Consultation report

prepared for the Victorian Alcohol and Drug Association

Jason Rostant

Integrated Framework for the treatment, care and support of people with mental illness and substance use or addiction

Summary AOD sector report

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Document purpose and contents

Document purpose

This document provides a summary of consultations undertaken by VAADA with AOD sector representatives in late August and September 2021.

The consultations were designed to contribute towards the development of an Integrated Alcohol and other Drug (AOD) and Mental Health and Wellbeing Framework for Mental Health and Wellbeing Services.

The document presents an overview of:

- the consultation workshops including their content and engagement activities
- stakeholders that participated in the consultations
- a summary of the insights collected through the forum breakout sessions
- key messages and themes from attendees

The structure of the document is set out below.

I acknowledge the traditional custodians of the land on which I work and live, and pay respect to Elders past and present. I acknowledge the sorrow of the Stolen Generations and the continuing resilience, pride and strength of the Aboriginal and Torres Strait Islander community.

Recommendations

General

Recommendation 1: That AOD sector consultation findings and recommendations inform the development of tender specifications and service model development for the fast-tracked MH&WBS.

Recommendation 2: That the finalised Framework be embedded as a core operational requirement of the fast-tracked and subsequent local and area MH&WBS prior to their commencement.

Recommendation 3: That timelines for development of the Integrated Framework be clarified, including how key consultation activities across and between sectors and interested parties can best be aligned to reduce duplication, maximise reach, and foster collaboration.

Conceptual model

Recommendation 4: That the four-quadrant conceptual model not be adopted within the proposed Framework.

Recommendation 5: That consideration be given to other current and more sophisticated conceptual models that are person-centred and holistic, system-wide, and consider intensity of need across all dimensions of a person's treatment, care and support journey.

Recommendation 6: That development of an alternative conceptual models privilege First Nations health and wellness, and focus on the intersectional experience of all people with co-occurring AOD and MH needs.

Recommendation 7: That development of alternative conceptual models actively engage 'dual diagnosis' best practice models currently in use and development, and learnings from other recent system reform and integration processes.

Recommendation 8: That the scope of the Framework expand to include articulation of shared definitions, goals and objectives; clearly articulated minimum standards; and a defined outcome framework.

Recommendation 9: That explicit consideration be given to the resourcing needed to support workforce engagement and practice alignment with the Framework.

Recommendation 10: That the Framework explicitly articulate the system features, supports and mechanisms that will drive accountability for leadership, cultural and practice change, with particular focus on the governance and oversight roles of consumers, MH&WB Service leadership, Regional Boards, and the Department of Health.

Draft principles

Recommendation 11: That consumers, family members and other supports be directly engaged in the development of the Framework principles.

Recommendation 12: Building on recommendation 7, that the principles seek to maximise alignment with leading DD integrated practice frameworks (Minkoff and Cline) and other leading frameworks relevant to AOD and MH sectors.

Recommendation 13: That the currently drafted principles be reviewed and refined, including by adding new principles relating to human rights; holistic and wrap-around care inclusive of bio-psychosocial, harm reduction and trauma-informed practice lenses; evidence-based / informed practice; and complexity and risk.

Recommendation 14: That the impacts, outcomes and implications of optimal delivery of Framework principles gathered through consultations support the development of the outcome framework proposed at Recommendation 8.

Service types

Recommendation 15: That a range of necessary service types be identified to ensure the delivery of integrated treatment, care and support in local and area MH&WB Services that is holistic, wrap around and responds to the whole needs of the person.

Recommendation 16: That minimum service expectations be determined to guide the establishment of all MH&WB Services, including partnership and consortia arrangements, and service model design.

Enablers and barriers

- **Recommendation 17:** That further cross-sectoral consultation on the development of the Framework further explore enablers/barriers identified through consultations, and that these dimensions are included as appropriate within the scope of the finalized Framework.

Consultation background

Introduction

A briefing session and series of workshops were held between 27 August and 15 September 2021 with representatives of the Victorian AOD sector.

The sessions were designed, delivered and co-facilitated by the Victorian Alcohol and Drug Association and Jason Rostant Consulting.

Consultations were also supported by an online survey that was open from 1 – 15 September 2021.

The sessions represented a preliminary opportunity for the sector to engage with a key recommendation of the Royal Commission into Victoria's Mental Health System.

Royal Commission into Victoria's Mental Health System

- Recommendation 35: That by 2022 all mental health and wellbeing services provide integrated treatment, care and support to people living with mental illness and substance use or addiction; and do not exclude these consumers

On 23 August 2021 the Department of Health released a consultation paper seeking feedback on the development of an *Integrated framework for the treatment, care and support of people with mental illness and substance use or addiction*. The consultation paper formed the basis of all consultation activities.

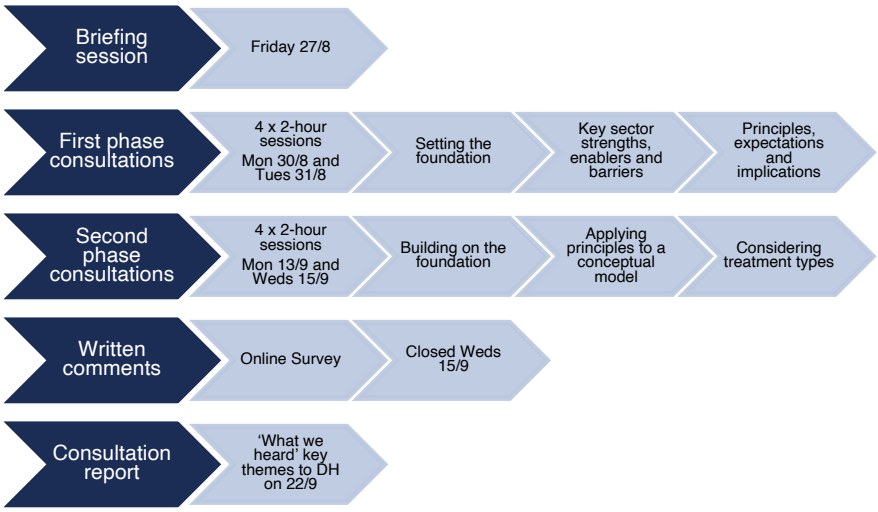
Consultation paper

- A **conceptual model** for people living with mental illness and substance use or addiction in an integrated mental health and wellbeing system
- Draft **principles and expectations** to guide the delivery of integrated treatment, care and support in MH&WB Services
- The types and mix of integrated **AOD treatment types** that should be delivered by MH&WB Services
- How best to **retain and integrate AOD system strengths** in the reformed mental health and wellbeing system
- Other key questions to inform the development of the Framework, including **critical enablers and key barriers** to integrated practice.

Consultation approach and participants

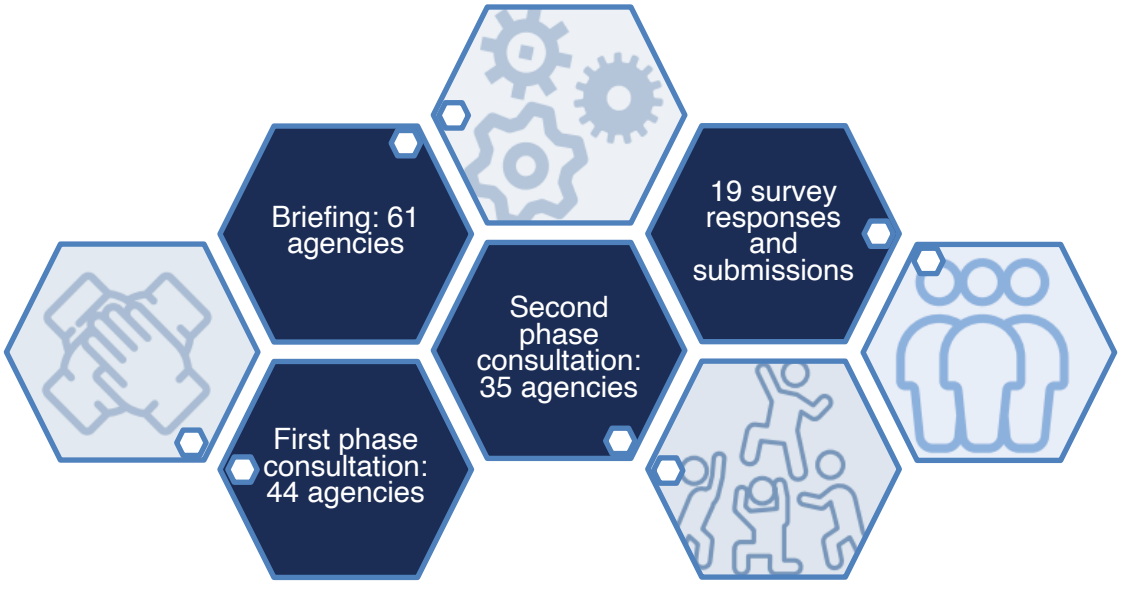
Consultation approach

A consultation plan was developed to maximise opportunities for AOD sector input and engagement between the release of the discussion paper on 23 August and provision of a report to the department on 22 September.



Consultation participants

Approximately **240 participants** representing almost **70 agencies** took part in the various consultation opportunities, bringing together attendees spanning specialist AOD, health and community health, consumer peaks, the Aboriginal community-controlled sector, unions, research and policy interests, other sector peak bodies, and more.



Workshop overview

In total, eight two-hour online workshops were delivered across two phases – the first to set the foundation and the second to build on the foundation. Each workshop included small breakout discussions facilitated by VAADA staff.

Briefing session

The primary purpose of the briefing session was to engage sector leaders with the proposed consultation process by providing an outline of:

- the AOD-related findings and recommendations, and key dimensions of a future transformed Victorian mental health system, delivered by the Royal Commission
- intent for a future Integrated Framework for treatment, care and support
- key dimensions of the DH consultation paper
- the VAADA funded project, including in the context of other consultation activities
- the consultation process being delivered over successive weeks

First phase consultations: Setting the foundation

First phase workshops focused on AOD sector strengths, integration enablers and barriers, draft principles drawn from the DH consultation paper, and exploration of key consumer and sector outcomes.

Discussion 1: Strengths, enablers and barriers

- What key strengths of Victoria's AOD system should be integrated in the future mental health and wellbeing system?
- What are the key enablers that would achieve this in an enduring way?
- What are the key barriers to integrated practice, and how should these be addressed?

Discussion 2: Draft principles

- Are these appropriate principles and expectations for the delivery of integrated AOD and mental health treatment, care and support?
- Are there any gaps or areas for improvement?

Discussion 3: Implications of the principles

- What do the principles and expectations mean in practice for consumers of MH&WB Services?
- Will these principles impact the delivery of AOD services?

Second phase workshops: Building on the foundation

Second phase workshops provided an overview of key messages heard in relation to the Framework and supporting principles, and further focused on the conceptual model and treatment types presented in the DH consultation paper.

Discussion 1: Model strengths, limitations and risks

- Is the model useful for determining who provides integrated treatment, care and support? What adaptations should be considered?
- What adaptations to the model or system are required to implement a model like this?
- What risks are associated with this conceptual model and how can they be mitigated?

Discussion 2: Giving effect to the principles

- What enablers will support delivery of integrated treatment, care and support in MH&WB Services?

Discussion 3: Treatment types

- Are these the right mix of AOD treatment types for Local or Area MH&WB Services? What is missing?
- What adaptations to AOD treatment types should be considered?
- What elements of AOD treatment, care and support are 'must haves' for MH&WB Services?

General insights

Framework development

Participants across all workshops advocated that the necessary time and resources be devoted to support the Framework's development through an integrated and collaborative process that:

- includes both AOD and MH sectors and people with lived / living experience, their families and supporters
- includes non AOD and MH stakeholders and other related service systems that will have a role in delivering integrated treatment, care and support to people with co-occurring needs
- considers integration practice across prevention, early intervention and tertiary responses, and within community and acute settings
- applies to all levels from individual clinician / client interaction; service; place, area or regional location; whole-of-system
- provides opportunities for these diverse stakeholders to work collaboratively towards the development of the Framework.

Framework scope

Participants identified a number of features in addition to the proposed conceptual model, principles and service types that should be considered within the scope of the Framework.

Clear and agreed definition of integration	Statement of shared goals and objectives	Universal application and interface with other key areas
Outcome framework that defines individual, service and system outcomes, material changes	Clealry articulated minimum requirements with improved accountability and oversight	System tools (standards, protocols, structures and resources) to apply principles, empower leadership and drive culture change
Shared data collection and reporting	Framework evaluation	Resourcing to support engagement, alignment and delivery of the Framework

Strengths, enablers and barriers

AOD sector strengths

First phase consultations commenced with an exploration of **AOD sector strengths** that should be retained within the future mental health and wellbeing system.

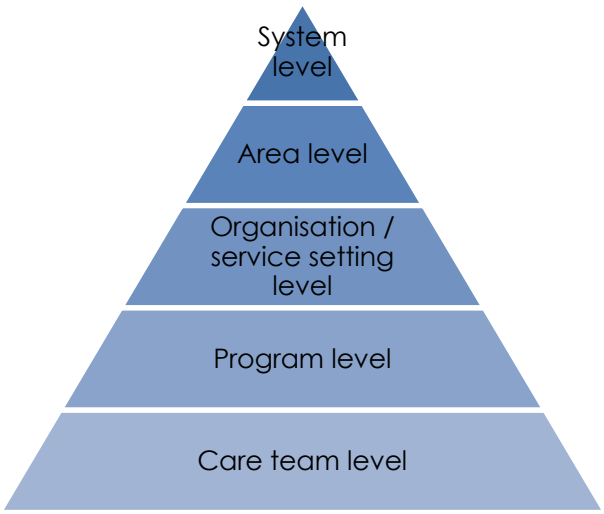
Identified strengths were broadly consistent with those reported by the Royal Commission in its final report.

- Staff skills and capabilities
- Peer, lived and living experience experience and consumer voice
- Holistic and integrated treatment, care and support
- Welcoming and inclusive services
- Existing engagement with 'dual diagnosis'
- System efficiency and ROI

Integration enablers and barriers

Participants identified enablers and barriers to the delivery of effective integrated AOD and mental health treatment, care and support in the future MH&WB Services across a number of thematic areas as below.

These factors have implications for integrated practice at multiple levels.



- Workforce
- Treatment, care and support options
- Access and inclusion
- Multi or interdisciplinary practice
- Shared intent and accountability
- Resourcing

Strengths, enablers and barriers

	Enablers	Barriers
Workforce	• Defined scope of practice, competencies between sectors, disciplines and roles • Core DD competence across disciplines • Collaborative and reflective practice networks • Workforce parity and equity • Resources for PD, change management • Inclusion / expansion of LE / peer and specialist DD workforces • Workforce strategies to address supply, recruitment, retention • Integration leadership roles and specialisations, • Secondment, rotation opportunities	• Workforce / skills shortages • Lower status, skills development, credentialing and recognition of AOD workforce • Inconsistent understanding, application of DD and other integrated practice / standards • LE / peer workforce bias, stigma, discrimination • Lack of confidence, skills to work with acutely unwell AOD /MH clients • Poor workforce knowledge about supports across different sectors and systems
Treatment options	• Robust co-design with service users • Comprehensive assessments regardless of entry • Holistic 'whole person' response to intersecting needs, issues and experiences • Coordinated care across and between services, • Shared care teams, planning, clinical reviews inclusive of person and family • Shared person-centred / driven principles for • Continuity of care; seamless transitions • Common trauma-informed approach • Commitment to evidence-based practice	• Poor client voice, co-design • Different treatment models and philosophies: • Overly medicalized view of AOD / MH • Absence of trauma-informed lens • Inconsistent practice, mechanisms, supports and leadership for coordinated offering • Poor access to primary / secondary consultation, stepped, after and continuing care when required • Integration fails to respond to whole person
Access & inclusion	• No wrong door: right care, right place, right time • System-wide, clear and concise I&A • I&A staffed by DD competent / peer workforce • Intersectional lens responsive to diversity • Diverse and representative workforce • Care and system navigation support • Maximum informed choice for clients	• Fragmented, complex intake systems • Bias, stigma and discrimination • Support and transition gaps / silos • Lack of culturally safe, targeted services • Different risk appetites and confidence in working with complexity
Multidisciplinary practice	• Intentional engagement with different sector approaches, language, principles, philosophies • Strong partnership and mutual respect • Clear, consistent and coordinated decision-making, communications, referral • Client-directed care teams with clear roles and resourced care coordination • Agreed standards for interdisciplinary practice	• Different language, philosophies, principles • Reliance on co-location without investment • Lack of shared accountability / responsibility • Hierarchies around 'specialists' and 'experts' • Assumptions, rigid views about 'other' sectors • Non-inclusive clinical governance, care
Shared intent / accountability	• Clear and agreed definition • Shared goals, vision, purpose, values, principles • Leadership to drive culture change • Practice guidelines, policies, standards • Governance, oversight, monitoring, reporting • Clear targets, KPIs, accountability, roles • Robust feedback and complaints mechanisms • Shared data and information sharing systems	• Integrated care poorly defined, lacking leadership to drive cultural change • Absence of clear guidelines, visions, goals, KPIs • Different reporting, data and client systems • Operating under different legislative frameworks
Resourcing	• Flexible / transportable funding options • Sustained resourcing to support integration partnerships, capacity building, pathways • Needs and population-based resourcing	• Reform fatigue • Competitive tendering • Siloed and rigid funding models that do not support or fund practice • Wage and condition disparities between sectors • Under-resourcing relative to need, resource parity by region, priority communities

Response to the conceptual model

Participants expressed a range of views about the value of the four-quadrant conceptual model presented in the consultation paper. **It was recommended that the conceptual model not be adopted.**

Many were unclear about the model's purpose and how it would be used. While acknowledging value in conceptualizing high-level system design and planning, many expressed concern the model may also inform service model planning leading to triaging of treatment, care and support in ways that are inconsistent with Framework principles.

Lack of definition and distinction in the paper about the various levels and forms of integration (individual treatment, care and support, service, system added to this uncertainty.

Conceptual model strengths

- Similar to the conceptual model reflected in the current dual diagnosis guidelines and is known and familiar
- Foregrounds and increases visibility of co-occurring AOD / MH need
- Acknowledges that response to these needs are a non-negotiable and a shared system-wide responsibility
- Clarifies that collaboration, coordination and partnerships are core requirements of integrated treatment, care and support
- May assist delineate roles and responsibilities, scope of practice
- May support stepped models of care and distinguish between primary and tertiary / local, area and statewide service requirements
- May support improved system accountability

Conceptual model limitations

- Hierarchy and compartments restrict integration by their very nature, people risk being categorised and 'pigeonholed'
- Model appears clinically and illness-focused, reads as system-centred not person-centred
- Model presents an overly simplistic view of complexity and need
- Broader treatment, care and support responses spanning prevention and harm minimisation; primary, secondary and tertiary; family and peer networks, community-based and acute are absent or not clearly defined
- The 'front door' and how people transition between and within systems is unclear
- How shared care and governance operate within specific quadrants or across an integrated response as a whole is unclear
- Various roles including AOD/MH, other sectors and disciplines, and of consumers, families and supporters are poorly defined, misaligned or absent

Response to the conceptual model

Conceptual model risks

- That the focus on AOD/MH to the exclusion of broader social determinants of health and biopsychosocial needs perpetuates siloing
- That gaps between systems are exacerbated by the creation of new barriers or exclusion criteria
- That changing AOD / MH complexity (together or independently) 'push' or restrict people's movement from one quadrant to another as their needs, wishes and life circumstances change
- That philosophical differences between sectors remain unreconciled and people / services continue to work within their comfort zone
- That clinical governance, scpe of practice and care responsibilities remain unclear within and between quadrants
- That continuity of care is compromised as people move between quadrants
- That funding streams remain siloed or rigidly defined according to model and program parameters

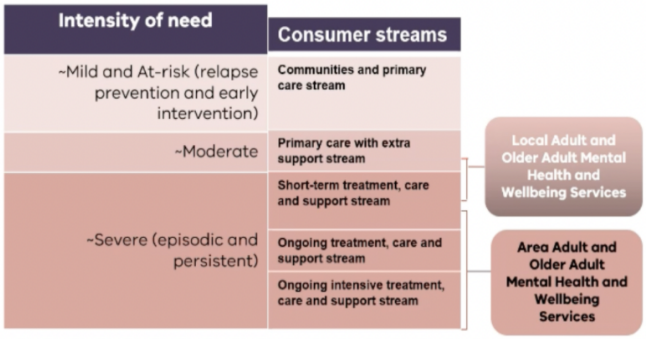
Participants advocated for a conceptual model that more clearly aligns with Framework principles; that is framed around the person and their journey rather than responding to levels of illness or system needs, and that explicitly addresses easy access, no wrong door, and low thresholds that support consumer choice.

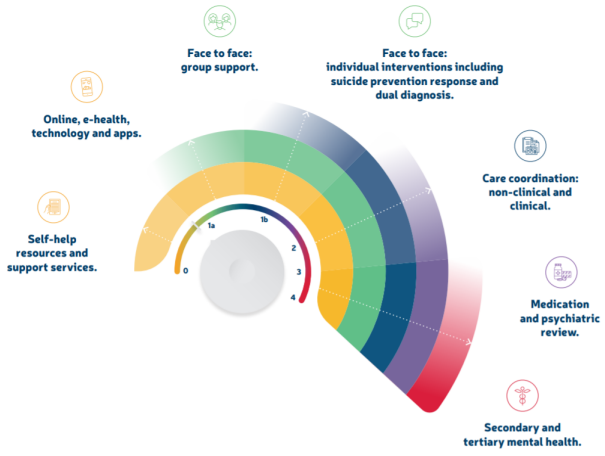
Other conceptual models:

The **Minkoff and Cline CCISC model was frequently cited as best practice and recommended for wider adoption.**

Participants also recommended looking to models applied in other contexts, for example:

- 6 level-model proposed by the RCVMHS
- First Nations Mental Wellness Framework
- VDDI and current First Step CCISC pilot
- Forensic/AOD integration processes
- MACNI
- Orange Door, MARAM
- The ASAM Criteria™





Response to the draft principles

Explicitly considered in phase one consultations, reflections on the draft principles were implicit in all workshop discussions. The substance of the draft principles was broadly accepted. There was strong support for co-designing the principles, language and scope with people accessing services, their family and supporters.

As outlined above, the Minkoff and Cline CCISC Model was presented as international best practice and its adoption in several Victorian contexts was noted.

Principles to add

- **Human rights:** Participants recommended the Framework be clearly grounded in a right-based approach. The Framework should articulates how integrated treatment, care and support links to human rights-based principles.
- **Holistic and wrap-around care**: Participants recommended the inclusion of a stand-alone principle that ensures response to the full range of treatment, care and support needs a person may have. This principle should include bio-psychosocial models of care, harm reduction and trauma-informed practice.
- **Evidence-based / informed practice**: As referenced in the previous section, participants recommended development of an outcome framework in which client, service and system experience, outcomes and impact measures drive evidence-informed parctice
- **Complexity and risk**: Participants cited a number of philosophical and methodological sector differences in how issues of complexity and risk are approached and responded to. These are relevant at multiple levels including responsiveness to individual need; workforce confidence, skills and capabilities; and enabling organisational and system leadership, policies and procedures.
- **Stigma and discrimination:** While referenced in existing draft principles, participants advocated for stronger emphasis on preventing, responding and advocating in relation to stigma and discrimination

Principles to strengthen

- **Substance use or addiction is a health issue:** Should engage the social, economic and cultural determinants of health linked to holistic and wrap-around care that consider the whole person's wellbeing.
- **Co-occurring support needs are the expectation not the exception:** Should elevate 'no wrong door' as the explicit frame with clear expectations of system-wide care coordination and shared care accountabilities regardless of entry point; include complex trauma as part of the expectation.
- **A person's mental health and AOD support needs are both considered a priority:** This equity provision should also engage cross-sector and cross-discipline equity that recognise and legitimizes skills, capabilities, specializations and philososphies at all levels (care team, service, system) as well as the role of clients, families and supporters, peer workforces and others with lived/living experience.
- **Integrated AOD and mental health treatment, care and support responds to the changing needs and preferences of individuals:** Should explicitly acknowledge non-linear stages of change as no impediment to care and explicIty include non-clinical dimensions including connecting with people and communities, building relationships, being included; living life to fullest, with purpose and reaching potential.
- **Integrated AOD and mental health treatment, care and support is delivered in a way that is respectful and puts consumers at the heart of decision making:** Should make explicit that care is delivered in response to a person's own goals via person-centred /directed care, ensuring the locus of control and choice resides with the person.
- **MH&WB Services are responsive to the needs of diverse communities:** Should include explicit recognition and responsiveness to intersectional need, including through Aboriginal and Torres Strait Islander leadership, cross-cultural models of care, age and developmentally sensitive approaches, and measures to equip, skill and empower workforces to engage culturally aware / sensitive practice in mainstream settings.
- **MH&WB Services work with and involve families and support networks:** Should include stronger articulation of the role of families and support networks, family-inclusive practice, as well as their own support needs.
- **Effective coordination, collaboration and communication / capable workforce / responsibility and accountability:** Participants endorse the intent of these principles but note a range of factors will impacttheir practical implementation. This principles should be underpinned by system-wide measures to support, enable, drive and monitor their delivery, including through oversight and accountability mechanisms embedded in MH&WB Service governance, Regional Boards, the department and others.
- **Partnerships are established between MH&WB Services and AOD service providers:** This principle should explicitly include partnerships required to deliver whole person, wrap around care (for example family violence; housing and homelessness; NDIS and Aged care systems; employment, education and training; primary health and pharmacotherapy; forensics / justice) and specialist services for diverse population groups, a commitment to service and system-level co-design and recognition, inclusion and development of sustainable peer and lived/living experience workforces.

Reflections on service types

Phase two workshops explored participant expectations about the range of AOD service types that should be available in local and area MH&WB Services.

Responding to the discussion paper, participants advocated use of less clinically / medically focused language than "treatment types" and that support be defined by types rather than issues (for example therapeutic counselling cf. AOD or MH counselling).

Reflections on specific service types are summarized below.

Intake and assessment

- Relationship of existing AOD intake and assessment processes (which include MH / FV screening) to new MH&WB Services to be clarified
- Seamless and staged processes as people move across and around system should be embedded

Family, carer and supporter-related services

- Family, carer, community and others acknowledged as crucial part of the support ecosystem
- Services should be well resourced and deliver family-inclusive supports

Support for specific cohorts

- Wrap around, person-directed and accessible services should be responsive to intersectional need for Aboriginal and Torres Strait Islander people, CALD, LGBTIQA+, mothers / young parents, women experiencing FV, forensic and other mandated clients, children in the child protection system, and people who are homeless / rough sleepers
- Partnerships with a wide range of service types and specialist providers should be embedded

Access to NSP, MSIR and pharmacotherapy

- MH&WB Services should include access to NSPs, inclusive of HCV/ HIV / BBV testing and treatment, liver care, and expanded access to medically supervised injecting rooms
- Access to pharmacotherapy and ORT should be embedded with expanded access to PAMS and prescription medication withdrawal

Residential and outreach supports

- MH&WB services should consider pre- and post-discharge support to facilitate transition between resi and other supports
- Assertive outreach models should be available to a wider cohort than young people to ensure right service, right place, right time

Peer and system navigation support

- Role of peer workforces and others with lived / living experience in strengthening system accessiblity should be embedded to build rapport, establish welcoming environments, inform, advocate and advise, and support continuity of care

Other service types and functions

- Other AOD / MH services should include after-care and continuing care services / care recovery coordination; addiction medicine and pain management; access to brief interventions and single sessions; and psychiatry services
- Other non-AOD / MH specific services should include (for example) primary and oral health, nurse practitioners, pharmacies; allied health including OTs, physios, dieticians, naturopathy and hypnotherapy; disability and aged care; housing, homelessness and supported accommodation; employment, education and training; FV and CASA; and justice and legal supports

Towards an outcome framework

Phase one workshops explored practical differences the principles would make to the experience of people with co-occurring needs, their families and supports and/or the practice of service providers if they were effectively and optimally implemented.

A range of key themes emerged which, by no means comprehensive, provide a starting point for consideration of the proposed outcomes framework.

	Clients, families & supporters	AOD / MH / other providers
Client / workforce	• Reduced AOD / MH related harms; improved health and wellbeing outcomes • Increased autonomy, self-determination • Greater stability; thriving / hope/ potential • Stronger relationships, feels cared for • Reduced justice engagement; improved housing, education, employment	• Less fragmented system • Services are trusted • Fewer presentations of acutely unwell people • More hopeful workforce, less burnout • Feeling valued and respected; increased workforce satisfaction, retention, engagement • A shift from 'defensive' practice
Care	• All bio-psychosocial needs are met • Support based on person's own priorities • No need to repeatedly re-tell story • No wrong door: more immediate support • Seamless stepped care, transition and care continuity • Warm handovers and acceptance • Earlier intervention • Families feel better supported, positive experience engaging with services	• Able to provide timely and efficient services • Seamless involvement of other providers • Strengthened, rigorous shared assessments • System less crisis driven • Clearer shared care arrangements • Able to support people as long as they need • Improved capacity to work with families • Capacity to work across response continuum
Access	• Increased cultural safety • Services when, where, how they're needed • Services easier to navigate; one stop shop; no wrong door • Warmly welcomed by care coordinators • Client experience is seamless • Choice when / where / how to access services • Services are flexible, with broad criteria • Reduced stigma when accessing support	• Consistent, streamlined I&A, referral processes • Cross-sector capability to provide holistic, judgement-free and culturally safe services • Increased outreach and assertive care • Improved reputations and seen as more welcoming in community
Collaboration	• Greater shared care, person-directed care • Empowered as the main driver of decisions; a voice, supported to be own care manager • Better peer supports • Clarity about care team, roles and responsibilities: who's who • Treatment, care and support is relational	• Collaborative, client-driven work • Culture, language shared across disciplines • Environment, resources, structures support collaborative practice • Shared care responsibility and accountability • Increased professional knowledge • Improved access to specialist supports • Cross-sector / discipline, respect, equity
Skills	• Increased skills, capabilities, resilience, assertiveness, self-advocacy	• Embedded PD, workforce development • Increased confidence, skills and capability • Interdisciplinary practice models supporting learning, understating of scope of practice • Recognition of skills and capabilities • Better utilized peer / LE workforces
Quality	• Access to evidence-based, holistic care • Success / outcomes determined by the person • Expectations are met; experience is improved • Access to review, complaint, redress • Strengthened co-design models and programs	• Outcomes consistently measured, reported • Improved service evaluation, CQI • Reduced data and reporting burden • Access to tools, supports needed to deliver highest quality care • Increased accountability to clients and community