POLICY IN AOD

CHAIR: MOLLY O'REILLY, GENERAL MANAGER, WITHDRAWAL & COMMUNITY SERVICES, WINDANA

1. What We Heard: The Statewide Centre for Addiction and Mental Health Consultation Update
2. Achieving drug decriminalisation amidst change: lessons for Victoria from the ACT
3. Connecting state priorities to a national voice: Driving holistic responses through a national peak

VAADA acknowledges the traditional owners of the land on which the conference is gathered, the Wurundjeri People of the Kulin Nation and pay their respects to Aboriginal culture and Elders past and present.

vaada CONFERENCE FEBRUARY 9-10 2023
Shifting Landscapes
Building the Holistic Treatment Mosaic

What We Heard: The Statewide Centre for Addiction and Mental Health Consultation Update

Shalini Arunogiri, Turning Point

VAADA acknowledges the traditional owners of the land on which the conference is gathered, the Wurundjeri People of the Kulin Nation and pay their respects to Aboriginal culture and Elders past and present.

Turning Point

Statewide Centre for People with Co-occurring Substance Use or Addiction and Mental Illness

Dr Shalini Arunogiri
Clinical Director, Turning Point

Associate Professor Leah Heiss, Design Health Collab

9 February 2023

Prepared by Monash Design Health Collab

Statewide Service Lead

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> Recommendation 36:
>
> A new statewide service for people living with mental illness and substance use or addiction

The Royal Commission recommends that the Victorian Government:

1) Set up a new statewide specialist service, based on the Victorian Dual Diagnosis Initiative, to:

   a) research mental illness and substance use or addiction
   b) support education and training for a range of mental health and alcohol and other drug specialists and clinicians
   c) provide primary consultation to people living with mental illness and substance use or addiction who have complex support needs
   d) provide secondary consultation to mental health and wellbeing and alcohol and other drug specialists and clinicians across both sectors.

1) As a priority, increase the number of addiction specialists (addiction medicine physicians and addiction psychiatrists) in Victoria.

1) Work with the Australian Government to look for opportunities for funded addiction specialist trainee positions in Victoria.

Statewide Service Lead & Network

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As the Statewide Service lead, Turning Point will:

- develop and deliver an education and training program that will increase workforce integrated care capability
- lead research into co-occurring mental illness and substance use or addiction
- provide brief centralised secondary consultation across both the mental health and wellbeing and AOD systems
- coordinate access to Addiction Services where further support is required for people with high-intensity AOD support needs.

The Statewide Service for people with co-occurring needs

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- The new Statewide Service for people with co-occurring needs (the Statewide Service) comprises Turning Point as the lead organisation, and an initial network of four Addiction Services (Partner Providers)- Western Health, St Vincent's Health, Austin Health and Goulburn Valley Health, and Eastern Health.

- The key role of the Statewide Service is to provide support to, and build the capability of, the mental health and wellbeing and AOD systems to deliver integrated treatment, care and support.

Contents

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Introduction & context

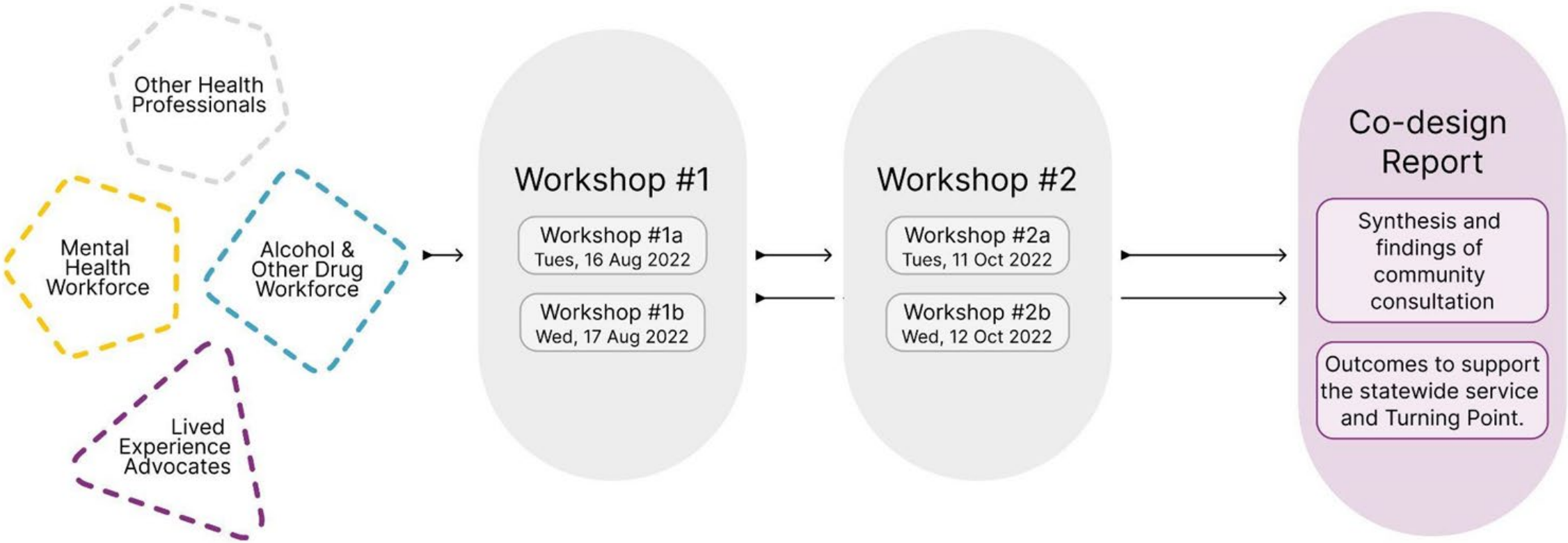
"The first thing for me is the acceptance that co-occurring substance use to mental health issues are the norm rather than the exception."

— Mental Health Nurse, Workshop 1

Methodology

- Project structure
- Tactile Tools digital workshop
- Persona users
- Consultation & workshop activities
- Approach to synthesis

Project structure



Tactile Tools digital workshop method

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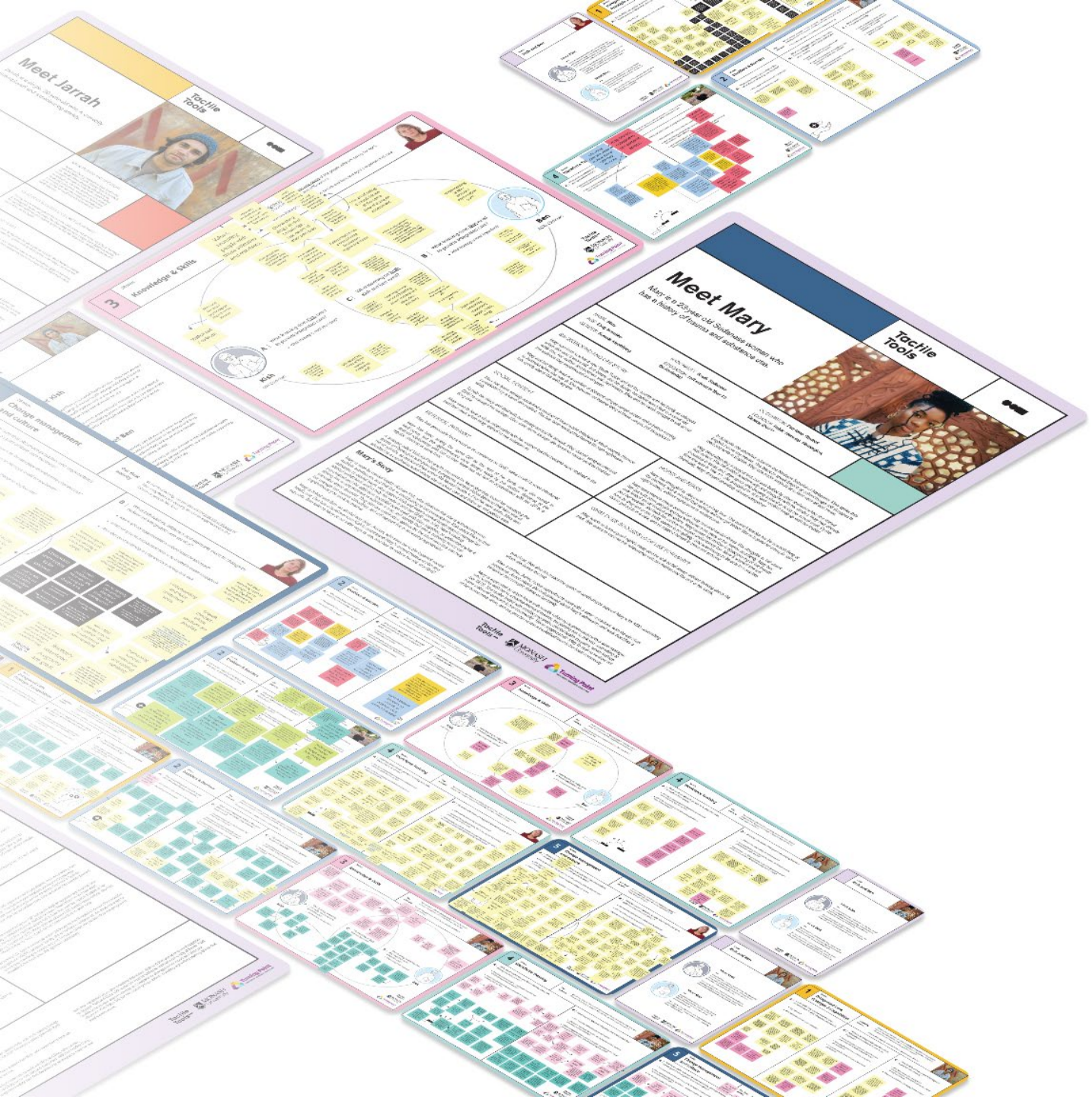
A digital, flexible and haptic approach for mapping networks of care and addressing complex health challenges.

We evolved the method to scaffold discussions about integrated care for mental illness and addiction in Victoria.



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40 Participants

Across the two sets of workshops

- AOD clinicians
- Peer support workers
- Clinical leaders
- Mental health clinicians
- Lived experience

Persona users

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Tactile Tools

Meet Johan

Johan is a 42-year-old homeless man who uses heroin regularly.

NAME: **Johan**
AGE: **Early forties**
GENDER: **Male identifying**
NATIONALITY: **White Australian**
OCCUPATION: **Unemployed, receiving Centrelink support**
EDUCATION: **Left school aged 15**
LOCATION: **No fixed address. Presents at Pakenham, Victoria (3810)**

BACKGROUND AND LIFE STORY

Johan was born and lived in the Mornington Peninsula for most of his adult life. Johan has no siblings. His father drank heavily and was violent and abusive. His father passed away more than twenty years ago and Johan has a strained relationship with his mother, who divorced from Johan's father when Johan was 5. Johan hasn't spoken with his mother in ten years.

Johan ran away from home at 13 and left school aged 15 for a job at the local butcher shop. Johan has always been interested in computers and programming and taught himself python and C# at local libraries in his spare time.

In his late teens and early 20s, Johan lived in crisis accommodation. He left his job in the butcher shop when it closed and started work as a labourer. He moved from crisis accommodation into a rental with friends from work. He managed to remain in housing, employed and enjoyed life.

Johan was involved in a car crash in his late 20s that left him with chronic back pain. He has self-medicated his back pain since. In his mid-to-late thirties, Johan started using heroin regularly to manage the pain. In recent times, Johan lost his job, became unable to pay rent, and then became homeless.

SOCIAL CONTEXT

Johan started smoking cannabis in his early teens. Later, Johan was prescribed Oxycodone as a result of a car accident. At some point, a friend introduced Johan to heroin and he continued injecting multiple times per day.

Johan became homeless again about 18 months ago when he lost his labouring job. He funds his heroin use through a combination of his Centrelink payments and savings.

HOPES AND FEARS

Johan is homeless, unemployed and receiving Centrelink support. He is afraid that nothing will ever change, and that he will always be a 'failure', never have a partner again, or establish meaningful relationships with others. Johan has had a couple of overdoses in the past, and has been thinking about this again because he feels so hopeless about his current situation and that nothing will change.

Johan hopes to manage his back pain without needing to spend almost all his income on heroin, and learn to manage his pain, isolation and low mood without needing to resort to drug use.

REFERRAL PATHWAY

Johan has no consistent GP and has not had a regular checkup in more than 10 years.

Johan previously received opioid pharmacotherapy (methadone), and has recently considered trying again because he has run out of funds to support his heroin use. He hopes that methadone will help with the back pain. Johan hears from a friend that a Local Mental Health and Wellbeing service in Pakenham can help with secure housing. Johan presents at the service to seek help.

WHAT DOES SUCCESS LOOK LIKE FOR JOHAN?

Johan would like secure housing, and to find employment in his community. Johan would like a job that is not dependent on his physical fitness, such as a desk job or working with computers. Johan hopes to improve his relationships with other people, feel more connected with others around him, and establish a relationship with his mother.

Johan's Story

Johan is linked with a housing worker at the local mental health and wellbeing service. Johan also regularly speaks to Ben, the alcohol and drug clinician at the needle and syringe programme. Johan feels like he can talk to Ben about how he has started to feel like life isn't worth living recently.

Ben recognizes that Johan isn't his usual self and is worried about him. Ben makes an appointment for Johan with a doctor who prescribes opioid pharmacotherapy at their Local Mental Health and Wellbeing service. Johan talks to the doctor about starting opioid treatment, and they recommend injection treatment, meaning he only needs to attend the clinic once a month. The doctor also refers him to a mental health clinician, Kieh, at the service, to help him with his mental health. The doctor also conducts an early assessment of Johan's other primary health care needs, such as his Hepatitis C risk, and wound care.

Ben and Kieh both work with Johan around harm minimization and overdose prevention interventions such as clean injecting equipment and take-home naloxone. Kieh discusses the relationship between Johan's use and his depression, and suggests a local coding group he can enroll in where he meets other people.

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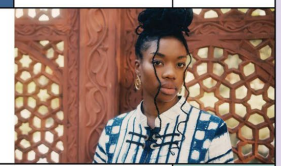
Tactile Tools

Meet Mary

Mary is a 23-year old Sudanese woman who has a history of trauma and substance use.



NAME: **Mary**
AGE: **Early twenties**
GENDER: **Female identifying**
NATIONALITY: **South Sudanese**
EDUCATION: **Left school in Year 10 (in Australia)**
OCCUPATION: **Part-time Student**
LOCATION: **Public Housing. Flemington, Victoria (3031)**

BACKGROUND AND LIFE STORY

Mary was born in what is now South Sudan and left the country with her family as refugees when she was 6 years old. Just before she left Sudan, her father was killed in a street riot while she, her mother and brothers watched nearby. Mary and her family struggle to talk about the violence they experienced as refugees.

Mary and her family lived in a number of different refugee camps across Africa before coming to Australia when she was 9. She experienced trauma living in these camps, but struggles to talk about this openly with anyone.

In Australia she attended school in the Northern Suburbs of Melbourne. Mary spoke little English before she moved. She learnt to speak English well at school though still struggles to read and write in English. Mary's favourite subjects at school were art and music.

Mary liked attending school at first, but was bullied by other students when she started high school. She fell behind academically and struggled with her studies. Mary had difficulty focussing in class, and often spent time drawing instead of doing her school work. By the time she was in Year 10, she struggled to 'fit in' and couldn't keep up with her studies. Eventually, Mary stopped attending classes altogether.

SOCIAL CONTEXT

Mary has been sexually assaulted a number of times whilst intoxicated. Most recently, this was perpetrated by a friend she trusted. She has been reliving this trauma through nightmares lately.

To help her sleep and deal with her anxiety around the assault, Mary started using alcohol and GHB to manage her feelings. Mary uses some savings she has from casual work to fund this drug use.

Mary used to have a close relationship with her mother, but this became more strained in the past few years when Mary started to use substances.

HOPES AND FEARS

Mary has struggled to sleep well for a long time. She doesn't feel like her life is worth living at the moment, and is worried that nothing will ever get better. She is hopeful for a simple 'good night's sleep', without nightmares or restlessness.

Mary feels intense shame around her drug use and mental illness. She struggles to talk about her use with other people and has withdrawn from many of her friends and family. Mary has only limited social contact with others. Mary senses her mother is disapproving of her friends and her lifestyle; she feels her mother no longer understands her. Mary is worried she will have to drop out of her TAFE course in hospitality. She was hoping to be able to complete this to get a job in a cafe, and to support herself to move out of home.

REFERRAL PATHWAY

Mary has previously had a number of overdoses on GHB, some of which were intentional.

Mary has been seeing the same GP as the rest of her family since she moved to Melbourne when her mother had made the appointments. Because of the strained relationship with her mother, Mary has not had an appointment with her GP or a regular checkup in some time.

A stranger called Victoria Police with concerns for Mary after they found her wandering the streets of Flemington with psychotic symptoms. Victoria Police believed that Mary was at risk of suicide, so detained Mary under the Mental Health Act for her own safety. Mary was admitted to a psychiatric ward where she received care and follow up out-patient care.

WHAT DOES SUCCESS LOOK LIKE FOR MARY?

Mary wants to have a good night's sleep and be able to fall asleep without thinking about the past. She wants to improve her relationship with her mother and the rest of her family.

Mary's Story

Mary is seen by mental health clinician Kieh, who identifies that she is withdrawing from multiple substances, and that this is contributing to her presentation. Kieh refers Mary to their addiction specialist team, who support Kieh and Mary's mental health team to manage her alcohol withdrawal, and suggest medications to support alcohol reduction, and to reduce and cease her GHB use. Kieh, Mary's treating psychiatrist and the addiction specialist team meet with Mary together, to understand what is driving her recent increase in substance use, and identify that she is suffering from post-traumatic stress disorder. They discuss medication options for the short-term that can help her manage her current difficulties, and will support her linking into appropriate psychotherapy to work on trauma.

Mary is linked with Ben, an alcohol and drug clinician, who sees her in the inpatient mental health unit. Ben has a handover from Kieh to understand Mary's current treatment plan and supports. Ben talks to Mary about safer ways to use, and how to reduce her risk of a GHB overdose. Ben also discusses the option of continuing to support Mary with AOD counselling when she leaves the unit.

Mary's mother, Achol, is also supported to meet with a carer consultant, with the aid of an interpreter. Achol relates she is distressed about Mary's admission, and feels that Mary's behaviour has brought shame on her family.

Mary is supported to return home with weekly follow-up appointments with a case manager, who works with her in a trauma-informed manner, supporting her to link into counselling at her TAFE. She continues to see Ben for AOD counselling. She is also linked with suicide prevention mental health supports, which include home visits and outreach in her community. They help her start to venture out of her home more often, and also help her link into a basketball team in her local community.

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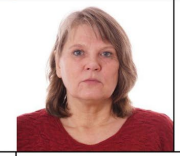
Tactile Tools

Meet April

April is a 54-year-old single woman experiencing depression and suicidal behaviour.



NAME: **April**
AGE: **Mid fifties**
GENDER: **Female identifying**
OCCUPATION: **Working casually in hospitality**
NATIONALITY: **Australian**
EDUCATION: **Left school aged 15**
LOCATION: **Euroa, Victoria (3666)**

BACKGROUND AND LIFE STORY

April was born in Sydney and lived with her parents, two brothers and a sister – Gary, Jim and Rachel – until moving out of home when she was 17. Both of April's parents have since passed away.

April came out as a lesbian when she met her partner Jane at 20. Because of their religious beliefs, April's parents and brother Jim were not supportive; April maintained contact with Gary and Rachel after moving out.

April and Jane lived in Sydney and travelled often. April managed her own jewellery making business. Their relationship deteriorated 10 years ago, and Jane left April 6 years ago. April's parents passed away in the same year. April decided to move to Euroa to be nearer her brother Gary, who worked as a teacher at a local school. She rents her own apartment and has a casual job in a local cafe.

HOPES AND FEARS

In times of distress April has suicidal thoughts. Living in regional Victoria means that April has limited services available in her local area and often must travel to access support. Recently, she has been drinking more heavily and feeling like her life isn't worth living.

Because of the discrimination April has faced as a queer woman earlier in her life, April is distrustful of many healthcare services. She feels that previous experiences with adult psychiatric services have not been helpful, so is reluctant to engage with existing services in her area.

April doesn't see the point in seeing her GP. The last time April saw her GP, she felt that her GP 'rushed' through her appointment and just wanted to get her out the door. She is also worried about her privacy and confidentiality about seeking help in a small town, where people may see and 'judge' her seeking help.

April hopes that she can find something to live for, such as developing her arts and crafts skills, and perhaps meeting a life partner.

SOCIAL CONTEXT

Gary visits April regularly and her sister Rachel - who she is very close with - moved to live in Western Australia 5 years ago. April and Rachel talk on the phone once a week.

April has lost a lot of weight. She isn't sleeping well at night, which she puts down to her daytime napping on the couch. She has started drinking alcohol on the days she doesn't work at the cafe, to get to sleep and to manage her negative thoughts.

She has stopped making jewellery and has withdrawn from the few friends she has made in local arts and crafts groups. Outside of her cafe work, April has little social contact with others.

REFERRAL PATHWAY

April has a long history of depression, with input from adult psychiatric services starting from when she first came out to her family. This has included inpatient admissions to manage suicidal behaviours. April had made several attempts on her life when she lived in Sydney. Her last suicide attempt was just after her separation from Jane and when her parents passed away, five years ago.

April is currently being supported by her GP but hasn't kept an appointment in some time. April's brother Gary is concerned about April when he hasn't heard from her in a few days. When he visits, he finds that April has attempted to take her own life. April is treated at her local emergency department (ED). While she has attended ED several times before, she has not been offered follow up support and so has been reluctant to seek help.

After leaving ED, April is contacted within 24 hours by the Hospital Outreach Post-suicidal Engagement (HOPE) program. Initially she is hesitant to engage as she does not want to spend time travelling to access support. However, when she realises that the program is available in her local area she agrees to participate.

WHAT DOES SUCCESS LOOK LIKE FOR APRIL?

April would like to be better connected with other people and manage her emotions and depression without using alcohol to dull her feelings. She would like to make contact with her brother Jim and make jewellery to sell at the local market.

April's Story

Kieh, a Mental Health Clinician from the HOPE team, spends time with April, talking through her mental health, suicidal thoughts and alcohol use. Kieh develops a safety plan with April before she is discharged from the hospital.

After leaving the ED, April continues to have support from Kieh, who refers her to Ben, an alcohol and drug clinician at her local service.

Throughout the next six weeks, April continues to work with Kieh and Ben, who remain consistent points of contact and help her to feel safe and supported. With her brother Gary, April starts to develop a longer term safety plan that identifies key strategies to help her feel safe and supported when she is feeling distressed. Kieh and Ben are able to work together to support April and Gary with a plan for April to withdraw from alcohol safely at home. April is able to learn new ways to identify and respond to changes in her mood and stressful situations. Kieh helps link her into social groups online, including a jewellery making group that meets every week.

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Tactile Tools

Meet Jarrah

Jarrah is a single, 29-year-old who is currently unemployed and experiencing anxiety.

NAME: **Jarrah**
AGE: **Late twenties**
GENDER: **Male identifying**
OCCUPATION: **Unemployed**
NATIONALITY: **Aboriginal and Torres Strait Islander**
EDUCATION: **Left school in year 10**
LOCATION: **Morwell, Victoria (3840)**

BACKGROUND AND LIFE STORY

Jarrah was born in Morwell and has lived in the Latrobe Valley in South Eastern Victoria his whole life. Jarrah's father struggled with alcohol use problems for most of his adult life. Jarrah's father completed suicide when Jarrah was ten, leaving Jarrah and Keira alone. Jarrah left school in year 10 to work, and has since been working as a labourer so that he could help his mum with the family finances.

SOCIAL CONTEXT

In high school, Jarrah started smoking cannabis socially, initially a few days a month with friends. He continued into his 20s as a way of managing feelings of loneliness or worry, or when he is having trouble sleeping. In the past Jarrah has experienced frequent and prolonged periods of anxiety, but he has never sought help from mental health services, due to feeling ashamed of his feelings and mood.

WHAT DOES SUCCESS LOOK LIKE FOR JARRAH?

Finding secure employment for the long term and moving out of home. He'd like to find ways to manage his anxiety and sleep other than using cannabis. Longer term, Jarrah hopes that he can seek treatments and support options to help him stop using cannabis altogether and improve his mental health.

REFERRAL PATHWAY

Jarrah has been seeing the same family GP for many years, but has usually been resistant to the idea of going to the doctor. He has never sought professional mental health or drug and alcohol services before.

Keira is very concerned about her son and worried he will harm himself. Her own wellbeing is also being impacted as she feels that she is constantly on guard watching him. A few years ago, Keira was diagnosed with anxiety by her local GP and was provided with medication and a treatment plan.

At Keira's insistence, Jarrah goes to see their family GP, who refers Jarrah to the Local Mental Health and Wellbeing service for support with his mental health.

HOPES AND FEARS

Jarrah worries that he is "going down the same path as his dad", but is fearful of seeking professional help. He fears the 'system built by white people' won't help or work for him.

One of his favourite hobbies is to travel interstate to music festivals and gigs. In the future, Jarrah hopes to secure longer term employment and form a band like he had in high school.

Jarrah's Story

Recently, Jarrah has been experiencing more anxiety as a result of not being able to find employment and has increased the frequency and quantity of cannabis he smokes. He feels strung out and easily panicked, and is having thoughts that disturb him, including thoughts about harming himself. He has withdrawn from friends and family, can't sleep without smoking cannabis, and is exhausting his saved finances from past labouring work. He worries that the lack of income might impact his family's financial stability and create more stress for his mum. He feels ashamed that his drug use has increased so much and that he can't find a job.

After his mother suggests he visits his GP, Jarrah and Keira are connected with mental health clinician Kieh from the Local Mental Health and Wellbeing team, who meets with them separately to discuss their situation and how they want to be supported.

Based on this discussion and initial needs assessment, Kieh suggests that Jarrah may additionally benefit from some support from an alcohol and drug clinician Ben, who also works at the Local Mental Health and Wellbeing Team. Kieh offers a supported referral option to Jarrah, which he accepts as he wishes to manage his cannabis use.

Things initially get better for Jarrah, and Ben helps to get him on to a waitlist for a detox service so he can quit smoking cannabis. The waitlist is long, and Jarrah decides to try and quit on his own. He finds his anxiety gets worse, and the thoughts of hurting himself become more intense. He mentions this to Ben at his weekly AOD counselling appointment, and Ben makes a referral to the crisis team at their Area Mental Health Service.

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Consultation & workshop activities

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Workshop #1 activities

1. Exploring the persona story and experience.
2. Investigating the integrated care principle of Inclusion.
3. Investigating the integrated care principle of Access.

Workshop #2 activities

1. Investigating the integrated care principle of capability
2. Investigating enablers and barriers
3. Investigating knowledge and skills
4. Investigating training and education needs
5. Investigating change management and culture.

Approach to synthesis

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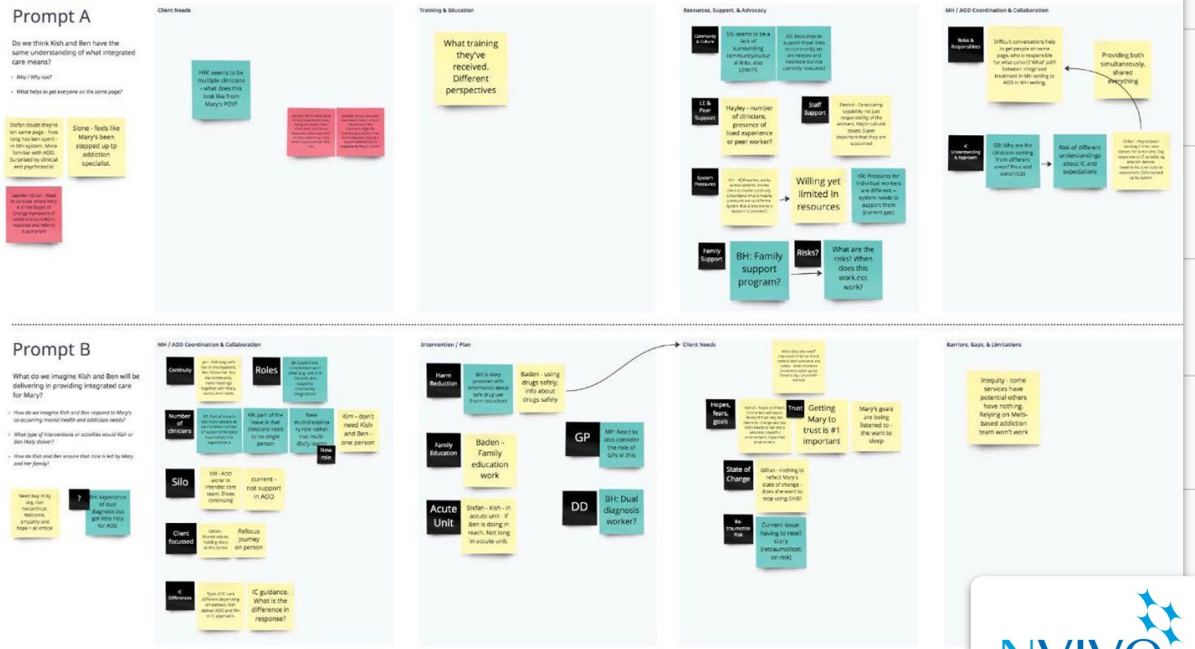
- We conducted a qualitative thematic analysis and coding of workshop data to discover overarching themes.
- Triangulation of data across multiple contributions, participants and workshop groups to validate the ‘findings’.
- Additional coding and evaluation of qualitative data in Nvivo.

Mary

1) Integrated Care Principle 3 (Capability): Key Themes & Insights



NVIVO

Themes & Insights

- **Understanding integrated care**

Understanding client needs
Barriers, gaps, & limitations
Enablers of integrated care
Training & education requirements
Change management & culture

Understanding integrated care

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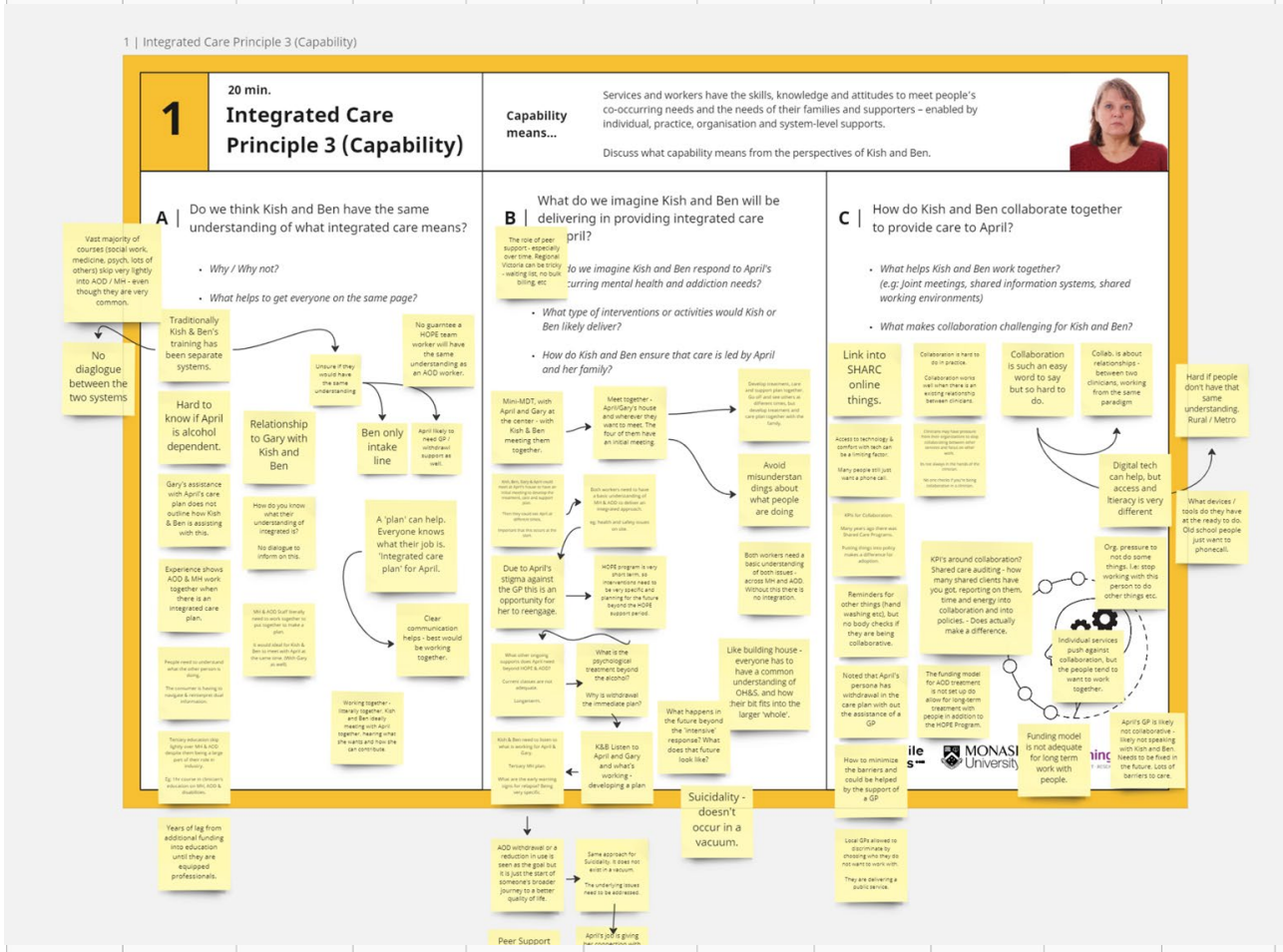
- A lack of shared meaning as to what ‘integrated’ care in practice means.
  - This exists at individual, service, organisational and institutional levels.
  - Ensure that everyone is on “the same page of the book”.

- Both sectors bring specialist skills that are required for the care of individuals with multiple needs.
  - Any model of integrated care should seek to build on, rather than replace, what’s already happening on the ground.



A screenshot of Activity #1 from Workshop #2, focussed on the experience of the April persona.

Actionable insights:

Enabling a shared understanding of integrated care

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- There is a need to get everyone ‘reading from the same book’, in relation to language, terminology, procedures and mindsets at work.
- A lack of shared understanding causes challenges relating to role clarity, responsibilities, duplication of service provision, ultimately resulting in poorer client outcomes.
- Encourage healthcare staff to become ‘Dual Diagnosis capable’, who are a blend of both a ‘generalist’ and ‘specialist’ providers. A kind of ‘T-shaped’ healthcare provider.

“Just say that there needs to be time that is funded to facilitate and nurture those new partnerships and relationships and to develop a deep understanding of what each other do and capabilities.”

— Policy Advisor, Workshop 2

“The future is how you actually broaden that understanding and people working in the system so that they're able to deal better with people coming at it from different areas. So if someone's got a a mental health issue, then if you've got a dual diagnosis, competent individual working there, they should be able to work both AOD and mental health.”

— AOD Executive, Workshop 2

“[...] the language, the terminology, even down to what a mental health service might call an assessment and we call an intake. [...].

So there's lots to like work out and work on so that we understand each other.”

— AOD Practitioner, Workshop 1

Themes & Insights

- Understanding integrated care
- **Understanding client needs**
- Barriers, gaps, & limitations
- Enablers of integrated care
- Training & education requirements
- Change management & culture

Understanding client needs

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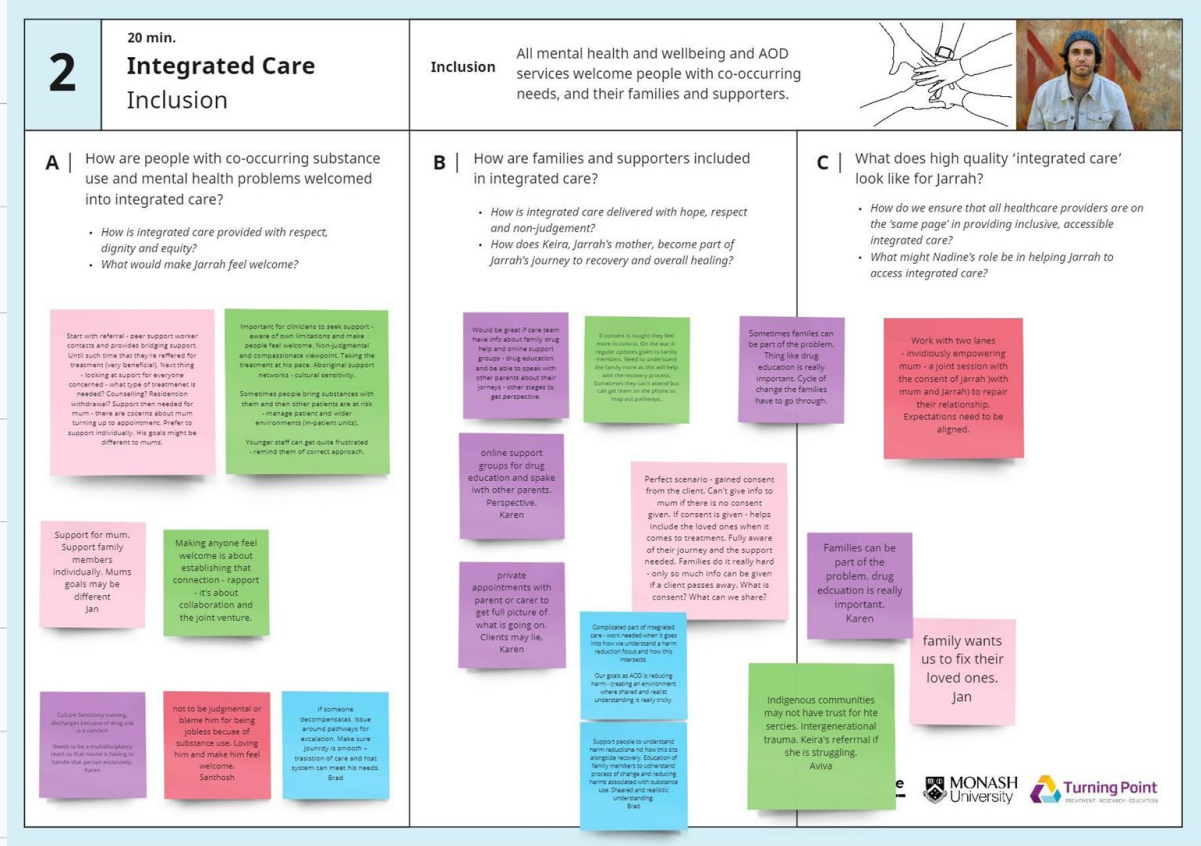
Understanding the individual with co-occuring mental health and addiction and their needs is the first step in ensuring holistic healing and recovery.

Best-practice integrated care should be:

- ➔ Led by the client and their needs
- ➔ Informed by their hopes, goals and motivations



A screenshot of Activity #1 from Workshop #1, focussed on the experience of the Jarrah persona.

Stigmas— as experienced by clients

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Social inclusion is central to successful integrated care delivery, as well as breaking down entrenched stigmas and stigmatising mindsets or attitudes.

Specific strategies are needed for:

- Engaging and supporting LGBTIQA+ communities
- Fostering cultural safety in integrated care
- Engaging with First Nations communities

"So when we talk about cultural safety it's about people being able to access services without feeling that their cultural identity is being a factor in the way people interact with them"

— Mental Health Clinician, Workshop #1.

"I spent 19 hours in a psych ward once after an overdose, and I was completely ignored. Every other person with a mental health issue was seen before me, obviously, I don't know all their stories, but there is a general feeling amongst people with lived experience that you will be judged if you go into hospital."

— Lived Experience Advocate / Peer Support Worker, Workshop 1

"So you have to be really proactive, loud and proud, about that spirit of welcome at that centre [...] You need help with anything else? You are welcome here. This is a safe place for you."

— Addiction NGO Professional, Workshop #1.

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Themes & Insights

Understanding integrated care
Understanding client needs
Barriers, gaps, & limitations
Enablers of integrated care
Training & education requirements
Change management & culture

Barriers, gaps, & limitations

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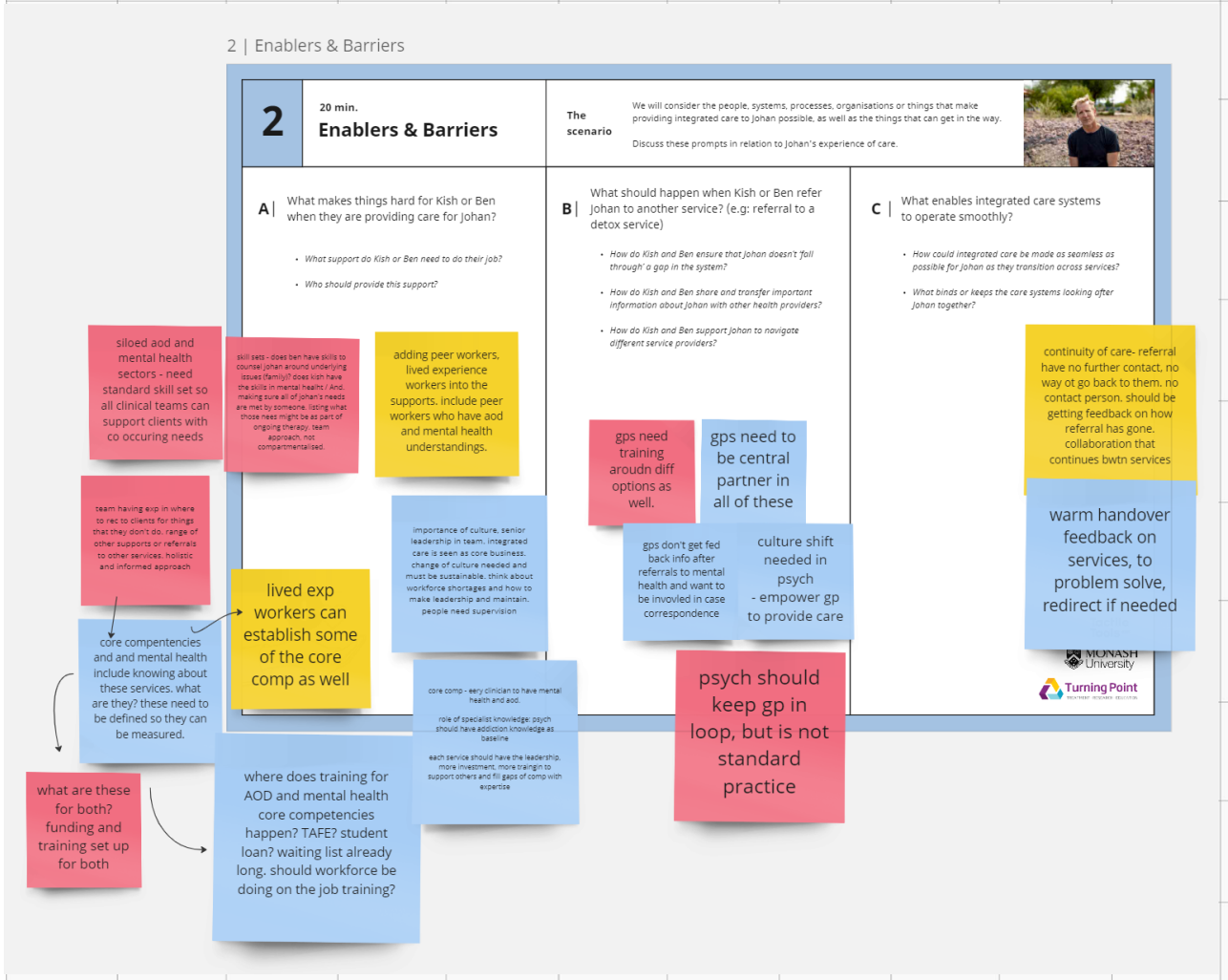
Barriers to integrated care are multifaceted and exist at individual, service, organisational and policy levels.

Themes that emerged in this project include:

- A variety of organisational and system-level constraints
- Inadequate resources and funding
- Limited workforce capabilities and capacity
- Challenges faced within regional contexts
- Attitudes and behaviours (including entrenched stigmas and mindsets)



A screenshot of Activity #2 from Workshop #2, focussed on the experience of the Johan persona.

Barriers at different levels of the service system

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"If you haven't got agreement and buy-in and a policy structure and overall governance environment to support that [integrated care], then you're relying on the will and skill of individuals, which will vary".

— AOD Clinician, Workshop 2

"[...] Unfortunately, I think that when we had the reform of the drug and alcohol sector, the centralising of all of the intake services in some instances has actually become a barrier to people."

— AOD Nurse, Workshop 1

" [...] those multiple, multiple missed opportunities. When a person interacts with the system when she is in the mental health ward, she's getting treatment for psychotic symptoms. But this is an opportunity where we can look at it as a detox, link it up with some sort of a daily rehab or residential rehab, depending on her motivation."

— Psychiatrist, Dual Diagnosis, Workshop 1

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Themes & Insights

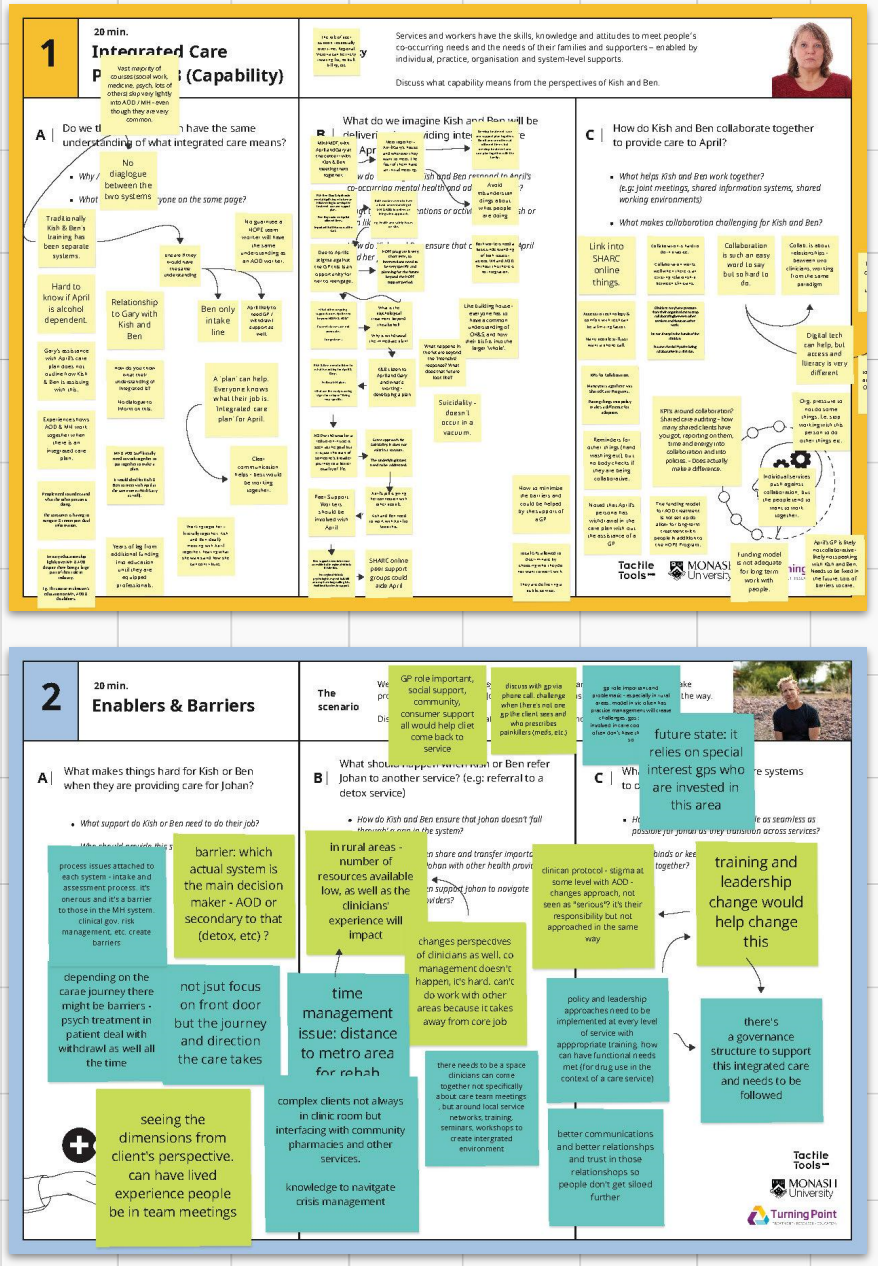
- Understanding integrated care
- Understanding client needs
- Barriers, gaps, & limitations
- **Enablers of integrated care**
- Training & education requirements
- Change management & culture

Enablers of integrated care

In the long term, broad transformation at every level of the existing system needs to occur to support integrated care. In the short term, the workshops highlighted a number of actionable ways that integration can be activated on a local level.

Specific enablers include:

- Sustained funding models
- Key performance indicators and metrics
- Targeted workforce recruitment
- Communication and relationship building
- Co-location and sharing of resources
- Mentoring, supervision and leadership



A screenshot of Activities from Workshop #2, focussed on the experience of the April and Johan personas.

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Themes & Insights

Understanding integrated care

Understanding client needs

Barriers, gaps, & limitations

Enablers of integrated care

- **Training & education requirements**

Change management & culture

Training and education requirements

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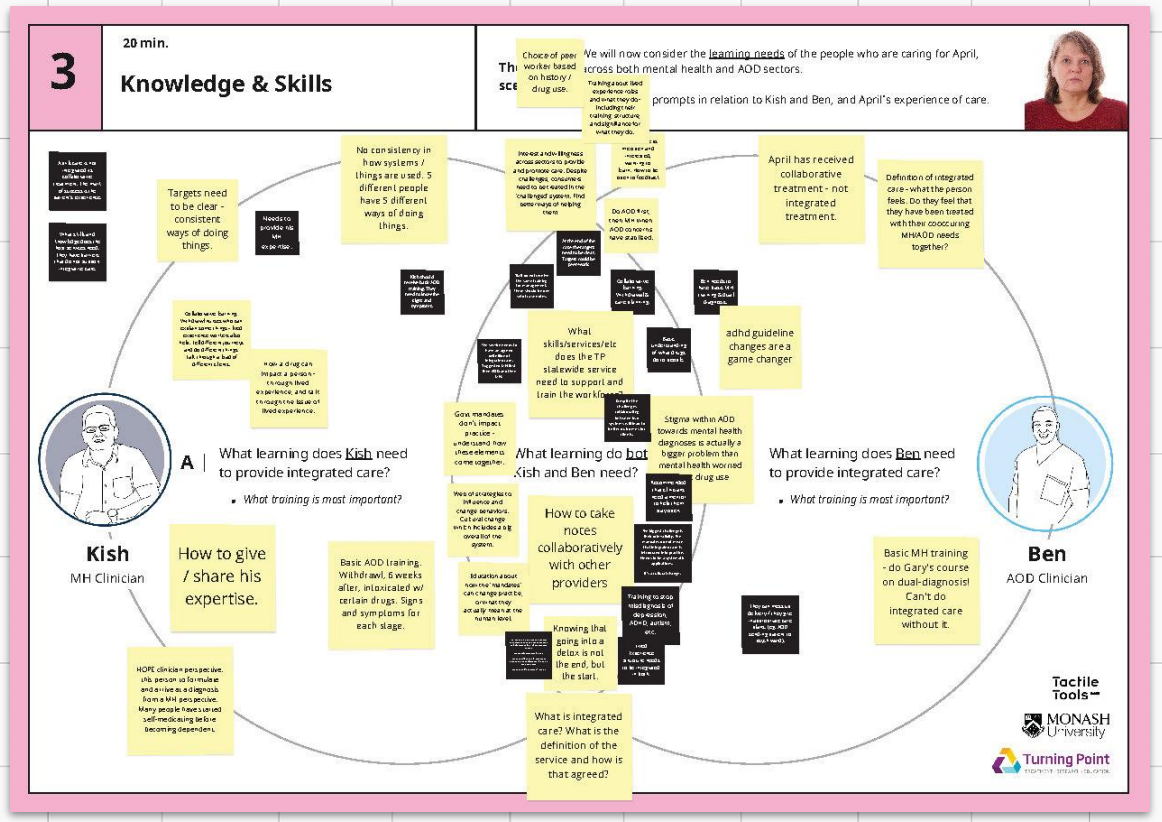
Training, education and learning are central to enabling integrated care and enshrining meaningful change well into the future.

Insights that emerged from this section include:

- Insights for AOD workforce training
- Insights for MH workforce training
- Insights for training peer mentors
- Insights for learning beyond frontline providers



A screenshot of Activity #3 from Workshop #2, focussed on the experience of the April persona.

Supervision — Training and education requirements

"I also think there's value in cross-sector reflective practice like all group supervision. So looking at case studies and identifying how the two sectors can work together and the benefits of that. So actually, you know, if they're not seeing it in practice, maybe they're seeing it in reflective practice sessions or case studies so that you [understand] how that might work in real life."

— AOD Manager, Workshop 2

"We can't give people huge caseloads and expect them to just drive things through and then expect them to be able to do good quality [work] if we don't give them the time for supervision and all the other good things that they need."

— Addiction Psychiatrist, Workshop 2

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Themes & Insights

Understanding integrated care
Understanding client needs
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Training & education requirements
Change management & culture

Change management and culture

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Transition toward integrated care as requiring broad transformation of existing systems and services.

Any strategy that seeks to enact change should develop a ‘web of iterative strategies and resources’.

Insights from this research include:

- → Barriers to change management
- → Enablers to change management
- → Organisational leadership needs
- → Actionable insights for change management to support integrated care delivery

“One of the approaches that I really like, is making sure everyone is on the same page when delivering integrated care is the use of validity tools. You've got a model of integrated treatment, an emerging model of integrated treatment in your service.”

— Dual Diagnosis Practitioner, Workshop 2

“Just about everything needs to change though. [...] That's really gotta start at the leadership levels, you know, and how we approach the leadership, how we build their coherent vision of integrated treatment. You know it's massive work.”

— Dual Diagnosis Practitioner, Workshop 2

“[...] acknowledging the challenges, particularly at that middle management level. They're often the people that are forgotten in terms of organisational change pieces and supporting their own capability to affect change, including by being supported through the provision of time as well.”

— Clinical Nurse Consultant, Workshop 2

Change management and culture

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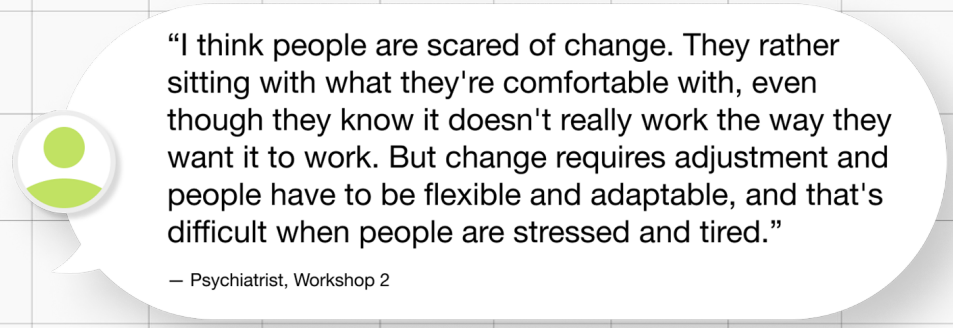
Alongside a shared vision and understanding of integrated care, change takes time.

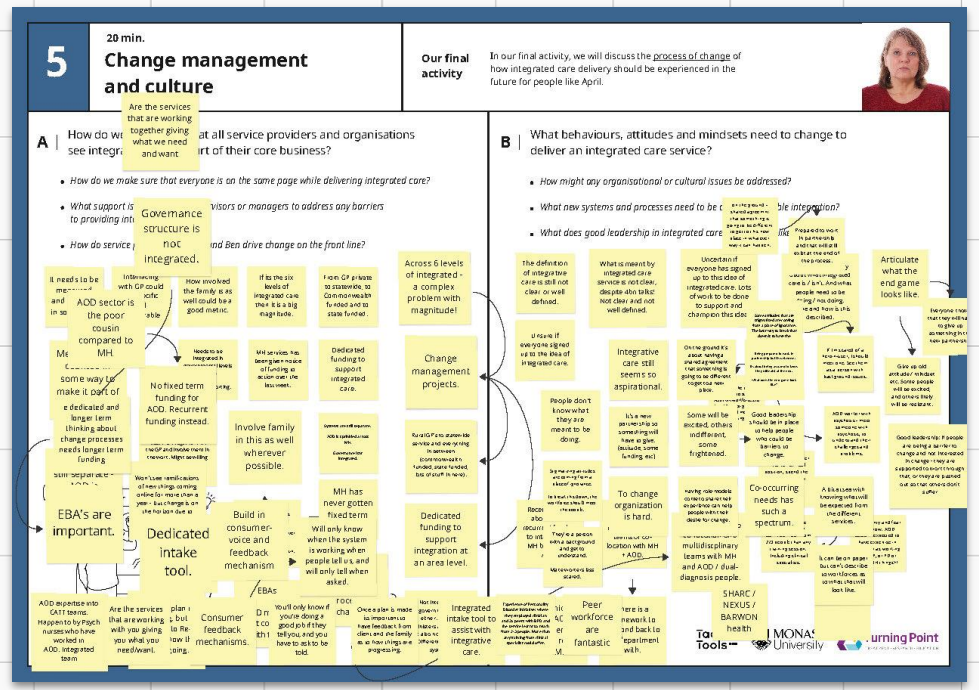
There is no one simple or easy solution.

A ‘web of solutions’ and strategies need to be implemented at frontline, local, service and statewide levels to support this work.



“I think people are scared of change. They rather sitting with what they're comfortable with, even though they know it doesn't really work the way they want it to work. But change requires adjustment and people have to be flexible and adaptable, and that's difficult when people are stressed and tired.”

— Psychiatrist, Workshop 2



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Next steps

- Thank you to all the participants who contributed to our consultation work thus far
- Next stage of engagement will be with managers and senior leaders to focus on needs in relation to system change and integrated care delivery in practice
- Also looking at other mechanisms to engage with clinicians about barriers and enablers on the ground- we will be reaching out soon!

Turning Point Team

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A/Prof
Shalini Arunogiri

Clinical Director

Prof
Dan Lubman

Executive Clinical Director

Jonathan
Tyler

Associate Director

Dallas
Wingrove

Program Lead Education and Training

Acknowledgements to:
Annette Peart
Rosemary Kalogeropoulos
Margret Petrie
Michelle Sharkey
Daniel Pham
Vicky Phan

Research Team

MONASH University

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A/Prof
Leah Heiss

Dr Troy McGee

Dr Amy
Killen

Dr Myra Thiessen

Dr Gretchen
Coombes

Hatoun
Ibrahim

Research collaborators
Dr Olivia Hamilton
India Macpherson
Maryke Laubscher

With contributions from
Professor Dan Lubman
A/Professor Shalini Arunogiri
Dallas Wingrove
Annette Peart
Nicole Kenny

Margret Petrie
Rosie Kalogeropoulous
Daniel Pham
Jon Tyler
Michelle Sharkey

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Thank you and please reach out!