Tuesdays with Nexus

Interactive online sessions

in partnership with NEMHSCA

Nexus Dual Diagnosis Consultation Service

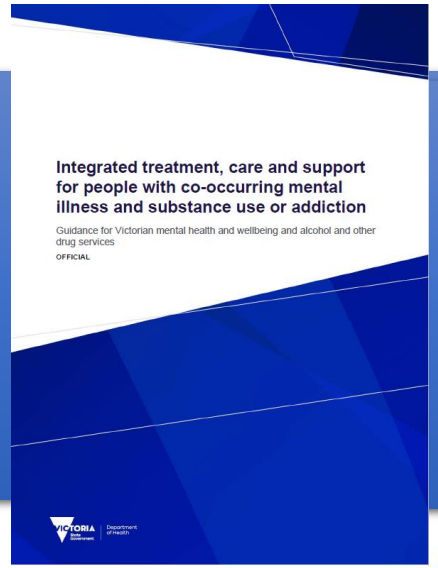
NEMHSCA NORTH EAST MENTAL HEALTH SERVICE COORDINATION ALLIANCE

Gary Croton

August 9th 2022

Dual Diagnosis Victorian Dual Diagnosis Initiative

Albury Wodonga Health



Integrated treatment, care & support for people with co-occurring MI-SU/A

Guidance for Victorian MHWB & AOD services

I am currently on the lands of the people of the Bpangerang nation - I pay my respects to their Elders past & present.

I acknowledge the Traditional Owners of the lands on which you are & I pay my respects to their Elders past & present

Lived Experience

I acknowledge the individual & collective expertise of people with experience of mental health &/or alcohol and other drug issues.

I recognise the value of their unique perspective & I celebrate their courage in sharing this knowledge & wisdom.

This handout is an interactive PDF:

Most images, in the PDF version of this presentation, hyperlink to more information on the topic


THE
BIG PICTURE

People with mental health with substance use or addiction

- PREVALENCE
- HARMS
- POTENTIAL *for better outcomes*

Since mid 1990's:

Work & investments towards

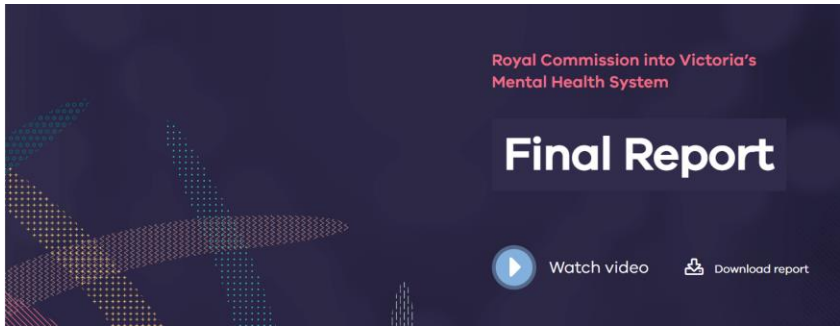
- Better outcomes
- Integrated Rx

by Victorian AOD & MH stakeholders

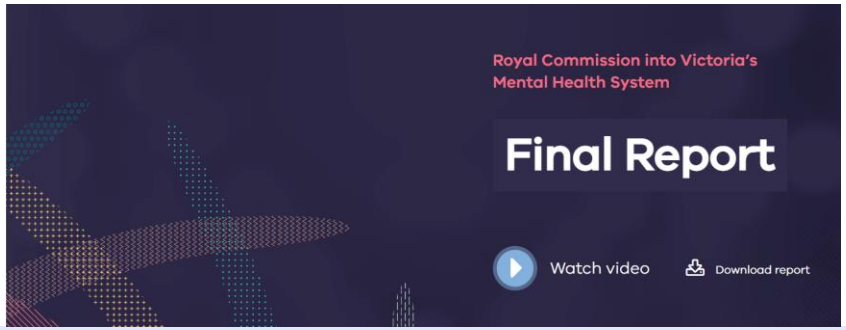
2019

Royal Commission into
Victoria's Mental Health System

2021



2021



35 Improving outcomes for people living with mental illness and substance use or addiction

The Royal Commission recommends that the Victorian Government:

1. by the end of 2022, in addition to ensuring there is at least one highest-level emergency department suitable for mental health and alcohol and other drug treatment in every region (refer to recommendations 3(3) and 8(3)(c)), ensure that all mental health and wellbeing services, across all age-based systems, including crisis services, community based services and bed-based services:

a. provide integrated treatment, care and support to people living with mental illness and substance use or addiction; and

b. do not exclude consumers living with substance use or addiction from accessing treatment, care and support.

Launched July 15th

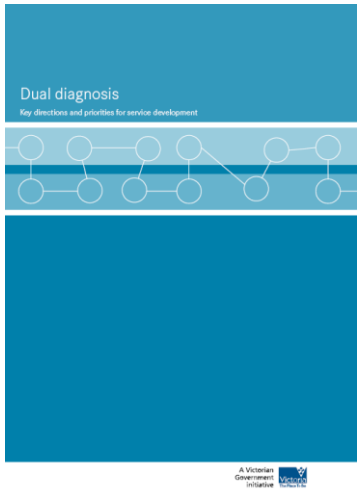
Cross sectorial remit:

- MHWB
- AOD

services

…implications for individual worker's practice ……

Development informed by & references:



- Victoria's Dual Diagnosis: Key Directions and Priorities for Service Development policy

- Minkoff & Clines Comprehensive Continuous Integrated System of Care model (CCISC)

ZIA PARTNERS

Comprehensive, Continuous, Integrated System of Care (CCISC):

An Evidence-based Approach for Transforming Behavioral Health Systems by Building a Systemic Customer-oriented Quality Management Culture and Process

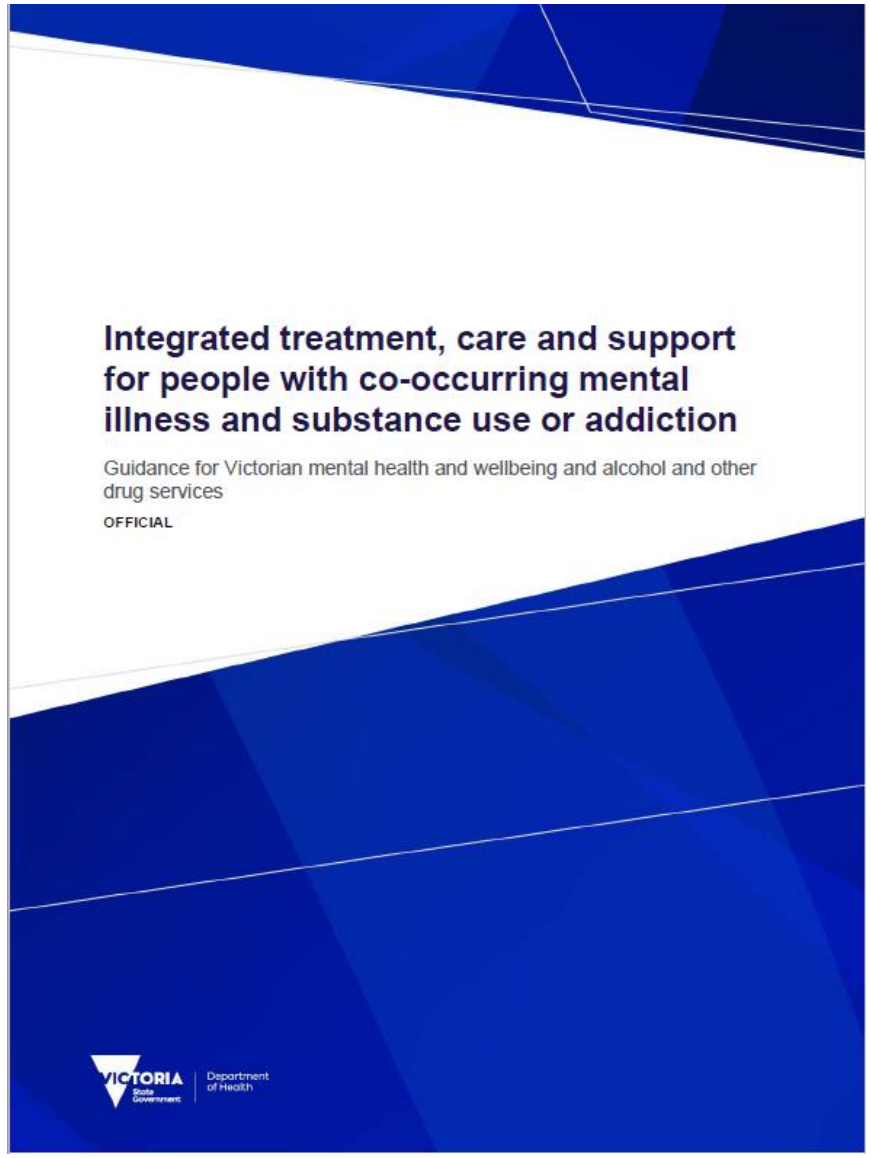
- Victorian DH **Integrated Care Pilot** of CCISC

Figure 7: Early insights from the Victorian Department of Health Integrated Care Pilot

The Victorian Department of Health-funded Integrated Care Pilot, which is being led by First Step and ten partner organisations, is testing the implementation of the Comprehensive Continuous Integrated System of Care (CCISC) model.

Participating organisations are implementing the CCISC model, building communities of practice, undertaking self-structured assessments, participating in training and implementing action plans to increase their capacity to:

https://bit.ly/3vQNwQZ

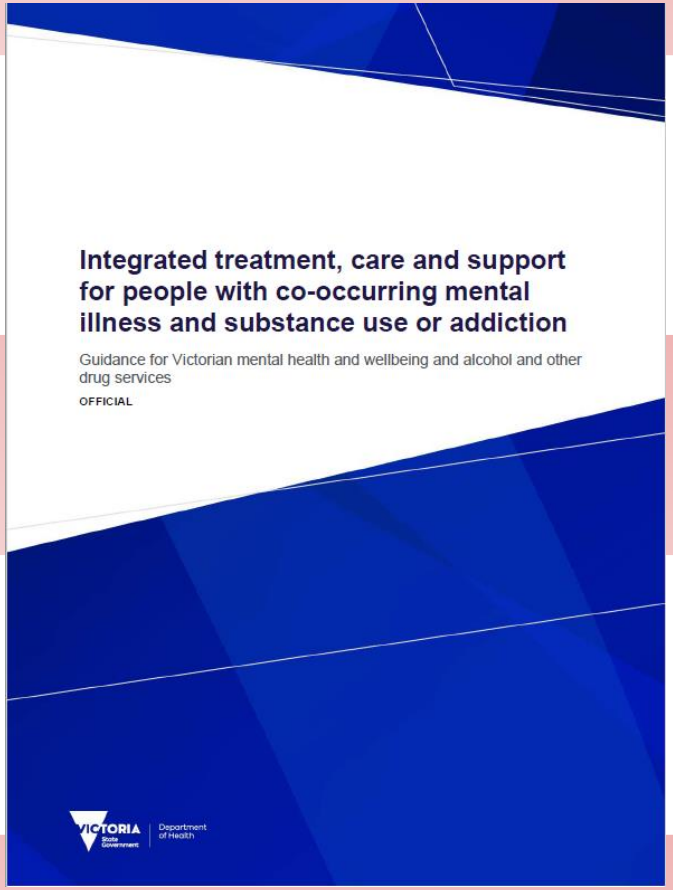


Guidance

Summary

Illustrative Stories

Towards Integrated treatment care & support



4 Principles

11 Expectations

Towards Integrated treatment care & support

4 Principles

1. Inclusion

2. Access

3. Capability

4. Participation

Shared Understandings

Expectations

Principle 1.

Principle

1. Inclusion

All mental health and wellbeing and AOD services welcome people with co-occurring needs, and their families and supporters

Shared Understandings

Rights → *Health & wellbeing* → *Respect* → *Dignity* → *Equity*

↓ trust → *Stigma & discrimination* → *↓ Worker knowledge* → *trauma* → *Involuntary Rx*

Building trust /engagement → *Compassion* → *Empathy* → *Relationally based* → *Fosters hope*

Principle

1. Inclusion

All mental health and wellbeing and AOD services welcome people with co-occurring needs, and their families and supporters

Expectations

A. Welcome people with co-occurring needs & their families & supporters

B. Offer hope, respect and non-judgement

Build hope

Build safety, connection, trust

Address stigmatising language

Principle 2.

Principle

2. Access

People with co-occurring needs, and their families and supporters, have equitable access to treatment, care and support

Shared Understandings

Prevalence → ***Expectation not exception*** → ***Core business***

Cohorts → *-ve experiences b/c access inequities* → *Aboriginal people* → *Complexity* → *High Suicide risk* → ***Need for tailored approaches***

People with co-occurring MI-SU/A likely to have other needs

Principle

2. Access

People with co-occurring needs, and their families and supporters, have equitable access to treatment, care and support

Expectations

C. Ensure there are 'no wrong doors' and viable support pathways

<u>No Wrong Door approach</u>

- **Provides treatment, care & support accessible from multiple points of entry**.
- MHWB & AOD services must **welcome all people with co-occurring needs**, & families & supporters based on philosophy of ***how can we help*?**
- *Meaningfully, actively* respond to co-occurring needs using trauma-informed practices, either through **direct service provisio**n or **supported referral processes**

Principle

2. Access

People with co-occurring needs, and their families and supporters, have equitable access to treatment, care and support

Expectations

C. Ensure there are ‘no wrong doors’ and viable support pathways

Integrated Rx no matter which point of entry

Maximise coordination, navigation, continuity of care

If service transition / referral then:

- *Proactive*
- *Seamless*
- *Minimal retelling stories*

Flexible judicious use of intake, Ax & referral to welcome people with MI-SU/A

Principle

2. Access

People with co-occurring needs, and their families and supporters, have equitable access to treatment, care and support

Expectations

D. Maximise accessibility, safety & capacity to respond to specific needs

- *People from CALD backgrounds*
- *Women*
- *Older people*
- *Younger people*
- *Gender Diverse People*
- *LGBTIQ+ Community*
- *People with Disabilities*
- *Family Violence Survivors*
- *In contact with Justice system*

Principle

2. Access

People with co-occurring needs, and their families and supporters, have equitable access to treatment, care and support

Expectations

E. Ensure Aboriginal cultural safety and self-determination

Build Cultural Safety

Partnerships with Elders & ACHOs

Self determination

Principle 3.

Principle

3. Capability

Services and workers have the skills, knowledge and attitudes to meet people's co-occurring needs and the needs of their families and supporters – enabled by individual, practice, organisation and system-level supports[4]

[4] This capability could be held by:
- a single worker,
- a team of workers in a multidisciplinary team or
- organisations from different disciplines & settings working collaboratively to deliver integrated treatment, care and support

Shared Understandings

MH & SU concerns interact → *Each concern can exacerbate the other* → *People with MI-SU @ risk of poor health & wellbeing* → ***Integrated Rx care & support can benefit***

Desirable effects/rewards / ***Possible Harm or Risk*** — ***Substance Use*** → *People have range of goals re both substance use & MH* → *Doesn't impact their right to access Rx* → ***Support should match persons priorities & preferences***

Families & supporters → *Particular stressors* → *Stigma* → *Inadequate Rx* → ***Have their own needs to continue to support***

Principle

3. Capability

Services and workers have the skills, knowledge and attitudes to meet people's co-occurring needs and the needs of their families and supporters – enabled by individual, practice, organisation and system-level supports[4]

Expectations

F. Meet both co-occurring needs

timely & coordinated

consistent with their priorities and preferences

trauma-informed practices

Principle

3. Capability

Services and workers have the skills, knowledge and attitudes to meet people's co-occurring needs and the needs of their families and supporters – enabled by individual, practice, organisation and system-level supports[4]

Expectations

G. Take a person-led approach

Understands person's own definition of their experiences

Strengths focused

Person's own goals & preferences

Principle

3. Capability

Services and workers have the skills, knowledge and attitudes to meet people's co-occurring needs and the needs of their families and supporters – enabled by individual, practice, organisation and system-level supports[4]

Expectations

H. Promote and support harm reduction

Practical opportunities to reduce risks

OD prevention

Safer consumption practices

Principle

3. Capability

Services and workers have the skills, knowledge and attitudes to meet people's co-occurring needs and the needs of their families and supporters – enabled by individual, practice, organisation and system-level supports[4]

Expectations

I. Support and involve families and supporters

Respond to needs of families & supporters

Practical strategies, information, linkages

Involve in decision making (consistent with person's preferences)

Monitor that person's preferences are still current

Principle

3. Capability

Services and workers have the skills, knowledge and attitudes to meet people's co-occurring needs and the needs of their families and supporters – enabled by individual, practice, organisation and system-level supports[4]

Expectations

J. Collaborate and learn.

local strategies to increase cross-sector collaboration, communication, learning & development

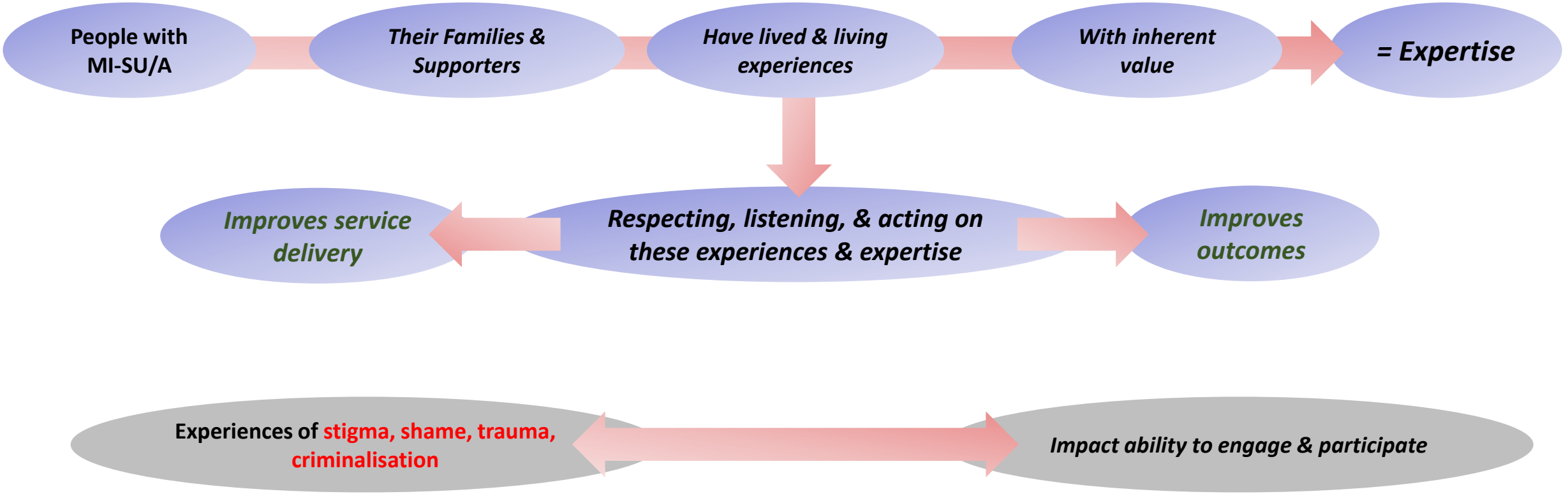
Principle 4.

Principle

4. Participation

People with co-occurring needs and their families and supporters are empowered to influence and improve the services that work to support them

Shared Understandings



Principle

4. Participation

People with co-occurring needs and their families and supporters are empowered to influence and improve the services that work to support them

Expectations

K. Create meaningful participation and leadership opportunities.

*Provide opportunities for **participation** & **leadership** in service design, development, delivery and evaluation*

*Create regular, accessible opportunities to **ask people with co-occurring needs** & their families & supporters (who may not be engaged with treatment, care & support), **what they may want from your service**.*

*Listen to their answers and take **meaningful action**.*

Partner /communicate with a diversity of peer-based lived experience org - that consist of, support and represent people with co-occurring needs

Summary of principles and expectations

Principles	Expectations
1. Inclusion 	A. Welcome people with co-occurring needs and their families and supporters B. Offer hope, respect and non-judgement
2. Access 	C. Ensure there are 'no wrong doors' and viable support pathways D. Maximise accessibility E. Ensure Aboriginal cultural safety and self-determination
3. Capability 	F. Meet both co-occurring needs G. Take a person-led approach H. Promote and support harm reduction I. Support and involve families and supporters J. Collaborate and learn
4. Participation 	K. Create meaningful participation and leadership opportunities

Definition of integrated treatment, care & support

Integrated treatment, care and support	Treatment, care and support should be led by an individual's priorities, goals and preferences, empowering people with co-occurring needs, and their families and supporters, to achieve the outcomes that are important to them. Treatment, care and support is **integrated** if it: • offers a **welcoming**, **hopeful, timely** and **coordinated** response to a person's co-occurring mental illness and substance use or addiction, prioritising **simplicity and continuity**[3] for the person and their family and supporters • provides **choice** and **control** for the person, offering **simultaneous responses** to both co-occurring needs as well as **support for people who may not, at a given time, wish to engage with some or all available aspects of treatment, care and support.**

The how of system change

Workplan: Integrated treatment, care and support

This document has been prepared as a companion to the *Integrated treatment, care and support for people with co-occurring mental illness and substance use or addiction: Guidance for Victorian mental health and wellbeing and alcohol and other drug (AOD) services* (the Guidance). It is intended to support stakeholder understanding of how various mental health and wellbeing system reforms intersect with, promote and contribute to the integrated treatment, care and support agenda.

The reforms are organised under the five 'enabler' categories that reflect advice from stakeholders during consultation on the Guidance as to the kind of implementation effort most needed to fully realise recommendation 35 from the Royal Commission. The reforms presented here do not represent the full mental health and wellbeing reform program or its structure.

The Workplan represents a point in time and will continue to evolve in line with the design and implementation of related reforms. The Department of Health will monitor its implementation to ensure integrated treatment, care and support is embedded across relevant reforms.

Questions regarding specific recommendations and their progress general reform questions from stakeholders can be directed to mentalhealth@health.vic.gov.au.

1. Collaboration and governance

Cross-sector relationships, collaborative spaces and new structures to support implementation and oversight of integrated treatment, care and support

Recommendation	Implementing integrated treatment, care and support	Intersections with integrated treatment, care and support	Indicative timeline	Lead Director
Recommendation 1 (interim report): Establish the Victorian Collaborative Centre for Mental Health and Wellbeing (the Collaborative Centre).	The Collaborative Centre will: • provide, promote and coordinate high quality services to people with mental illness, including people with co-occurring substance use or addiction • deliver interdisciplinary, translational research into new treatments and models of care, inclusive of integrated treatment, care and support • support the workforce through education and professional development, including building their integrated care capability • work closely with the new statewide service for people living with mental illness and substance use or addiction (recommendation 36) to drive integrated practice.	• Establish via Governor in Council appointment the Board of the Collaborative Centre, including representation of people with lived experience of mental illness or psychological distress, families and supporters.	Mid 2022	Director, System Architecture and Planning
		• Establishment of the Collaborative Centre, with joint leadership from a clinical academic and person with lived experience of mental illness or psychological distress. • Establishment of advisory and guidance structures for the Collaborative Centre and its Board that include experience of co-occurring mental illness and substance use or addiction and their families, carers and supporters.	Late 2022 Early 2023	
		• Consensus between the Collaborative Centre and the new statewide service for people living with mental illness and substance use or addiction (see recommendation 36) on respective roles and responsibilities particularly in relation to research and workforce development functions. The Collaborative Centre will support the new Statewide Service to drive integrated care and deliver better outcomes for people with co-occurring needs.	Late 2023	

The how of system change

Service providers

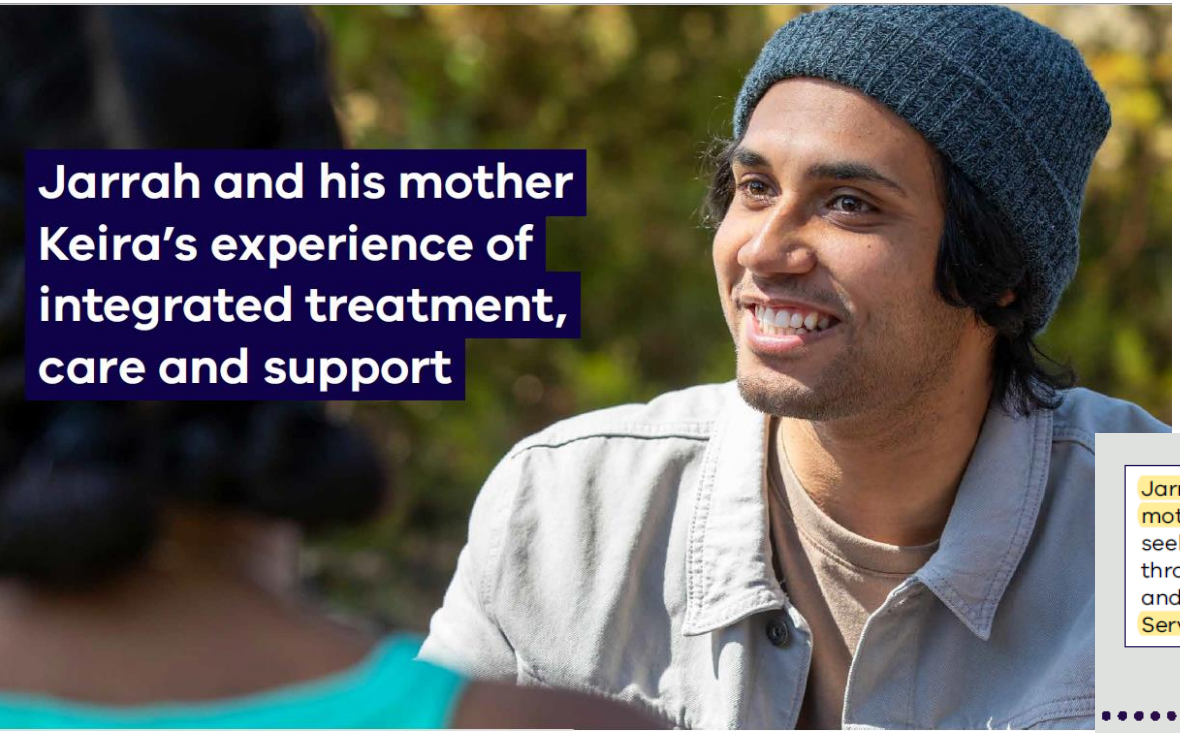
- implement principles & expectations when supporting people with MI-SU/A & families & supporters

Services:

- identify **leaders** to drive change
- build **collective ownership** & **responsibility** for integrated practice,
- incorporate principles & expectations into **policies, plans, models of care & processes**
- develop **staged implementation plans** for programs and services to become more integrated care capable

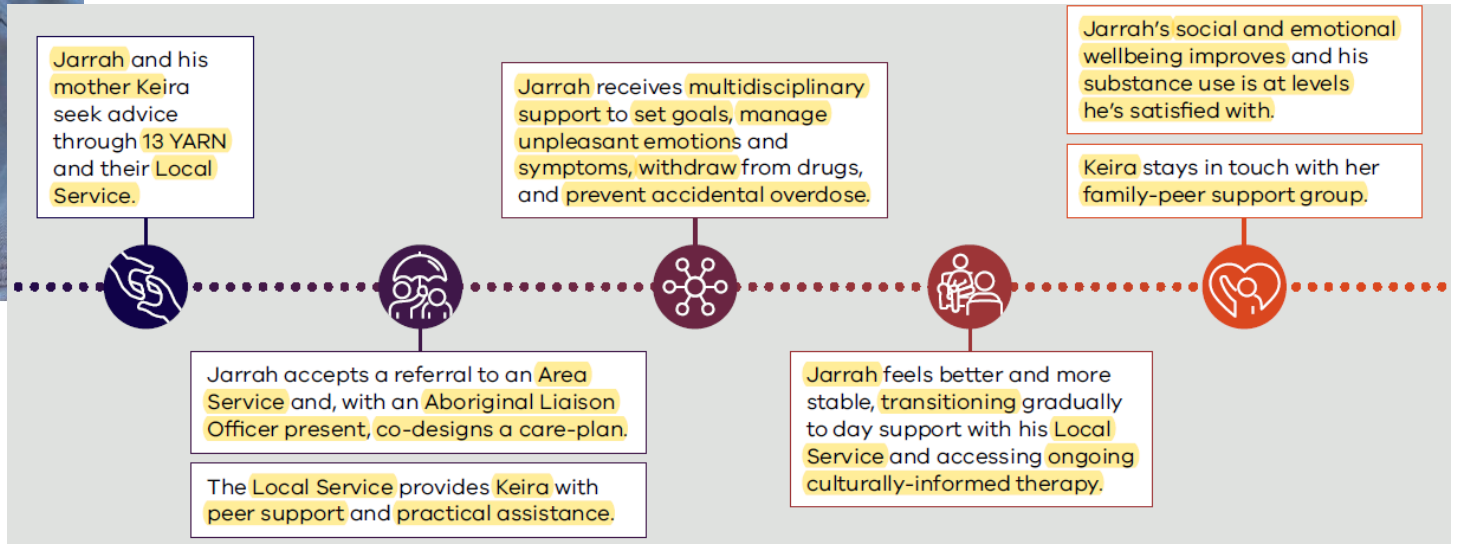
Illustrative Stories

Illustrative Stories



Jarrah is a 29-year-old Aboriginal man. Since he was a teenager, he has used illicit drugs in social contexts, usually a few days a month. In the past Jarrah has experienced frequent and prolonged periods of emotional distress, but he is not currently in touch with any services.

Recently Jarrah has been having thoughts that disturb him, including thoughts about harming himself. He's also started to see things that aren't there. This is causing him significant emotional distress and is interfering with his day-to-day life. Jarrah has also increased his use of illicit drugs from occasionally to daily. Using drugs provides Jarrah with some relief, but his daily use is also affecting his sleep and finances, and he feels ashamed that his drug use has increased so much.



Illustrative Stories

Ahmed is 16 years old. He and his family arrived in Australia ten years ago as refugees. Ahmed is fluent in English; however, his parent's Yasmin and Amir prefer to speak Arabic.

As a young child, the experience of fleeing his home country had a profound impact on Ahmed's mental health and wellbeing. To help him process the trauma associated with his migration experience, Ahmed has been engaged with his local headspace for almost three years.[2] Through headspace he has participated in a range of individual and group trauma-informed counselling sessions, including sessions that involve his parents Yasmin and Amir. Ahmed has occasionally used drugs in the past. While his local headspace has offered to connect him with an AOD worker, he has been reluctant to take up this referral, as substance use is common in his peer group, and he does not want to jeopardise his connection with his friends.

Over the last few months, Ahmed has started to experience increased and prolonged periods of significant distress. This has been accompanied by hearing voices – a new experience for Ahmed which he has found distressing. Ahmed has also increased his substance use and is now using drugs most days, and more often on his own. Ahmed does not feel well enough to go to school despite efforts from the school to engage Ahmed and his family. His parents, Yasmin and Amir, are concerned that he is becoming increasingly withdrawn and isolated.

Illustrative Stories

Ahmed speaks to his existing headspace counsellor about getting support for his increased distress and substance use.

Ahmed accepts a supported referral to a YPARC residential service. He and his parents receive cultural and linguistic support, and his support workers coordinate to minimise Ahmed's need to retell his story.

Yasmin and Amir are connected with family-peer support and get regular updates on Ahmed's progress.

Ahmed accesses trauma-informed and family therapy, medical support, and support to help him transition back to his home, school and social life.

Ahmed's distress eases and he leaves the YPARC. He continues to receive support to manage early symptoms of psychosis, and makes new social connections with young people from refugee backgrounds.

Yasmin and Amir stay in touch with their family peer support worker and build skills to help with Ahmed's transition home and ongoing support needs.

Illustrative Stories

April is a 54 year old woman experiencing mental health challenges related to ongoing alcohol use. In times of distress April has suicidal thoughts. Living in regional Victoria means that April has limited services available in her local area and often must travel to access support. Recently, she has been drinking more heavily and feeling like her life isn't worth living.

Through the HOPE program, April learns new ways to respond to mood changes and stressful situations. Together with her brother Gary, she co-designs a safety plan.

Through trauma-informed counselling and family peer support, Gary processes his own feelings of emotional distress.

April is supported by an AOD counsellor and peer support group to work towards her goals of reducing her alcohol use.

April's use of alcohol reduces. She continues to draw on skills from the HOPE program to manage suicidal thoughts. April and Gary's peer support groups continue to be a source of ongoing support.

Illustrative Stories

Alex is 46 years old and identifies as non-binary. They drink socially and use drugs occasionally. Two years ago, Alex had an accident at work and was prescribed medication to help manage the pain. While Alex's physical pain has improved, they still have traumatic memories of the accident and have continued to take their prescribed medication at increasingly higher-than-recommended doses. This is having a negative impact on Alex's daily functioning – they don't feel confident about re-entering the workforce and are finding it hard to engage in the social activities they used to enjoy.

Alex and their friend Kirsty's experience of integrated treatment, care and support

With support from their friend Kirsty, Alex seeks support via their GP about their use of pain medication and experiences of anxiety and trauma.

Alex accepts a referral to an AOD withdrawal service that respects their non-binary identity. Together with Kirsty, they co-design a plan with the aim of facilitating withdrawal and reengaging in social activities.

Alex starts therapeutic day rehabilitation at an AOD service, but soon after withdrawing, starts to experience acute anxiety.

Alex and the AOD service develop a plan to help Alex manage their anxiety. The AOD service is also supported by the Local Service to co-design an after-hours safety plan and collaborate on best practice.

Alex starts to rebuild their confidence and feels well enough to engage in everyday activities and work towards their goals. They continue to be supported by their GP and a psychologist accredited in supporting non-binary people.

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