# DFCMHC2022160 Immediate Drug Assistance Coordination Centre Facility

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# Table of Contents

## Contents

# Introduction

Lived Experience Australia is a national representative organisation for Australian mental health consumers and carers, formed in 2002 with a focus on the private sector. Our core business is to advocate for systemic change to improve mental health care across the whole Australian health system. This includes input to important initiatives within state and territory jurisdictions, from time to time, as they relate to mental health communities. This includes advocating for empowerment of consumers in their own care, promoting engagement and inclusion of consumers and carers within system design, planning and evaluation and most importantly, advocating for consumer choice and family and carer inclusion.

LEA is represented in Western Australia by our active Western Australian Coordinator Ms Lorraine Powell and State Advisory Forum and, as such, we are pleased to provide feedback on the draft Request requirements prior to calling for formal Offers for the provision of the Immediate Drug Assistance Coordination Centre (IDACC) Facility in WA.

Our Submission comes from the perspectives and experiences of people with lived experience of mental health issues, their families, and carers. We welcome the opportunity to provide our comments to the WA Mental Health Commission.

# Feedback on the Request Requirements

We understand the significant consumer and family/kin consultation has occurred to inform the design of the Immediate Drug Assistance Coordination Centre (IDACC) Facility and we thank the WA Mental Health Commission for this work. We are also very pleased to see such a Centre being offered to the WA community, though we acknowledge and recognise that it's capacity is far smaller than the likely demand for such a service in WA.

The IDACC will address a gap in service provision for the target cohort that is currently being met in an uncoordinated and fragmented way by telephone only (e.g., Alcohol and Drug Support Line) and/or emergency services (e.g., hospital, police). The existing arrangements are likely to do little to address the complexities of MH/AOD challenges; even worse, they are likely to continue to contribute to harm to individuals and their families and kin and to perpetuate trauma arising from these challenges for all concerned. This includes the workforces that attend to people with these challenges.

The provision of AOD short-term critical intervention services is a significant gap, with consumers, family members and carers often left to navigate a system that is complex, unclear and unsafe. It has been a highly stigmatising experience for many consumers and their family/kin, involving discrimination, racism, ignorance and neglect towards individuals and communities that experience challenges with AOD and mental health. For many years, the needs of people experiencing co-existing challenges with drug and alcohol issues and mental health have been fragmented and siloed. It is heartening to see such a model of service that brings the two together, albeit only for those in the acute stage of intoxication and only involving more intensive support for the short-term. This type of Centre is definitely needed, as the evidence of increasing concerns with amphetamine and other drug use indicates.

We therefore provide the following brief specific views on the Request requirements for the services and the facility infrastructure, as well as clarity of the specification of the requirements:

- Some overall impressions are that the terminology of the consumer changes - service-user, consumer, client and is inconsistent in the document. There is considerable over-use of the word 'appropriate' which leads to ambiguity. Also, from a consumer perspective, the word 'engage' has also been extensively used throughout. It may not be received will by some and some contexts regarding its use. For example, it has often been held over some individuals as a threat in receiving or not receiving services.

- Too many people fall through the gaps between services. We believe there could be more clarity in the detail of the crisis service coordination to guide the decision about whether a person who may not meet the criteria for admission to the IDACC, or is referred on after contact with the IDACC, is referred to either mental health or AOD services for further follow-up. How will this be determined and by whom as the ultimate decision-maker?

- We understand that the model of care provides system navigation functions to consumers of the IDACC Facility, health professionals and family members/significant others. Here For You also supports individuals and families to access the IDACC Facility and provide support to those exiting the IDACC Facility, as required. This is commendable; however, there needs to be an expectation of and action to establish clear MOUs with other parts of the system to avoid individuals simply cycling around and between this IDACC program and other services.
- P.7 Regarding Section 3.2 dot point "Not experiencing a psychiatric emergency", how will this be defined? And how will the needs of young people who may present are then realised to be under 18 years of age be managed?
- P.10 The information about how families will be supported is very brief and could be more explicit in the document give their important role and the likely vicarious trauma that they may experience.
- P.13 Should more be said about handling of medication and any treatments for handling and supporting this for individuals who may have pre-existing chronic physical health conditions or disabilities that may require unique types of support?
- P.14 In the section on family and significant others (and more broadly in the document), there is no mention of how information sharing, privacy and confidentiality will be handled?
- Regarding Component 2: Drug and Alcohol Clinical Advisory Service (DACAS) phone line, which currently operates 8am to 8pm Monday to Friday. What is available outside of these hours? It is our experience that many people with MH and AOD challenges experience crisis outside of these hours. Also, the nature of many services is that their workforces that may 'cover' the afterhours times may struggle to access sufficient supervision to support their decision-making and actions. This can lead to or exacerbate the many issues noted previously.
- p.15 Regarding the dot point about AOD Worker/Counsellor/Peer Support Workers, we encourage you to separate these disciplines out so that Peer Support Workers are more evident as being required. This currently reads as an either-or.
- P.15 Two (2) Nursing staff (mental health/AOD and general health) – is there scope to include a Nurse Practitioner role, given the complexity of needs of the population being served by the IDACC?
- P.15-16 We suggest revision to the wording of this statement where you have used 'engaged' – "Peer support workers should be employed to complement the roles of clinical and counselling staff by establishing rapport, sharing experiences, and strengthening engagement with individuals experiencing crisis. They may also work briefly with the family or significant others of those accessing the IDACC Facility to educate them about self-care and ways to access ongoing support.
- P.16 Regarding the statement "Governance and support of peer support workers must be comprehensive and robust to reduce any associated risks. This governance framework must be developed by the service provider prior to service commencement." – This reference to 'risk' requires substantial qualification. Currently, it could be interpreted as Peer Support Workers being 'risky'. We also suggest that you include mentoring in addition to governance and support for this workforce, and that it must be comprehensive, robust, and in line with the National Mental Health Commission's Peer Workforce Guidelines (2021).
- P.16 Regarding the statement "Security staff must be appropriately trained in the use of de-escalation techniques, cultural security training and present as non-threatening to service users to reduce the risk of escalating presenting issues (including paranoia)." We suggest that consideration also be given to security guards' body language, unforms and visibility within the IDACC as part of an

environment that aspires to provide trauma-informed care, especially given that many people who will be admitted to the Centre are likely to have experienced significant past trauma.

- p.16 Regarding the statement "All staff trained in and working from a trauma-informed, culturally secure, recovery and strengths-based approach." We suggest adding the word 'recovery'. This Centre and its various linkages with follow-up support represent a real opportunity for consistent support beyond the crisis period of intoxication. This includes a mental health recovery-oriented approach and an AOD recovery pathway opportunity.
- P.16 Regarding the dot point "Suicide risk assessment", we suggest an assessment of risk of self-harm also be included here.
- p.17 Regarding the dot point "Safe storage and access to own use medication", we suggest adding the words "for consumers" to the end of this point to make it clearer.
- P.17 Regarding the dot point "After hours staff safety", we note that this is already planned as a 24-hour service. Therefore, it would be useful to clarify what you mean here.
- p.18 Regarding the statement "Similarly, individuals with dependent children in their care will not be able to access the 'living room' area of the Drop in Hub or Short-Term Crisis Beds, but they are to be provided with immediate brief intervention, support and referral as required." We envisage that family and kin who may accompany the person being admitted to the Centre may not have any alternative childcare due to their own personal circumstances. How will this be managed?
- p.19 Regarding the dot point "An appropriate dining area for service users to be provided meals", we don't think the word 'appropriate' is needed. It isn't clear what is meant by this term as used here.
- p.21 Regarding the statement, "Consist of a multidisciplinary team with staff from at least three different professions including nursing, psychology, social work, Aboriginal health worker, or AOD worker", it is disappointing that Peer Support Workers are not included as a must-have discipline within the core workforce.
- P.18 Regarding the dot point "Incorporation of Aboriginal signage throughout the facility, for example rooms named after Aboriginal places in the Perth CBD (e.g. Derbal Yerrigan, Kaarta Koomba)" – Why are only 'places' suggested; there are other Aboriginal terms which could be utilised; for example, ones that promotion inclusion, hope, support, etc.
- P.18 Regarding the dot point "Designed so that there is a central, "living room" style space with multiple exits and open sight lines for staff where people can move around or sit in a lounge room style and be appropriate and observed while they are agitated/awake" - There is an overuse of the word 'appropriate' in the document which is not adding value nor providing clarity on expectations. We suggest replacing it with another term that provides greater clarity and less ambiguity.
- P.19 Regarding the dot point "Pleasant, landscaped outdoor areas incorporating plants and trees visible from within the facility and an outdoor area appropriate for individuals waiting to access the facility (as an alternative to waiting inside in the waiting room, depending on demand). A designated outdoor smoking area will also be required." Our concern is that this may be fraught with issues. Despite not being a health facility, and therefore the non-smoking policy will not apply, providing such a space may be difficult, especially given the location of the service. In stating that, it is recognised that the majority of individuals accessing the service will be smokers. We also note that Item 25, on page 31 is in conflict as it states there will be no smoking area permitted.
- Regarding section 4.3.1 Evidence based practice – "The service provider will ensure that clinical practice and services are consistent with current best practice and undertake evidence based AOD prevention and treatment strategies. Practice must be consistent with MHC's Counselling Guidelines: Alcohol and Other Drug issues 2019." We question why only a focus on clinical practice here. We expect that all staff will be required to delivery current best practice approaches to care.

- Regarding section 4.3.2 Accreditation - Will there be a requirement to also receive accreditation/ endorsement from the Licensing and Accreditation. Regulatory Unit (LARU) regarding Code of Conduct for Approved Supervisors?
- Regarding section 4.3.3 Staff qualifications – "The Respondents will be required to provide assurance that if successful, all counselling and training will be delivered by suitably trained, qualified or experienced staff. In the Request qualitative requirements, the Respondent is required to provide details of the training and qualifications of staff." Again, we have suggested wording to replace 'appropriately', as underlined.

## Contact

We thank the WA Mental Health Commission for the work that has gone into the development of this important and much needed service and wish you every success with the next steps in its development. We would be keen to discuss further, any clarification or issues raised with you.

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