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# SUMHIT
## Substance Use and Mental Health care InTegration

*Accessibility of mental health services for people with substance use*

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Background

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# Accessibility to mental health services

- categorial organization mental health & substance use services
- unclear whether available care effectively meets the needs for persons with addiction problems (KCE report, 2019)
- with a specific focus on

  ‘Met and unmet needs’
  Accessibility
  Lived experiences

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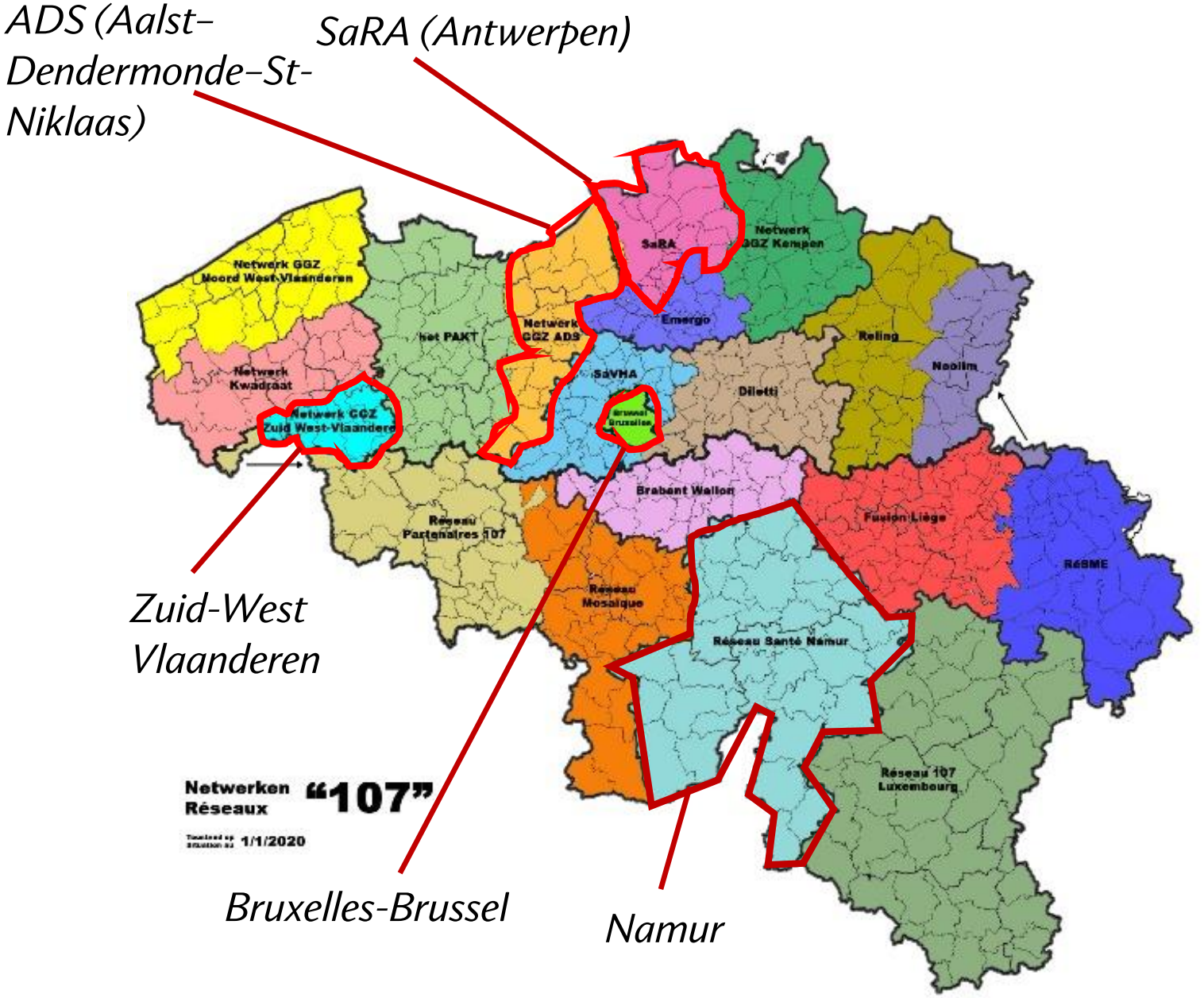
# 5 networks areas

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# WORK PACKAGES

1. Literature
2. Needs assessment of service users
3. Analysis of the network
4. Qualitative interviews service users
5. Focus groups caregivers

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# METHODOLOGY

3 groups 3 flemish regions

5 barreers presented as statements

GPS methodology to organise solution-focused brainstorm and prioritizing ideas

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# CONSTELLATION FOCUS GROUPS

South-West Flanders: 6

ADS: 9

Antwerp: 10

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# STATEMENT 1

**How can we prevent the negative effects of waiting lists?**

- ➔ **How can we provide continuity of contact while waiting for admission?**
- ➔ **How do we prevent further detoriation?**

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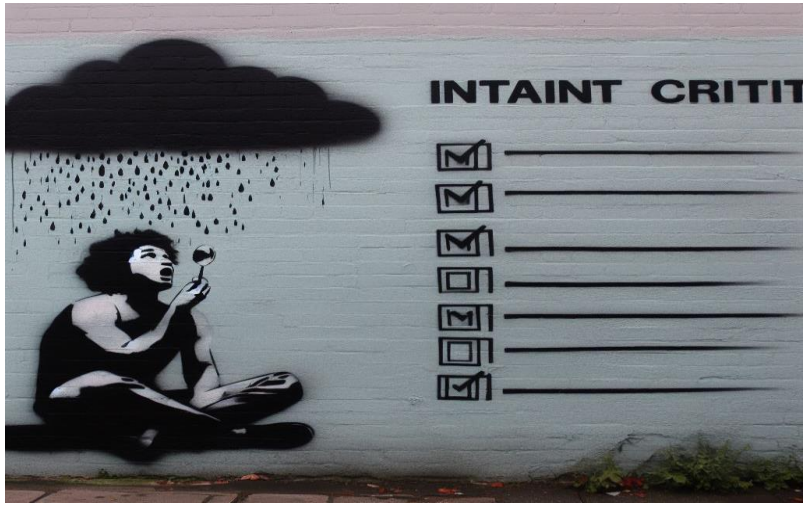
IDEAS

- **iatrogenic effect** of the organisation of care – network orientated?
- solutions strongly focused on **continuation of care**
- start with **asking for help**
- **frequent contact** is minimum
  - who's in charge (GP, buddy/peer worker, crisis team, residential settings?)
  - importance of coordination
- residential settings - **short admission** to increase turnover, not a shared idea
- inform client sufficiently about **existing services** that can cover interim needs
- **ambulatory pre-therapeutic care group**
- **1 fixed contact person** to manage waiting lists (easily achievable)
- **1 central access point** (requires reorganisation of organisational model)

# STATEMENT 2

**How can we use intake criteria to reach alignment with the client/personal support rather than start raising the threshold?**



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# IDEAS

- better **coordination** of & knowledge about the various organisations an essential precondition
- prior to the intake interview a kind of **open introductory interview** (avoiding one-way traffic)
- **time** to take intake interview
- **checklists**: curse and blessing -> sufficient attention reciprocity in relational dimension
- sufficient attention **strength-oriented domains** instead of invalidated domains
- ideally **shared decision**
- importance of finding an **appropriate solution** together -> knowledge gap caregivers!
- elimination of **homelessness** as an explicit or implicit refusal criterion

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# STATEMENT 3

**How can we respect choices that clients make,**

**even if they are inconsistent with what caregivers**

**see as "the most appropriate solution"?**

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# IDEAS

- exploring rationale behind choices and the value clients give to certain options
- non-judgement
- expressing concern is possible
- preparatory talks together from an equal position
- flexibility in residential settings is not evident, considering other elements like group safety, rigor in rules etc.
- position caregiver as a travelling companion instead of a wizard, given the sometimes erratic recovery process
- attending clients & context to formal client meetings

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# STATEMENT 4

**How can we avoid remaining on our island as caregivers?**

**How can we build a working network with and around a client?**

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# IDEAS

- **retaining what is there**, both professionally and contextually

logical but... residential sometimes means isolation from context and professionals

joint pathway determination, also strongly involving first line actors & context

- **aftercare** strongly insufficient, focus on this. Can also be organised at network level
- **informal context**: involve in as many elements of treatment as possible BUT
  - sometimes stigmatising image of mental healthcare or addiction care
  - professional secrecy
  - need for methodology
- **restoring broken relationships** rather than forging new ones
- stronger involvement of **self-help groups** and knowledge of **experience** of fellow clients
- attention to **socio-cultural activities** or work-related activities "exciting" clients

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# STATEMENT 5

**How can we work more trauma-sensitively?**


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# IDEAS

- possible solutions are highly variable: increase know-how at **network or organisation** level?
- proposal to install at network level an **open group** focusing on trauma
- however, use must be under control: risk of escape behaviour
- sufficient space in the **relational framework**
- importance of setting up **follow-up trajectories**
- no consensus on whether or not to treat mental health problems and/or addiction **separately** from trauma

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