TUNA BLUE

Government of **Western Australia**
Mental Health Commission

AOD CRISIS INTERVENTION

Great Southern Community Workshop (3rd June 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.

OVERVIEW OF ACTIVITIES

Participants considered the following questions during a facilitated discussion:

- What should "safe" look like for people experiencing AOD Crisis in the Great Southern?
- What are the current challenges and gaps in AOD Crisis Intervention services in the Great Southern?
- What additional services or changes to existing services are required to optimise the AOD Crisis Intervention system in the Great Southern?

SUMMARY OF DISCUSSION

The discussion points are summarised below each focus question.

What should "safe" look like for people experiencing AOD Crisis in the Great Southern?

- Confidence on the users part to access whatever service is offered. Crisis intervention and compulsory treatment in the one discussion seem at either end of the safety spectrum. Getting people through the front door is one of the biggest challenges. Takes multiple service points to get people to meaningful change (can be coerced, can be stepped process of teetering on choice). Crisis intervention requires emotional safety - confident that you'll be protected in your vulnerability, a non-judgemental experience right from the first contact. You're at desperation point but you're on the precipice and only takes one sense or experience that you're not being heard or losing control of what you expected, to drop the grenade and walk away.
- CADS remit is counselling, but do a whole lot of emergency relief work, support that a drop-in style centre could create opportunities for people when they're ready for counselling. A lot of our resource and effort goes towards responding to wider crisis (housing, food, FDV, support for men). A service that deals with would allow us greater focus on delivering the counselling.
- Often withdrawal is not for the person, it's under pressure because they'll lose housing, children etc and often leads to relapse.

What are the current challenges and gaps in AOD Crisis Intervention services in the Great Southern?

- Only option is the hospital, often that's not safe (judgement) - small communities. Often people do walk out at their most vulnerable but willing to change. Even if you can hold them to a stage of getting people to next step, with waiting times and a lack of transport, you can lose people in the process. Getting people to rehab can be really difficult.
- Who else is in there, always at the forefront of a client's mind. Small communities, people sometimes don't want to see others.
- Katanning emergency accommodation service for 72hrs but not allowed to go if intoxicated, can't use on-site, must be independent (no-one on site), can't go with MH issues, co-location with men and women (no safety). Needs full non-judgemental acceptance and support. Plus, transitional housing.
- 72 hours is just long enough to sleep, get the food and then feel stronger and then out on their ear - won't work.
- A lot of outreach, fortnightly visits from community services. Can take 6 weeks to get an appointment for someone to safely withdraw in an evidence-based way. Leaves GPs and some are doing it safely, some are doing it properly and some are cowboys.
- The next step of withdrawal after a CADS presentation, the ongoing support is difficult.
- Crisis intervention within business hours, we can intervene and jump in the car as CADS - support, advocate etc. But when we do get to the hospital and they're turned away from Community Mental Health, that's difficult. Katanning CADS and Community Mental Health communicate well, depends on the staff triaging often (people open to doing assessment quickly, takes the time to assess and safety plan).

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

- An immediate access safe place is a great option to have. But what happens after the 72 hours? Need to have options for improving their life after the 72 hours, otherwise cycles of use reoccur and people are back for the next 72 hours.
- The addiction is not about the drug or the substance. If nothing changes for their life circumstances after 72 hours (food, housing, employment, FDV) then people are likely to go back to substance use to cope.
- Managing the demand without hardline, ostracising criteria would be a huge challenge but it reduces the likelihood of them coming back (these are the people who need it the most).
- Should be flexibility, multiple pathways in and out. One size fits all won't work. Assume all people using the service will have complex needs, none of them have simple needs. Will take a complex assessment to get a proper sense of people's needs. None of these people have a single stream issue - all co-occurring multiple causes for crisis - 72 hours won't do it. Will silo itself as a service.
- Some sort of centre for counselling, detox, basic needs, accommodation, education - the one place to move through it all. A Hub of sorts - a place where people can come, meet their needs where they're at and more resources to support people, families, children, people in crisis. A whole system in the one place run by a trusted NFP, to support clients and transition them to the next step, not moving clients around.
- Need for a 'next step' place for people to withdrawal after crisis intervention on country, in the region. Need for family support and networks. Integration back into community is really important, a local.
- Involve safe withdrawal processes, especially for alcohol. Not dying whilst drying out. Currently limited options for community-based detox, most cases involve a referral detox. Some success with hospital detox if GPs are cooperative. No formal community detox in place.

- Someone in crisis - a way to access the hospital in. meaningful, supported way is probably the most cost effective way (would it be a good client option?) Some clients prefer to stay home, some prefer to leave the community for treatment (can this be an option statewide to take people out of situations for using). Via statewide bed management systems (already have this for Mental Health beds which manages mandated and non-mandated patients). State MH beds are largely dealing with State run statutory MH services, the AOD system is more NFP based (can deliver a service more locally).
- CADS in the region with limited options for crisis, are more flexible in their service delivery and responding to individual crisis. More resource geared towards mobility in the regions (e.g. access to fleet vehicles). Mobility of services in the regions is an advantage.
- Very well trained and stable workforce in the Great Southern.
- There is a good propensity to collaborate in agencies across the Great Southern to case manage individuals and develop collaborative models. Grassroots relationships between services are key to any services and they're good here. Staff across our region will look at clients as individuals and think outside the box for them as a person. We have access to a pot of community foundation money, creative in our solutions and their implementation - goodwill in the community prepared to take a risk. Indigenous Advancement Strategy worker, connected to community, in Katanning is really helpful and important.
- Co-location options and direct partnership with State services (Police, MH, even ambulances) is really important as an idea. A change of scope would be required for CADS and community services in their current forms - would require a crisis scope expansion, to deliver locally tailored responses to community need. More beneficial than a standardized, prescribed State model transplanted into communities - even within regions, the responses for local problems should be locally developed and structured to the local community. We have a great network and connection between community organisations.
- Things we can leverage in each community are different. Need for cross-sector broadening of scope, ability to come together in community networks to provide a response to a community in crisis. To do so, every organisation currently has to push boundaries, break their scope for a response. Often hamstrung organisations.
- Similar to Suicide Prevention coordination concept. We have the role to respond to suicide, postvention and frontline intervention but no dedicated services to deliver that - it is a coordination effort and responsive.
- Needs to be an interconnected network of services options at the place of need. Real sense of cooperation between the agencies in the Great Southern, so any solution would need to include all the stakeholders (case management) moving forward. Interface with Health, GPs, Justice services