TUNA BLUE

Government of Western Australia
Mental Health Commission

AOD CRISIS INTERVENTION

Community Workshop #3 (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 potential future services, both new and changes to existing ones, that have emerged as themes from engagement to date - what they might look like and how they could be implemented.

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OVERVIEW OF ACTIVITIES

The facilitator gave an overview of a selection of potential future service options, as proposed throughout consultation to date. As a plenary group, the participants were asked to consider the draft outline options, commenting and challenging as required.

We also conducted ‘deep dives’ into the following areas:

- Peer Support Workers (benefits and challenges)
- Barriers to Entry
- Compulsory AOD Detox / Treatment

COMMENTARY ON THE DRAFT MODEL

The following comments were made in regard to the draft outline options for the future system (Appendix A contains a snapshot of the draft pictorial representation that was considered).

CRISIS OUTREACH

- Peer-led services, e.g. peer-based harm reduction
- Need for 24-hour provision of services, when people need it the most (potentially in the middle of the night)
- Need free-lance "detached workers" - individuals working alone, developing relationships - funded by Government
- Some people who are desperate will call a helpline, but biggest hurdle is waiting times for beds in medical detox.
- Range of potential outcomes - i.e. abstinence and harm reduction; AOD crisis is often episodic; recurring crisis is a feature
- Advocates to support people in crisis - peer volunteers to hold people's hands

IMMEDIATE ACCESS CENTRE / INTERVENTION CENTRE

- Relationship with the Justice system - anecdotally people in prison currently go "cold turkey" on their own without detox support. Currently work is being undertaken to look at AOD support services in-house within prisons. Justice own this issue.
- Stable housing is a critical issue - this is a critical factor in long-term success. Many interim housing providers only allow a certain period for people to stay and just as they start to achieve stability, they are forced to move on. Stable housing before and after.
- One of the main basic needs is nutrition - Immediate Access centre needs to offer food and water
- Dedicated support worker - holding a person's hand throughout their journey (think "AA sponsor") - attempting to avoid future instability and the "revolving door" effect
- Sowing the seed - minimising the occurrences - need it to be safe for everyone (including prison)

DEEP DIVES

PEER SUPPORT WORKERS

Benefits:

- Building rapport and trust through intentional disclosure of their own experiences;
- Supported by lived experience;
- Alcoholics Anonymous as an example - we're in it together, do it with not to;
- Understanding and compassion;
- New research talks about benefits of peer support;
- Education of medical staff is an important component too;
- From an educator's point of view, MHC does offer courses and qualifications in AOD so many peer workers do have some qualifications;
- People supported by peers are more likely to achieve recovery;
- Peer support worker could also be a coordinator - need a team;
- Need more consideration of non-sectarian and trauma-informed approaches.

Challenges:

- Active compassion is key with peer support work - this can potentially be delivered by someone who doesn't have specific AOD lived experience;
- Balance of skills and experience is needed - some non-lived "professional" experience can add a valuable balance too;
- DEVIL'S ADVOCATE: How do funders guarantee that the peer support function will deliver what it says it will? What are the KPIs? Evidence of peer support outcomes and benefits. How can we ensure quality of delivery? How will peer support workers be supported in their roles?

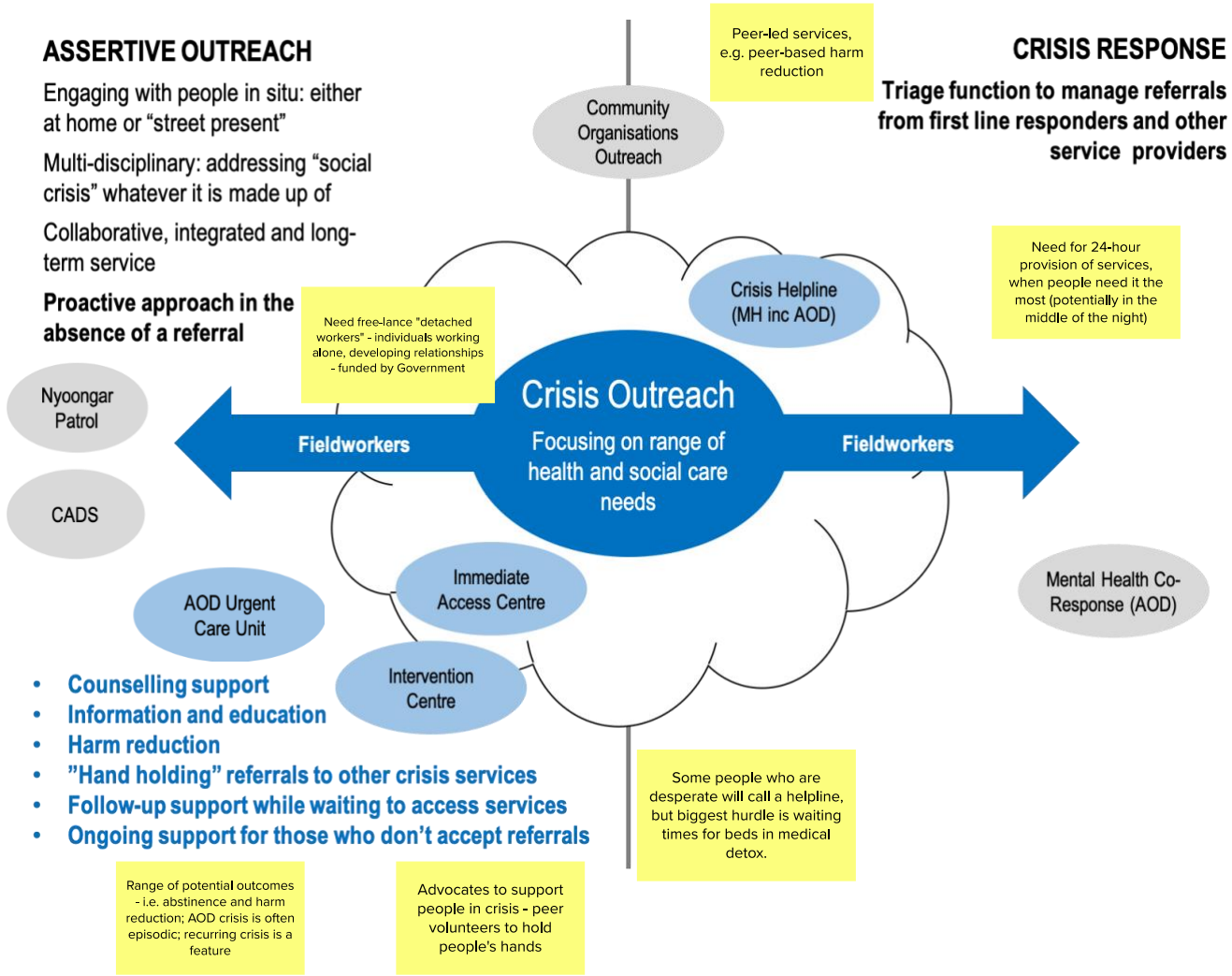
BARRIERS TO ENTRY

- Lacking the desire to stop using;
- Cost of rehab services;
- Need to feel safe (e.g. separation of women from men; nature of drug use - should Meth users be with alcohol or other drug users?);
- Long wait times for rehab – moment of opportunity passes;
- Lack of follow-on care from rehab and transition into the community afterwards - some have housing and some have family, but some do not - regardless what about triggers that may be there? Need for safe places after crisis and rehab care.

COMPULSORY DETOX / TREATMENT

- Can see both sides of the coin – can see all perspectives. People need to want to change, but if they're not in a state to decide for themselves, then do they need that decision to be made by somebody else?
- How can we assess whether a person has the cognitive ability to decide for themselves though?
- Every situation is unique, there is no one size fits all.
- Can lean toward possibly compulsory detox but definitely not compulsory treatment. That needs to be that person's decision once they are "cleaner" – when would they have capacity?
- What do you do when somebody is psychotic? They need to be calmed down.
- When is a person a danger to others?

APPENDIX A: WORKSHOP GRAPHICS



IMMEDIATE ACCESS CENTRE

Drop-in centre plus referrals

Short-term (72 hours) overnight support and stabilisation in a calm and welcoming space

Ongoing drop-in support

Relationship with Justice system - anecdotally currently go "cold turkey" on their own without detox support. Currently work is being undertaken to look at AOD support services in-house within prisons. Justice own this issue. (Margaret Doherty - Mental Health Matters 2)

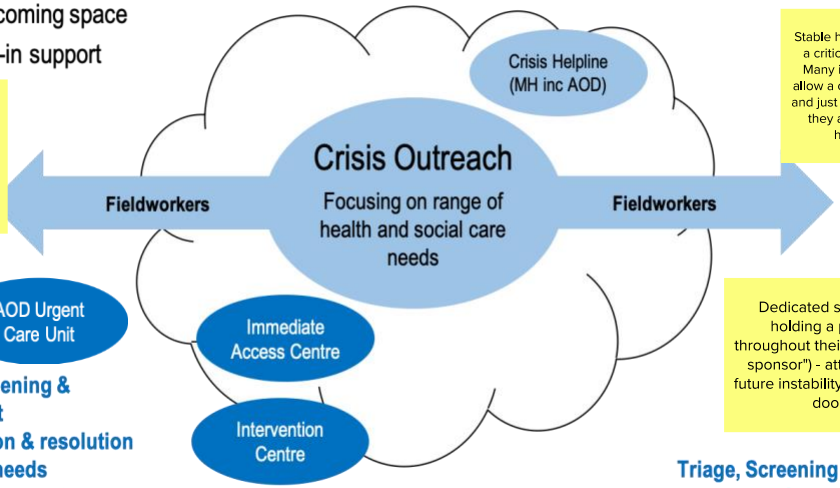
INTERVENTION CENTRE

Enable opportunity for further stabilisation through an extended length of stay (21 days)

Setting the foundations for longer-term recovery

Stable housing is a critical issue - this is a critical factor in long term success. Many interim housing providers only allow a certain period for people to stay and just as they start to achieve stability, they are forced to move on. Stable housing before and after.

(AODCCC Chair) - one of the main basic needs is nutrition - Immediate Access centre needs to offer food and water



Dedicated support worker - holding a person's hand throughout their journey (think "AA sponsor") - attempting to avoid future instability and the "revolving door" effect

- Triage, Screening & Assessment
- De-escalation & resolution
- Basic care needs
- Active engagement
- Information and education (consumers & families)
- Sobering up (low-med detox?)
- "Hand holding" referrals to other crisis services
- Follow-up support while waiting to access services

Triage, Screening & Assessment
Low-med withdrawal
In-reach from range of other services
Information and education (consumers & families)
Facilitated referral and mentoring follow up for consumers
Facilitated referral and follow up for families

AOD URGENT CARE UNIT

Supporting individuals presenting to hospital ED that are affected by drugs and alcohol and who need medical treatment, particularly where sedation is used to assist de-escalation and withdrawal.

Treating patients with behavioural disturbances away from the main ED environment.

- Secure unit
- Triage, Screening & Assessment
- De-escalation
- AOD specialists
- Sedation
- High-med and complex detox
- Referrals to other crisis services

Reduce barriers to entry at rehab

Sowing the seed - minimising the occurrences - need it to be safe for everyone (including prison)