VICTORIAN ALCOHOL & DRUG ASSOCIATION

Local Mental Health and Wellbeing Service Framework

Summary and reflections from an AOD perspective

2022

VAADA Vision

A Victorian community in which alcohol and other drug (AOD)-related harms are reduced and well-being is promoted to support people to reach their potential.

VAADA Objectives

To provide leadership, representation, advocacy and information to the alcohol and other drug and related sectors.

Contact Person: Gillian Clark
(gclark@vaada.org.au)

Victorian Alcohol and Drug Association
211 Victoria Parade, Collingwood 3066
p. 03 9412 5600 f. 03 9416 2085
vaada@vaada.org.au
www.vaada.org.au
ABN 19 039 293 679

Contents

1. About VAADA

VAADA is a non-government peak organisation representing Victoria's publicly-funded alcohol and other drug (**AOD**) services. VAADA aims to support and promote strategies that prevent and reduce the harms associated with AOD use across the Victorian community. VAADA's purpose is to lead AOD policy, workforce development and public discussion across membership, related sectors and the community to prevent and reduce AOD harms in Victoria. .

VAADA seeks to achieve its aims by:

- Engaging in policy development;
- Advocating for systemic change;
- Representing issues identified by our members;
- Providing leadership on priority issues;
- Creating a space for collaboration within the AOD sector;
- Keeping our members and stakeholders informed about issues relevant to the sector; and
- Supporting evidence-based practice that maintains the dignity of those who use AOD (and related) services.

VAADA's membership comprises agencies working in the AOD field, as well as those individuals who are involved or have a specific interest, in the prevention, treatment, rehabilitation or research aimed at minimising the harms caused by AOD.

2. Introduction

The introduction of Local Mental Health and Wellbeing Services was a recommendation of the Royal Commission into Victoria's Mental Health System. The Department of Health has released the Local Adult and Older Adult Mental Health and Wellbeing Service Framework which can be found here. VAADA welcomes the release of this document and the opportunity to understand and explore how the yet-to-be-defined 'standalone AOD sector', can intersect and continue to provide high-quality services. The following summary outlines key elements of this Framework that relate to the AOD sector. *All italicised sections in this document are direct quotes from the Framework*.

This summary has been prepared to both inform the AOD sector and to generate thinking and opportunities for future collaborative AOD and Mental Health sector work on ensuring access to treatment for all with co-occurring mental health and AOD needs.

We have included questions at the end of each section, following an analysis of the full document, from an AOD perspective.

3. Scope and Purpose of Local Mental Health and Wellbeing Services

Local Services will provide easy to access, high quality treatment, care and support for ***people aged 26 years and over*** *experiencing mental illness or psychological distress, including those with co-occurring substance use or addiction****, whose needs cannot be met by primary and secondary mental health care providers*** **(GP's, private psychologists and psychiatrists)** ***alone, but who do not require intensive episodic or ongoing care from tertiary area mental health and wellbeing services.***

They will operate;

- In 60 Local areas across the State by the end of the reform process
- During business hours on weekdays, after business hours on weekdays and on the weekend throughout the entire year
- Headspace Centres have been identified as the 'Local' service for those under the age of 26 years across the State

4. Types of AOD services offered by Locals

All Local MHWB Services must provide an integrated model of care for those with co-occurring mental health and AOD issues. Providers can determine if they choose co-location, multidisciplinary teams or service partnerships to achieve this. As is outlined in the Local Adult and Older Adult Mental Health and Wellbeing Service – Service Framework Local Services must offer the following AOD service types;

- Initial screening and comprehensive biopsychosocial needs assessment
- Range of evidence based psychological therapies
- Pharmacotherapy prescribing if;
    - The person is receiving active clinical treatment of mental illness from the Local Service **AND**
    - Do not have access to pharmacotherapy prescribing from a local GP or NP
    - If a provider of a Local Service is funded separately (from a funding source other than for the delivery of the Local Service) to provide pharmacotherapy and management, they can provide this service to consumers of the Local Service.
- Psychoeducation for individuals and families
- Overdose prevention and response training
- Peer workers
- Care-Coordination
- Family-inclusive integrated treatment
- Can provide NSP services but if they do not they must ensure that consumers have access to an NSP

A key condition of the provision of these services types is that they:

> *Make sure the service complements but does not result in duplication, or cost shifting of services reasonably and more appropriately provided by Commonwealth-funded primary and secondary mental health care systems or other systems, such as the standalone AOD sector and the National Disability Insurance Scheme (with regard to psychosocial disability supports).*

5. Out of scope

Providers of a Local Service will **not deliver** the following service types.

- Residential and non-residential AOD withdrawal and rehabilitation services*

*Funding allocated to a provider for the delivery of the Local Service will not be used to fund the delivery of residential and non-residential AOD withdrawal and rehabilitation service types. A Local Service provider may deliver these services if they have been funded separately to do so. **Notwithstanding this, the Local Service will collaborate with providers of residential and non-residential AOD withdrawal services to provide co-ordinated mental health treatment, care and support when a consumer is concurrently receiving withdrawal and rehabilitation services.**

6. Who supports who?

The revised mental health system has been designed on a stepped-care model that aims to provide support to all people across a spectrum of mental health needs. The following diagram indicates where the AOD sector is to sit within this stepped care system.

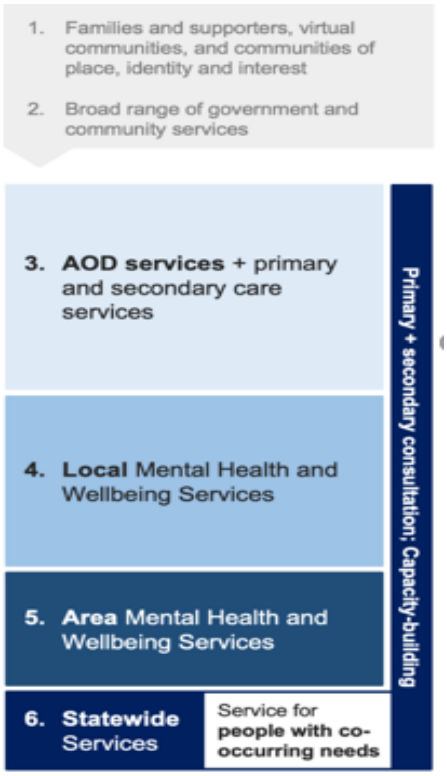

Figure 3: Continuum of care for people with co-occurring needs, and their families and supporters (Integrated Treatment Guidance)

This diagram sets the framework for how people will access support based on their identified *'intensity of need'*.

The intensity, risk and complexity of a consumer's mental health needs (including the degree of impact on their daily life, work and wellbeing, any AOD use, and associated distress) and their preferences will determine which broad 'consumer support stream' they best align with at a given time. This will inform;

- *Which part of the mental health and wellbeing system they should most appropriately receive treatment, care and support from, e.g. a Local Service or an Area Service, a standalone AOD provider, or a primary or secondary mental health care provider.*

***AOD services** are responsible for supporting people with substance use or addiction, including people who experience **low intensity mental health support needs**.*

Local Services** are responsible for supporting people with substance use or addiction concerns who are **experiencing moderate to higher intensity mental health support needs.

The following table from the Local Framework document outlines descriptions of low and moderate intensity mental health needs.

Low intensity mental health needs	Moderate intensity mental health needs
• Typically, minimal or no risk factors, mild symptoms/low levels of distress, and where present, this is likely to be in response to a stressful environment. • Symptoms have typically been present for a short period of time (less than 6 months but this may vary). • Generally functioning well but may have problems with motivation or engagement. • Moderate or better recovery from previous treatment.	• Likely mild to moderate symptoms/distress (meeting criteria for a diagnosis). • Symptoms have typically been present for 6 months or more (but this may vary). • Likely complexity of risk, functioning or co-existing conditions but not at very severe levels. • Suitable for people experiencing severe symptoms with mild or no problems associated with Risk, Functioning and Co-existing Conditions.

Figure 1.1 Intensity of need definition

Question 1: How will the introduction of Local Services change the profile of people accessing AOD treatment? How can we work collaboratively to prepare for any changes?

Question 2: How will the 'intensity of need' classifications be tested in the "practice world"? This classification system is new to health professionals and consumers alike, how will the new language and concept be implemented in a way that is universally understood and workable across sectors? How will these relate to existing understandings of risk and need?

Question 3: How will individual preferences for service type access be assured through this tiered system? For example, if an individual prefers to seek support from an AOD sector service but has moderate intensity mental health needs, do they still have the choice to access AOD services

Question 4: At present, there are only 2 designated dual diagnosis residential rehabilitation services in Victoria, Westside Lodge and Bendigo Dual Diagnosis Residential Service. These services have established intake criteria targeted toward those with high intensity co-occurring needs. Given residential treatment for AOD needs is a core treatment stream for many individuals, how will the Local services access residential rehabilitation for individuals they see (with moderate intensity of need), given there are no residential withdrawal or rehabilitation services established to meet the moderate intensity of need? Further, will capacity testing be undertaken within the AOD residential rehabilitation system to plan for foreseeable growth in need?

Question 5: Mental health symptoms may present in an individual following cessation of substance use. What supports will be available for the individual and the AOD service supporting them if this occurs? How will consumer preferences and the stages of change be factored into this situation?

Question 6: Part of the AOD service sector routinely supports people who choose to continue to use substances of dependence and have mental health issues. As a result of isolation, homelessness and other social issues, AOD services, through mobile NSPs or outreach services and the like, may be the only support system that the person connects with. How are the needs of this cohort of individuals met through this tiered system of care? How can the complexity that psychosocial needs create be best met through this system?

Question 7: The relationship and presentation of co-occurring mental health and substance use issues can be extremely difficult to separate and attribute cause and effect to. What resources will be offered to address the potential need for culture and attitude change within a current mental health system that is often underpinned by the premise that recovery from mental illness is dependent on cessation of substance use? In light of the complex interwoven relationship between MH and AOD issues what tools and resources will be available to aid in determining the difference between the intensity of need for mental health needs versus AOD needs?

7. Moving between tiers of care

A core component in the success of shared care systems is how individuals transition between services and/or systems. The following excerpts from the Local Service Framework, provide detail on how different tiers of the system will work collaboratively to achieve seamless care across the system.

*'Where a person presents to a **Local Service with no or low intensity mental health support need**s but has substance use or addiction needs, the Local Service will provide a supported referral to an **AOD service** who will provide integrated treatment and care. The provider of the Local Service will maintain treatment, care and supports to the consumer until the consumer has transitioned to the AOD service.'*

> **Question 8: What resources will the AOD sector have access to for meeting the needs of this new referral pathway, in light of current significant waiting lists and workforce pressures?**
>
> **Question 9: How will the concept of 'transition' be defined? At what point does the Local Service cease service? Is it upon acceptance of the referral, following 1st appointment with an AOD provider or when the consumer determines they are ready to transition?**
>
> **Question 10: How will the capacity of the AOD sector be tested to ensure it can meet demand as part of the stepped-care model? How can demand modelling and forecasting information help inform planning within the AOD sector?**

'Where a person with moderate to higher intensity mental illness and co-occurring substance use or addiction presents to an AOD service, the AOD service will provide a supported referral to a Local Service for the provision of integrated treatment, care and support.'

> **Question 11: How is individual preference assured in this situation? Readiness to address mental health issues is a significant factor in the success of any treatment or support offered. What supports will be available to the AOD service, if a person they are supporting with this scenario does not wish to address their mental health issues?**
>
> **Question 12: What assurances can be made to an individual and their family and supporters that a person's AOD needs will be met in the same way in the AOD sector as they are in the mental health sector through Local Services?**

*'If a consumer has **moderate intensity mental illness and high intensity AOD needs, shared care arrangements should be put in place between the Local Service and the AOD provider** to support the consumer. This is particularly important for consumers receiving a concurrent mental health and residential/non-residential AOD withdrawal and rehabilitation service.'*

Question 13: What support and resources will the AOD sector receive to ensure reciprocal high-quality shared care arrangements are possible between all Local and AOD services?

Question 14: Typically, people receiving treatment through residential rehabilitation services will not be actively using substances of dependence and thus during this period of treatment, their intensity of AOD need may be considered low. What assurances will the individual and the AOD service provider have that any mental health support arrangements between Local and AOD residential providers will be for the duration of the person's residential treatment?

Question 15: Residential withdrawal and rehabilitation services in Victoria operate as 'Statewide services'. Will the onus of shared care for these individuals accessing residential withdrawal and rehabilitation be held by the Local Mental Health and Wellbeing service closest to the residential rehabilitation or withdrawal or a similar service close to the individual's previous address?

Question 16: Individuals with substance use issues may access treatment unaware that some of the issues they face are a result of mental illness. How can AOD services have access to psychiatrists to ascertain diagnosis and treatment for an individual and to inform adequate treatment pathways?

Question 17: Both AOD and mental health issues can be constantly relapsing conditions that present for an individual with variable intensity and a wide range of symptoms over their lifetime. How can the changing needs of an individual be best addressed in this tiered system of care without requiring them to constantly move between service systems as their needs change?

Question 18: How will client management databases, data collection and outcome measurement be functional in an integrated treatment model? What 'rules' of data collection will be put in place to ensure the credibility of data collection when dual services are working with an individual either within a Local or as part of a shared care arrangement?

*To facilitate the smooth transition and continuity of care of consumers **between Local Services and Area Services, an agreed intake and triage classification scale** and associated referral processes will be used. The department will co-design the triage classification scale in collaboration with health services funded to deliver Area Services, providers funded to deliver Local Services, people with lived experience of mental illness, families, carers and supporters and other stakeholders*

Question 19: Will the AOD sector be involved in the development of this agreed intake and triage classification system?

***Service providers are required to work collaboratively with AOD services**. Providers of Local Services will work with Area Services, local health, mental health, AOD, health and social support services to establish smooth referral pathways so that consumers will have reliable access to services in their local area and experience coordinated care.*

Question 20: How can service access equity be assured through an individual service-to-service referral pathway?

Question 21: Victoria currently operates a Statewide AOD intake system. How will this system be impacted by any Local referral pathways made?

Question 22: What systems will be put in place to support AOD services to refer individuals to Area Mental Health Services at times when high intensity need is identified? Will Local services, as the gateway to Area Mental Health services have a role to play in supporting the transition with the individual?

8. How do harm reduction principles align with the Local Services Framework?

In respecting consumer choice, integrated mental health and AOD treatment, care and support will not be contingent on a consumer's commitment to reduce or cease the use of alcohol or other drugs.

Integrated treatment, care and support must meet people where they are at across the stages of change with a focus on reducing AOD-related harms and improving mental health and wellbeing.

Question 23: What resources will be available to Local services to ensure that the principle and working knowledge of harm reduction is embedded into service models successfully? What supports can be available to Local providers when working with someone who is pre-contemplative about change related to their substance use?

9. Referral pathways and service access

Referral pathways from primary and secondary mental health care providers will be facilitated through the common use of ***the Initial Assessment and Referral (IAR) tool.***

Providers of ***Local Services and AOD services will establish and maintain protocols for facilitating smooth referrals and shared care arrangements****, including communication and information sharing protocols.*

Where people present with co-occurring mental illness and substance use or addiction, ***professionals with competency in assessing substance use or addiction within the Local Service****, or if necessary, through secondary consultation,* ***should be involved in the assessment and the subsequent co-design of an integrated care plan*** *with the consumer, their family, carers and supporters (as appropriate).*

Question 24: The majority of the AOD sector does not currently use the IAR tool how will this impact referral or is there an assumption that AOD services could also use the IAR?

Question 25: How will the Statewide AOD intake system and use of Penelope database be used and coordinated with the intake that Local Services provide?

Question 26: What will be the time frame expectation for assessment completion?

Question 27: How will people with mandated AOD treatment be assessed and treated if they are receiving service from a Local MHWB provider?

10. Primary and Secondary consultation services for AOD Sector

AOD services will be supported by Local Services and Area Services, via primary and secondary consultation, to ensure that the needs of the consumer can be met by their preferred AOD provider. *This approach will build the capability of AOD services to deliver integrated treatment, care and support and ensure people receive continuity of care from their preferred AOD provider.**

**Local Services will only provide primary or secondary consultation to AOD services when treatment, care and support is being provided to a common consumer i.e. when a consumer of a Local Service is in a shared care arrangement with an AOD service.*

Question 28: What provisions will be made to provide primary and secondary consultation for people with co-occurring needs receiving treatment in the AOD sector that are not clients of the Local Service?? Will there be an assessment of AOD sector engagement on the need for primary and secondary consultation to inform planning on the delivery of primary and secondary consultation?

Question 29: Will there be the provision of tertiary consultation with AOD services (amongst others) to collaboratively address the needs of individuals?

11. Concluding Summary

We feel it is of significant importance to the future functioning of the Local Service system that the questions raised are collectively discussed and answered as a matter of urgency before the ongoing establishment of Local Services.

VAADA hopes to continue to work collaboratively with all partners to find innovative solutions that will best meet the needs of those with co-occurring mental health and AOD needs. We also feel it is imperative to do so without minimising the strength of the current AOD sector or the specific needs of those who use substances of dependence.