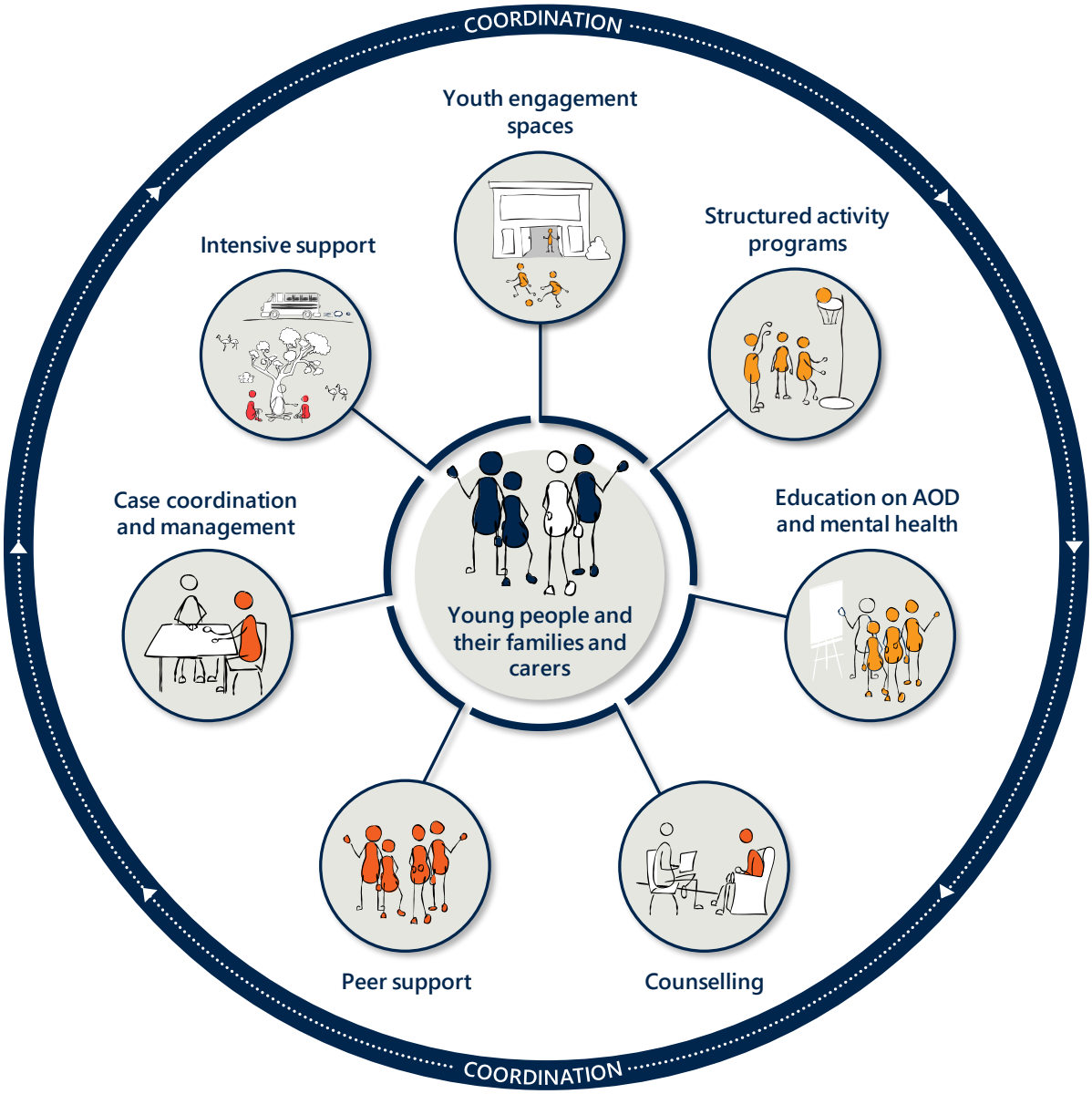
All components should be delivered in a coordinated and integrated manner, to provide young people and their families with seamless, wraparound support and ensure that they do not 'fall through the gaps' as they step up or down from one tier to the next.

The seven components of the Service are summarised in Figure 5 below and described in detail below.

[2] Some of these components may already be delivered in the priority locations. Where this is the case, only some elements of the model may be purchased in that location to complement existing services.

[3] For the Service 'severe' AOD and co-occurring mental health issues refers to where a young person's AOD use is having a severe impact on their lives, and the lives of their family. For example, a young person with severe AOD and co-occurring mental health issues may be completely disengaged from schooling and other social, health and community services.

Figure 5 | Seven components of the Service



Youth engagement spaces

Target cohort: All young people aged 10-18 years old

In each priority location, there should be a safe and engaging space available for young people aged 10-18 years old – based out of an existing youth-friendly space such as a recreation or youth centre. It should provide young people with a safe place to drop-in and spend time, and a venue for some activities to be delivered such as movie nights, and job and life skills training. Additionally, the space should be open to local and drive-in-drive-out (DIDO) service providers to drop-in and provide in-reach support to young people. For example, the Service will access the youth engagement space to engage with young people.

The space should have multiple spaces dedicated to various activities. There should be private spaces that can be used by the Service and other service providers for counselling and meetings, indoor and outdoor areas for various activities (e.g. basketball courts), and a large kitchen for meal preparation. Young people should be provided with – at a minimum – free wi-fi, air-conditioning, a television, sports gear, bean bags and couches, and dinner and snack foods. Further, there could be computer and gaming facilities, musical instruments and a foosball, pool or table tennis table. Acknowledging that equipment may be damaged or lost on occasion, there should be an allowance for repairs and replacements.

The space should be open and staffed from 2:30pm-10:00pm from Monday to Saturday. Between these hours, young people can drop-in anytime. When the venue closes, young people will be provided with transport home. Where possible and practical, consideration should be given to extending the opening hours until 12:00am on Friday and Saturday and opening on Sunday.

Existing youth-friendly spaces may require investment and refurbishment to meet the requirements set out above, which the Service could support with brokerage funding. If a re-design or refurbishment process is undertaken, local young people should be engaged to co-design any changes to the spaces to reflect the priorities of the Service.

Structured activity programs

Target cohort: All young people aged 10-18 years old

The Service will provide a structured program of activities to young people aged 10-18 years old to reduce boredom, support them to explore their interests and strengths and build their resilience and skills for life. The program will involve a wide range of activities to ensure there is something to appeal to most – if not all – young people. The activities prioritised by young people during the co-design process included, but were not limited to, on Country trips, job and life skills training, movie nights, sports, spending time with animals, horse riding and music. Activities delivered will vary in each location depending on the interests and strengths of young people. It will be critical for young people to lead decision-making around which activities are provided in each location.

The Service should deliver a blend of 'real' activities such as job and life skills training, and 'fun' activities such as movie nights, sports and spending time with animals. 'Fun' activities will be used as a vehicle for building young people's resilience and skills for life and having important conversations about AOD and mental health. To enable this, staff will be trained to deliver brief educational interventions. Further, AOD counsellors will play a role in the delivery of structured activity programs – which will provide them with opportunities to deliver brief counselling, as needed.

Activities should be delivered as part of a consistent and structured program every day from Monday to Saturday, either after school (i.e. 3:00pm onwards) or at night (i.e. 6:00pm onwards), depending on the day. However, if this is not possible, activities will be delivered as many days per week as possible – with Friday and Saturday nights as a priority.

While some activities are being delivered by existing service providers in most towns across the Kimberley, there may be investment required to meet the requirements set out above.

Education on AOD and mental health

Target cohort: All young people aged 10-18 years old, their families and carers, and targeted community members

The Service will deliver education on AOD and mental health to young people aged 10-18 years old, their families and carers, and significant community members who are well-placed to identify young people at risk of or with AOD issues. This could include young people's extended families, community and cultural leaders, police officers, religious guides, sports coaches, and teachers and other school staff. The aim will be to both improve young people's awareness of AOD and mental health, but also to build the capability and capacity of families and the community to identify the warning signs of AOD use and mental health issues and equip them with the tools to intervene early and support young people to seek help. The education may include sessions on how to deliver brief interventions to peers, how to talk with peers about mental health, AOD use, suicide, sexuality and sexual health.

Education on AOD and mental health will be provided through a combination of formal sessions and brief interventions. Formal sessions will be delivered at scheduled times in locations which young people, their families or carers and targeted community members already go, to ensure they are convenient. For young people, this may include recreation and youth centres, schools, skate parks, and other youth-friendly spaces. For families, this may include family centres, parenting support program venues, and other family-oriented spaces. Brief interventions will be delivered whenever the opportunity emerges – at anytime from anywhere. For example, staff involved in providing structured activity programs will be trained in delivering brief interventions to ensure they are equipped to capitalise on opportunities to educate young people on AOD and mental health.

The language and structure of education materials should be adapted to be culturally appropriate and sensitive, while maintaining content fidelity. Materials will need to align with local cultural beliefs, norms and values, and acknowledge complex cultural histories through, for example, the inclusion of culturally based anecdotes and metaphors. The focus of materials should be on social and emotional wellbeing – rather than 'mental health' – given the ongoing stigma associated with mental health. Adopting these materials will improve their accessibility and resonance and thereby, increase their effectiveness.

Counselling

Target cohort: Young people aged 10-18 years old at risk of or with AOD issues (and co-occurring mental health issues), and their families and carers

The Service will provide counselling to young people aged 10-18 years old who are at risk of or have AOD issues. Young people can self-refer or be referred by their families or carers, or other service providers. The aim will be to assist young people to address their AOD and co-occurring mental health issues in order to strengthen their social and emotional wellbeing. Similar to the education component of the Service, it will be critical for the focus and messaging of the counselling to centre on social and emotional wellbeing – rather than solely on AOD and mental health.

Counselling may involve brief or ongoing interventions. Brief interventions will be delivered whenever and wherever required. AOD counsellors (see Section 5.2) will visit youth engagement spaces and play a role in the delivery of structured activity programs – this will provide them with an opportunity to build trust and relationships with young people in the town or community, and to provide brief interventions, as needed. Ongoing counselling will be more structured. Young people will attend sessions on a regular basis for an

agreed period of time. While this period will typically be six months or less, the AOD counsellor will work with the young person to set goals and timeframes, which should be revisited on an ongoing basis based on the progress of the young person. Further, the AOD counsellor will work with the young person to understand where they would like their sessions to take place and will be flexible about where they will meet the young person.

In addition to being skilled in delivering brief and ongoing interventions, AOD counsellors will be trained to provide individual, group and family interventions. Individual interventions will involve a young person working one-on-one with the AOD counsellor. Conversely, group interventions will involve a small group of young people receiving counselling together. Lastly, family interventions will involve a young person's family – the AOD counsellor will work with the young person and their family to address their AOD and mental health issues. These interventions vary in terms of their purpose and the approach that the AOD counsellor will adopt. The AOD counsellor will work with the young person to identify whether individual, group or family interventions – or some combination of these – will best address their needs.

Peer support

Target cohort: Young people aged 10-18 years old at risk of or with AOD issues

The Service will encourage informal peer support through the delivery of other components of the Service such as structured activity programs and counselling. Staff will be equipped with strategies to help young people to build relationships with each other, to create safe opportunities for young people to share their experiences and learn from one another, and to identify and support natural leaders and mentors. These natural leaders and mentors may be invited to become peer support workers once they have exited the Service, to deliver formal peer support to other young people.

Additionally, the Service will provide formal peer support to young people aged 10-18 years old at risk of or with AOD issues. When a young person accesses formal peer support, they will be matched with a peer support worker (see Section 5.2). The peer support worker will be a young person aged 16 years old and over with lived experience of AOD and/or mental health issues. They will work with young people at-risk of or who have AOD issues to achieve their personal recovery goals including accessing the emotional, social and practical support they need. Peer support workers will be flexible in the level and type of support they provide. For example, one young person may need a confidant, while another may need an advocate who can help them to make and communicate decisions. Further, peer support workers will play a key role in supporting the young person to navigate the service system – assisting them to access other components of the Service, and other services in the community. Although a peer support worker will typically mentor a young person for a period of 12 months or less, they will work with the young person to set timeframes.

All peer support workers will be provided with comprehensive training and support, and opportunities to complete relevant qualifications such as a Certificate IV in Mental Health Peer Work. Training may be delivered by the community lead (see Section 5.2), and should equip peer support workers with the knowledge and skills to support young people in a culturally safe, trauma-informed manner and manage crisis situations, if they arise. Additionally, all peer support workers will be provided with ongoing supervision and training that is specific to peer work.

Case coordination and management

Target cohort: Young people aged 10-18 years old at risk of or with AOD issues, and their families and carers

The Service will provide case coordination and management to young people aged 10-18 years old at risk of or with AOD issues. Young people can self-refer or be referred by families, carers and service providers. The role of the case manager (see Section 5.2) will be broader than simply coordinating a young person's journey through the Service – they will coordinate the young person *and their family's* journey through *the broad range of services* they are engaged in at the same time. In line with the principles underpinning the Service (see Section 2.5), a youth or family-led decision-making approach will be adopted.

When a young person enters case coordination and management, they will be assigned a case manager. They will be supported to decide whether they would like their family or carers to be involved, and which of their family or carers will be involved. While family has a central role in young people's lives, there are various reasons why a young person may not want their family to be involved in their care. It is important that the young person's decision about whether to involve their family or carers is respected and followed. Once a decision has been made, the young person and their family will work with the case manager through a holistic assessment to determine the young person's AOD and co-occurring issues, their needs and engagement with other services, their interests and strengths, and their motivation for change, among others. The young person and their family will be assisted by the case manager to set goals and develop a plan for their future. This will be an iterative and ongoing process – their goals and plan may change over time.

The case manager will form relationships with the other services that the young person and their family are engaged with and act as a coordination point for them. As part of this, the case manager will organise regular meetings with all the services that the young person and their family is engaged in to coordinate a wraparound response. If appropriate, the young person and their family could be involved in the meetings. If the assessment reveals that the young person and their family need other services, the case manager will identify appropriate options and support them to access them.

The case manager will meet with the young person and their family regularly to discuss their progress and review the plan. Where required, other services that the young person and their family are engaged in can be brought into these meetings. If the young person experiences a crisis, the case manager will undertake a rapid assessment of the situation to determine the appropriate course of action, which could involve the case manager providing an intervention or referring the young person to a suitable service.

During the case management process, the case manager will support the young person and family to develop a transition plan, and a plan for what should happen in the person relapses, or becomes unwell. The focus of this plan will be on minimising risk of harm to the young person, preventing them from relapsing and supporting them to re-integrate into the community. It will consider where the young person will live, who their support network will be, how their basic needs will be met, and explore their goals, aspirations, and what they want to achieve in the future (i.e. employment, education). As part of transition planning, the case manager will refer the young person and their family to other services that will support them to follow the plan.

Intensive support

Target cohort: Young people aged 10-18 years old with severe AOD issues, and their families and carers

The Service will provide young people with severe AOD issues with intensive support in three locations: in their home, in an alternative housing arrangement with their family, and on Country. The most appropriate location will depend on the needs and circumstances of the young person. For young people whose AOD use is not attributable to their environment, and who have safe and suitable home environments which are supportive of recovery, intensive support in their home would be the most suitable option. Conversely, for young people who need a 'break' from their AOD use and environment, intensive support will need to be delivered in an alternative housing arrangement with their family, or on Country.

Given the complexity of delivering this component, referrals for intensive support will need to be managed carefully, and in close partnership with consortium partners (see Chapter 4) and other local service providers. To access this component of the Service, young people should be referred through one of two pathways. The first is through the case coordination and management process, where the case manager, young person and their family decide collectively that the young person and their family should 'step up' to access intensive support. The second is through referrals from other local service providers, which will require engagement with, and assessment by the Service.

The purpose of intensive support is to provide a safe and supportive environment for a young person and their family to recover from AOD use, and build their resilience, capability and capacity during the intensive support period. Some young people may need to undertake low-medical or hospital-based withdrawal prior to being able to access intensive support. The service provider(s) assess the young person either at the point of referral, or as part of the case management process to identify whether the young person requires low or high medical withdrawal. The Service will establish partnerships other local service provider (either through the consortium, or other formal mechanisms) to ensure the young person can access safe withdrawal prior to commencing intensive support.

Intensive support will be episodic and time-bound and span a period of up to six weeks. Following the intensive support period, the Service will support young people and their families to 'step-down' to other services, including case coordination and management, counselling, formal peer support and other local community services.

In the young person's home

This option will provide young people aged 10-18 years old with severe AOD issues and their families with intensive support in their home over a period of up to six weeks. For this option to be effective, the young person's family must be engaged, and the young person's home environment must be safe and conducive to their recovery. Young people and their families will be provided with a wide range of in-reach supports, including counselling, specialist mental health services, education on AOD and mental health, parenting coaching, and practical assistance (e.g. support with household tasks, setting and maintaining schedules), among other supports.

Intensive support will be tailored to the specific needs and circumstances of each young person and their family. To ensure this is the case, a program will be developed with the young person and their family prior to commencement. This will have the additional benefit of building commitment and ensuring that there is clarity around the goals and desired outcomes of the program.

This option will not be staffed full-time but will allow for staff and services to in-reach into the home periodically and as needed to provide support and services.

In an alternative housing arrangement with the young person's family

This option will provide young people aged 10-18 years old with severe AOD issues with intensive support in an alternative housing arrangement with their families for up to six weeks – this will enable them to get a 'break' from their AOD use and environment. It will be highly challenging for the Service to identify and access appropriate alternative housing arrangements for young people and their families. To facilitate this, formal partnerships with the Department of Communities (WA) and other service providers will be critical. This may require the MHC – as the commissioner of the Service – to broker memorandum of understandings (MOUs) with various government and non-government bodies.

To be available to the young person, this option requires that the young person's family is engaged and prepared participate in the alternative housing support arrangements. During their stay, the young person and their family will be provided with a broad range of in-reach supports, including counselling, specialist mental health services, education on AOD and mental health, parenting coaching, and practical assistance (e.g. support with household tasks, setting and maintaining schedules), among other supports. Other service providers will have the option of dropping-in to provide in-reach support to young people.

This option will not be staffed full-time but will allow for staff and services to in-reach into the home periodically and as needed to provide support and services.

On Country

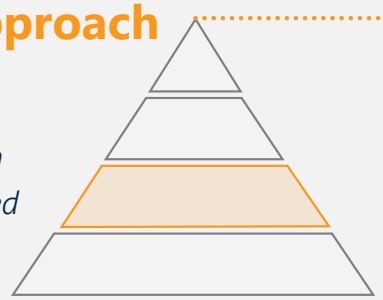
This option will provide young people with severe AOD issues with intensive support delivered on Country over a period of up to 10 days – this will enable them to get a 'break' from their AOD use and environment. There may be camps for young people only, and camps where young people will be accompanied by their family members or carers. Each camp will differ – depending on where it is located, who is going, and their specific needs and circumstances. Camps will need to be supported by a range of staff and others, including community and cultural leaders, community navigators and AOD counsellors. While the camps should be open to young people aged between 10 and 18 years old, the Service will ensure that young people attending an individual camp are of a similar age and need.

Going on Country has been found in the literature to positively contribute to people's physical, social and emotional wellbeing.[4] In addition to these inherent benefits, during the camp, young people may receive counselling, education on AOD and mental health, structured activity programs, among other supports. Additionally, service providers may have the option of dropping-in to provide in-reach support to young people.

[4] G. David, R. Wilson, J. Yantarrnga, W von Hippel, C. Shannon & J. Willis, Health Benefits of Going On-Country, Lowitja Institute, 2018, https://www.lowitja.org.au/content/Document/Lowitja-Publishing/Lowitja_Inst_Health_Benefits_OnCountry__report__WEB.pdf.

4 Commissioning approach

This chapter outlines the approach and process that should be adopted to commission the Service.



SUMMARY

- A consortium approach should be adopted to the delivery of the Service
- There are two options in relation to how this can be commissioned: with one whole-of-Kimberley consortium, or two consortiums (one in the East Kimberley and one in the West Kimberley)
- The lead agency and consortium partners will have distinct roles in the delivery of the Service
- The commissioning process should be informed by early engagement with potential lead agencies and consortium partners

4.1 A consortium approach should be adopted to the delivery of the Service

As discussed in Chapter 3, the Service comprises of a wide array of components which sit across the entire continuum of AOD services – from prevention to treatment. Given this, it is not expected that one service provider will be positioned to deliver all components of Service. Equally, it is not intended that the Service will be delivered in a fragmented, poorly integrated manner, by multiple, separately commissioned service providers.

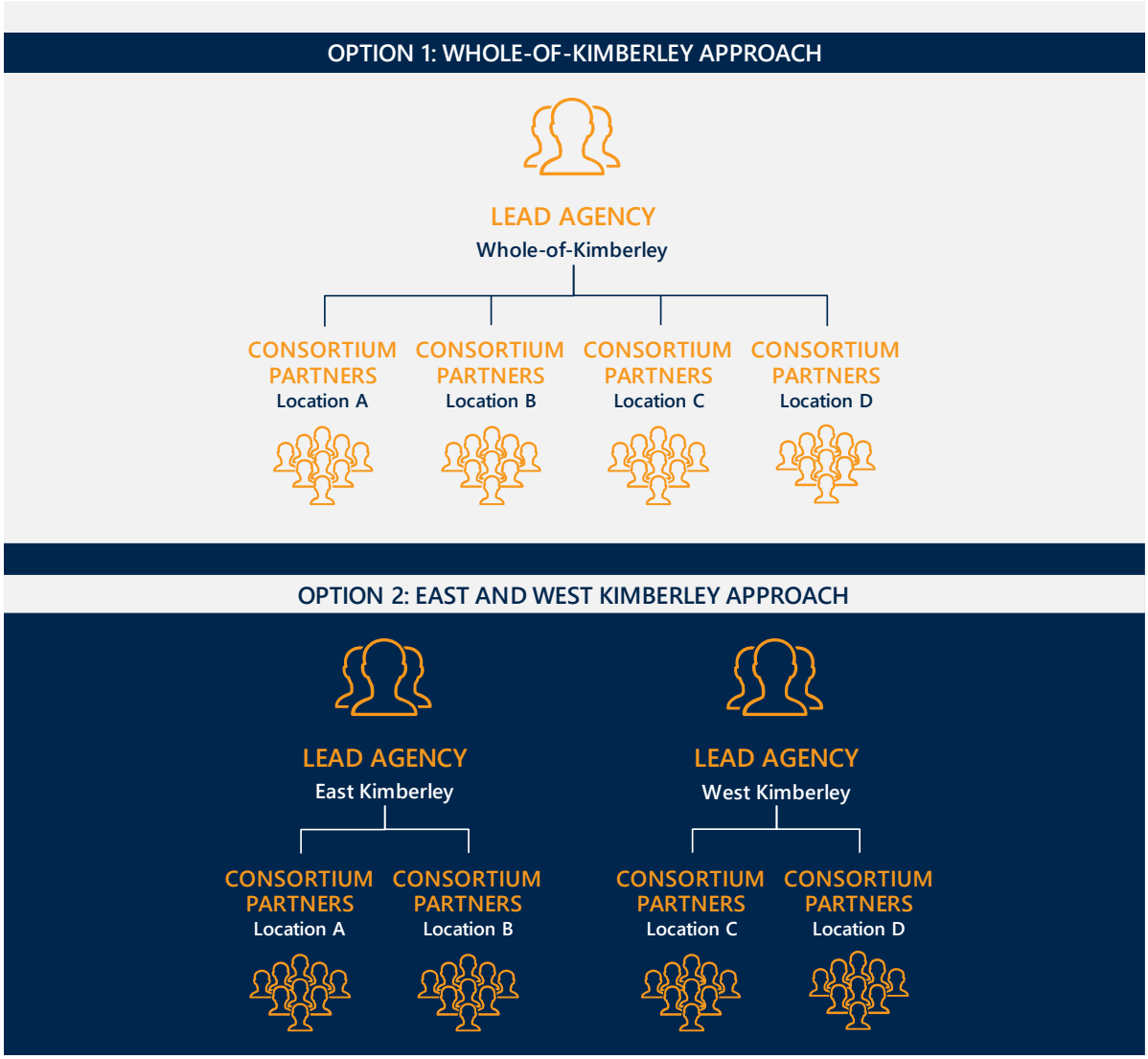
To deliver on the vision for the Service outlined in Chapters 2 and 3, a **consortium approach** will need to be adopted. A consortium approach will involve:

- One organisation will be appointed the 'lead agency' – either for the entire Service or for a specific region of the Service (see Section 4.1.1). The lead agency (or agencies) will be directly contracted by the MHC and therefore, be ultimately accountable for the delivery of the Service.
- During the pre-commissioning stage, the lead agency (or agencies) will be required to identify and enter formal or informal arrangements with consortium partners in each location that the Service is based in. These consortium partners will be responsible for the delivery of the Service in partnership with the lead agency. It is expected this process may need to be supported by the MHC (see Section 4.3).
- During the commissioning stage, the lead agency (or agencies) and consortium partners will need to propose how the Service will be delivered in each location that the Service is based in. This includes assigning each component of the Service to consortium partner, and proposing how the components will be coordinated and integrated.

4.1.1 There are two options in relation to how the consortium approach can be commissioned

A consortium approach will be essential to delivering the Service, as intended. There are two options for the MHC to consider in relation to how the consortium approach can be progressed, which are set out in Figure 6 and detailed below.

Figure 6 | Two options for the consortium approach

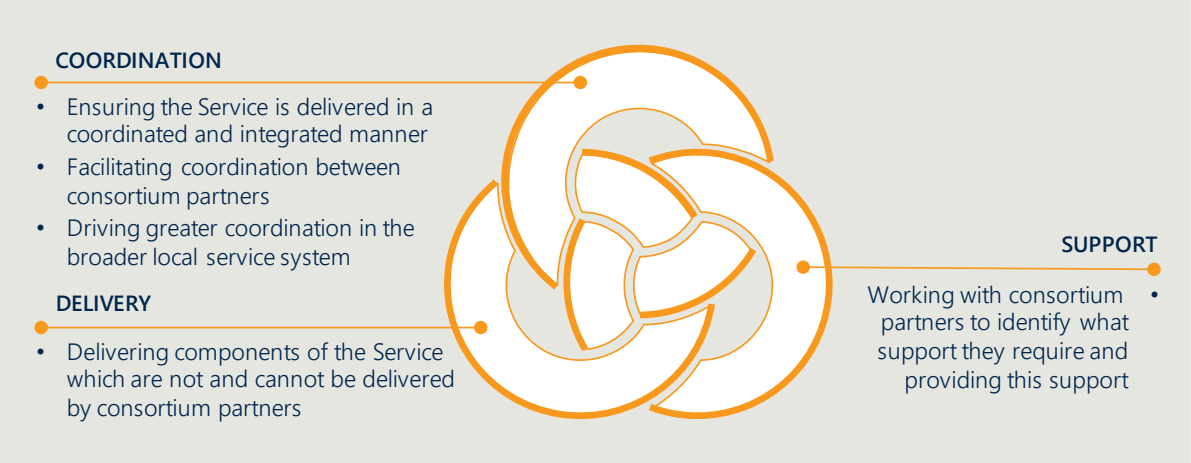


- ***Option 1: A whole-of-Kimberley approach.*** One organisation would be appointed as the lead agency for the Service across all locations in the Kimberley. The lead agency would be responsible for forming a consortium with organisations from each priority location of the Service. If Option 1 is pursued, the MHC would progress one procurement process, which would see one organisation directly contracted to deliver the Service. While this approach would likely be more efficient than separate procurement processes for each town or community, it may lessen the extent to which the Service can be adapted and shaped to meet the specific, unique needs of each location.
- ***Option 2: East and West Kimberley approach***. This would see two organisations appointed as the lead agencies for the Service – one for the East and one for the West Kimberley. Each lead agency would be responsible for forming a consortium with organisations from the priority locations of the Service in their sub-region (e.g. the West Kimberley lead agency would be responsible for forming consortiums in Broome, Derby and Fitzroy Crossing, while the East Kimberley lead agency would be responsible for forming consortiums in Halls Creek, Kununurra and Wyndham). Though this option will impose a greater administrative and contract management burden on the MHC, it has the benefit of enabling more a place-based approach to be adopted to the delivery of the Service. Based on this, **Option 2 is recommended.**

4.2 The lead agency and consortium partners will adopt distinct roles

The **lead agency (or agencies)** will adopt three roles, which are summarised in Figure 7 and described in detail below.

Figure 7 | Three roles of the lead agency (or agencies)



- ***Coordination:*** The seven components of the Service will need to be delivered in a coordinated and integrated manner, to provide young people and their families with seamless, wraparound support. The lead agency will be responsible for ensuring that the Service is delivered in this manner, and for facilitating coordination between consortium partners. This should include organising and chairing meetings, establishing and maintaining governance processes and systems, and facilitating data and information sharing. The lead agency will also hold ultimate accountability for the integrity of the Service, which will include providing oversight over delivery by consortium partners.

  Additionally, the lead agency should play a role in driving greater coordination in the broader service system in each town or community, which will involve establishing relationships with other local organisations and advocating for stronger service coordination and integration.

- ***Support:*** The lead agency will work with each consortium partner to identify how it can best support them to deliver the components of the Service. This may involve supporting them to enhance their capability or capacity by providing clinical supervision and support, delivering coaching and training, providing brokerage funding or seconding staff to fill gaps in their workforce.

- ***Delivery:*** Together, the lead agency and consortium partners will deliver the seven components of the Service outlined in Chapter 3. The lead agency and consortium partners should already deliver, or be able to demonstrate the capability to deliver, all seven components of the Service. The specific role of the lead agency will be to fill the gaps, delivering components which are not and cannot be delivered by consortium partners. Given the uneven spread of services across the Kimberley, a gap in one town or community may not be a gap in another. Consequently, the role of the lead agency – in relation to delivery – will differ from location to location.

The **consortium partners** will adopt three other roles: a delivery role, an advisory and guidance role and a data collection and recording role.

- ***Delivery:*** Consortium partners will be responsible for delivering at least one component of the Service, with support from the lead agency.

- ***Advisory and guidance:*** Consortium partners will provide advice and guidance to the lead agency, and assist with planning and any other activities needed to ensure that the Service is delivered as intended.

To gather this input from consortium partners, an advisory group – comprising of representatives from all consortium partners – could be established. This would have the additional benefits of ensuring all partners' issues and needs are acknowledged and addressed and promoting transparency. The level of representation of each consortium partner should be reflective of their contribution to the Service, and clearly defined during the commissioning process.

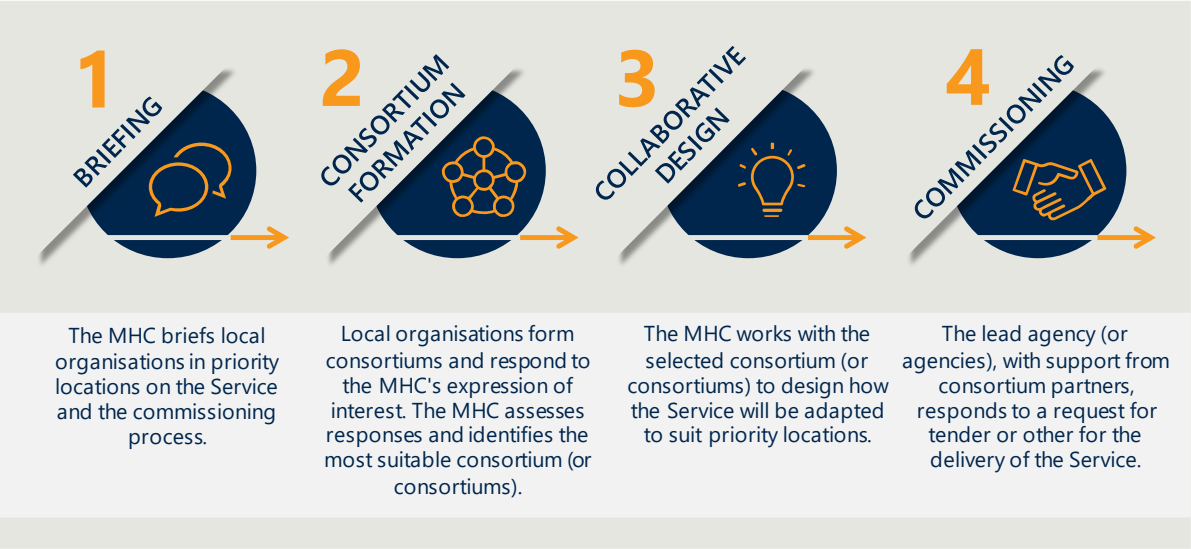
- ***Data collection and recording:*** Consortium partners will collect and record all pertinent information relating to the young people, family members and community members supported by the Service. All partners will ensure that their collection and recording practices are consistent across the consortium to ensure data and information can be easily shared across services to enable seamless referral pathways for young people and families being supported by the Service.

4.3 The commissioning process should be informed by early engagement with potential lead agencies and consortium partners

To ensure the Service is place-based and tailored to suit the unique contexts and needs of each location, the commissioning process should be preceded by early engagement between the MHC and potential lead agencies and consortium partners. The purpose of this early engagement will be to brief potential lead agencies and consortium partners on the Service and commissioning process, and once proposed consortiums have been formed, work collaboratively with them to tailor the Service to each location prior to commissioning.

The early engagement process should involve four stages, which are set out in Figure 8 and described in detail below.

Figure 8 | Four stages of the early engagement process



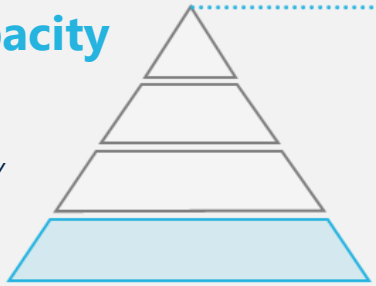
- ***Stage 1 – Briefing:*** The MHC should deliver virtual or in-person briefings to local organisations in each priority location for the Service. The purpose of these briefings will be to provide local organisations with information about the Service and the upcoming commissioning process. This should include a detailed overview of the Service, consortium model, and capabilities required of the lead agency and consortium partners.

- ***Stage 2 – Consortium formation:*** The MHC should develop and issue an expression of interest (EOI) to invite local organisations to form a consortium, through formal mechanisms, and submit a response to the MHC. The response should be submitted by the lead agency and include, at minimum, details of the consortium partners, the proposed structure of the consortium, and descriptions of the capabilities and experience of the lead agency and consortium partners. The MHC should assess EOI responses and select consortiums which best demonstrate the capability and capacity to deliver the Service.
- ***Stage 3 – Collaborative design:*** Following the selection of the consortium (or consortiums), the MHC should facilitate a rapid, collaborative process with the consortiums to design how the Service will be adapted to suit the priority locations. This may include developing the staffing structure, mapping out referral pathways, and determining the specifics of each component (e.g. the modes and frequency of intensive support). This rapid, collaborative process should enable the consortium (or consortiums) to develop a detailed tender submission to the MHC.
- ***Stage 4 – Commissioning:*** Informed by the outputs of Stage 3, the MHC should issue the consortium (or consortiums) with a request for tender or other procurement instrument to deliver the Service. The lead agency, with support from consortium members, should then develop and submit a response to the procurement document. Should the response provided be deemed unsatisfactory, the MHC may wish to seek clarification and iterate the proposal with the lead agency. However, if this process is unable to be resolved to the satisfaction of all parties, the MHC should retain the ability to go to market for alternative providers.

It is envisioned that this process will be more resource and time intensive than a traditional commissioning process. As such, adequate time and resources should be directed to the process, to ensure the success of the Service, once implemented.

5 Capability and capacity

This chapter outlines the capability and capacity required to deliver the Service.



SUMMARY

- The lead agency and consortium partners should be local ACCOs with experience in youth specific AOD and/or mental health service delivery
- A range of staff roles will need to be filled to deliver the Service: regional coordinators, clinical leads, community leads, case managers, case support workers, AOD counsellors, community navigators and peer support workers
- Local Aboriginal employment should be prioritised, where possible

5.1 The lead agency and consortium partners will need to meet three requirements

To deliver the Service as described in Section 3.1, in line with the principles set out in Section 2.4, the lead agency and consortium partners will need to meet three key requirements: they should be local ACCOs, they will need to have experience in youth specific AOD and mental health service delivery, and they will need to have a track record of partnering with other services. Each of these requirements are summarised in Figure 9 and detailed below.

Figure 9 | Three requirements of the lead agency and consortium partners

- ***They should be local ACCOs.*** Reflecting the underpinning principles of the Service (see Section 2.5), and given the likely clientele, the lead agency and consortium partners should be local ACCOs. This will ensure that the Service genuinely reflects the needs and aspirations of each priority location, is acceptable to the community, and is culturally safe and secure. In addition, the Boards of the ACCOs could play an important role in ensuring the right community and cultural governance is in place.

  If local ACCOs do not currently possess the capability and/or capacity to deliver the Service, strategies to build their capability and/or capacity should be explored. For example, other organisations could be commissioned to deliver the Service alongside local ACCOs in a joint venture. However, this approach

should be accompanied by a genuine commitment from the other organisations to strengthening the capability and/or capacity of local ACCOs with the view to fully transition the Service to local ACCOs within a specified period of time.

- ***They will need to have experience in youth specific AOD and mental health service delivery.*** Working with young people with complex issues such as AOD and mental health issues requires specific knowledge and skills, which the lead agency and consortium partners must possess. They must deliver – or have the capability and capacity – to deliver one or more components of the Service.
- ***They will need to have a track record of partnering with other services.*** For the consortium approach explained in Chapter 4 to be successful, the lead agency and consortium partners must work together effectively – they will need to share a purpose, undertake joint activities and communicate frequently and openly. Therefore, it is essential that the lead agency and consortium partners can demonstrate a track record of successfully partnering with other services.

5.2 A broad array of staff roles will need to be filled to enable the delivery of the Service

To deliver the Service as described in Chapter 3, a wide range of staff will be required. Some of the staff required to deliver the Service will be already be in place (e.g. youth workers staffing youth engagement spaces or delivering structured activity programs). However, other staff will need to be recruited or drawn from the existing workforces of the lead agency and consortium partners. Staff roles – which may be part or full-time – to be filled include:

- ***Regional coordinators:*** Responsible for coordinating the consortium, overseeing the delivery of the Service, ensuring integrity and quality control for the Service, and managing risks.
- ***Clinical leads:*** Responsible for developing and reviewing the clinical and educational elements of the Service, and providing supervision and support to case managers and AOD counsellors.
- ***Community leads:*** Responsible for coordinating, training and providing supervision and support to community navigators and peer support workers.
- ***Case managers:*** Responsible for providing case coordination and management to young people and their families, which will include providing a coordination point for *all* the services that young people and their families are engaged in.
- ***Case support workers:*** Responsible for supporting case managers to collect and record information, providing an alternative touch point for young people and their families (when case managers are unavailable), and delivering client-related administrative and logistical support.
- ***AOD counsellors:*** Responsible for providing individual, group and family counselling to young people and their families and contributing to the delivery of education on AOD and mental health.
- ***Community navigators:*** Responsible for identifying young people and their families and helping them to engage with the Service, supporting and advising case managers, AOD counsellors and other staff, and contributing to the delivery of components of the Service, as needed. These roles may be casual, part time or full time.
- ***Peer support workers:*** Responsible for identifying young people and their families and helping them to engage with the Service, providing advice, guidance and support to young people, and modelling positive behaviours and resilience. These roles may be casual, part time or full time.

These staff roles are described in greater detail in Table 2 below.

Table 2 | Staff roles to be filled to enable the delivery of the Service

Regional coordinators	
Responsibilities	**Capabilities**
• Overseeing the delivery of the Service, ensuring it is coordinated and well-integrated • Ensuring the Service complies with relevant standards and maintains a high level of quality • Developing and maintaining appropriate risk management plans • Coordinating the consortium, including organising and chairing regular meetings bringing together the lead agency and consortium partners • Identifying, monitoring and developing solutions to issues and trends in the local service system • Advocating for and enabling greater coordination in the local service system • Providing line management to the clinical lead and community lead • Representing the Service at forums, as appropriate	• Advanced experience in leading and managing staff in service delivery contexts • Experience in directing financial, human and physical resources in service delivery contexts • Experience in coordinating and managing consortium and governance arrangements • Experience in building and maintaining productive relationships with a diverse range of organisations and stakeholders, and facilitating coordination • Experience in communicating with and influencing diverse stakeholders • Experience in community development and working with Aboriginal communities and organisations • Knowledge and understanding of the challenges and issues experienced by Aboriginal young people and their families in the community • Experience in youth specific AOD and mental health settings is preferred
Clinical leads	
Responsibilities	**Capabilities**
• Developing and overseeing the implementation of clinical and educational elements of the Service to ensure fidelity and integrity • Monitoring and reviewing clinical and educational elements of the Service to promote high-quality practice and continuous improvement • Providing ongoing supervision and support to case managers and AOD counsellors • Chairing complex consultations with young people and their families, as needed • Delivering training to Service staff to equip them with contemporary, evidence-based approaches • Establishing and maintaining relationships with other services to support the delivery of clinical elements of the Service, including clinical plans, and social and emotional plans • Advising the regional coordinator on issues and trends in the local service system	• Experience in leading and managing staff in service delivery contexts • Demonstrated experience in conducting complex clinical assessments and consultations • Experience in working with young people with AOD and mental health issues and their families • Deep knowledge of child development, AOD issues, mental health issues, trauma and family functioning • Knowledge of contemporary, evidence-based clinical and non-clinical interventions for young people with AOD and mental health issues • Knowledge and understanding of the challenges and issues experienced by Aboriginal young people and their families in the community • Proficiency in providing clinical supervision to others • Experience in delivering training • A tertiary qualification in Clinical Psychology (preferred), Psychology, or Social Work.
Community leads	

Responsibilities	Capabilities
• Coordinating and providing ongoing supervision and support to community navigators and peer support workers • Delivering training to community navigators and peer support workers to equip them to work with young people and their families • Participating in the case management process, as needed • Advising the regional coordinator on issues and trends in the local service system	• Experience in leading and managing staff in service delivery contexts • Experience in working with young people with AOD and mental health issues and their families • Experience in community development and working with Aboriginal communities and organisations • Understanding of the roles of community navigators and peer support workers and the support they need to succeed • Knowledge and understanding of the challenges and issues experienced by Aboriginal young people and their families in the community • Working understanding of case management • Experience in delivering training

Case managers

Responsibilities	Capabilities
• Conducting holistic assessments of young people and their families and supporting them to undertake goal-setting and planning • Managing the referrals process for young people and their families • Keeping up-to-date files on young people and their families and updating the client management system • Establishing relationships with other services young people and their families are engaged in • Assisting young people and their families to identify and access additional services they need • Meeting with young people and their families on a regular basis to discuss their progress • Providing crisis support to young people, as needed • Supporting young people and their families to plan their transition out of the Service • Providing ongoing supervision and support to case support workers	• A Certificate IV or higher qualification in Child, Youth and Family Intervention • Experience in providing case management to young people and families, including undertaking holistic assessments • Knowledge and understanding of the challenges and issues experienced by young people and their families in the community • Deep knowledge of child development, AOD issues, mental health issues, trauma and family functioning • Experience in community development and working with Aboriginal communities and organisations • A tertiary qualification in Social or Behavioural Science would be desirable

Case support workers

Responsibilities	Capabilities
• Supporting case managers to complete client-related administrative and logistical tasks • Engaging with young people and their families and other stakeholders on behalf of case managers	• Experience in providing administrative support and customer service • Experience in working with young people and their families

• Providing practical support to young people and their families, including providing material aid or transport • Providing administrative support and responding to (or escalating) stakeholders' queries relating to the Service	• Knowledge and understanding of the challenges and issues experienced by young people and their families in the community • Understanding of the local service system • Strong communication and interpersonal skills – with the ability to build and maintain trusting relationships

AOD counsellors	
Responsibilities	**Capabilities**
• Conducting holistic assessments of and making appropriate referrals for young people and their families • Providing individual, group and family interventions to young people and their families • Delivering brief interventions to young people and their families, as needed • Maintaining accurate clinical records of young people and their families • Contributing to the delivery of education on AOD and mental health to young people, their families and the broader community • Participating in the case management process, as needed	• A Certificate IV or higher qualification in AOD, Mental Health or Counselling • Experience in providing counselling to young people and their families • Deep knowledge of child development, AOD issues, mental health issues, trauma and family functioning • Knowledge and understanding of the challenges and issues experienced by Aboriginal young people and their families in the community • Positive and non-judgmental attitude towards young people with AOD and mental health issues • Proficiency in delivering assessments and individual, group and family interventions • Experience in community development and working with Aboriginal communities and organisations • Experience in delivering education to varied cohorts

Community navigators	
Responsibilities	**Capabilities**
• Identifying and building relationships with young people and their families and supporting them to engage with the Service • Providing advice and guidance to case managers, AOD counsellors and other Service staff on cultural protocols • Supporting case managers, AOD counsellors and other Service staff to build relationships with young people and their families • Working with Service staff to enhance the cultural safety and security of the Service • Mentoring and supporting staff, to help them to be successful in their undertaking with the Service • Contributing to the delivery of components of the Service, as needed	• Local and respected community member with strong cultural knowledge and networks • Knowledge of and relationships with local Aboriginal leaders and organisations • Experience in working with young people and their families • Knowledge and understanding of the challenges and issues experienced by young people and their families in the community • Positive and non-judgmental attitude towards young people with AOD and mental health issues • Strong communication and interpersonal skills – with the ability to build and maintain trusting relationships

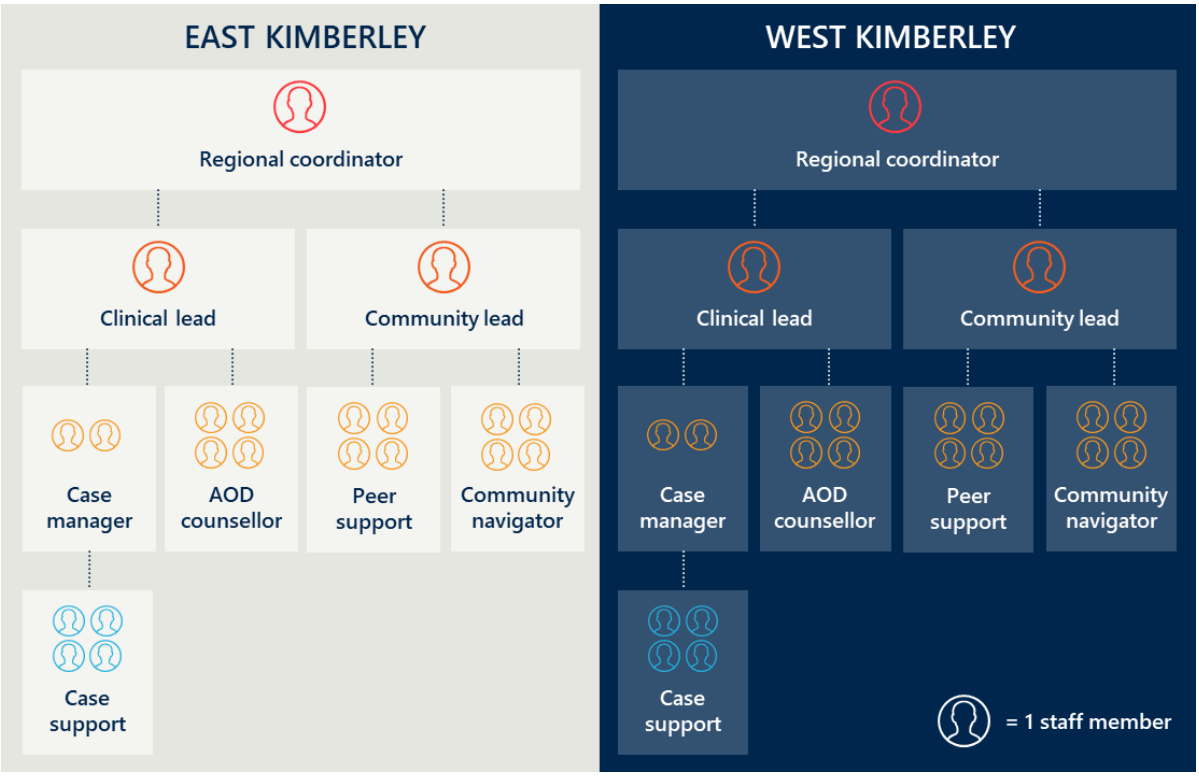
Peer support workers

Responsibilities	Capabilities
• Identifying and building relationships with young people and their families and supporting them to engage with the Service • Providing advice and guidance to young people, sharing experiences of recovery to inspire hope • Supporting young people to meet their emotional, social and practical support needs • Assisting young people to navigate the Service (and other services, if required) • Modelling positive behaviours and resilience for young people • Representing the Service at youth specific forums, as appropriate	• Local young person aged between 16 – 25 years old • Lived experience of AOD and mental health issues • Enthusiasm for sharing experiences of recovery and inspiring others towards recovery • Knowledge and understanding of the challenges and issues experienced by young people and their families in the community • Positive and non-judgmental attitude towards young people with AOD and mental health issues • Strong communication and interpersonal skills – with the ability to build and maintain trusting relationships • A Certificate IV in Mental Health Peer Work would be desirable

To ensure that the Service is place-based and meets the specific needs and service gaps in each town or community, there will need to be one regional coordinator overseeing the Service in the East Kimberley, and one regional coordinator overseeing the Service in the West Kimberley. In addition, to ensure that the Service is culturally safe, there will need to be at least one female and one male case support worker, AOD counsellor, peer support worker and community navigator based in each town or community the Service is located in.

Figure 10 sets out an example staffing structure, outlining roles, reporting lines and capacity requirements. The capacity requirements identified in the example staffing structure represent the minimum number of staff required to enable the delivery of the Service in the priority locations of Derby, Fitzroy Crossing, Halls Creek and Wyndham (see Section 2.4).

Figure 10 | Example staffing model



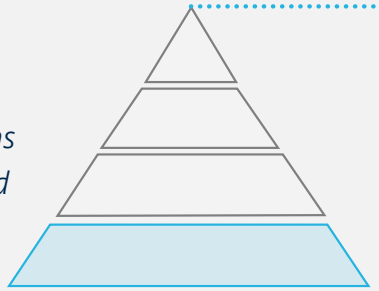
5.3 Local Aboriginal employment should be prioritised, where possible

To ensure the Service meets the needs of the community, employing local people – who understand first-hand the challenges experienced by young people in the community – should be a priority. Additionally, employing local Aboriginal people, who are respected and trusted in the community, will help to not only build the credibility and legitimacy of the Service, but also create a culturally safe and secure environment for young people and their families. An additional benefit of local employment is increased sustainability, given that staff will be permanently located in the community.

However, it is critical to recognise that non-local people can play a key role in the Service. Firstly, non-local staff may be preferred by some young people and families, due to concerns relating to confidentiality and privacy. Secondly, recruiting and retaining appropriately qualified staff – in particular, in the smaller, more remote towns and communities – can be a major challenge. It is critical that all Service staff are equipped with the right experience, knowledge and skills, so employing non-local people to address gaps could be required. However, if non-local people are employed for this purpose, upskilling and transferring capability to local people should be a key part of their role.

6 Governance

This chapter outlines considerations in relation to how the Service could be governed.



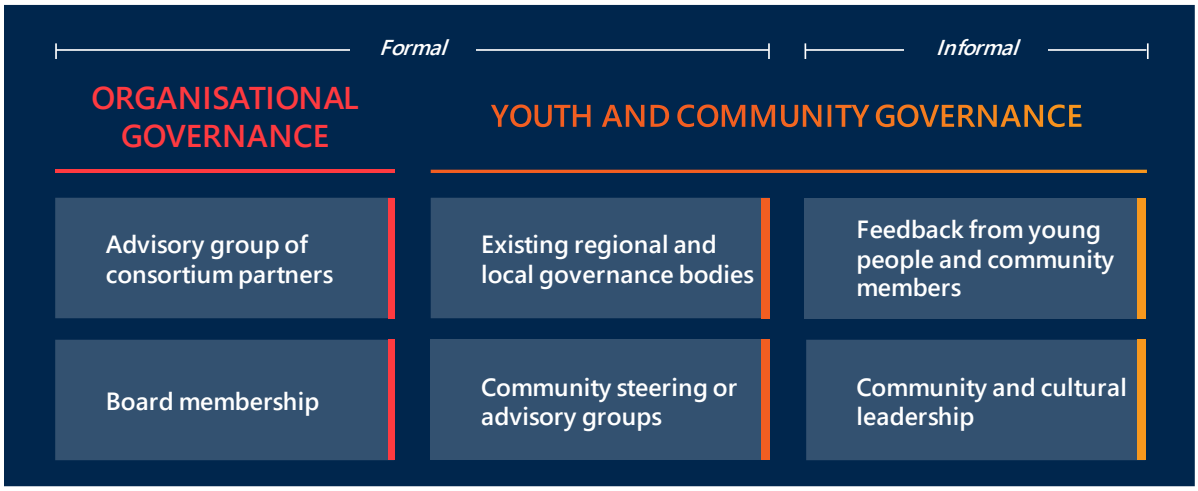
SUMMARY

- The Service will need strong clinical, organisational, youth and community governance
- There are a wide range of formal and informal youth and community governance mechanisms that the Service could adopt, including forming steering or advisory groups, leveraging existing governance bodies and conducting surveys and focus groups
- It will ultimately be the responsibility of the lead agency (or agencies) and consortium partners to propose the governance mechanisms they will use

Governance is a priority element of the service model. To deliver on the principles set out in Section 2.5 – in particular, the principles around being youth-led, community-informed and anchored in culture – the Service will need to be underpinned by strong youth and community governance. This will sit alongside strong clinical and organisational governance. Effective governance will be key to ensuring the Service is accountable to the community, and for providing assurance to the MHC that the Service is meeting the needs of young people, families and the community.

It will ultimately be the responsibility of the lead agency (or agencies) and consortium partners to propose the governance processes and structures that they will adhere to. However, it is recommended that there is consideration for both formal and informal governance mechanisms. Examples of governance processes and structures which could be considered are shown in Figure 11 and listed below.

Figure 11 | Six examples of formal and informal governance mechanisms



Formal organisational governance mechanisms

- ***Advisory group of consortium partners***. As identified in Section 4.2, the lead agency and consortium partners should form an advisory group, made up of representatives of each consortium partner. In addition to providing advice to the lead agency, the advisory group should have oversight over the delivery to ensure the Service is meeting the needs and expectations of young people, their families and the wider community. The level of representation of each consortium partner should reflect their contribution to the Service, and be clearly defined during the commissioning process.
- ***Board membership***. It is expected that most – if not all – consortium partners will be local ACCOs. Therefore, it is expected that the Boards of each organisation will provide oversight of service delivery in each town or community, and be ultimately accountable to the local community for the effectiveness and appropriateness of the service.

Formal community and youth governance mechanisms

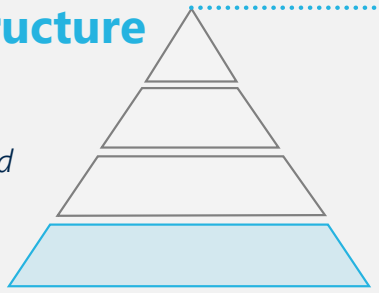
- ***Existing local and region-wide governance bodies.*** The consortium could form a formal arrangement with existing local and region-wide youth governance bodies such as the Kimberley-wide Empowered Young Leaders, and local youth advisory groups in Derby and Wyndham. The purpose of these groups would be to inform decision-making by the consortium, and play an advocacy role for young people in each town and community.
- ***Community steering or advisory groups.*** The consortium could form new steering or advisory groups at a sub-region level or in each town and community. The purpose of these groups would be to help inform decision-making by the consortium, and act as an informal mechanism to collect feedback from young people, families and the broader community. However, establishing these groups requires a significant amount of capacity and resources to support the young people to grow as leaders. These processes are long-term and require genuine investment and effort by organisations and funders.

Informal community and youth governance

- ***Feedback from young people and community members.*** The consortium could develop mechanisms to collect feedback from young people and community members on an ongoing basis. This feedback should be used to inform decision-making and service improvement. It should also be collected on a periodic basis for reporting to the MHC as part of its contract management.
- ***Community and cultural leadership.*** It is expected that the Service will be guided and informed by local community and cultural leaders in each town and community it serves. These community and cultural leaders will play a critical role in not only the delivery of the Service, but also its governance. The consortium should ensure that it provides opportunities for local community and cultural leaders to inform the design of how the Service will be adapted to suit the priority locations (see Section 4.3), and subsequently, inform service improvement on an ongoing basis. To acknowledge how valuable their participation would be, there should be brokerage funding to remunerate these leaders for their expertise and time.

7 Assets and infrastructure

This chapter outlines the assets and infrastructure required to deliver the Service.



SUMMARY

- To enable the delivery of all components of the Service, investment is required in:
  - Transport, including buses and cars
  - Recreation or youth centres
  - Alternative housing arrangements
  - Secure data recording and sharing infrastructure

Assets and infrastructure refer to the non-staff enablers (staff enablers are discussed in Section 5.2) that will be required to realise the vision for the Service set out in this report. There are four key categories of assets and infrastructure required to enable the delivery of the Service, which are described below.

- ***Buses and cars:*** Transport will be required to support the delivery of the Service. The consortium will require investment to purchase and maintain a set of buses and cars to enable transport to and from young people's homes within a town or community, appointments at other service locations, remote communities, and on Country. All vehicles should be 4WD and capable of travelling on Country and to and from remote communities safely, including during the wet season.
- ***Recreation or youth centres:*** As identified in Chapter 3, there should be a recreation or youth centre in each location that provides young people with a safe and engaging space to drop-in and spend time. It should include multiple spaces, including private spaces, indoor and outdoor areas (e.g. basketball courts). If possible and practical, it may include a large kitchen for meal preparation. Most – if not all – recreation or youth centres will need investment and refurbishment to meet the requirements set out in this report.
- ***Housing:*** As noted in Chapter 3, intensive support can be delivered to young people and their families in an alternative housing arrangement. The housing arrangement must be able to support the young person and their family for a period of up to six weeks, and meet relevant environmental health and public housing standards. It should also be based in a location that offers genuine respite from their AOD use and environment. It is acknowledged that it will be challenging for the Service to identify and access appropriate alternative housing arrangements for young people and their families. To facilitate this, formal partnerships with the Department of Communities (WA) and other service providers will be critical. This may require the MHC – as the commissioner and funder of the Service – to broker MOUs with various government and non-government bodies, and underwrite any debt, property damage or unforeseen costs which occur.
- ***Secure data recording and sharing infrastructure:*** To enable seamless coordination and integration, all consortium partners will require investment in their data storage and information sharing systems. Each consortium partner should possess a data recording and sharing system that fulfils the following requirements:
  - Capable of securely recording client information, including clinical and personal information.
  - Has mechanisms to protect the confidentiality and privacy of the young person and their family.
  - Is accessible by all consortium partners 24 hours a day, seven days a week – without comprising privacy and confidentiality.
  - Supportive of information sharing between consortium partners and other local service providers.
  - Enables the lead agency and consortium to record and report information to the MHC to enable future commissioning decisions.