Langford

Integrated Systems of Care to support people with mental health, alcohol and other drug issues (ISC)

Community Engagement and Co-Design Workshop Report

2017

Executive Summary: Langford Area

[Langford population: 5,671]

Richmond Wellbeing, in collaboration with consortium partners, has been commissioned by WA Primary Health Alliance (WAPHA) to develop an integrated system of care program to support people with mental health, alcohol, and drug issues in the Perth South Primary Health Network region from April 2017 to June 2018. The purpose of this activity is to improve the health and wellbeing of people who are living with co-occurring AOD (alcohol and other drugs) and MH (mental health) conditions.

The Richmond Wellbeing (RW) ISC engagement team conducted outreach into communities in this location to listen to community member's experiences, concerns, issues and ideas regarding problematic mental health and AOD use in the community. The RW team heard from community members who experienced these issues themselves, and from people who are carers, families, friends and supporters of people experiencing problematic AOD and MH issues.

Mental health services, AOD services and other service providers in the area were also contacted by the RW team to gather information on issues and concerns of the organisations. Ideas on ways to provide better access to services for vulnerable and disadvantaged community members and better integrate AOD and MH services were discussed in this engagement process.

Feedback from the local community was collated to provide themes for place-based co-design workshops attended by local community members and service providers working together on solutions to address these issues.

LANGFORD AREA:

CONSULTATION AND ENGAGEMENT	
Community Members	Service Providers
N/A*	N/A*
WORKSHOP ATTENDANCE	
Community Members	Service Providers
12	5 (6 people)

*Pre-workshop engagement did not take place in the pilot.

Co-design Workshop

Workshop Themes:

- **Services need to be integrated and focus on the individual as a whole regardless of diagnoses.**
  One person with many needs.

- **Services need to collaborate and develop systems and processes to reduce people falling through the gap.**
  Enhance continuity of care across providers.

- **Services need to be culturally appropriate, welcoming, and delivered out in the community.**
  Increase appropriate services and programs in the local area.

- **Services need to build a local workforce that is trusted and understands local people and works across cultures.**
  Increase local workforce with adequate cultural and local understanding.

A co-design workshop was held in Langford on Sep 6^{h} 2017 for community members and service providers. This workshop provided an opportunity for service providers and local community to come together to co-design local service activity.

Workshop Findings:

The co-design workshop identified nine key findings to be considered by the Project Management Group:

1. Build local capacity by training and employing community members with lived experience, language skills, and cultural understanding.
   1A: Develop a local community program to provide opportunities for learning and certified skill development.
   1B: Employ local community members with diverse experiences, language skills and cultural understanding to be peer workers.
2. Trial an integrated care coordination project that provides Care Coordinators and Lived Experience Advisors to facilitate access to services and meet individual client needs for physical, mental, social and emotional support.
   2A: Employ Care Coordinators that work locally across service providers to support system navigation for individual clients.
   2B: Employ Lived Experience Advisors (LEAs) as 'companions' to provide physical, mental, social and emotional support to clients.

2C: Develop project processes to support referrals, decision making touchpoints, and the overall patient journey.

3. Develop a central hub where the community can access a range of services and community support.
   3A: Create a one-stop shop where services are co-located to reduce barriers related to access and transport.
   3B: Create a central hub that provides a safe space for people to come together to develop family support networks.
4. Develop a database of all local service providers and services and share with health professionals and the community.
5. Increase bi-lingual support services available across AOD and MH sectors.
6. Develop and trial a holistic integrated single assessment process that is culturally sound, accessible, flexible, and transparent to the client and service providers.
7. Create a mobile outreach hub that provides a number of services out in the local community.
8. Develop cultural awareness training to educate existing staff and services on how to engage with the diverse local community.
9. Develop a school and community empowerment programs to build capacity, address stigma, and drive local resilience.

Solutions to Address Key Findings:

1. Build local capacity by training and employing community members with lived experience, language skills, and cultural understanding.

1a. Develop a local community program to provide opportunities for learning and certified skill Development.

Identified need:

- ❖ Need to provide opportunities for local community members who have valuable lived experience to work within services to help others.
- ❖ Need to create employment opportunities and pathways for people who are in recovery.

How to do it:

- o Encourage local agencies to have volunteer or funded programs for local community members to develop on-the-job skills and training.
- o Partner with local City of Canning council, education and university sectors to develop a program that may allow for certification and qualification.

- Funding for training of people with lived experience to work the same way that apprenticeships are funded.
- Bring together those with AOD and MH experiences and pair those who are AOD and MH trained and get them job ready.
- Provide complementary training in cross cultural education and communication to support working with diverse local communities.
- Provide opportunities for skilling across both AOD and MH sectors.
- Support peers into volunteer programs that do not need working with children (WWC) checks.
- Provide a pathway to employment as a local peer worker (link with Part 1B).
- Identify and engage with visible community champions – those with lived experiences and have success stories to share.
- Bring local community champions together for an initial morning tea consultation to explore their interest and ongoing involvement.

1b. Employ local community members with diverse experience, language skills and cultural understanding to be peer workers.

Identified need:

- Need peer workers within service that have lived experience AND diverse language skills and cultural understanding.
- Need to value those with lived experience and what they can contribute to improving the system and patient journey.
- Lived experience at the forefront is more important than a 'professional'.
- Agencies need to be more flexible with their HR employment criteria to provide equal opportunities – especially related to criminal records.

How to do it:

- Identify peers who are interested and/or certified through community, workplace, or volunteer programs (link with Part 1A).
- Identify and employ local community leaders and/or those with:
  - Lived AOD and/or MH experience;
  - Appropriate cultural knowledge;
  - Adequate language and communication skills; and
  - Relevant certification and qualification or support on-the-job learning and progress towards this.
- HR policies need to recognise and value the lived experience of AOD and MH – especially related to criminal records and employment history.
- Support peers via a social worker or case worker for first year of employment.

- Provide a ‘mentor by guarantor’ who will supervise and support peer workers.
- Provide feedback loops that value and support sharing of those with lived experience to improve the client journey within service provision.

2. Trial an integrated care coordination project that provides Care Coordinators with Lived Experience Advisors to facilitate access to services and meet individual client needs for physical, mental, social and emotional support.

2a. Employ Care Coordinators that work locally across service providers to support system navigation for individual clients.

Identified need:

- Need one overarching person that understands the system and local services that can advise and coordinate services on behalf of clients.
- Someone to communicate in plain language to clients to help them bridge any gaps in understanding around system navigation.

How to do it:

- Most likely a ‘professional’ role.
- Provides the top layer of direction and support to LEA (see Part 2B below) to provide integrated, coordinated care.
- Conducts initial comprehensive needs assessment in client home (across all physical, mental, social needs) – client tells story once.
- Discuss client past experiences, options and preferences for support.
- Determines if need and preference for LEA and arranges if necessary.
- Understands assessment, referral processes, and criteria for entry and navigation through services.
- Has excellent understanding of the local services available and how they work together.
- Makes contact with service providers and General Practitioners (GPs) on behalf of the client to organise, access, entry, and appointments.
- Is the ‘gatekeeper’ working on behalf of the client directly with services to overcome barriers and organise support that is needed.
- Organises everything on the service provider ender to reduce the need for the client being handballed between providers and getting lost.
- Reports back to the client with progress and outcomes.
- Stays in regular needs assessments with client, with ongoing contact and communication with LEA.
- Conducts regular needs assessments with client to keep abreast of progress, issues, and change in client needs.

- Overall aim of this role is to reduce unnecessary red tape, clients bouncing from provider to provider, clients falling through gaps, and to leverage someone within the system who knows the system to do the best they can to meet and service the needs of each individual.

2b. Employ Lived Experience Advisors (LEAs) as 'companions' to provide physical, mental, social and emotional support to clients.

Identified need:

- Clients often need someone that they can rely upon to support their needs beyond strictly care coordination.
- Someone to provide physical, mental, social and emotional support to clients to help them address everyday barriers.
- This is particularly needed for those with moderate to complex conditions, and those with co-occurring disabilities.
- Someone to communicate in plain language to clients to help them bridge any gaps in understanding around system navigation.
- Someone who understands what it is like to go through these issues that clients can identify with (i.e., someone with lived experience).

How to do it:

- Best fit would be a peer worker or someone with lived experience and relevant skills, qualifications and cultural understanding.
- Providers a safe and supported space for clients to get the support they need in their own home.
- Liaises with and reports back to care coordinator (see Part 2A above) to provide integrated, coordinated care.
- Provide support and home visits to clients across a range of issues, including:
    - Helping clients access transport, medications and scripts, attend appointments.
    - Sitting in on sessions with the client to advocate for them and help with communication or language barriers.
    - Following up with clients to make sure they attended appointments.
    - Providing emotional and social support to reduce risk of social isolation (e.g., opportunities to talk and de-brief).
    - Attending home visits to check in on clients and touch base regularly.
    - Working on clients' behalf to make appointments and other related arrangement (e.g., transport).
    - Sharing experiences and journeys.

- Overall aim of this role is to a trusted 'companion' that the client feels understands them, can walk with them through their journey, and can talk to them and share experiences to boost overall feelings of wellbeing and reduce feelings of isolation.

2c. Develop project processes to support referrals, decision making touchpoints, and the overall patient journey.

How to do it:

- Program similar to:
  - MH Connects Program (WAPHA) which utilises MH nurses in care coordinator roles working with GPs.
  - HBF Health Support Program (HBF and Bethany) that provides personal health coaches that focus on chronic disease to help clients navigate the system to avoid hospital admission – could be similar to this but include MH and focus on vulnerable people that do not have access to private health insurance – potential opportunities for partnership and shared learnings?
- Need to map out services in the area to develop a local database.
- Referral considerations:
  - Any clinician can refer client into the program;
  - Client can also approach the program and request support;
  - If client approaches, facilitate a GP referral with client permission or link to a GP if client does not have a GP;
  - Approach GP, give info on program (also awareness raising), and activate referral for client;
  - Contact client to advise of outcome and then conduct in-home initial assessment;
  - If GP does not consider referral appropriate, consider LEA meeting with client to discuss what is really needed; and
  - Provide warm referrals to non AOD and MH services as needed.
- Select one geographical region to pilot in (e.g., Gosnells/Armadale).
- Pilot and collect data on service engagement and impact beyond AOD and MH sectors for potential ongoing funding.

3. Develop a central hub where the community can access a range of services and community support.

3a. Create a one-stop shop where services are co-located to reduce barriers related to access and transport.

Identified need:

- Services need to work together in the same location so people do not have to travel far.
- Need culturally appropriate services that are community friendly, have flexible delivery models, and easily accessible by public transport.

How to do it:

- A one-stop shop where services include:
    - MH, AOD, social services;
    - GPs and specialists;
    - Family support groups, rehab groups, social groups, spiritual and church groups;
    - Volunteer organisations; and
    - A holistic residential rehab centre specifically for Aboriginal and Torres Strait Islander (ATSI) families and children.
- Provide access to interpreter services for all appointments.
- Provide access to transport.
- Provide easy access for new migrants.
- Provide an on-site crèche or child minding facility.
- Provide support with related AOD and MH issues, such as financial support, legal support, and domestic violence support.
- Provide peer support and lived experience staff workers that have diverse language skills and cultural understanding.
- William Langford community House could partner with Langford Aboriginal Association.
- Engage further with community to determine what they want different service models to look like.
- Develop multi-disciplinary meetings between hub staff to share information and facilitate the best support for individual clients.
- Have regular community open days, inviting the community and consulting with them asking what they want and need.

3b. Create a central hub that provides a safe space for people to come together to develop family support networks.

Identified need:

- More support is needed for family members and carers.
- Provide group-specific programs and support (e.g., for youth, family members, within and across cultures).
- Provide opportunities for cross-cultural relationship building – need to "step outside individual silos of culture".
- Use "culture as a vehicle" to bring the community together.

How to do it:

- Establish a small working Community Action Group that will work in partnership with local organisations to develop the hub (e.g., Langford Aboriginal Association, Lions AOD Foundation, City of Gosnells, local primary and high schools).
- Develop support groups where the community get together on a weekly basis and discuss their AOD and MH experience and share feelings.
- Create opportunities to organise positive social activities for local people and their families affected by AOD and MH.
- Employ people to facilitate groups that are not necessarily 'medical' (e.g., peer work).
- Provide education about AOD and MH issues.
- Provide education on other cultures.
- Provide support for family members of those struggling with AOD and MH issues.
- Aim to address stigma and discrimination associated with AOD and MH.
- Develop group-specific programs such as youth programs and men's sheds.
- Develop a 'peer language' program.
- Develop social groups and activities to bring members of different cultures together (e.g., painting).
- Run a community event, e.g., a walk or open day to bring people of the community together and inform of the local hub and what it offers.
- Advertise community even on local radio (Heritage FM) and around town.

4. Develop a database of all local service providers and services and share with health professionals and the community.

Identified need:

- Doctors, services, and community need to be more aware of what local AOD and MH services are available.
- GPs need to increase their awareness of local services to improve referral networks.

How to do it:

- A lead agency to gather information on local services available, make this a publically available resource, and maintain current information.
- Develop a share dynamic document or database that can be continuously revised and updated.
- Advertise programs and services on bus stops and via local community outlets and media.

5. Increase bi-lingual support services available across AOD and MH sectors.

Identified need:

- Need to address communication barriers and connect with individuals with language and cultural understanding.

How to do it:

- Employ bi-lingual staff who have a good understanding of many local cultures.
- Employ translators to support assessment processes and to be able to explain the course of action.
- Provide a mobile interpreter service to visit people in their homes.
- Provide staff who speak preferred language – the need for translator is a distant second option.
- Provide bi-lingual and translator services over the phone and face-to-face across all services.

6. Develop and trial a holistic integrated single assessment process that is culturally sound, accessible, flexible, and transparent to the client and service providers.

Identified need:

- Need to simplify the assessment and referral process.
- Need to conduct one assessment with service providers then leading coordination rather than relying on individuals to navigate the system.

How to do it:

- Use a common assessment framework which promotes services communicating and integrating with each other.
- Actively encourage or mandate services to use a common assessment framework so people do not need to keep repeating their story.
- Provide client access to this information via variety of methods, including online, mobile app, hard copy etc.
- Client to be able to provide additional information and negotiate what information is to be included and shared.
- Share this information with all relevant parties including doctors, GPs, AOD and MH services, social support services, Medicare, carers etc.
- Employ translators to support assessment processes and to be able to explain the outcomes and next steps.
- Following assessment, allocate an agency lead and facilitate multi-disciplinary meetings between relevant parties to share information and allocate agencies and health professionals to provide support to meet individual case-by-case client needs.

7. Create mobile outreach hubs that provides a number of services out in the local community

Identified need:

- Services need to be provided out in the community to overcome barriers associated with cost and access to transport.

How to do it:

- A mobile hub or bus based on the Street Doctor model across local suburbs.
- Provide direct access to services (e.g., counsellors).
- Increase awareness of the different types of services available.
- Provide access to translators and bi-lingual staff.
- Conduct pre-assessments or one intake assessment.
- Gosnells City Council had a Youth Nomad Trailer through school holidays – this concept can be used to visit smaller community spaces to share information on local AOD and MH services available and gather further feedback on what the local community wants and needs.

- Identify specific cultural group needs or geographical area needs and provide outreach 'pop ups' to service specific groups and areas.

8. Develop cultural awareness training to educate existing staff and services on how to engage with the diverse local community.

Identified need:

- Local staff need increased understanding and education of how different cultures relate, show respect, and community with each other.

How to do it:

- Develop partnerships with local leaders and elders in the community to create education program.
- Develop education programs that focus on how different cultures:
  - Speak within their communities
  - Communicate within their communities
  - Use of language and tone of language
  - Use of body language
  - What words are used and what they mean
  - Way respect is shown
  - Conduct relationships
  - Have different family dynamics, restrictions, expectations and religions

9. Develop a school and community empowerment program to build capacity, address stigma, and drive local resilience.

Identified need:

- Need to work outside of the current system and current frameworks, beyond the provision of services, to empower individuals.
- Upskill the community with life skills and how to deal positively with a range of social, emotional, and financial pressures.

How to do it:

- Develop a centralised message to be shared in the community as part of the program.
- Run community, cultural, youth, and school programs to increase community engagement and educate about AOD and MH issues.
- Provide education and skill development on how to increase awareness and support your own family.

- “Resource our family to support each other”
- Reduce barriers and red tape to support by providing individuals to support themselves and support their own families
- Strengths-based approach to celebrating the community
- Help educate family on “how to” list.
- Deliver the program in school and through education systems to empower young people and activate their parents and families.
- Engage with local businesses and community groups to share the message (e.g., footy groups).
- Identify community champions to be role models, program facilitators, and share positive success stories.
- Help people to help themselves.
- Give people permission to value themselves.
- Teach people about their own feelings and how to deal with them.
- Educate families and fathers on how to listen.
- Facilitate families to share and talk to each other.
- Deliver variations of the program to align with different culture and family roles.
- Develop simple tools and resources to support families at the front line dealing with AOD and MH issues in a positive and empowering way.