TUNA BLUE

Government of **Western Australia**
**Mental Health Commission**

# AOD CRISIS INTERVENTION

**Kimberley Community Workshop (26th May 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 should "safe" look like for people experiencing AOD Crisis in the Kimberley?
- What are the current challenges and gaps in AOD Crisis Intervention services in the Kimberley?
- What additional services or changes to existing services are required to optimise the AOD Crisis Intervention system in the Kimberley?
- What are your thoughts on the introduction of compulsory AOD detox and/or treatment in WA?

## 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 should "safe" look like for people experiencing AOD Crisis in the Kimberley?*

- A non-judgemental, walk-in place open 24/7 (or on-call) to go to instead of ED (or after ED discharge) and be assessed and supported holistically
- More balanced, holistic and culturally appropriate approaches to AOD crisis that consider the range of stressors and additional issues a person often is experiencing at the same time, including mental health, family & domestic violence, homelessness, poverty
- Services that are trauma informed and culturally safe
- Short stay crisis accommodation, family support and food security options
- Private and secure options for families at risk of family & domestic violence

*What are the current challenges and gaps in AOD Crisis Intervention services in the Kimberley?*

- Lack of prevention, early intervention and cultural healing programs to address normalised AOD abuse and support long term recovery following successful crisis intervention
- Lack of place based local recovery options and planning in towns to support people re-entering the community following crisis intervention or rehab, particularly to navigate complex and traumatic social and housing situations
- Lack of focus on the co-occurring needs of people in AOD crisis (FDV, MH, Justice) and limited flexibility for services to provide appropriate holistic, wrap around health and social support in crisis, as opposed to a justice based approach
- Lack of suitable detox and rehabilitation options for people in the region, particularly for meth users and residential options for people returning to their community
- Lack of step down options and patient planning for people discharged from ED after an AOD crisis

*What additional services or changes to existing services are required to optimise the AOD Crisis Intervention system in the Kimberley?*

- Provision of youth services and safe places for young people
- Proactive and well resourced outreach and care coordination roles
- Increased community designed, owned and run place based responses that draw on local peer networks, community governance and family approaches
- More family programs focused on diversionary, therapeautic and cultural healing programs to deal with trauma as the underlying issue to AOD crisis
- Increased voluntary crisis intervention options including ED asssement, post ED support, local detox facilities and culturally appropriate after hours services (not hotlines)
- Appropriate and safe crisis accommodation and short term housing options
- Appropriate financial supports for individuals in AOD crisis

*What are your thoughts on the introduction of compulsory AOD detox and/or treatment in WA?*

- If it were to be introduced, it would need to sit within a suite of voluntary, diversionary and justice reinvestment options and pathways, with consideration given to the preventative and early intervention pathways as well as the longer term recovery step down and step out pathways
- Families impacted by AOD crisis require direct support and safety options
- How to manage clients who are unwilling or unready to change
- Need for increased focus and investment in existing voluntary services and gaps first, with justice and court diversion options also already in place
- How will complex needs (suicide, mental health, FDV) and their associated complex support systems be factored into the assessment and treatment, not just the presenting AOD issue and response?
- Concerns with negligent enforcement of the legislation and stigma it may create
- Need for greater information and evidence on the benefits of compulsory AOD detox and treatment

## APPENDIX ONE: DETAILED INPUT BY COMMON THEME

The following section provides the detailed input from participants under key theme headings (as identified by the facilitator).

### *What should "safe" look like for people experiencing AOD Crisis in the Kimberley?*

**A non-judgemental, walk-in place open 24/7 (or on-call) to go to instead of ED (or after ED discharge) and be assessed and supported holistically**

- Desperately need an alternative to ED (their goal is to discharge once medically cleared), no resources or planning for what happens after the presentation; often people require. Longer admission to hospital but are discharged. Locally rely on hospitals for a haphazard detox admission. But what happens after we assist the acute detox (MH and family issues)?
- Emergency evacuation centres 24hrs
- Discharged against medical advice often occurs and there are no suitable support options
- Often people are brought into ED by police monitored and then discharged, so somewhere that provides care and support and has options for treatment
- Safe should look like a facility that is community run by Aboriginal community run organisations that provides reactive services to people in crisis that operate on referral from ED or direct presentation to provide services to people when they are ready to make a change in their lives and not when other services feel they are ready. Additionally staff should all be local Aboriginal people to be able to develop relationships immediately and not take 6 months to establish like occurs with many outside Kimberley based orgs
- Somewhere people can go free of judgment and harm where ideally it would be through agreement
- A walk in service for voluntary consult for people able to access a 24 hr service:
  - A place to go, a service to access other services holistically – not just the melt down stage. How to keep the families safe, go into rehab third time round, intervention plan for partners at risk. Someone there 24/7 on call
- A safe, non judgemental place to go when intoxicated and linkage to further support
- Family members have a say or give consent in the event individuals cannot make them due to their level of intoxication or psychosis

**More balanced, holistic and culturally appropriate approaches to AOD crisis that consider the range of stressors and additional issues a person often is experiencing at the same time, including mental health, family & domestic violence, homelessness, poverty**

- A balanced assessment of family member views and perspectives with the readiness and views of the young person. Parents often end up in family and MH crises that are a result of the AOD crisis – end up bouncing between different services
- Choices which consider the range of stressors and additional issues a person often is experiencing at the same time as the AOD crisis. For example FDV / Mental ill health

/ poverty / homelessness, etc. For some it will be preferable and safe to remain in home town and for others it is not. Options are important. Safety is also about cultural safety in those services and options

- Focus on comorbidity and poly substance use\

**Services that are trauma informed and culturally safe**

- Services that are trauma informed
- A service that is respectful and responsive to the needs of the individual and their support networks, embedded cultural safety
- Physical and emotional safety plus confidentiality

**Short stay crisis accommodation, family support and food security options**

- If experiencing homelessness, then crisis accommodation / short stay options
- Secure accommodation with accessible available help or supervision. Access to medical support if needed. A free service (having to pay for accommodation or rehab prevents many people from accessing services)
- Appropriate accommodation, family support, financial assistance or stability
- Supportive living around food security and income

**Private and secure options for families at risk of family & domestic violence**

- Private and secure
- Immediate, enhanced victim support for those at risk of dv where alcohol is involved
- Security options for families at risk
- Increased dv perpetrator programs Kimberley wide
- Safety for the person but also safety for others in relation to the possible harm that person could cause during their crisis.

**Other comments**

- Harm minimization verses Abstinence and more proactive educational programs that young people will engage with
- Enhanced specialisation of crisis services

## *What are the current challenges and gaps in AOD Crisis Intervention services in the Kimberley?*

**Lack of prevention, early intervention and cultural healing programs to address normalised AOD abuse and support long term recovery following successful crisis intervention**

- Early intervention and prevention programs
- AOD use / abuse has become normalised in the Kimberley, maybe we need to try and change attitudes
- Often people are not willing to address their AOD problems and shy away from the few services available, even after repeated crisis
- Really limited resourcing into the community level and prevention / earlier intervention supports – especially options that are culturally embedded
- Services, workers, cultural healing programs
- Whilst the AOD crisis is a point for intervention – the healing and change process re: problematic AOD use is often a much longer road to recovery – so any crisis support need to be really well linked to the longer term recovery process and services

**Lack of place based local recovery options and planning in towns to support people re-entering the community following crisis intervention or rehab, particularly to navigate complex and traumatic social and housing situations**

- Lack of options at the place based level and then the need to navigate a prolonged referral / transport to service process that often means people are away from their natural supports during treatment and often relapse on return home where they have limited supports and stressors are present
- Extremely difficult to get away from the context in small towns / communities. Very often, overcrowded houses with multiple AOD users in the house make it hard for people that are considering change or are recovering. Context is also a constant reminder of trauma where perpetrators and victims cross paths several times a day
- No real sustainable or realistic plan for people re-entering communities, just back into the same old cycle that hasn't changed whilst they have been in rehab or even prison

**Lack of focus on the co-occurring needs of people in AOD crisis (FDV, MH, Justice) and limited flexibility for services to provide appropriate holistic, wrap around health and social support in crisis, as opposed to a justice based approach**

- Restrictions on individuals with co-occurring needs (FDV, MH, Justice) – push this aside and deal with the individual at hand
- Has to be a health response and alternative to the justice response that often becomes the circuit breaker last resort in an AOD crisis
- Current focus on the criminal consequences – needs to link in to the mental health / health sector. Reduce the stigma.
- Gaining insights into underlying issues which involves things like trauma, DV, etc and looking at that instead of just the AOD issues. Compassion needs to be used for people who are at risk of AOD issues due to these issues

- A lack of services which are linked, putting the individual at the centre and providing wrap around support

**Lack of suitable detox and rehabilitation options for people in the region, particularly for meth users and residential options for people returning to their community**

- No detox service (either home detox or inpatient), the one rehab in Broome doesn't take meth users, because prolonged meth use does affect mental health, people can be kept on rehab waitlists too long whilst trying to stabilise MH
- Lack of suitable rehab options to deal with meth
- Lack of local adequate detox services
- Where out of the Kimberley is deemed more suitable for rehab – there is no funding available to support transport
- Residential option in the community need to be created, leaving the community to address issues leaves the issues right where you left it on their return
- Remote locality, referral agencies into residential rehab
- Free of charge or flexible charging rehabs, is really important. Taking 80% of Centrelink payment makes it difficult if you've got debts
  - People don't have any money for short term accommodation. Post ED discharge, free service would see less people seen in limbo
    Short stay accommodation struggles with the medical and security needs of people; high need clients
  - Need residential facilities for complex clients in the region; Carpu NT / Alice Springs model

**Lack of step down options and patient planning for people discharged from ED after an AOD crisis**

- Too often ED are left to deal with Crisis response and there are no back door consult with very slow reactive services
- Lack of patient planning when patients exit ED, ED limited in scope lack adequate social work, psychology
- No detox unit, no step up step down – nowhere for people to go after ED, falls back onto the family

**Other comments**

- Getting service to fully understand the size of the issue, eg: intravenous drug use, needle exchanges promoting good practise as harm minimisation strategy
- Where do men go in DV cases?
- COVID handouts and super handouts for the most vulnerable without any support or indication on how to use that money responsibly

***What additional services or changes to existing services are required to optimise the AOD Crisis Intervention system in the Kimberley?***

**Provision of youth services and safe places for young people**

- Look to link with the Statement of Intent $9.2m East Kimberley Youth service investment
- Derby feasibility study (funded by Government) – took 3 mins to identify the need for safe place for kids. Kids vote with their feet if trouble at home. Have presented to politicians. Need safe places for kids, the collateral damage for the AOD / FDV issue (drives the youth crime issue in town). A safe place for kids, provide programs with the family (not a DCP pathway)

**Proactive and well resourced outreach and care coordination roles**

- Outreach is really important, education and meet people before it escalates; needs the manpower to resource it:
  - Ability to go to where people are, meet them at a neutral safe place, meet people at ED
  - But desperately needed after hours outreach (otherwise it's Police and ED)
  - Must be people who ae respected and accepted in the community, knowledge of the services and options; accepting, non-judgemental attitude; good list of contacts and willingness to phone them instantly
  - After hours team / service to respond to crisis is a major gap. A lot of the SEWB workers end up taking calls, responding after hours anyway; important to have a supportive / flexible workplace (KAMS)
  - Need comprehensive service system so that those who provide outreach have services that they can connect people to for the longer term supports
  - The support needs be holistic and not focus on AOD only as a siloed issue
- Care coordination roles – to ensure that the links are made across health / mental health / AOD and healing process is a process not a stop and start / in and out cycle

**Increased community designed, owned and run place based responses that draw on local peer networks, community governance and family approaches**

- Implement a training package for a community based reference group that could support a crisis situation in our communities
- Peer to peer network established across the Kimberley, and peer support workers available at each service / facility
- Too much drive in drive out services, need to be community based, use of local role models and advocates supported, therapeutic supports applied, resilience building implemented, residential options offered for individual and family affected
- Culturally conceived of, owned and run responses.
- Place based services which are flexible to the needs of the community they serve. This would include having local community members involved in the governance, design, and delivery of the service.
- Reactive / responsive community run services in remote areas are critical; they have the relationships in community

- Empowering more Indigenous workers in programs, ED's rehabs, etc for more cultural safety

**More family programs focused on diversionary, therapeautic and cultural healing programs to deal with trauma as the underlying issue to AOD crisis**

- Diversionary programs for people, especially young people, to go back out on country. Really difficult to measure the outcomes (KPIs) but we can feel that in our liyarn (spirit), its critically important
- More trauma (daily, family, intergenerational) programs to engage young people and their families
- Family focused responses – support the person alongside their natural network – not in isolation
- A specialist healing place for individuals and/or families to heal and recover, and to develop skills for sustained recovery. A rehab that operates as a therapeutic community (a place to go after worst of the immediate crisis is past). Access to services without having long waits on waitlist
- Separation of bandaid services like sobering up shelters and focus on investment into actual services that focus on therapeutic solutions
- More cultural content and a greater emphasis on the prevention services
- I would like see a remote health Farm for people to attend after presenting to the Hospital to divert them from the justice system
- Second the comment regarding small retreats for individuals and families with support workers
- Smaller Accommodation Cultural Healing Retreats
- We need more programs that undertake the recovery process of Trauma and issues that lead people to AOD usage

**Increased voluntary crisis intervention options including ED asssement, post ED support, local detox facilities and culturally appropriate after hours services (not hotlines)**

- Improved assessment in ED and improved post ED support as well as alternatives to ED
- Major detox facility out of town, semi-isolated at a nice location.
- Any crisis intervention options outside of emergency departments or police would more than what we have at the moment
- Funding for cost effective, voluntary services
- Hotlines or after hours are not user friendly (1800) normally a Gardiya in the city)

**Appropriate and safe crisis accommodation and short term housing options**

- Appropriate crisis accommodation is needed
- Trauma informed programs ,safe accommodation ,staffed programs

- More housing options for people to have the a quiet place to stay, away from overcrowding and parties

**Appropriate financial supports for individuals in AOD crisis**

- Better education regarding the covid handout and other government related payouts that generally people spend on AOD
- Improved financial support for people in crisis requiring access to services such as rehab out of the Kimberley – where pats doesn't apply

### *What are your thoughts on the introduction of compulsory AOD detox and/or treatment in WA?*

**If it were to be introduced, it would need to sit within a suite of voluntary, diversionary and justice reinvestment options and pathways, with consideration given to the preventative and early intervention pathways as well as the longer term recovery step down and step out pathways**

- Would need to review all options. One reality is that during the COVID restrictions, people weren't following the restrictions because they have AOD problems. We need services for people who are and aren't ready for change (but are causing FDV, violence, crime in the community):
- We need some intervention. from Government – funding and services followed by some sort of harder line option through the courts, etc
  - Money spent in the justice system, sending youth to Perth, could we extract some of this money to better services for youth and adults Justice reinvestment
  - Always hard for a system without voluntary safe houses, detoxes, etc (what we know does work but isn't accessible) and we're going down the involuntary path?
  - Agreed – stepping people up into an involuntary setting – what are our step down and step out options
  - Preventative and community based options first? Before legislation and costliness
- Keep in mind the justice reinvestment model as this type of service may empty the prison, a large proportion of prisoners are in for drug and alcohol related crimes
- Could there be multiple pathways? Justice? Frequent presentation to ED's (not breaking the law but a clear AOD crisis occurring)? Needs a whole series of checks and balances to ensure people's rights are upheld during the process
- COVID epidemic – some remote community members have mentioned they've gone back to community to reconnect. Could we instead give people a financial supplement to go home, get off the streets in town, reintegrate with community and services, and use that as a form of incentive for recovery
- Compulsory, but with choice of where and type might work
- Detox must include pathway to treatment. Detox alone won't support change. We also need to look at the harm minimisation and trauma informed response options. Compulsory as an alternative to jail (also compulsory) is reasonable
- Very supportive of compulsory, peoples addiction is so deeply entrenched, the voluntary change is becoming rarer

**Families impacted by AOD crisis require direct support and safety options**

- Concern that if it doesn't happen, we go back to softly softly and that meth users and their families are back in the same boat:
  - We have a normalisation of AOD, suicide, poverty, etc in the Kimberley. We need to start working on the legislation to make real change
- I believe it should be introduce in a family group setting. each family member should be aware and encourage through consistent support
- There is also a lack of support for other family members during and after AOD issues, such as children

**How to manage clients who are unwilling or unready to change**

- The cohort that never want to change their substance use behaviour
- First thought is the client's willingness to change if it's compulsory. May not feel they are ready despite the order to attend. Second thought is the need for services / housing once they exited this program – may be ineffective if they go back to previous housing situation

**Need for increased focus and investment in existing voluntary services and gaps first, with justice and court diversion options also already in place**

- Meet the voluntary treatment needs and demand first.
- Having services in Derby talking to each other in regards to intervention approach and combine a financial contribution to a program that already exists rather than competing for $$$
- Perhaps the focus should be on ways to support people to seek voluntary AOD detox and/or treatment
- There is a lot to consider in implementing compulsory treatment. The legislative basis for it, how to enforce it.... I think the financial outlay required could be better invested in prevention and making treatment more accessible. The MHC did a lot of work a few years back on investigating compulsory treatment.... perhaps review the work done there?
- A large investment is needed in the gaps in the voluntary system and social supports people require
- We kinda do compulsory already through the justice system and/or mental health system when issues get to crisis for people with severe AOD issues. It would be better to look at this within a health system response rather than a justice response
- Court diversion – assessment made at court, an alternative is AOD counselling. All justice system based
- Why not for severe AOD related offence

**How will complex needs (suicide, mental health, FDV) and their associated complex support systems be factored into the assessment and treatment, not just the presenting AOD issue and response?**

- I'm just a bit worried about what will be determined an AOD crisis as opposed to a suicidal behaviours or self harm crisis, how will they both be treated which where the latter may not involve AOD?:
  - How do we ensure the assessment doesn't just see the AOD
- The issue of addiction is so complex, causal pathways to addiction need to be addressed, and family upskilling around support in the home / outside of service provision. Holistic wrap around service provision that is culturally based
- It can get very complicated, especially when you consider the multi-system dynamics that would be involved... eg: will treatment orders be processed via the courts, or the health system? How could the court system be adapted to address health issues safely and with compassion – in whose best interests would legislation or orders be made? An individual's or communities?

**Concerns with negligent enforcement of the legislation and stigma it may create**

- Not just another legislation that could be used by people enforcing it in a negligent way
- Concerns regarding the long term impact on mental health and stigma attached to compulsory detox and/or treatment

**Need for greater information and evidence on the benefits of compulsory AOD detox and treatment**

- Would have to have some strict criteria on meeting the need for compulsory detox / treatment
- I need a lot more information about what this model looks like before I could comment
- I would need more information before I make an opinion on what are the benefits of compulsory AOD detox or treatments
- There needs to be more evidence – where would the 'trial' take place? More consultation with Aboriginal and Torres Strait Islander

## APPENDIX TWO

## RAW FORUM OUTPUT (UNTHEMED)

| *Title* | *Comments* |
|---|---|
| ***What should "safe" look like for people experiencing AOD Crisis in the Kimberley?*** | |
| Desperately need an alternative to ED (their goal is to discharge once medically cleared), no resources or planning for what happens after the presentation; often people require. Longer admission to hospital but are discharged. Locally rely on hospitals for a haphazard detox admission. But what happens after we assist the acute detox (MH and family issues)? | |
| A balanced assessment of family member views and perspectives with the readiness and views of the young person. Parents often end up in family and MH crises that are a result of the AOD crisis - end up bouncing between different services | |
| Safety for the person but also safety for others in relation to the possible harm that person could cause during their crisis. | |
| Services that are trauma informed | |
| Family members have a say or give consent in the event individuals cannot make them due to their level of intoxication or psychosis | |
| Emergency evacuation centres 24hrs | |
| Discharged against medical advice often occurs and there are no suitable support options | |
| Focus on comorbidity and poly substance use\ | |
| Choices which consider the range of stressors and additional issues a person often is experiencing at the same time as the AOD crisis. For example FDV / Mental ill health / poverty / homelessness, etc. For some it will be preferable and safe to remain in home town and for others it is not. Options are important. Safety is also about cultural safety in those services and options | |
| Often people are brought into ED by police monitored and then discharged so somewhere that provides care and support and has options for treatment | |
| Safe should look like a facility that is community run by Aboriginal community run organisations that provides reactive services to people in crisis that operate on referral from ED or direct presentation to provide services to people when they are ready to make a change in their lives and not when other services feel they are ready. Additionally staff should all be local Aboriginal people to be able to develop relationships immediately and not take 6 months to establish like occurs with many outside Kimberley based orgs | |
| Somewhere people can go free of judgment and harm where ideally it would be through agreement | |
| Enhanced specialisation of crisis services | |
| If experiencing homelessness, then crisis accommodation / short stay options | |
| Private and secure | |
| Secure accommodation with accessible available help or supervision. Access to medical support if needed. A free service (having to pay for accommodation or rehab prevents many people from accessing services) | |
| Immediate, enhanced victim support for those at risk of dv where alcohol is involved | |
| Harm minimization verses Abstinence and more proactive educational programs that young people will engage with | |
| Security options for families at risk | |
| Appropriate accommodation, family support, financial assistance or stability | |
| Supportive living around food security and income | |

A walk in service for voluntary  consult for people able to access a 24 hr service

A place to go, a service to access other services holistically - not just the melt done stage. How to keep the families safe, go into rehab third time round, intervention plan for partners at risk. Someone there 24/7 on call

A service that is respectful and responsive to the needs of the individual and their support networks, embedded cultural safety

Physical and emotional safety plus confidentiality

Increased dv perpetrator programs Kimberley wide

A safe, non judgemental place to go when intoxicated and linkage to further support

***What are the current challenges and gaps in AOD Crisis Intervention services in the Kimberley?***

COVID handouts and super handouts for the most vulnerable without any support or indication on how to use that money responsibly

Intervention and prevention programs

Restrictions on individuals with co-occurring needs (FDV, MH, Justice) - push this aside and deal with the individual at hand

No detox service (either home detox or inpatient), the one rehab in brome doesn't take meth users, because prolonged meth use does affect mental health, people can be kept on rehab waitlists too long whilst trying to stabilise MH

AOD use/abuse has become normalised in the Kimberley, maybe we need to try and change attitudes

Too often ED are left to deal with Crisis response and there are no back door consult with very slow reactive services

Lack of patient planning when patients exit ED, ED limited in scope lack adequate social work, psychology

Getting service to fully understand the size of the issue, eg:  intravenous drug use, needle exchanges promoting good practise as harm minimisation strategy

Often people are not willing to address their AOD problems and shy away from the few services available, even after repeated crisis

No real sustainable or realistic plan for people re-entering communities, just back into the same old cycle that hasn't changed whilst they have been in rehab or even prison

Really limited resourcing into the community level and prevention / earlier intervention supports - especially options that are culturally embedded

Where out of the Kimberley is deemed more suitable for rehab - there is no funding available to support transport

Residential option in the community need to be created, leaving the community to address issues leaves the issues right where you left it on their return

Lack of suitable rehab options to deal with meth

Lack of local adequate detox services

Services, workers, cultural healing programs

Has to be a health response and alternative to the justice response that often becomes the circuit breaker last resort in an AOD crisis

Where do men go in DV cases?

Whilst the AOD crisis is a point for intervention - the healing and change process re: problematic AOD use is often a much longer road to recovery - so any crisis support need to be really well linked to the longer term recovery process and services

No detox unit, no step up step down - nowhere for people to go after ED, falls back onto the family

Extremely difficult to get away from the context in small towns/communities. Very often, overcrowded houses with multiple AOD users in the house make it hard for people that are considering change or are recovering. Context is also a constant reminder of trauma where perpetrators and victims cross paths several times a day

Current focus on the criminal consequences - needs to link in to the mental health / health sector. Reduce the stigma.

Remote locality, referral agencies into residential rehab

Free of charge or flexible charging rehabs, is really important. Taking 80% of Centrelink payment makes it difficult if you've got debts

People don't have any money for short term accommodation. Post ED discharge, free service would see less people seen in limbo

Short stay accommodation struggles with the medical and security needs of people; high need clients

Need residential facilities for complex clients in the region; Carpu NT / Alice Springs model

Gaining insights into underlying issues which involves things like trauma, DV, etc and looking at that instead of just the AOD issues. Compassion needs to be used for people who are at risk of AOD issues due to these issues

A lack of services which are linked, putting the individual at the centre and providing wrap around support

Lack of options at the place based level and then the need to navigate a prolonged referral / transport to service process that often means people are away from their natural supports during treatment and often relapse on return home where they have limited supports and stressors are present

***What additional services or changes to existing services are required to optimise the AOD Crisis Intervention system in the Kimberley?***

Look to link with the Statement of Intent $9.2m East Kimberley Youth service investment

Hotlines or after hours are not user friendly (1800) normally a Gardiya in the city)

Derby feasibility study (funded by Government) - took 3 mins to identify the need for safe place for kids. Kids vote with their feet if trouble at home. Have presented to politicians. Need safe places for kids, the collateral damage for the AOD/FDV issue (drives the youth crime issue in town). A safe place for kids, provide programs with the family (not a DCP pathway)

Outreach is really important, education and meet people before it escalates; needs the manpower to resource it

Ability to go to where people are, meet them at a neutral safe place, meet people at ED

But desperately needed after hours outreach (otherwise it's Police and ED)

Must be people who ae respected and accepted in the community, knowledge of the services and options; accepting, non-judgemental attitude; good list of contacts and willingness to phone them instantly

After hours team / service to respond to crisis is a major gap. A lot of the SEWB workers end up taking calls, responding after hours anyway; important to have a supportive / flexible workplace (KAMS)

Need comprehensive service system so that those who provide outreach have services that they can connect people to for the longer term supports

The support needs be holistic and not focus on AOD only as a siloed issue

Implement a training package for a community based reference group that could support a crisis situation in our communities

Empowering more Indigenous workers in programs, ED's rehabs, etc for more cultural safety

Diversionary programs for people, especially young people, to go back out on country. Really difficult to measure the outcomes (KPIs) but we can feel that in our liyarn (spirit), its critically important

Appropriate crisis accommodation is needed

Any crisis intervention options outside of emergency departments or police would more than what we have at the moment

More trauma (daily, family, intergenerational) programs to engage young people and their families

Better education regarding these coved handout and other government related payouts that generally people spend on AOD

Funding for cost effective, voluntary services

Family focused responses - support the person alongside their natural network - not in isolation

A specialist healing place for individuals and/or families to heal and recover, and to develop skills for sustained recovery. A rehab that operates as a therapeutic community (a place to go after worst of the immediate crisis is past). Access to services without having long waits on waitlist

Separation of bandaid  services like sobering up shelters and focus on investment into actual services that focus on therapeutic solutions

Peer to peer network established across the Kimberley, and peer support workers available at each service / facility

More cultural content and a greater emphasis on the prevention services

Care coordination roles - to ensure that the links are made across health / mental health / AOD and healing process is a process not a stop and start / in and out cycle

I would like see a remote health Farm for people to attend after presenting to the Hospital to divert them from the justice system

Second the comment regarding small retreats for individuals and families with support workers

Trauma informed programs ,safe accommodation ,staffed programs

Too much drive in drive out services, need to be community based, use of local role models and advocates supported, therapeutic supports applied, resilience building implemented, residential options offered for individual and family affected

Improved financial support for people in crisis requiring access to services such as rehab out of the Kimberley - where pats doesn't apply

Major detox facility out of town, semi-isolated at a nice location.

Smaller Accommodation Cultural Healing Retreats

Improved assessment in ED and improved post ED support as well as alternatives to ED

Culturally conceived of, owned and run responses.

We need more programs that undertake the recovery process of Trauma and issues that lead people to AOD usage

A Cohort of services such that

More housing options for people to have the a quiet place to stay, away from overcrowding and parties

Place based services which are flexible to the needs of the community they serve. This would include having local community members involved in the governance, design, and delivery of the service.

Reactive / responsive community run services in remote areas are critical; they have the relationships in community

***What are your thoughts on the introduction of compulsory AOD detox and/or treatment in WA?***

Concern that if it doesn't happen, we go back to softly softly and that meth users and their families are back in the same boat

We have a normalisation of AOD, suicide, poverty, etc in the Kimberley. We need to start working on the legislation to make real change

The cohort that never want to change their substance use behaviour

I'm just a bit worried about what will be determined an AOD crisis as opposed to a suicidal behaviours or self harm crisis, how will they both be treated which where the latter may not involve AOD?

How do we ensure the assessment doesn't just see the AOD

COVID epidemic - some remote community members have mentioned they've gone back to community to reconnect. Could we instead give people a financial supplement to go home, get off the streets in town, reintegrate with community and services, and use that as a form of incentive for recovery

Concerns regarding the long term impact on mental health and stigma attached to compulsory detox and / or treatment

Would need to review all options. One reality is that during the COVID restrictions, people weren't following the restrictions because they have AOD problems. We need services for people who are and aren't ready for change (but are causing FDV, violence, crime in the community)

We need some intervention. from Government - funding and services followed by some sort of harder line option through the courts, etc

Money spent in the justice system, sending youth to Perth, could we extract some of this money to better services for youth and adults Justice reinvestment

Always hard for a system without voluntary safe houses, detoxes, etc (what we know does work but isn't accessible) and we're going down the involuntary path?

Agreed - stepping people up into an involuntary setting - what are our step down and step out options

Preventative and community based options first? Before legislation and costliness

Could there be multiple pathways? Justice? Frequent presentation to ED's (not breaking the law but a clear AOD crisis occurring)? Needs a whole series of checks and balances to ensure people's rights are upheld during the process

Meet the voluntary treatment needs and demand first.

Court diversion - assessment made at court, an alternative is AOD counselling. All justice system based

The issue of addiction is so complex, causal pathways to addiction need to be addressed, and family upskilling around support in the home/outside of service provision. Holistic wrap around service provision that is culturally based

I believe it should be introduce in a family group setting. each family member should be aware and encourage through consistent support

It can get very complicated, especially when you consider the multi-system dynamics that would be involved... eg: will treatment orders be processed via the courts, or the health system? How could the court system be adapted to address health issues safely and with compassion- in whose best interests would legislation or orders be made? An individual's or communities?

Having services in Derby talking to each other in regards to intervention approach and combine a financial contribution to a program that already exists rather than competing for $$$

First thought is the client's willingness to change if it's compulsory. May not feel they are ready despite the order to attend. Second thought is the need for services / housing once they exited this program - may be ineffective if they go back to previous housing situation

Perhaps the focus should be on ways to support people to seek voluntary AOD detox and/or treatment

Not just another legislation that could be used by people enforcing it in a negligent way

Detox must include pathway to treatment. Detox alone won't support change. We also need to look at the harm minimisation and trauma informed response options. Compulsory as an alternative to jail (also compulsory) is reasonable

Keep in mind the justice reinvestment model as this type of service may empty the prison, a large proportion of prisoners are in for drug and alcohol related crimes

Would have to have some strict criteria on meeting the need for compulsory detox/treatment

I need a lot more information about what this model looks like before I could comment

Compulsory, but with choice of where and type might work

We kinda do compulsory already through the justice system and/or mental health system when issues get to crisis for people with severe AOD issues. It would be better to look at this within a health system response rather than a justice response

There is a lot to consider in implementing compulsory treatment. The legislative basis for it, how to enforce it.... I think the financial outlay required could be better invested in prevention and making treatment more accessible. The MHC did a lot of work a few years back on investigating compulsory treatment.... perhaps review the work done there?

There is also a lack of support for other family members during and after AOD issues, such as children

Very supportive of compulsory, peoples addiction is so deeply entrenched, the voluntary change is becoming rarer

I would need more information before I make an opinion on what are the benefits of compulsory AOD detox or treatments

A large investment is needed in the gaps in the voluntary system and social supports people require

Why not for severe AOD related offence

There needs to be more evidence - where would the 'trial' take place? More consultation with Aboriginal and Torres Strait Islander people across WA

Absolutely, we don't want to be used as the 'guinea pigs' lots of draconian laws already adding to the top down approach of indigenous policy making