

Multiple and Complex Needs

Chair | Gillian Clark, VAADA

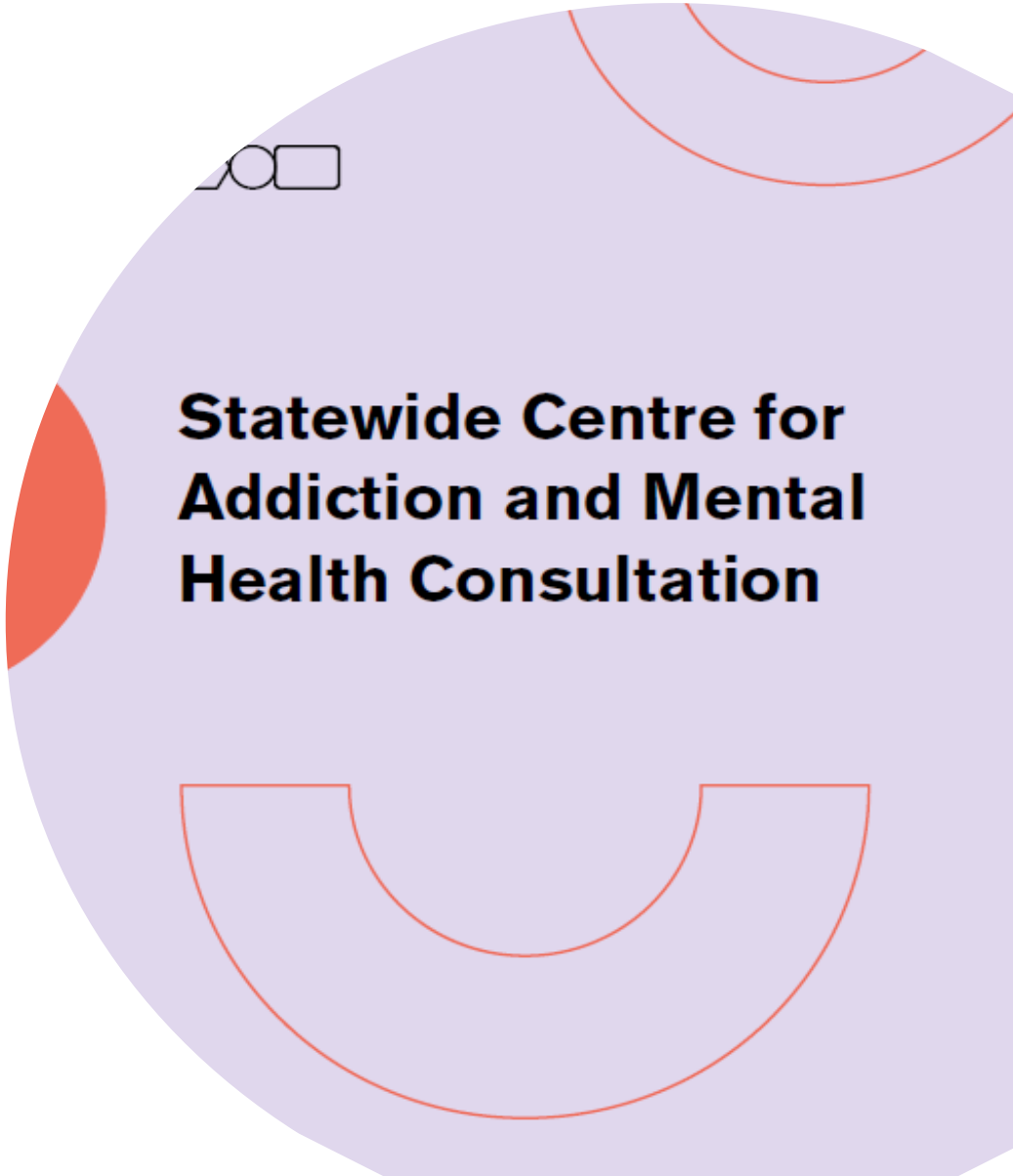
1. Expanding the toolbox for an ongoing challenge: the Comorbidity Project
2. (Re)imagining integrated care: exploring barriers and opportunities through co-design
3. Enhancing clarity in case management: the Windana case management manual

Integrated care in action: Exploring barriers and opportunities through co-design

A/Prof Shalini Arunogiri – Clinical Director, Hamilton Centre

Dr Ali Cheetham – Research Fellow, Hamilton Centre

VAADA Melbourne, 13 February 2025



**Statewide Centre for
Addiction and Mental
Health Consultation**

Disclosure of interest

This work was supported by the Victorian Department of Health.
Co-design workshops were undertaken in partnership with Monash
University Arts and Design (Design Health Collab)

Assoc/Prof Shalini Arunogiri is supported by a National Health and
Medical Research Council (NHMRC) Investigator Grant (GNT2008193).



Hamilton Centre



Recommendation #36

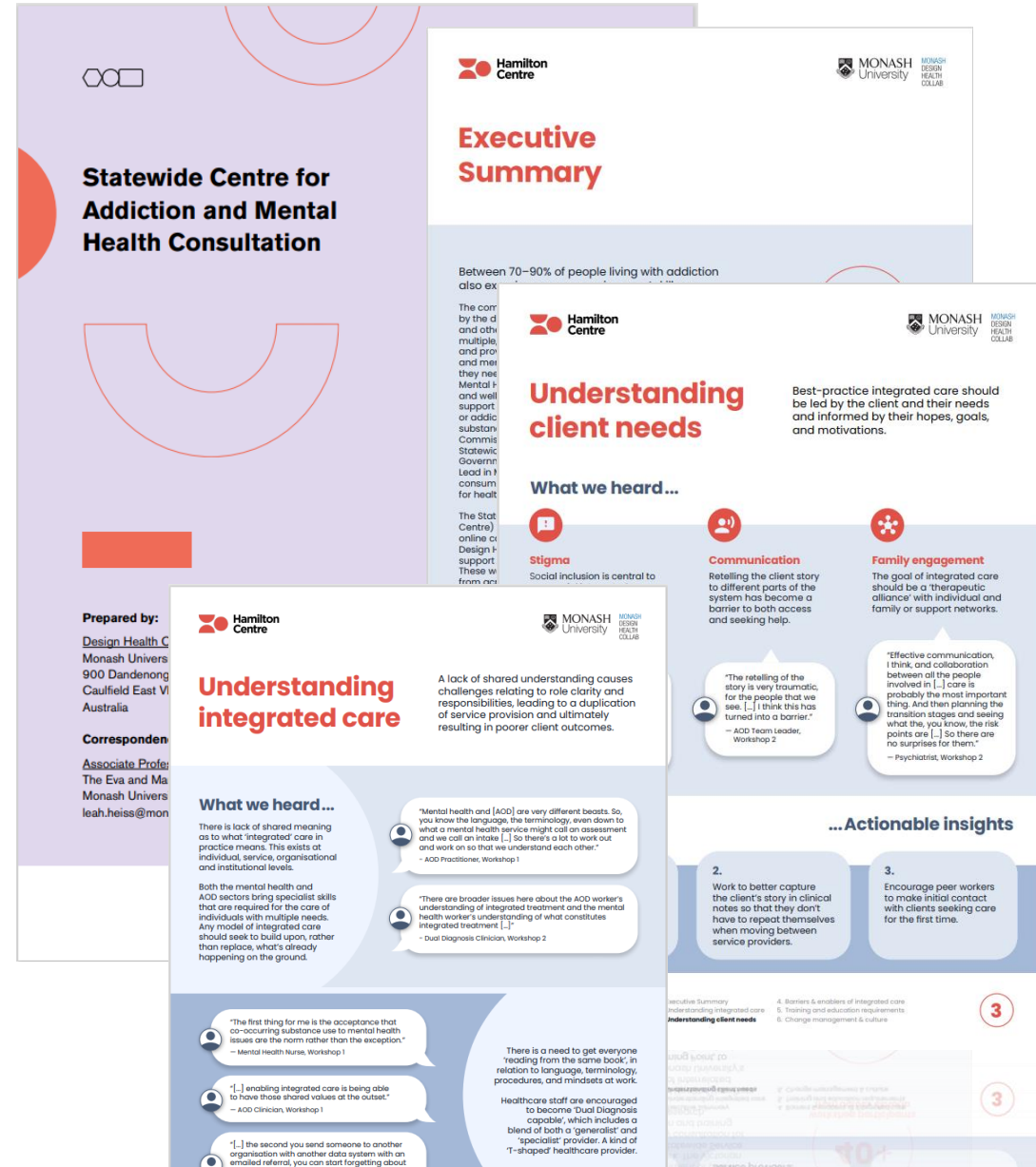


Hamilton Centre's role:

- Improve integrated MH & AOD support
- Statewide clinical, education, & research leadership



Co-designed best-practice integrated care model



**Statewide Centre for
Addiction and Mental
Health Consultation**

**Executive
Summary**

Between 70–90% of people living with addiction also ex...

The corr
by the d
and othi
multiple
and pro
and mer
they nee
Mental h
and well
support
or addic
substanc
Commis
Statewic
Governm
Lead in
consum
for healt

The Stat
Centre)
online c
Design
support
These w
from net

**Understanding
client needs**

Best-practice integrated care should be led by the client and their needs and informed by their hopes, goals, and motivations.

What we heard...

Stigma
Social inclusion is central to

Communication
Retelling the client story to different parts of the system has become a barrier to both access and seeking help.

Family engagement
The goal of integrated care should be a 'therapeutic alliance' with individual and family or support networks.

**Understanding
integrated care**

A lack of shared understanding causes challenges relating to role clarity and responsibilities, leading to a duplication of service provision and ultimately resulting in poorer client outcomes.

What we heard...

There is lack of shared meaning as to what 'integrated' care in practice means. This exists at individual, service, organisational and institutional levels.

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

"Mental health and [AOD] are very different beasts. So, you know the language, the terminology, even down to what a mental health service might call an assessment and we call an intake [...] So there's a lot to work out and work on so that we understand each other."
— AOD Practitioner, Workshop 1

"There are broader issues here about the AOD worker's understanding of integrated treatment and the mental health worker's understanding of what constitutes integrated treatment [...]"
— Dual Diagnosis Clinician, Workshop 2

"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

"[...] enabling integrated care is being able to have those shared values at the outset."
— AOD Clinician, Workshop 1

"[...] the second you send someone to another organisation with another data system with an emailed referral, you can start forgetting about

There is a need to get everyone 'reading from the same book' in relation to language, terminology, procedures, and mindsets at work.

Healthcare staff are encouraged to become 'Dual Diagnosis capable', which includes a blend of both a 'generalist' and 'specialist' provider. A kind of 'I-shaped' healthcare provider.

... Actionable insights

2. Work to better capture the client's story in clinical notes so that they don't have to repeat themselves when moving between service providers.

3. Encourage peer workers to make initial contact with clients seeking care for the first time.

Executive Summary
Understanding integrated care

4. Barriers & enablers of integrated care
5. Training and education requirements
6. Change management & culture

3

3

10+



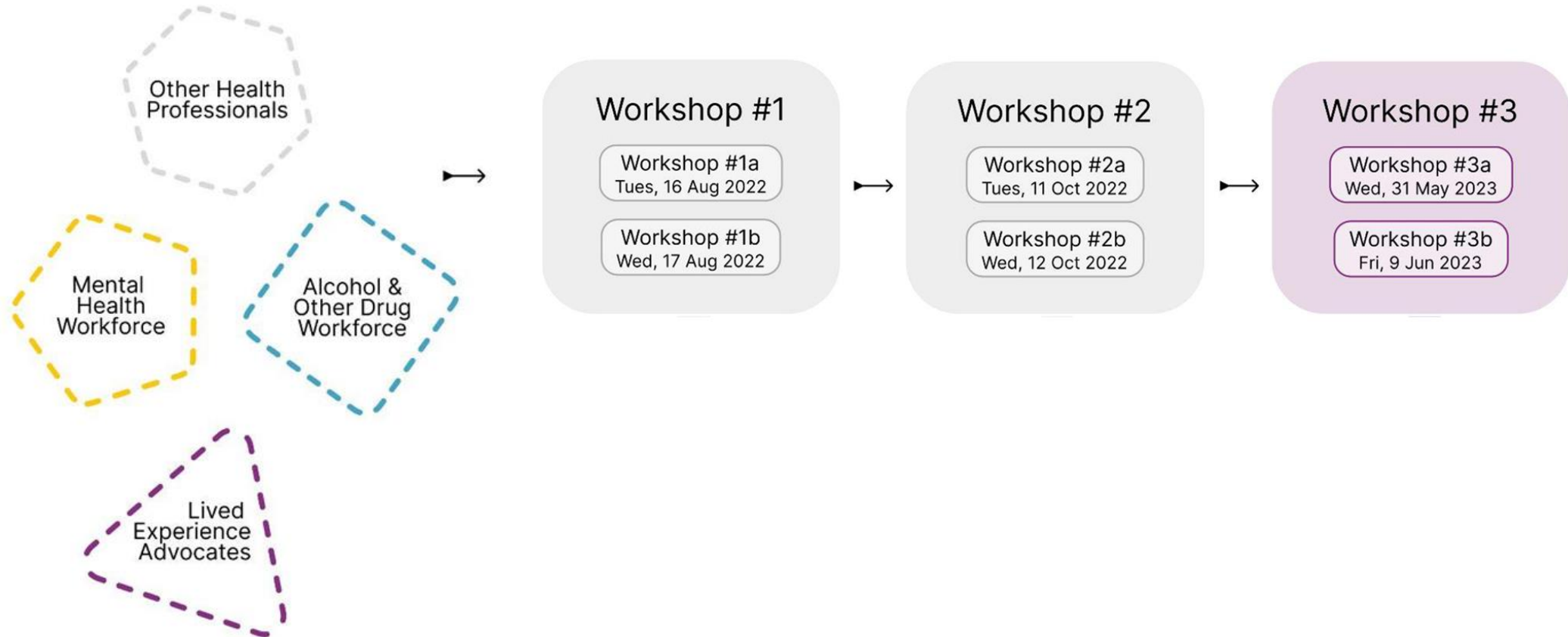
Wurundjeri Country

Methodology

Section 1 in report

- Co-design consultation structure
- Co-design method
- Approach to synthesis

Co-design consultation **structure**



Workshops 1 & 2

57 participants across
40 organisations

Mental health and AOD
practitioners, clinical leaders,
peer workers, and lived
experience advocates

Workshops 3a & 3B

27 Participants

across the two workshops

Senior clinical leaders or
managers of Victorian Area
Mental Health and Wellbeing
Services (AMHWBs)

Co-design **method**

Tactile Tools Digital Workshop



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

We evolved the method to scaffold discussions about how integrated care should be experienced and delivered in the future.



Workshop #1 & #2 activities

1

How can we improve the person's experience of care?

Using client personas, the first activity asked participants to discuss the experiences of people seeking care and how these experiences could be improved.

2

What are the barriers and opportunities in delivering care?

The second activity asked participants to explore the principle of capability and interrelated barriers and opportunities of integrated care delivery.



Workshop #3 activities

1

25 min.

Understanding the current state of integrated care across your services

The first activity asked participants to describe the current state of implementing IC across their services, as well as the barriers and enablers to this implementation.

2

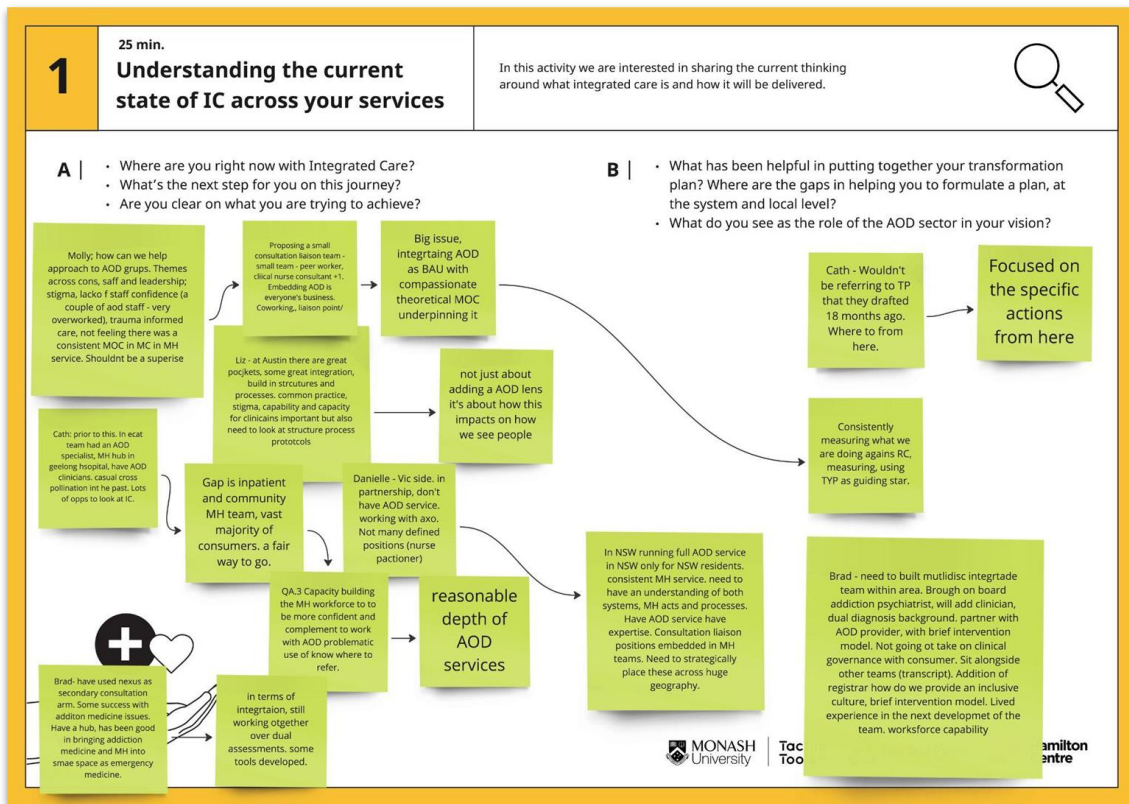
25 min.

Workforce and training, organisational leadership

The second activity asked participants to identify work that needs to happen to support their service to deliver integrated care through workforce training and organisational leadership.



Workshop #3 activities



MONASH UNIVERSITY

- Example of Miro synthesis board from Workshop #3.

Themes and insights

Workshops #1 & #2

Workshops #3A & #3B

Themes: workshops 1 & 2

1. Understanding integrated care
2. Understanding client needs
3. Barriers, gaps, and limitations
4. Enablers of integrated care
5. Training and education requirements
6. Change management and culture

Understanding integrated care

A lack of shared understanding causes challenges relating to role clarity and responsibilities, leading to a duplication of service provision and ultimately resulting in poorer client outcomes.

What we

Understanding client needs

Best-practice
be led by the
and informed
and motivat

What we heard...



Stigma

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

"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



Communication

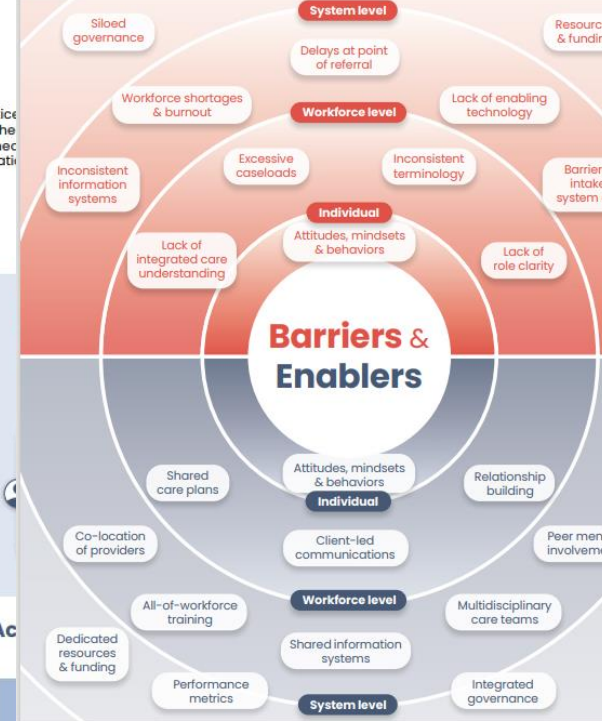
Retelling the client story to different parts of the system has become a barrier to both access and seeking help.

"The retelling of the story is very traumatic for the people that we see. [...] I think this has turned into a barrier."
— AOD Team Leader, Workshop 2

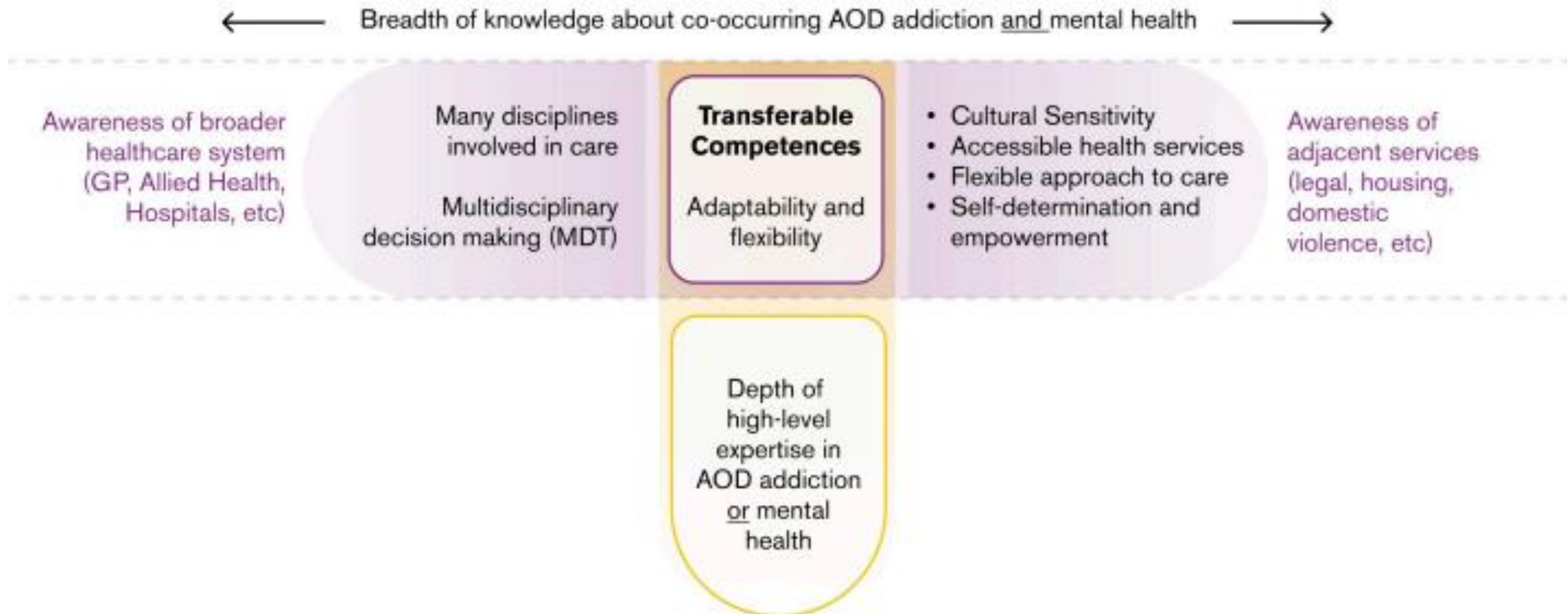
...Ac

1. Develop strategies for engaging and supporting LGBTQIA+ communities, fostering cultural safety, and engaging with First Nations communities.

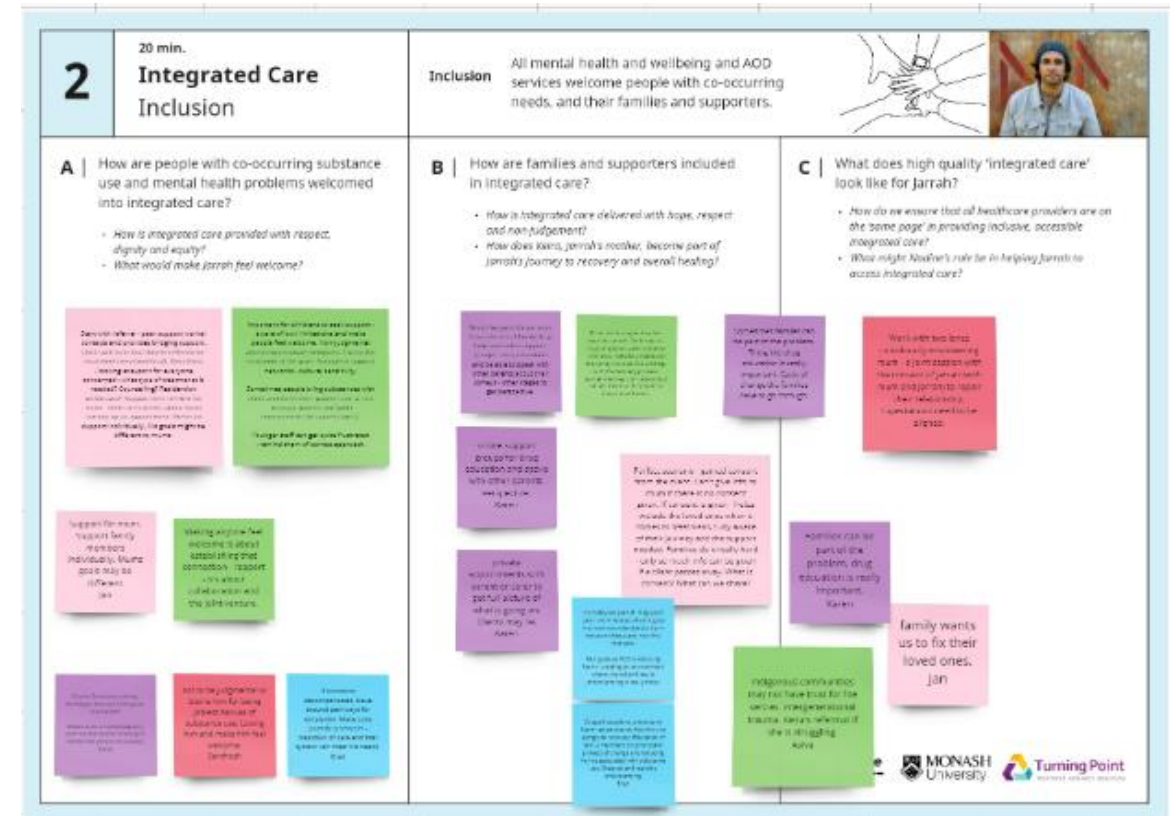
2. Work to better capture the client's story in clinical notes so that they don't have to repeat themselves when moving between service providers.



1. Shared understanding of integrated care

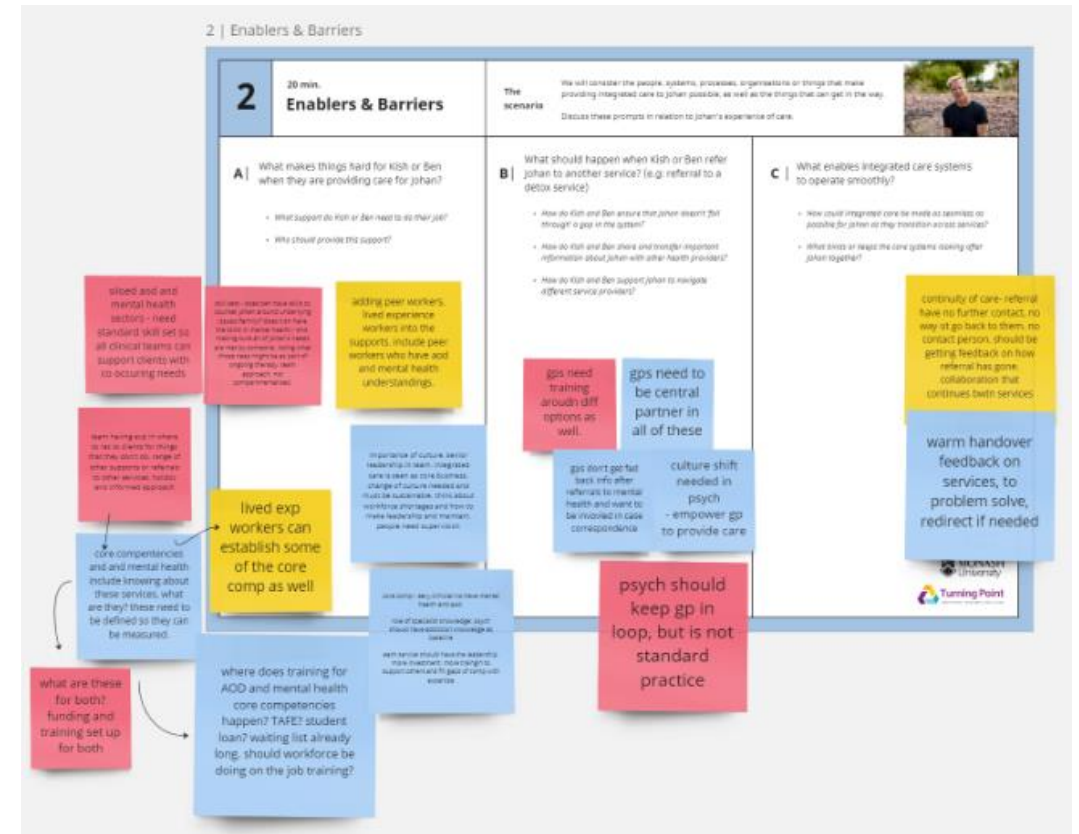


- Capture client story
- Peer workers
- Wrap-around care
- Address stigma



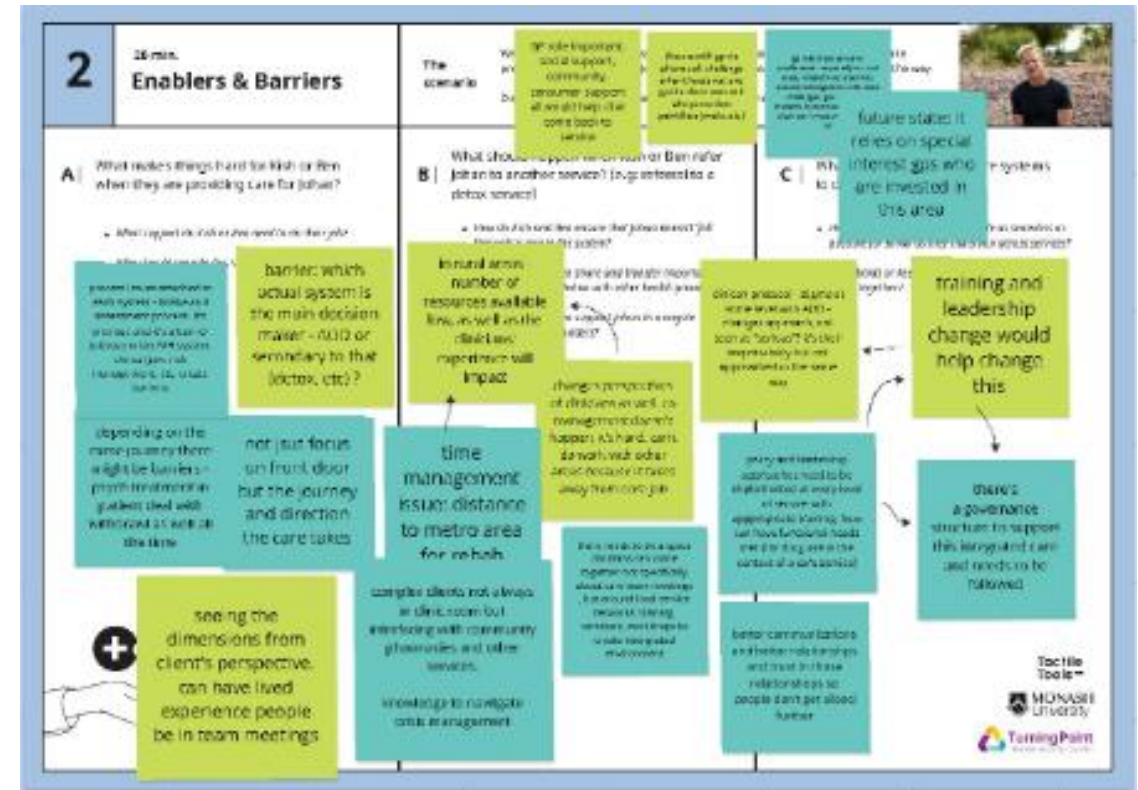
3. Barriers, gaps, and limitations

- Inadequate funding
- Limited workforce capabilities
- Challenges in regional contexts
- Problematic attitudes
- Entrenched stigmas & mindsets



4. Enablers of integrated care

- Sustained funding models
- Good governance
- Targeted workforce recruitment
- Building good relationships
- Mentorship & supervision
- Good leadership



- # 3

10 min.

Knowledge & Skills

Th **se**

Group of people based on finding a drug use

We will now consider the **learning needs** of the people who are caring for April, across both mental health and A&D sectors.

Learning that relates to the mental health and A&D sectors, including the challenges of working across the two sectors.

prompts in relation to Kish and Ben, and April's experience of care

Kish
MH Clinician

What learning does Kish need to provide integrated care?

 - What training is most important?

How to give / share his expertise.

How A&D learning will affect the mental health, signs and symptoms for each drug.

How to give / share his expertise.

How to give / share his expertise.

Ben
A&D Clinician

What learning does Ben need to provide integrated care?

 - What training is most important?

How to give / share his expertise.

How A&D learning will affect the mental health, signs and symptoms for each drug.

How to give / share his expertise.

How to give / share his expertise.

April

What learning does April need to provide integrated care?

 - What training is most important?

How to give / share his expertise.

How A&D learning will affect the mental health, signs and symptoms for each drug.

How to give / share his expertise.

How to give / share his expertise.

6. Change management and culture

Change takes time

a web of solutions

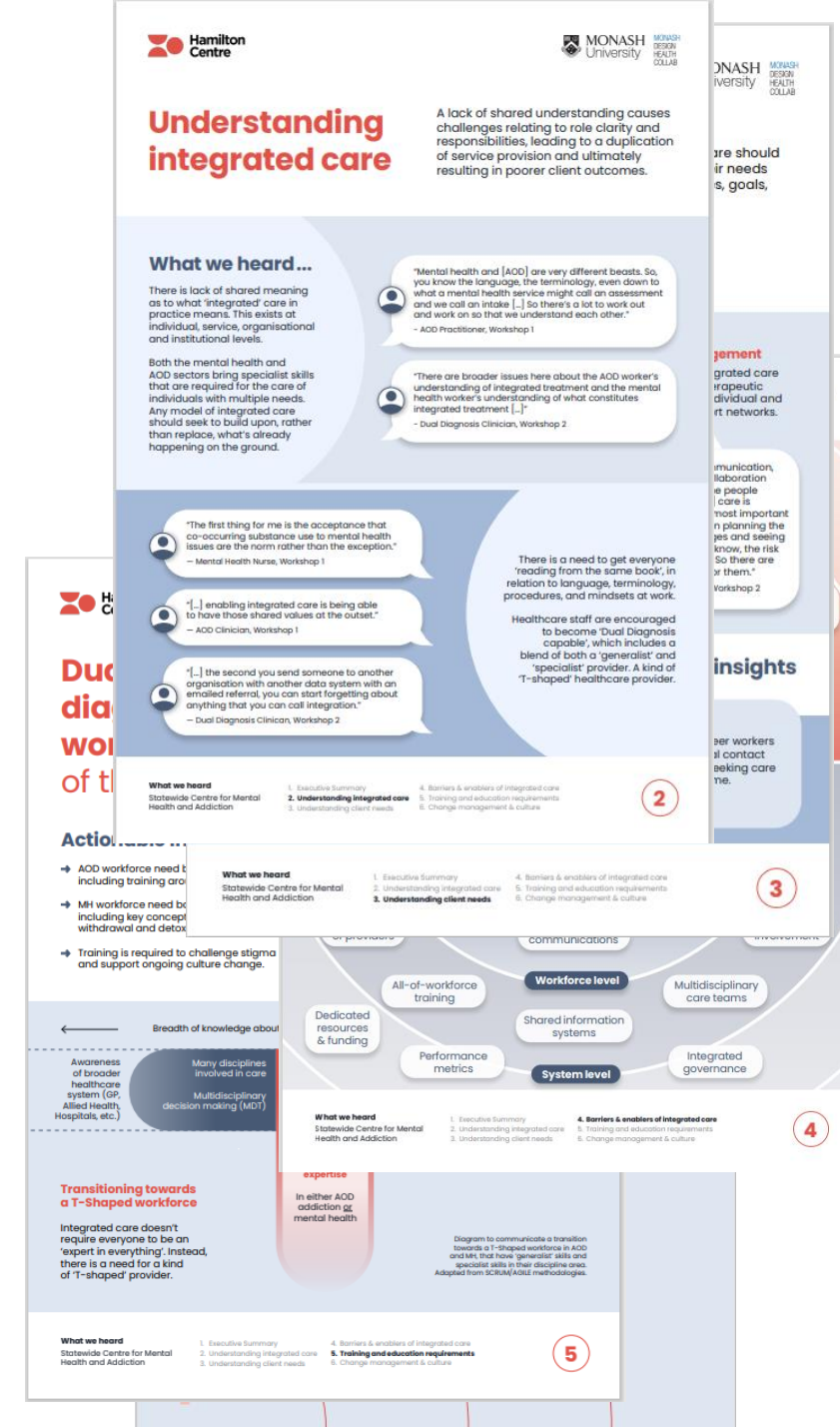
Themes: workshops 3a & 3b

Understanding the current state of integrated care

- Defining integrated care
- Having a united vision of integrated care
- AOD and MH in integrated care
- Resourcing
- Training and education

Building an integrated care plan for future state

- Capacity building
- Change management
- Culture



Understanding the current state of integrated care

Section 2 in report

- Defining integrated care
- Having a united vision of integrated care
- AOD and MH in integrated care
- Resourcing
- Training and education

Challenges

Defining integrated care/Shared vision



“Once there is a vision for IC across the system, what does IC look like in each individual system?”

— Workshop #3b

Aligning AOD and MH



“We’ve got a couple of dedicated AOD staff and everybody was trying to refer everybody to those people because they didn’t feel they had the skills to do anything themselves. Things around trauma informed care, not having a trauma informed approach to AOD, and not really feeling like there was a consistent model of care... within the mental health service.”

— Workshop #3a




“If our medical workforce or other clinical workforce, leaders, or anyone on the ground, if there is stigma and discrimination towards people who use drugs and alcohol, or who have a co-occurring addiction, that has to be a key target to break that down because we can’t create inclusive, welcoming, informed care if there’s covert or overt stigma and discrimination.”


— Workshop #3a

Challenges

Resourcing


 "There is a need for consensus across all levels to plan effectively for equitable access in care, otherwise each individual is left doing what they think is best."


— Workshop #3b

 "There is a lack of experience in actually providing treatment for people with dual diagnosis. So the focus tends to be on mental health issues and what is done for drug and alcohol issues then tends to be to try and motivate the patient in order to seek treatment elsewhere."

— Workshop #3b

Training and education

 "They have a tool for everything and what that means is they're not experts in anything. We've got multiple disciplines performing a very similar role".

 "It is important to clarify what a clinician's role in IC is because one of the challenges for clinicians at the moment is pressure to upskill in multiple domains (such as eating disorders, personality disorders, trauma, for example).

How do we support them to know and to develop those skills and to maintain those skills? When we bring in our multidisciplinary teams, how do we support them as well to not be a very small component of a larger service that they really struggled to get traction with?"

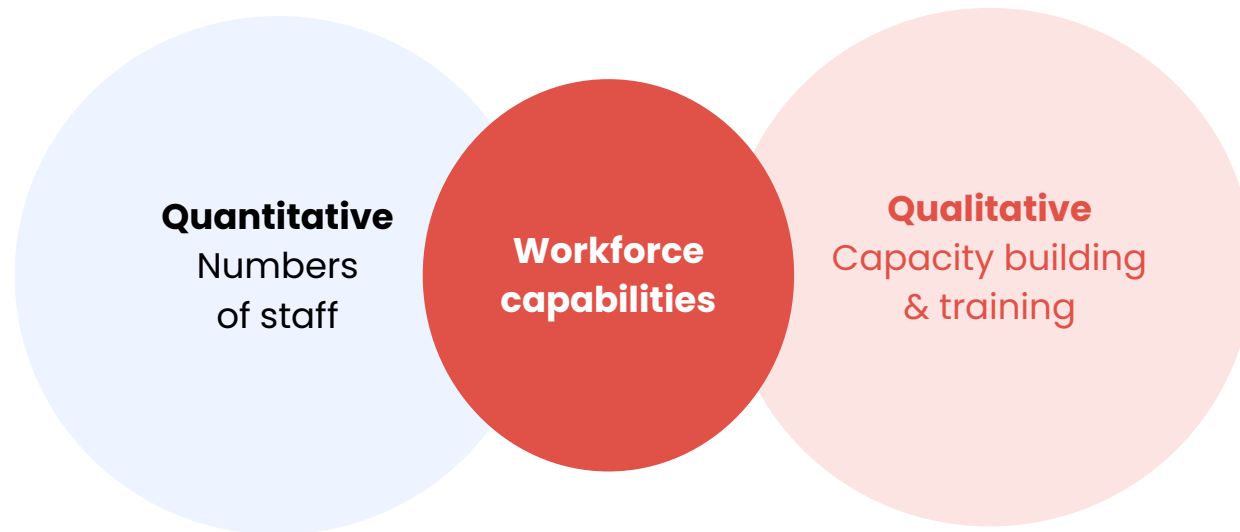
— Workshop #3b

Building an integrated care plan for future state

Section 3 in report

→ Capacity building
Change management
Culture

Capacity building – clinicians




Challenges for clinicians

- Mentorship and placements training
- Multidisciplinary teams
- Lived experience
- Community consultations and partnerships


Capacity building – leadership

Manager level



“We need to be really clear that managers are both empowered, given the resources and ability, but also need to drive the change and support the change for clinicians on the ground.”

Senior leadership level



“At the moment we’re carrying the biggest number of vacancies we’ve ever had, and there seems to be no end to that. And when you talk with the senior managers, their frustration is trying to work out what’s the biggest priority. And unfortunately they don’t see this as being top of their list. So no matter how gentle and how much you go back to support and help keep them focused, as soon as you’re not in the vicinity, they resort to dealing with more pressing issues.”

Change management



"[There are] competing priorities in the space so really keeping that focus on the future state vision and the clear rationale for why we're trying to do things differently is really important"

— Workshop #3a



"We need tangible milestones around capability and what it is that we are expected to have in contrast to the scope of a tier four or a tier three or a tier two."

— Workshop #3a



"[We need to] increase the supervisory frameworks to fund new positions, say in addiction medicine and addiction psychiatry and to develop some work around strategic directions around transformation plans, et cetera. And we need not only [to] develop our ability to drive change management, but we also need to develop our ability to train people to the competencies that we're trying to teach them."

— Workshop #3b

Cultural & organisational **change**

Change management

There is a need for:

- Defining capability requirements for IC
- Building policies to measure IC effectiveness
- Breaking down stigma related to AOD
- Preserving jobs and protecting current workforce
- Empowering senior leadership
- Collaboration across organisations
- Embracing a non-linear, adaptive planning approach



The plans need to go beyond 12 month cycles.



"Change is gradual and requires sustained, iterative, coherent deployment, monitoring and adaptation."



"It is an iterative process - so you have to keep going back and revisiting and rethinking not just charging forward."



"Plans are not linear - they don't just go A to B to C and there needs recognition for a more messy, less linear evolution."

Key takeaways

- Communicate 'small wins' early
- Provide continual feedback
- Good leadership
- Spend time on the ground
- Support clinicians in upskilling
- Consider capability tools
e.g., COMPASS-EZ™ DDCAT



Thank you

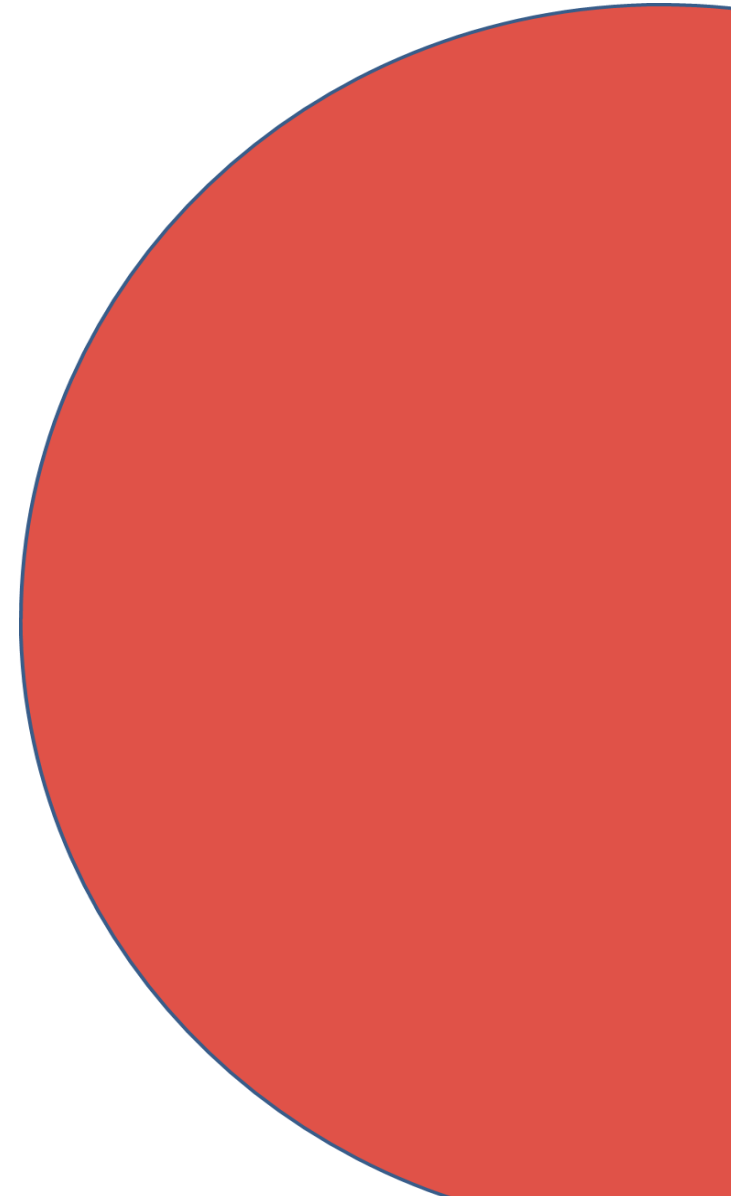
Study participants who freely gave their time

Research team:

Hamilton Centre &
Monash University
A/Prof **Shalini Arunogiri**
Prof **Dan Lubman**
Dr **Ali Cheetham**
Dr **Katrin Oliver**

Monash Design Health Collab
A/Prof **Leah Heiss**
Dr **Troy McGee**
Dr **Amy Killen**

Acknowledgments: MDHC: Dr. Myra Thiessen, Dr. Gretchen Coombes, Hatoun Ibrahim; Monash: Dr Annette Peart, Dr Daniel Pham, Dr Vicky Phan





shalini.arunogiri@monash.edu
ali.cheetham@monash.edu

OUR DOOR IS OPEN.

FOLLOW US ON:



@HCENTRE_AU



FACEBOOK.COM/
HAMILTONCENTREAU



LINKEDIN.COM/COMPANY/
HAMILTON-CENTRE-AU

 **Hamilton
Centre**
Open minds. Open doors.