TUNA BLUE

Government of Western Australia
Mental Health Commission

AOD CRISIS INTERVENTION

Community Workshop (22nd April 2020)

Output Summary Report

CONTEXT

The aim of this Community Workshop was to facilitate engagement with community members to inform development of an AOD Crisis Intervention System Service Model. In particular, it sought to explore what the ideal future of crisis intervention looks like, as well as specific challenges and opportunities relating to service delivery.

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OVERVIEW OF ACTIVITIES

Participants considered the following questions during facilitated and self-managed group discussions:

- What does 'safe' look like for AOD Crisis Intervention?
- What are the current challenges and gaps in AOD Crisis Intervention services in WA?
- What additional services/changes to existing services are required to optimise the future system?
- Should a compulsory AOD element be introduced?
- If a compulsory AOD element is introduced, do you think it should be just detox, just treatment, or both?

SUMMARY OF KEY POINTS

The following themes emerged from responses to the questions specified above. A full account of the responses and any associated comments can be found at APPENDIX A.

What does SAFE look like for AOD Crisis Intervention?

- Physical environment – appropriate physical location with good environmental design (preferably non-clinical, although recognising need for specialist medical care too);
- Person-centred approach – complex and differing emotional and physical needs are met with a range of collaborative services;
- Breadth of skills and experience among staff, including peer support programs and continued training for front-line workers;
- Culturally and demographically appropriate services – including understanding that rural and remote service have unique needs and being able to provide for them;
- Supporting family and carers in a crisis, including follow-on support;
- Easy access to appropriate care when, where and how needed;
- Clear pathways and structure for initial and ongoing care.

What are the current challenges and gaps in AOD crisis intervention service delivery?

- Resourcing of AOD services – funding, quantity of staff, skills and experience; access to specially trained AOD personnel;
- Lack of clarity around pathways for people suffering AOD crisis – and their families – through the whole system;
- Co-occurring mental health and AOD needs – how to coordinate an "open door" approach to caring for the needs of individuals;
- Lack of beds, long waiting lists, and provision of 24/7 services;
- People struggle to communicate in a crisis;
- Need for improved collaboration and communication between services;
- Balancing need for police / security presence in some situations with risk of escalating situations when people are fearful and possibly paranoid / psychotic;
- Provision of basic food, shelter and support needs that are accessible on a walk-in basis;
- Catering for cultural, geographic, linguistic and other demographic needs of a range of people across WA;
- Attitudes, stigma and discrimination.

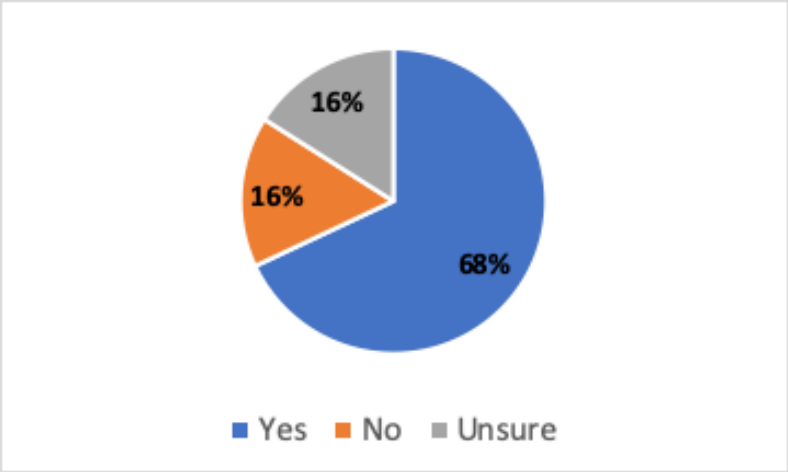
What additional services/changes to existing services are required to optimise the future system?

- Specialised units in ED to deal with AOD issues;
- Immediate access (drop-in / walk-in centres) centres in a non-clinical environment that can support basic human needs as well as begin to address AOD issues (e.g. detox) – short-term, 24-hour supported, residential care that Police and ED can discharge people to.
- Appropriately trained staff – e.g. trauma informed; clinical addiction specialists; peer workers; able to provide an appropriate range of responses;
- Culturally and regionally appropriate facilities and support – one size does not fit all and different people and places have different needs;
- Single point of contact / facilitator between all service providers for anything AOD related;
- Checklist to develop clear pathways for ongoing care;
- Recovery College – collaborative sharing of information regarding AOD and education
- Clear communication channels and messages – community education and involvement;
- Reduced barriers to service entry – inter-sector relationships and collaboration – working together to reduce service gaps for a more streamlined experience;
- Step-up step-down program specific to addiction.

COMPULSORY AOD TREATMENT

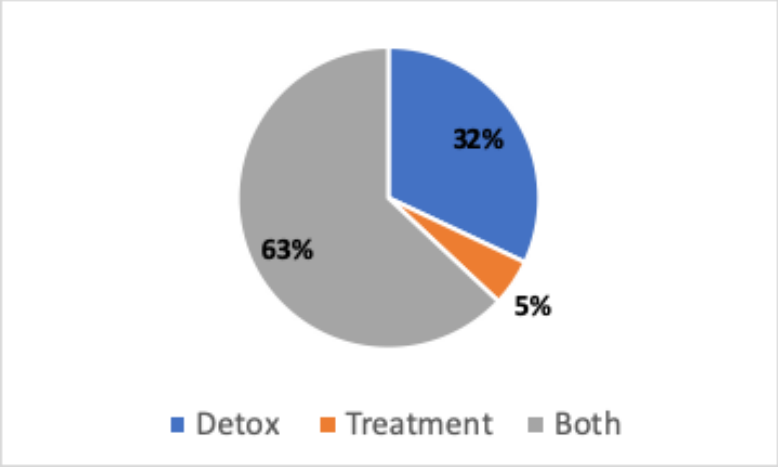
All attendees were asked the following questions through an online anonymous poll.

Question 1: Should a compulsory element be introduced?
Poll results:



Yes: 68% (13),
No: 16% (3).
Unsure: 16% (3)

Question 2: If yes, detox, treatment or both?
Poll results:



Just Detox: 32% (6),
Just Treatment: 5% (1).
Both: 63% (12)

APPENDIX A: RAW GROUPMAP OUTPUT

Title	# Likes	Comments
What does "safe" look like for people experiencing AOD Crisis?		
Community understanding of the presence and reality of drug use in society, a health and mental care system that responds at both a prevention and intervention level staffed by a workforce that includes an equal peer worker presence who deliver services and treatment without judgement or bias to all ages, cultures and socio-economic groups.	3	
A place where a person's needs are met. They are being treated as a whole person.	3	
An appropriate physical location, with good environmental design.	3	
Safe also means that there is an actual facility available.	2	Absolutely.
Safe for people experiencing AOD crisis would look like a beautiful respite homely space instead of clinical settings or police cell.	2	
A place where people understand AOD issues, are properly resourced and have the requisite skills and empathy.	2	
Cultural change in ED and mental health staff.	2	
Availability of health service that doesn't trigger legal issues at first instance/priority (e.g., recovery focussed not conviction focussed): Continued training for front line workers.	2	Specialised addiction workers, nurses and doctors in ED. Access to advocacy support workers for both the client and their family or carer. Emotional and physical dual diagnosis support.
Ability to access treatment easily when it's wanted.	1	Knowing where to go for help, the service you approach having network pathways. For example, police and ED being able to refer people to an AOD service.
Wrap-around services to support not further isolate individuals - do no further harm.	1	
Follow up process for family and carers.	1	
Our rights maybe should be a compulsory education for ED workers.	1	
Co-designed!	1	
Where the person is safe from harm (themselves, to others), have access to medical support (physical and mental health) and options for follow-up.	1	
Carers and family members feeling safe when a person is in psychosis and having options other than straining order.	1	
Safe place where support staff can assess and maintain assessment during crisis period - i.e. after ED and specialist staff at ED to deal with mental health and AOD issues.	1	
Safe to me for people experiencing AOD crisis looks like a non-clinical setting, somewhere that is warm, welcoming, in a beautiful setting.	1	
Clear pathways for all to understand as some else said checklist.	1	
Easy access to appropriate care.	1	
Providing clear structure and expectations, give clear explanations and options, and comfortable and relaxed environment - i.e. offered a cup of tea/coffee.	1	
They are provided with access to medical care.	1	Financial assistance / subsidised ambulance fees.

		Outreach AOD crisis intervention team.
Culturally appropriate services, that support the client, staff and family.	1	
Not retraumatising clients, families and service providers.	0	
When you take a person in a psychosis state and there happens to be police present for some other area of ED can send them off worse even though they aren't for them, that make the situation worse.	0	
Information and knowledge that can be used after the initial access.	0	
Timely access to services for the individual and their significant others	0	
Understanding that rural and remote service are much different for the client and family.	0	
Continued training for front line workers.	0	
The system understands that in some cultures its "the whole village supports the person " attitude. It is important that the system understands who in the village is the right support.	0	
Separate area from general area in ED so you can have a chance on Calming the situation down.	0	
A place where a client's individual needs can be met.	0	
If possible, there is support for family, friends or carers. They are consulted.	0	
A person who seeks treatment feeling the service they go to for help is 'on their side', a safe space.	0	
Interpreter service available for CalD clients.	0	
Safe to me looks like a place that is surrounded in beautiful lush nature instead of concrete buildings.	0	
Clear pathways for care: from assessment, intervention and treatment, to discharge and relevant and timely community follow-up. This is applicable to service users; family and friends; clinicians and workers; and all related services (e.g.: MH; medical; DCP&FS.	0	
Better collaboration between AOD Sector/Services & Mental health response to support consumers, family & services to feel safe.	0	
Safety nets in rural areas where little to no services exist and families are left to deal with crisis situations e.g. sent home from E.D. with no support or information.	0	
Families have confidence that care is being provided.	0	
CALD clients feel safe.	0	
Assistance to have support in a crisis.	0	
Peer worker for carers.	0	
Trust in others to provide crisis intervention without fear of repercussions or prosecution.	0	
Appropriate staffing levels to assist both individuals and families helping to keep all involved safe.	0	
A list to look out for.	0	
What are the current challenges and gaps in AOD Crisis Intervention services in WA?		
Huge lack of leadership for this issue - the services are so fragmented.	1	Workers and sector leaders are burnt out.
Fears of calling out an ambulance due to financial impacts as well as risks if person is aggressive: No ways for lower socio-economic groups to re-negotiate ambulance fees, some have huge bills.	1	
Understanding of clients' needs and not retraumatising people involved.	1	

More resources for social, mental wellbeing & healing.	0	
Lack of assistance to heal pain rather than numb the pain.	0	
Services are not on a continuum, detox, home support, rehab, counselling, MH.	0	
MH & AOD services need to learn to play better & work together.	0	
The way services are funded e.g. funded for AOD but not for MH.	0	
GP's are ill equipped to respond.	0	
Not enough staff to operate services.	0	
Lack of specialised addiction workers and passing the information down the chains we do have.	0	
Lack of safe spaces that provide basic food, shelter and support that are accessible on a walk-in basis.	0	
Harm reduction approach to methamphetamine use. Reduce the need for acute emergency by reducing AOD use.	0	
Experts in addiction that are not being asked for their opinions.	0	
Attitudes, stigma, discrimination of health staff and police.	0	
Funding, AOD services are not funded adequately.	0	
Lack of specialised staff, ED are not across other drugs.	0	
Acute beds or alternates to ED. More 24/7 services required.	0	
ED needs to be supported to handle detox, and be more inclusive of other drugs, not just alcohol.	0	
We don't hear positive stories coming through re strategies being trialled- do not hear Positive messages and attitudes are not coming through for the changes in treatments that are being offered. There are lots of newer treatments (involving drugs, suicide etc).	0	
Police also need support ED seems to be only option but may not be the best place as hospital environment can be quite stimulating and escalate the situation, police presence may also escalate the crisis.	0	
Police can escalate the situation, increase the risk however required to mitigate the risk.	0	
Containment between crisis point & intervention.	0	
Ideal response would be an outreach team with peers and professional staff.	0	
Many new strategies being trialled.	0	
The psychosocial environment is important (colour, furniture, calming elements).	0	
Language barriers cause perceived or power differentials is an important issue.	0	
Detox at home is hard, pathways to detox take a lot of paperwork and time.	0	
Poor communication between services.	0	
Do not know what services are available- what has been cut or not offered anymore.	0	
Lack of walk in options! Can't capitalise on momentum when someone wants to get themselves right.	0	
Poor coordination of the services that are there.	0	

Crisis point = increased risk. Acute, high risk situations require appropriate response to manage the risk without Police presence escalating the situation.	0	
Needing more places that offer support to “feel like home” not so clinical however this is tricky to provide crisis intervention in a community setting.	0	
Minimal advocates for the clients themselves.	0	
Staff are not trained or confident to deal with an AOD crisis, potential utilisation of peer workers here in relation to training and workforce.	0	
Lack of advocates for families and carers.	0	
TICP gaps - not being delivered. Medical Professionals matching with lived experience.	0	
No clear pathways for people in alcohol and drugs crisis. Nobody wants them- where are they meant to go?	0	
Lack of beds and waiting list.	0	
Lack of understanding from Police & Mental Health Response Teams, Mental Health Services & ED when contacted in a crisis.	0	
Family and people are unable to communicate or explain what type of drug due to language barriers- lack of integrated services.	0	
Having to continually repeat story / background with dealing with multiple services.	0	
Care plans in reality don’t play out that well between all different stakeholders - capacity lacking for dealing with multiple health needs for an individual.	0	
Police are often good, but people do not feel safe with Police presence.	0	
Mental health does not want to take people with drug issues.	0	
Need for a specialised unit, no one wants to deal with AOD, MH are overwhelmed and can't deal with AOD client as it distresses others, usually end up in lock up.	0	
Getting both AOD, mental health support from one service is quite difficult.	0	
Limited experience from supporting services - Book experienced, not experienced in practice.	0	
Lack of 24 hr availability	0	
Trauma Informed Care Practice not being implemented. Apply a cultural component.	0	
People struggle to communicate particularly when they’re in crisis, there are a lack of advocates and peer workers that can work with the person to convey the situation and their needs.	0	
Keep going back and forth with medical care.	0	
Presenting to hospital with comorbidity not seen due to AOD use.	0	
Lack of support for family.	0	
Lack of Policy & Procedures.	0	
People have to tell their story multiple times before they get to someone who is willing either willing to take the client on or within the service that retraumatises the person in crisis.	0	
Lack of detox facilities across the state.	0	
Lack of staff particularly in regional areas.	0	
Lack of staff in Health Department & organisations. Lack of growth in AOD specific trained staff; medical, peers support workers, Carer Advocates, Social Work.	0	Particularly in regional areas.

Funding for AOD in a crisis.	0	
Not retraumatizing clients, families and service providers.	0	
When you take a person in a psychosis state and there happens to be police present for some other area of ED can send them off worse even though they aren't for them, that make the situation worse.	0	

What additional services/changes to existing services are required to optimise the future system?		
Emotional and physical dual diagnosis support. Access to advocacy support workers for both the client and their family or carer. Specialised addiction workers, nurses and doctors in ED.	2	
Specialized units to deal with drug use and mental health so that the mental health clinics are not overwhelmed with this type of crisis.	2	
Lack of walk in services such as detox.	1	
A specialised unit to deal with the client, a unit to deal with family and an education unit for ED and specialised unit.	1	
A facility that the ED and Police can take people to that is open 24hs and can take people for short term residential assessment, then refer them to suitable longer-term service providers.	0	
Strategies to address workforce burnout- e.g. funding and resourcing specifically for people in the sector to be able to debrief with.	0	
Culturally appropriate AOD services that acknowledge culture.	0	
Programs that support families, healing environments not just for private programs.	0	Funded for all.
Capacity building / grassroots education e.g. sporting clubs, knitting nannas, yarning circles about AOD issues in their community about drug use and effects and how to assist/respond. Info not universal needs to be adapted to what is affecting the community.	0	
Peer work force - lived experience more impact.	0	
Long term programs that focus on ongoing issues caused by drug use e.g. early dementia, damage to organs.	0	
Streamlined support for recovery process from acute to recovery. Support that follows through the experience.	0	
Model of care needs to be flexible (regional versus metro focused) and sensitive to culture, trauma, past trauma and supportive to families and carers.	0	
Have support person more involved in persons recovery, treatment, discharge plan if person consents.	0	
Consumers action stage of change disappears whilst waiting for entry into services - need low barrier services.	0	
Comparative beds & staff ratios.	0	
Services that can re locate to safer areas with support.	0	
Development of appropriate mandatory treatments to support families and loved ones seeking treatment for people in AOD crisis.	0	
Increased resources in AOD Crisis - not funded in regard to identified need.	0	
Step-up step-down program that is specific to addiction.	0	
Models of care should be developed from the bottom up not from the top down.	0	
ED - to reduce the sedate & discharge approach & explore 12 hours hold period to allow time & safe place for all involved to recover.	0	
Include the person in the recovery plan, be aware of the language being used e.g. in recovery instead of recovered.	0	

Support into and out of clinics to ensure its ongoing support not just straight into community. e.g. heal for life foundation, step up step down.	0	E.g. Blue knot foundation.
More seamless approach and whole of government approach.	0	
The ability and funding to have available clinical services onsite in AOD residential rehabs to access clients in their care to prevent unnecessary cycling through other mental health services only to return.	0	
Crisis Point - service or space to mitigate the risk whilst keeping consumer, family & community safe.	0	
Trauma informed practice across services - healing trauma as well.	0	Focus on the healing not just detox.
Lack of relationship between sector services.	0	
Better, more specific trained staff.	0	
Require 'walk in' level services.	0	
As all services are limited there needs to be one central service that can meet the needs of people in crisis.	0	
Share the positives from peers and people with lived experience - good news stories, not so negative.	0	Perhaps include with university student curriculum.
Lack of walk in services for basic needs to be met.	0	
Increase in clinical addiction professionals for all regional areas.	0	
High Barriers to secure somewhere safe.	0	
MHERL appear unwilling to engage in AOD crisis.	0	
Community approach to services - at all times.	0	
The ED does not represent a safe place for many people.	0	
AOD Services, particularly detox & residential high barrier & difficult for consumers to enter especially at crisis point.	0	
Alternates to ED where the environment is safe for people to go.	0	
Cultural awareness, cultural safety and cultural security education and training for medical and non-medical staff.	0	
Collaborative groups.	0	
Sharing of information and training at a “recovery college” from health professionals, community members, lived experience etc	0	
AOD Services not equipped to deal with AOD Crisis.	0	
Services that deal with CalD clients have to be approached - adequate training given to both medical and non-medical staff.	0	
More direct efficient medical/health support provided to a person straight away so that the person’s accommodation is not places at risk if they are staying in supported accommodation services.	0	
Crisis Point - needs facilities.	0	
Education to community for recovery.	0	
Equal peer and professional workers.	0	
Discharge from ED to homelessness or unsafe address requires attention.	0	
Need a whole of government approach and look at from all angles to address the gaps in services.	0	
Funding - sessions x6 increased for MH Care Plan not capped.	0	

Provide drop-in centres with food, shelter, showers, beds, peer and professional support if the person wants it.	0	
Increase in peer services lived experiences.	0	
Trauma informed policies across all organisations- not just for family and clients but also the staff.	0	
Better options for crisis admissions as ED and Police are not always the right option.	0	
more community forums to provide what is available and for what in their regions for families etc.	0	
Streamline people presenting at hospital with AOD support straight away so do not have to navigate a system with different pathways depending on other health needs.	0	
AOD and mental health workers need to be better trained in seeing past stereotypes and appropriate responses.	0	
Propensity to address the acute presentation, not ongoing supports.	0	
A re-vamp of training for mental health and AOD services to increase confidence and capacity in working with people who have dual issues. Dropped the ball on this one in the last 10 years.	0	
Lack of knowledge & understanding within mainstream health services for ongoing support.	0	
Communication and collaborate to ensure support is helping, not hindering.	0	
More culturally sensitive responses for people in crisis.	0	
Services to explore underlying issues better - i.e. alcoholism may have underlying MH issue or unaddressed trauma behind the substance use.	0	
A team to fill the gap at ED at crisis point - so people are not sent home unassisted.	0	
More up to date research for treatment to be relied upon.	0	
Clearer communication through a centralised number so that referrers have a clear idea of where to send people and the services available.	0	
One model does not fit all rural and remote are very different to metro.	0	
24-hour support is required.	0	
Responses need to be more contemporary rather than business as usual.	0	
Clear pathways with a checklist are the way forward.	0	
Mental Health & AOD Services working together better & not hand balling between each other leaving the consumer without assistance.	0	
The police and emergency department having a clear channel for referring people. They currently have too many numbers and do not always know who to call.	0	
Funding allocated specifically for AOD crisis teams Not pilot programs ongoing funding with ongoing evaluation.	0	