Integrated Care in Action: A Model for Mental Health and Addiction Treatment

Annie Williams (00:00:06):

Hello and welcome to tonight's webinar, integrated Care in Action, a Model for Mental Health and Addiction Treatment. I extend a warm welcome to all of you joining us live tonight, and for those watching the recording later on. Thank you also to the people who submitted questions, the themes of which we'll do our best to include in tonight's discussion. I begin by acknowledging with deep respect the traditional owners of the unseated lands on which this webinar is recorded. The Wurundjeri Woi-wurrung people of the Kulin Nation and pay respect to their elders past and present, and to any Aboriginal or Torres Strait Islander people here this evening. I acknowledge that these lands always were and always will be Aboriginal land. I'd also like to recognise the contribution of the lived and living experience workforce and to the people that utilise our services as their expertise helps us shape services that are safe, accessible, and inclusive.

(00:01:09):

My name's Annie Williams and I'm a registered nurse with a long history or long background in acute and complex pain management and luckily building on from those linkages with the A OD and mental health sectors and now the relationship and partnership lead at the Hamilton Centre. The Hamilton Centre is the Victorian statewide service for people living with co-occurring mental illness and substance use conditions, and was set up in response to recommendation 36 from the 2021 Victorian Royal Commission into mental health. The Hamilton Centre provides three key things, clinical support, education and training and research, and we'll talk about those resources later in the evening. We know that 70 to 90% of people who have substance use problems also have mental health issues with drug and alcohol services. We know that 60% of people are presenting with both drug and alcohol issues and mental health challenges, and that's about 50% in the mental health settings.

(00:02:16):

This webinar was planned and developed in partnership between the MHPN and Hamilton Centre and aims to showcase the how to have integrated interdisciplinary care. So whilst the Hamilton Centre is Victorian based and there are different services and offerings and regulations in each state, we hope this could be seen as an aspirational model of care for other states and territories. And a reminder that there are resources available on the MHPN website as well as the Hamilton Centre website for your convenience. So we'll get down to business and introduce our panel. The extended biographies of all the panel members are available on the website, so I'll keep it brief. Just an FYI. All the panellists are connected through Eastern Health and some of us have worked together for a long time. I'd like to introduce Dr. Vicky Phan, who's an addiction psychiatrist and the medical lead at the Hamilton Centre Eastern Health Clinical partner. Vicky has strong interest in mental health, comorbidity, harm minimization, pharmacotherapy, and training and education. Vicky is the current director for advanced training in Addiction Psychiatry in Victoria and chair of the RANZCP, faculty of Addiction Psychiatry Victorian Subcommittee. Welcome Vicky, and thanks for joining us.

(00:03:44):

Dr. Ferghal Armstrong is an addiction medicine specialist at Eastern Health. Ferghal is committed to improving delivery of clinical education and the improvement of outcomes for all people experiencing alcohol and other drug issues. He has strong interest in complex medical detox, lifestyle medicine, as well as cannabis medicine. Ferghal is also the host of the successful podcasts Cracking Addiction and Med Heads Welcome Ferghal and thanks for being here. Alice Frank is the senior clinical pharmacist at Hamilton Centre and the Eastern Health Clinical Partner and has a particular interest and expertise in mental health and substance use disorders. She's been instrumental in establishing clinical mental health pharmacy services in two Victorian public health networks and is passionate about raising the profile of pharmacists and their role in contributing to an integrated care model. Alice has also lent her expertise to several pharmacotherapy webinars, the links to which will be available in the resource pack. Welcome Alice and great that you are here.

(00:04:57):

Ben Veenker is the manager of the lived experience workforce and advocacy at Turning Point in Victoria. Ben is a passionate recovery advocate and is committed to breaking down the stigma associated with substance use and mental health, as well as reducing the time it takes for individuals to seek help for their substance use and mental health issues. A link to Ben's recent MHPN webinar will be also available in the resource pack. Welcome, Ben. For the purposes of this hypothetical, I'm going to introduce a dem, the subject of our case study, and then we'll be asking each panel member questions in relation to their area of expertise. We'll learn how they could assist them as well as the clinicians involved in his care to navigate his way through the a OD and mental health system, and then move to a broader panel discussion about some of the issues raised by this case.

(00:05:53):

And the role of integrated care is a familiar case to many a young man shaped by the intersection of substance use, suicidality and social and cultural disconnection. So let's explore how integrated care might change his trajectory. Adem is a 27-year-old man of Turkish heritage brought into ed by ambulance following a polysubstance overdose that included paracetamol THC with a potential for synthetic cannabinoids to have been adulterated and alcohol. He was found unconscious by his mom and dad and his bedroom and his parents noted that for two weeks prior, EM had been stating that the avatars featured in his video games were real and his conversation had been increasingly difficult to follow. His mom also observed that his appetite had reduced and his meals remained untouched. He was discharged after four days from short stay of the care of his family and cat team have arranged follow up via phone with some suggestions made to the parents for a GP appointment. The GP has been tasked with numerous things he's been asked. They've been asked to advise to refer to a psychiatrist for a review, a psychologist as part of a mental health care plan, as well as a connect a de to the mental health local for peer support and some additional service linkages. The mental health local has been advised to refer to the Hamilton Centre for a secondary consultation on how best to support his co-occurring needs.

(00:07:37):

In addition to that, I'll just give you some psychosocial context and some social determinants. The family immigrated from Turkey when den was 10. He completed year 10, however, had significant issues with truancy and school refusals in years nine and 10 in response to bullying within the peer group because of his difficulties in fitting in and his disruptive behaviours in class school reports actually detail

proficiency in mathematics and music. He was articulate but very disruptive and appeared distracted in class. He had aspired to complete a motor mechanic apprenticeship but now lives alone in a separate house on the parents' property, plays, video games all day with just online acquaintances with limited interaction with his parents and no close friendships. His only social contacts appear to be the dealers and online gaming acquaintances. He's receiving unemployment benefits, but his parents subsidise all living expenses with mum providing meals, doing his washing and cleaning.

(00:08:41):

He purchases his substances from the dark web and they're delivered via mail. The cannabis comes via a local dealer and he orders alcohol online and has that delivered directly and he has no employment history. So Vicky, I'll just give you some additional mental health history. His experienced difficulties, as we said with concentration, disorganisation, impulsivity. The school counsellor actually advised that he'd be treated for anxiety, depression or following advice from the school counsellor. He attended the GP and was treated for anxiety and depression from the ages of 14 to 16. He was referred to a private psychologist at the time as part of a mental healthcare plan, but attended inconsistently and actually stopped attending appointments and self ceased his antidepressants at the age of 16 and there's been no follow up. The psychologist noted that was deep seated anger towards his parents for their perceived disappointment in him, and he seemed to have displayed some insight into the reasons for his drug use because they made him feel better and he was actually bored. His mom, who's 47, has periods of low and anxious moods and his father, who's 55 has bowel cancer but is in remission. So Vicky, if I may start with you, can I ask you firstly, how would you define integrated care?

Dr Vicky Phan (00:10:13):

Thanks, Annie. I guess when we speak about integrated care in this context, what we are talking about is care of both the persons presenting substance use and mental health concerns at the same time. Traditionally, there's been three different ways in which people might have those co-occurring issues managed. There might be a parallel model where people go to a mental health service and then get advised to go to an alcohol, another drug service to get their substance use or addiction issues met. But the teams are working in isolation and there's not necessarily collaboration or communication between the two. There might be a sequential model where people go to see one service first and get one issue managed, whether that's mental health or a OD, and then after that it's you go see the other service to complete management of other issues after. But what we often find is that people are presenting with these issues in mesh together. At the same time, Adem's experience has certainly been that there's substance use and mental health concerns at the same time and to really meaningfully manage and respond to both, what we really need is for those two issues that are occurring to be held together and responded to simultaneously. And that has been demonstrated by stakeholder feedback and also in the literature that has really meaningful outcomes for people and is really responsive to the issues at hand as well.

Annie Williams (00:11:26):

So as an addiction psychiatrist, what does your initial assessment involve?

Dr Vicky Phan (00:11:31):

Yeah, so there's a lot going on in Adem's case, and I'd love to get more information about this case first and foremost as well. But the key things that are striking to me is that he's had an overdose. So I'd like to know whether that was intentional, unintentional, and to really unpack that to look at risk management and vulnerability after. He's also just been released from hospitals. So there's been acute management, there's been a period of containment. We're really looking at now is longer term monitoring, recovery remission, and there's quite a bit there that we need to explore further to get diagnostic clarity on and also to look at best treatment responses and preferences. So there are these psychotic symptoms that have emerged. The avatars that he has been convinced are real for two weeks that somehow wasn't brought to attention earlier. We've got the concerns around the anxiety and depression when he is younger.

(00:12:18):

So was that related to prodromal symptoms underlying a psychotic disorder that's just emerging now or the other issues that were going on? And developmentally there's a lot that we can understand his identity to understand his psyche too. So it's really interesting that he immigrated to Australia when he was 20 and then these issues started to occur around the age of 14. So how did he go with adjustment acculturation? What's the timeline of his father's bowel cancer diagnosis? Was he impacted by that? And I guess also what were the experiences of the mental health care earlier that anxiety and depression management, the GP and psychologists, what were the enablers, the barriers to engagement of that? Were they really clearly explored or was there potentially missed opportunity to really deeply delve into what was going on for 'em at an earlier time for earlier intervention?

Annie Williams (00:13:04):

So can I ask you, what do you see as the higher order priorities in relation to this young gentleman's presentation? Yeah,

Dr Vicky Phan (00:13:13):

Definitely. The key priority for me is engagement and keeping this person involved in services so we can really oversee what's going on for Adem and his family who are supporting him and really engage him in care to respond to these issues because the risk is without that, then he'll have another episode or have further presentations related to his substance use or mental health concerns. So I would like to keep him engaged working with his preferences. It sounds like there's been some exploration of that while he is been in hospital and the forward has been that community management with a GP and psychiatrist community might be an appropriate level. They might've previously indicated that their preference was to go that way in that discharge summary recommendation, but really looking at what that would be like for Adem and the family and really exploring what worked and what didn't work previously so that we can bundle in a workable plan going forward.

Annie Williams (00:14:06):

So in the context of the indirect and direct causality of a OD use and mental ill health, could you speak to us please about the bidirectionality of substance use and psychosis?

Dr Vicky Phan (00:14:19):

Yeah, one of the questions that often comes to me as an addiction psychiatrist is what's the chicken, what's the egg in this situation? But the reality is it's often a reciprocal influence when people are presenting to us, it's not so meaningful. So more what was B? And often that's a theoretical discussion anyway, what's happening is that the person in front of us, it's presenting with the things together. So in Adem's case, he's talked about using substances to manage things like boredom and to manage his difficulties in how he's conceiving himself right now, but he's experiencing psychotic symptoms and we know for example that that's a big vulnerability with cannabis use and synthetic cannabis use, which is in the picture in Adem's case. So on the one hand, you've got substances that are very psychogenic and can induce psychotic symptoms in anyone. But then also we've got a gentleman who's really struggling with adjusting to life in a new country it sounds like, and has had some battles and is experiencing a disorder of his reality in the last two weeks. And you can appreciate that substance use might be a retreat from those things that are going on in Adem's world.

Annie Williams (00:15:27):

Would you have expected Kat to have started him on any medications?

Dr Vicky Phan (00:15:33):

It potentially would've been an option for them, and this is where the history would be good, was he offered some in the first few days and was there a flight to health and complete recovery of symptoms where they thought that the risk of that was more than the benefit of offering it in terms of the symptoms were still there. I think it's probably something to consider in the plan and in the preferences, knowing that there's that vulnerability to psychosis. Would there be a role for any psychotics ongoing? Would that be something that they would like to explore further? These sorts of instances where people are being discharged from acute services are a really nice opportunity to explore people's preferences for care because often they don't get to announce those things when they're presenting acutely unwell unless there's been that discussion before. And it's really important to give voice to what a person's preference are in treatment because that's more likely to support continuation of that plan and investment in that plan.

Annie Williams (00:16:26):

So agency would be another high order priority. Yeah. Ferghal, I'd just like to turn to you please and add some more information to the panel about a DEM substance use. Following his admission, we learned that he's been using cannabis daily since the age of 15, on average about a gramme a day, which he mixes with illicit tobacco and smokes via a bong occasionally. He has synthetic cannabis use. His alcohol use has been heavy with episodic drinking since the age of 16, but actually reduced as his cannabis use increased. However, recently it's increased back to eight to 14 standard drinks of spirits per day and up to three to four days at a time to complicate things. For the last 18 months, he's been smoking methamphetamine daily and using variable amounts subject to availability and finances and reports that this helps him feel normal. He denies cocaine, heroin, or GHB use and is pre-contemplative about reducing his cannabis. So we're aware that young men with functional impairments and no formal diagnosis often fall through the cracks. And with your experience as an addiction medicine specialist in the public and community settings, how can someone like AADE be supported to move through these settings? The hospital primary care and community?

Dr Ferghal Armstrong (00:18:03):

Thank you, Annie. Can you hear me?

Annie Williams (00:18:05):

Yep.

Dr Ferghal Armstrong (00:18:06):

Yeah, so that's a great question and it's a question that is faced by many, many community practitioners nearly every day. Overall, the answer has to rely on the individual community practitioner having an in-depth understanding of their local ecosystem, and also it behoves other specialist service providers to have a warm reach out to their community partners in care so that there are those warm hot linkages that can be exercised for the benefit of patient care. But we're not just talking about specific a OD withdrawal services or for that matter, addiction psychiatric services or the Hamilton Centre. We're talking about as wide a range of care services as possible, and that includes social services, that includes peer support groups, that includes the entire social structure that is available for someone's life because I'm looking at Adem's history and there are a number of vulnerabilities that he's demonstrating.

(00:19:18):

Now, I don't want to repeat those that were excellently postulated by Vicky, but I'm particularly interested in the question ask, not why the addiction, but why the pain? I still don't, from the history that's been given to me, I still don't really understand his journey into substances. And also he's got a significant lifestyle vulnerabilities set. He's very isolated, he doesn't do any self-care. So as a community from the point of view of a community practitioner, I would actually be starting to chip around the edges and trying to engage in some form of community engagement to try and overcome that isolation because I'm very worried that his isolation, not only is it going to be a symptom of his underlying mental health disorder and addiction, but also it could be contributing to a less than good prognosis in terms of recovery. So sometimes community practitioners and gps can look at a case like this and think, heavens above, where do I start? The answer's always got to be try and form the therapeutic engagement and try and learn more about your patient and find out what your patient wants in terms of relationships.

Annie Williams (00:20:40):

So if we go back to the gp, if a generalist GP in this case is involved, how can they be supported?

Dr Ferghal Armstrong (00:20:51):

Well, every state has a telephone advice system for addiction services, and in Victoria we have the drug and alcohol Clinical Advice Service. And so that's the first port of call for an ad hoc immediate set of advice. Secondly, then every area of Australia is covered by PHNs and so via the PHN via the primary health network, it's possible to arrange or seek help in that regard. And then of course there's the option of referral to second opinions from psychologists and also referral to secondary and tertiary care services such as the Hamilton Centre.

Annie Williams (00:21:36):

So how do we balance the autonomy and the risk in cases where individuals like em have been disengaged from care, but as you say are highly vulnerable?

Dr Ferghal Armstrong (00:21:50):

Yeah. Well firstly it's love. And lastly it's love. I mean, I've spent my entire career learning all the bits in between, but it does start out with love and ending with love. There has to be some form of emotional connection there. Somebody somewhere surely has got the ability to reach out to AEM and ignite that spark in AEM that will make AEM want to realise that there is a life out there outside his bedroom, outside his gaming station, and that there is fun, there's a life, there's meaning out there. And in particular, I want to emphasise the absolute value of two key things in Adem's potential recovery, and that is time spent with non-drug using peers and time spent engaged in meaningful activity. And he does not have either of those issues or those factors in his life at the moment. So he's really got to make that transition. And any help that can be given to him to help him translate that theory into practise is that's the start. He needs to find someone who's going to get him out of his bedroom and give him a hobby.

Annie Williams (00:22:59):

Indeed,

Dr Ferghal Armstrong (00:23:00):

That's the first story

Annie Williams (00:23:02):

I'm going to give you all a little bit more about his family history. Both parents worked as teachers in Turkey, but their qualifications weren't recognised in Australia, so they purchased a market garden business in outer suburban Melbourne. The younger sister who's 25 is married and works as a university research assistant. The extended family remains in Turkey. And even as a young person seeing the gp, the perception of his mental health issues was minimised by his parents. So Ben, after listening to Adem's story, what role do you think that peer support would have for him and or for his parents?

Ben Veenker (00:23:46):

Thanks, Annie. I think Virgo was on the brink there of speaking to the value of peer support, and I really relate to AEM story of that isolation. And I think for people like them who do isolate, that's a really common behaviour because the substance use is not something that we feel proud about and it's something that we hide away from. So pushing friends, family away and isolating is really common behaviour. And hearing how em is also pointing, his anger towards his parents is really, for me, very common as well. And with the people that I've worked with in the past, that's something that I've come across quite frequently because we don't know where to direct that frustration, that internal frustration and anger. So we tend to direct it at those that are closest to us. In terms of for a demo, I couldn't see peer support be introduced quick enough because when someone does present to a health service, voluntary or not often unaware of what peer support is and what it is like to connect to somebody with a lived experience.

(00:25:11):

So I feel there'd be great value in AEM being someone who has immigrated, who is not familiar with a lot of people. For someone to be able to sit with him and really validate and understand, you can almost put the culture aside and go, I understand what it's like to feel the way you are. I understand what it's like to use substances the way you are. Where are you at with it at the moment? I understand that you don't want to give up cannabis fair call. Neither would I. It's serving a purpose and it's keeping you safe, but this is my experience when I access services. So peer support has a big role to play and I think Vicky mentioned it at the start as well around we want to keep him engaged in services. I feel peer support alongside clinical services is the way to keep somebody engaged with service and feel safe and feel trusted in that service.

Annie Williams (00:26:09):

Can you explain to us a little bit about how you decide which peer worker would be suitable to work with someone like a dem?

Ben Veenker (00:26:20):

Sure. I think if we've got the luxury of people who've got a lived experience with various types of different substances or you've got the luxury of having people who of different genders or life experience, then of course you would lean into those to lean into em and provide him with that support because as we said, it's that piece of keeping someone connected and opening their eyes to that bigger picture of what change could possibly look like if you've got someone validating and understanding the experience, but then also role modelling that, Hey, I've made these significant changes, this is where I'm at in my life now. But really it puts that flicker of hope for somebody to go, well, if they've done it, maybe I've got a bit of a chance here as well. And so yeah, I'd be looking for people that hopefully have a similar experience, but if not, I think anyone who's got a lived experience of a OD use, it's always, as feral said, it's the symptom of a much bigger problem, like what's underlying there. I can validate the and appreciate the substance use, I can understand the reasons why, but now I want to understand you. What motivates you? Who are you as a person and how can we move forward from that?

Annie Williams (00:27:44):

And what about the family? Would you introduce a carer, peer worker or peer support into their picture?

Ben Veenker (00:27:54):

Absolutely. I'd be very keen to speak to the family initially to share and be vulnerable about our own lived experience and give them a bit of hope that change can happen, but then to be able to speak to them about the benefit of not just to them connecting to peer support but themselves as well so they can voice their concerns and their experience. And I think so often the individual is treated and the family and carers are okay, that's the person now you can go home. Where I think it's such an impact on family and loved ones when someone is working through their substance use and the challenges associated with that. So yeah, I'd be very quick to want to be able to offer that to the family. And if it's not care or peer support straight away, then it's at least providing linkages to family support groups, whatever they are for your local area.

Annie Williams (00:28:59):

Alice, could you tell us a little bit about what role pharmacists can play in the public system and the community in this scenario, this type of scenario?

Alice Frank (00:29:11):

Yeah, and they're quite different relationships that pharmacists would have in this case. Vicky, I mean Annie apologies. And I guess also recognising that bio dem coming into ed, it might actually be his first real engagement with health services with Australian settings and all that sort of thing. So it could be quite an overwhelming experience for him. But I guess acutely in the ed, some of the things that the hospital pharmacist would probably be involved with would be probably in the OD management, which I won't go into too much detail, but there'd be some input there, particularly around the paracetamol monitoring, if there was any need for treatment of that specifically. Also given his alcohol history, it'd be important to make sure that he gets thy supplementation in as early as possible, preferably IVIM depending on where he is in the ED department as well. And then I guess the other opportunity that this presents by him presenting to a hospital is perhaps getting some physical health screening and assessments done if his opportunity as well and if he consents to that as well.

(00:30:16):

So given his substance use history, I'd be concerned about his cardiac health, his liver function, particularly given the paracetamal overdose and the alcohol as well. And probably also his respiratory function given that his smoking use as well. So there'd be some opportunity in that ED initial setting to screen for some of those other physical health concerns that might present that he may not have had engagement with in GP care before. So then moving on through his admission, depending on what the assessments were from the rest of the mental health team, if there was medications that were commenced during his stay, I mean Vicky alluded that there might be the option potentially for some treatment to commence. There would be some education involved around what that might look like for him as well and if he was concerned he'd be a good opportunity to get his family involved if they were present and engaged as well. The other things that I'd be thinking about in an ED setting before he left would be talking about take home naloxone as well. So even though he doesn't use opioids, we're becoming increasingly aware of the potential risks of contamination with things like methamphetamine. So making sure that he ideally gets access to it before he leaves ed, if the ED comes to has it present would be a great opportunity. But otherwise making sure he knows how to access it in the community as well.

(00:31:38):

Moving into the community setting, I guess it would depend on what the rest of the team came up in terms of treatment with medications. So there might be ongoing input around concerns with medications as well. If there would be opportunity for engagement in terms of if he wanted to look at his smoking, there might be opportunity to engage in discussions around smoking pharmac therapy as well, for instance.

Annie Williams (00:32:04):

Thank you. Just with the theme of pharmacotherapy, could you explain to us or share with us what's the current status of pharmacotherapy and methamphetamine disorder? Because we're aware that the evidence is limited, but what do you say to people that ask about this?

Alice Frank (00:32:24):

Exactly that the evidence in this space is really limited, but it's definitely a space that's still rapidly emerging. So there is lots of research going on in this field and I feel like there's more and more studies being published each day in this area as well. And some of those areas that have been looked at around the use of prescribed stimulant medication, I'm aware in New South Wales, not that I've worked in that setting, that there are actually processes in place for people to be prescribed stimulants for up to six months. Vicky might want to comment more on that if she has more information on that, but there's also other studies around, for instance, mirtazapine also showed some evidence in terms of reducing methamphetamine use. But unfortunately none of these studies to date have given us anything that's really robust in terms of recommending in terms of robust clinical practise yet.

Annie Williams (00:33:17):

So just on that question around stimulants, I might ask you if I could, what are your thoughts about initiating this prescription of stimulants in the context of active methamphetamine use?

Alice Frank (00:33:34):

It's a tricky one and it does come up quite more and more commonly and in practise at the moment. And I guess obviously the first thing in terms of prescribing stimulants in most states it does rely on the diagnosis of A DHD, which hasn't necessarily been confirmed in the case of a m, but I guess it is a really tricky grey area because if you have concurrent methamphetamine use with prescribed stimulants, there's sort of that additive effect. So there's sort of concerns around potential toxicity, particularly in terms of cardiac and also psychiatric side effects as well. I'll probably throw to Vicky to add in her comments on that as well, Annie.

Dr Vicky Phan (00:34:15):

Yeah, thank you Vicky. Thanks, Alice. Yeah, I think just to add to what Alice was saying, the main sort of service I'm aware of in Australia that has considered use of stimulants for stimulant use disorder would be the St Vincent's stimulant treatment programme out of Sydney. It's not something that's widely available because the evidence is so limited as Alice was flagging, and it's never a standalone treatment either. It's combined with psychosocial interventions where the evidence really is weighted in terms of methamphetamine use disorder recovery. So it's always important that we're making sure we're offering the gold standard treatments that exist for stimulant use first and really making sure that we're giving people the best goal at recovery through offering those things before we try the things that are a bit more novel and experimental because we don't have robust evidence that those things work. The other thing that I guess worries me about Adem in terms of stimulants is the synthetic cannabinoids because a lot of the toxicity risk later to them is cardiotoxicity and neurotoxicity. So it's that balancing risk first benefit. So if he was five, 10 years from now when we tried everything we had for methamphetamine use disorder and he hadn't had remission and we were considering looking at novel treatments and things, it would still be considering what would be the potential risk of if there's

concurrent methamphetamine use of stimulants with synthetic cannabis, is that potentially going to put us in a situation where there's more cardiac risk that's being with through medical services versus is it going to provide any kind of benefit to his presentation either?

(00:35:47):

I think it's coming back to what Ben and Ferghal have highlighted before. We really need to understand what's specifically is unique to em and his circumstances to really target because sometimes we can fall into that trap feral literature of the doing to and really focusing on what kind of treatments we can throw at this person. But a lot of the work is also the being with and understanding and having a really clear formulation on why this person is presenting with these issues right now. There's so much to unpack there in terms of why his family came to Turkey, were they economic migrants, were they political issues, what his role is in that family system, he's got parents who are teachers, his sister has fulfilled the kind of educational banner of the family for becoming a university assistant himself. What is it for him to be in Australia and have the roles and identity he has now?

(00:36:37):

Is he satisfied with that? Is there pressure around that? And also, I think we talked about the difficulties of being in a new culture, but also I'm also interested in his religious identity being Turkish. Is there a Muslim background here and how does that sit consuming alcohol and other substances and are those potential barriers to engagement with treatment? And understanding what's going on for him too, to make sure that we're providing culturally appropriate care and practise which has to be thrown in this case, not just a debit to his family. So sometimes it's really tempting to forward a medication responses because they're often quick and they're tangible, but there's so much in the non-medication space that's of value here.

Annie Williams (00:37:18):

Thanks, Vicky. That's fabulous. Alice, just in terms of his alcohol use disorder and prescribing pharmacotherapy for alcohol use disorder, what is the advice around concurrent prescribing with methamphetamine use?

Alice Frank (00:37:39):

I mean, the thing we know about alcohol pharmacotherapy is it's majorly underutilised. So often the discussions not even had that there is treatment options in terms of medications available. And so what we see is significant delays in people even attempting to use pharmacotherapy options, and there are a range of pharmacotherapy options that would be available for Adem if that was something he was interested in. And I suspect that's probably something that no one's ever had a conversation with him around his alcohol use as well. So I mean, I guess the first thing would be around seeing where he was at with his alcohol use and seeing if he was looking at whether it was reducing, whether it was sort of more of an abstinence based approach, which I suspect at the moment probably isn't in his goals. So I mean there's definitely options available. And in terms of contraindications with his methamphetamine, there's no reason not to start treatment with the alcohol pharmac therapy if he was interested in that as well. And that would be best placed in terms of alongside with all of the other interventions that everyone else has mentioned in terms of psychosocial supports and counselling as well. But in terms of which option, I suspect he'd probably be best suited to something like naltrexone, which is just a once a

day dose, which has also been shown to help with reducing alcohol intake as well. But others in the panel might have a thought on that as well.

Annie Williams (00:39:03):

Well, yes, I was just going to throw to feral for his opinions on this.

Dr Ferghal Armstrong (00:39:11):

Yeah, I agree with everything that Alice has said and an naltrexone might be an option, assuming he's not actually taking any opioids. I know he denies cocaine, heroin, and GHP use. And Alice, you're absolutely right when you say that alcohol pharmacotherapy is less frequently discussed and used and then would be appropriate or optimal, but I do believe that the role of pharmacotherapy has to go hand in glove with a wide range of psychosocial interventions as Vicky was alluding to. The answer's not just a pill, it includes a pill, but it's not just a pill. But to kind of broaden it out a bit, I mean we do need to mention the fact that there are two licenced alcohol pharmacotherapy drugs in Australia that RACI andone, and there are a number of medications that are used outside licence including Baclofen, Sulur and Topiramate and many, many others. But yeah, I think it would be good to have a discussion around a comparate and Alteryx zone for this gentleman.

Annie Williams (00:40:21):

And these are drugs that a GP could prescribe?

Dr Ferghal Armstrong (00:40:24):

Absolutely. I mean, GPS could prescribe Baclofen Topiramate as well, and if they're unsure of it, then they can phone in Victoria, they can phone the drug and alcohol clinical advisory service for a quick chinwag chat and somebody some hotspot advice.

Annie Williams (00:40:46):

So we've established that there's a role for pharmacotherapy, but there's an even broader role for psychosocial education and support that includes culturally appropriate and informed care. So as representatives of your particular disciplines in the real world, how do you connect with each other?

Dr Ferghal Armstrong (00:41:14):

Lots and lots of coffees. I think that's how we do it.

Dr Vicky Phan (00:41:21):

As gel says, it's making sure that you're having chaps and available to other people. So if you've got the opportunity to be part of a multidisciplinary team, you've got to use it because you're only as good as what and what everyone knows is going to be a lot better in terms of what you can offer a person. And there's lots of opportunity for collaboration here because there's a bit of danger in the recommendations because you've got recommendations to go see a gp, go see a psychiatrist, go see a psychologist, and that would all be well and good, but that will be better if those free parties are all communicating with each other and having a really clear view on what are the goals, what are the

recovery outcomes we're seeking, what do we need to monitor, who's responsible for what and how do we communicate change in status and risk to each other so that the system is operating the best way it can, but also partnering with Emini family in that process if AEM has consented to his family being partners in recovery because they have a really valuable role in knowing what's going on too.

(00:42:18):

I mean, the family have demonstrated it here. It's the parents who detected that he was in the study, he was in the bedroom. So they have a really important role in checking in on his progress and how he's going. And they're probably going to play a role in facilitating attendance at appointments and things as well because it sounds like he's quite isolated and ability to get out of his bedroom on his own might be a bit challenging, but using your services and Ferals flagged the example of the drug information hotlines that are around for health providers and welfare professionals across the states and territories. There are other resources that are probably underutilised, to be honest. It's not often that you get access to a specialist on the phone that you can get an answer from.

Annie Williams (00:42:57):

Indeed. Ben, what other scaffolding would the peer support worker be offering in this space?

Ben Veenker (00:43:06):

I think it's important to, I think initial engagement can be challenging at times, and sometimes people don't want to engage and connect. So I think for a peer worker to be able to provide the options that are there for them as well and the simplicity that engagement can take over for peer support. So that could be as simple as something as connecting him or introducing him to online support groups that are easy to engage with. He's already got access to computer, he can control the environment, he can keep his camera off, but he can have that slow introduction and control the environment and get an understanding that, hey, I'm not alone. There's plenty of people out there who live the way I've been living and have made big change. So I think it'd be trying to just introducing him to the variety of supports that are available to him because we don't know if we're going to have a chance to connect with him again. We are hoping that we'll see him again. But I think in that first initial engagement piece that we do connect as well as we can by intentionally sharing our lived experience, but then looking at, okay, if I don't see you again, here's some things that I think are really important, which might just help shift some attitudes and some direction that you might want to take.

Annie Williams (00:44:38):

And would those things include smart recovery groups or,

Ben Veenker (00:44:43):

Yeah, I'd be looking at all the peer support groups that are available, smart recovery, 12 step programmes, whatever, and encouraging to really try on all of them or both of them. If you're looking at just those two, often there's local community peer support groups and operating out of community health settings. So really trying to find what's what aligns with his own beliefs. And often those meetings, they're very different meeting to meeting. So it's finding those ones that not just trying at once and then throwing the towel in, but being able to give yourself an opportunity to have the best possible experience and chance of finding people who are your cup of tea, so to speak.

Annie Williams (00:45:34):

And I'd be interested to know whether any of you would consider referring to other expertise groups. So OT for example?

Dr Ferghal Armstrong (00:45:48):

Yeah, anyone who has the potential to lever or access aada and lever him towards recovery can and should be involved in his care. And that can include ot, that physiotherapists that include the exercise physiologists

Annie Williams (00:46:06):

From

Dr Ferghal Armstrong (00:46:06):

My point of view with an interest in lifestyle AAM could do with a walk. So I can't think of a single discipline that wouldn't necessarily be able to have some form of benefit for AAM in his longer term recovery. I'd be interested in the opinion of others. Vicky, what would you say?

Alice Frank (00:46:27):

I'll jump in gel, and I think it's also important in how you set up your team. So you mentioned that we have lots of coffee, but we do have a great setup in our multidisciplinary team where everyone's input's encouraged, it's valued and it's really sought. And I don't see how that would be any different for Adem. It would definitely be valuable for input from everyone.

Annie Williams (00:46:50):

And would that include his gp?

Alice Frank (00:46:53):

Has to include his gp? I would say,

Dr Ferghal Armstrong (00:46:56):

Yeah, I can't overemphasise the value of a empathetic understanding GP who can reach out to aada. I think the GP is absolutely crucial in this man's recovery.

Annie Williams (00:47:13):

And Vicky, what are your thoughts on additional specialties?

Dr Vicky Phan (00:47:17):

Yeah, I'd agree feral and Allison, the roles that I'm wondering whether potentially have scope in it in Adem's case would be roles like social workers support, workers care recovery coordinators to help connect all of the services and help him navigate all of this. Just really recognising that as Alice flagged,

they're in a new health system. This isn't a health system that the family has worked within before. This is early encounters to health system for a m. And it's not clear what the health literacy of this family is in terms of what services are around and what they offer. So having support to navigate an Australian health system might be really crucial in this case, but also to help make sure that there is that really nice assertive follow-up at this point to solidify the recovery that he is got and maximise his potential In terms of recovery and prognosis, those are all things that would be nice to offer. But as gel mentioned earlier, it's knowing the local ecosystem and knowing what's available too. So it would be drawing on that local knowledge and understanding about what practitioners are around who can be referred to, what's the timeline to really make sure that we're acting quickly and making sure we're using the resources that are feasibly available.

Annie Williams (00:48:30):

And who's charged with the responsibility of coordinating this?

Dr Ferghal Armstrong (00:48:36):

So it's got to be the GP working with specialists, but can I just go back to the point about the range of disciplines first? Yes.

(00:48:43):

I mean it's very easy to go on and on about it and provide a long list of people that you should think of in terms of his care and recovery. I like to simplify it down to what I call the famous five. And they are the gp, the specialists, and that includes addiction specialists and addiction psychiatrists, all forms of talking therapists, so that's psychologists, counsellors, et cetera, the sponsor, which reminds us about peer support groups and the 12 step group, but also it doesn't exclude smart recovery, et cetera. And then the accountability buddy, which I think it's important to identify that there are people in Adem's life who are not necessarily clinically qualified, who can be leveraged to help AEM start developing short-term goals, medium term and longer term goals. And they all have to be part of that team. So if people are thinking about those core famous five, I think that's a great start. So sorry to interrupt. I just wanted to shoehorn that last point and sorry.

Annie Williams (00:49:48):

No, that's very important. Ferghal too, and Vicky's already alluded to the health literacy issue. We don't know a lot about the father's engagement with health services for his bowel cancer, and mom has had some interaction with the GP for her mood issues, but the cultural overlay is just as significant and the expectations and also the identification of mental health issues in particular cultural groups may not be as strong as it is in others. So to be sensitive to that as well, assuming that AEM stays at home and is motivated to engage in your experience, does it start off with a bang and then Peter out, or is there a process by which he has more assertive engagement applied?

Dr Ferghal Armstrong (00:50:54):

Who are you asking that of first

Annie Williams (00:50:57):

To all of you?

Dr Vicky Phan (00:51:00):

It's really difficult to predict the past for different people, but I think the more important question is how do we use clinicians and representatives of health services, prepare people for that journey and explain what to expect because that's where the challenge can sometimes be. If there's an expectation that everything's going to be fine in a week or two and that timeline is not realistic, then there can be a sense of disenchantment with health services and a rupture in the rapport because what was fought to be available doesn't actually happen in practise. So if you can explain to people what recovery looks like, and this is where the lived experience workforce is really valuable because they've been in the trenches and they get it and they lived it, and they can really clearly model and explain that you're more likely to get buy-in and you're more likely to get aligned support and expectation of the treatment management plan so that people consistently stay across the services and the support period.

(00:51:57):

Often I find that where people disengage or where people have concerns about what's being offered in management is when they haven't really understood what's really going on or what's on offer in the first place. And we've also really got to be careful about making sure that we include the person and support systems in the review because things change along the way as well. And sometimes what we think management is going to look like from the outset doesn't happen in practise because we might get a couple of WS or certain treatment options aren't feasible, the timeline doesn't work and we have to pivot. Sometimes people move and at that case it's really important to come back and go, okay, that was the plan. We've got to revise the plan. This is where we're now, does everyone understand that? And let's keep plotting along and working together until we get to where we need to get. So it's about those meaningful treatment episodes and really making sure that people share that meaning and understanding with you.

Dr Ferghal Armstrong (00:52:48):

Having said that, it's almost impossible to predict patient's response to treatment. And you've got to understand that substance use disorder and mental health disorders are a continuum on the cycle of change and that people may spend a long time in various stages of the cycle of change and they may require multiple episodes of engagement. And so I think it's really important to emphasise that every engagement has the potential for recovery within it, but even if the patient doesn't want to engage a recovery journey at that time, being able to demonstrate empathy and warmth and receptiveness to that patient and a welcome to that patient sets the foundation for future engagement, which is vital.

Alice Frank (00:53:44):

I think it really highlights the importance of having positive interactions with people and making that interaction that you have at that point as positive as it can be. So even if that isn't an ED department, which isn't pleasant for anyone, trying to make those interactions as meaningful as they possibly can be in that clinical space because while it's his first interaction with healthcare potentially in Australia, that could then shape the rest of his treatment journey as well.

Dr Ferghal Armstrong (00:54:13):

So even if you're having a bad day and he's the fifth patient you've seen that day, it's his first experience of healthcare in Australia. Don't forget that.

Alice Frank (00:54:22):

And that affects if he comes back to ED or if he comes to a mental health inpatient unit. Those future engagements really depend on that as well.

Ben Veenker (00:54:31):

Yeah, I can speak to our team around that really positive experience for people and being seen plans that we might not get to see them again next week, but at least we can provide them with a powerful example of this is what it looks like, this is what's possible for you. I'm just going to leave that with you, and you can make up your mind. It's like an invitation. And if that is positive, then that might shorten that time it takes for someone to reengage rather than extend the amount of time that it takes for 'em to come back into the service. So yeah, I think that's really important. And I just wanted to also come back to the importance of really speaking to a dam around what he sees as his primary issues and his primary concerns, because often we look at what we feel could benefit his life and benefit his family, but I think really to come back to what are your concerns, and then that can also help us define where do we do those future referrals and how do we keep them connected?

Dr Ferghal Armstrong (00:55:48):

I also think it's important in the concept that we're not trying to guide him to abstinence necessarily on the first encounter. I think it's important to go back to Vicky's point about harm reduction, and I'll hand over to Vicky about what kind of harm reduction can we do literally on the first, second, third engagement episode.

Dr Vicky Phan (00:56:10):

Thanks gel. Yeah. Harm reduction is so important because incremental change matters and going from regular use to abstinence, there's a lot that happens in between and sometimes people need to just move to safer using as an initial step to reduce the health burden. So in his case, if there's alcohol, if there's synthetic cannabinoids, then really what we're looking at is alcohol. Trying to consider things like Naltrexone, even from a harm reduction perspective because that can limit the quantity of alcohol consumed in sitting in some people. It's not necessarily just an abstinence-based medication. Firemen like Alice mentioned, is so important because it can affect your absorption of fire as a really crucial vitamin to protect our nerves, our memory, and then also looking at reducing impacts of potential hazardous, harmful situations that can arise in the alcohol. So seeing if there's any risky issues like driving that we need to be careful about looking at things like the synthetic cannabis smoking, is he smoking in a ventilated room or does he have his window shut when he's smoking in his bedroom?

(00:57:16):

And the risk of respiratory harms from that. And even accidental fires in the room from smoking a life flame in a bedroom, looking at trying to move him to regular cannabis in the first instance by letting him know of the increased toxicity risk, given that there's been this overdose that's warranted. A presentation to hospital looking at making sure that he's being very careful about methamphetamine

contamination with synthetic opioids, for example, like Alice flagged and having Naloxone available for the bystanders likely to come and support Adem so that he's responded to really quickly if he was ever exposed to opioids unintentionally for a methamphetamine batch that has happened in Australia within the last year. All those things are really important. And harm reduction, it's another invitation because it's understanding the person where they're at and recognising that we're not expecting you to move to abstinence. That's often the thing that people expect.

(00:58:10):

A health clinicians going to say to them, we're seeing you where you are, we just want to help keep you safe, and we respect your choices right now too. So if the choice is to keep using these substances because this is what feels safe or this is what's helping you survive right now, here's a way where you can do it, but you can also limit the harms and hazards to yourself. A lot of clinicians get caught in that, does that mean I'm colluding with and condoning the substance use? But there is evidence that harm reduction is a health-based intervention and it keeps people connected. It creates a positive experience to get them coming back to treatment services because if we have the prohibitionists just say no approach, they don't feel seen, they don't feel welcome, they don't feel invited. So those interactions are really, really crucial. And for a younger person like em, we need to make sure that we're using all strategies in our arsenal, including harm reduction.

Dr Ferghal Armstrong (00:59:01):

Following on from that, in terms of chipping away incrementally at the edifice of his recovery and taking a community lens, I think does he smoke? Does he smoke tobacco? So he probably smokes tobacco. I don't know many cannabis users that don't smoke tobacco and does he drink a lot of coffee? I mean, these are simple things that a GP can start doing or thinking about is getting him off caffeine and then getting him off the tobacco and telling him to just use cannabis rather than a mixture of tobacco and cannabis as a prelude to helping him think about cannabis detox and to make that cannabis detox less severe and more smooth as it were. So there are many, many things the community practitioners can do around the edges whilst AAM himself is thinking about what AAM thinks as his core issues. And I always hammer home the issue of caffeine and tobacco in the context of cannabis withdrawal. So I'm just putting it in here.

Annie Williams (01:00:05):

Yeah, that's a really interesting point feral. And in Adem's case, he's using illicit tobacco, which brings its own risks as well. Alice, I was just thinking about community services, the community pharmacists, where would they sit here?

Alice Frank (01:00:26):

I guess it depends on what sort of community pharmacists that we're working with. So if you had a nice setup where you've got a good relationship with your GP clinic and your community pharmacist next door, and hopefully they're part of a good team, it could be a really meaningful engagement here. And I guess the thing to really highlight with a lot of community pharmacists is I guess they don't have the access to a lot of clinical information that other teams have. So they're often trying to support people almost blindly, and that can be really quite challenging. So again, I guess it would really focus on building that relationship with Adem. Hopefully that can be a really meaningful relationship as well. And then

ideally if that pharmacist can then have a meaningful contribution to the team in terms of Adem's overall care, that would be really beneficial as well.

(01:01:16):

But I mean specifically, there's lots of things that the community pharmacists could be involved in around discussions around smoking pharmacotherapy, if that was something that Adem was interested in. There's certainly, I mean, thymine supplementation, that's something that pharmacists can have direct involvement in because we don't need scripts for those things as well. Provision of take home naloxone as well. So there's lots of those things that they could definitely involved in. And then if there was any sort of mental health medications that were prescribed, supporting that as well in terms of any concerns that arise with treatment, discussing those medications as well.

Dr Ferghal Armstrong (01:01:55):

And you're also forgetting, Alice, the essential role that pharmacists have on keeping me on the straight and narrow and making sure I haven't forgotten anything. And that happens with GPS as well, but on the subject of tobacco smoking and mental health drugs, Vicky, would you like to comment on that?

Dr Vicky Phan (01:02:10):

Yeah, I think it's really important to be aware that there can be drug interactions between tobacco smoke and the antipsychotics that can sometimes be given people like Olanzapine and Clozapine. I emphasise smoke because you don't get the same drug interactions with nicotine. It's the polycyclic aromatic hydrocarbons that are in the smoke that actually cause the drug interaction. So another harm reduction strategy if we've identified now that he's smoking illicit tobacco is moving him to things nicotine vaping, which is now available over the counter at pharmacists. So it strengths under 20 milligrammes per meal. And then you can get a prescription for doses over that. And I will always guide people towards pharmacists based nicotine vapes over the ones from the Deb Tobacconist one because I don't like to support illegal crime activity because it's not actually legal from a tobacconist. But also secondly, because there's a little bit more oversight over the nicotine products and nicotine salts and liquids that are in the pharmacist ones because there's regulations in terms of we only have free flavours on offer at the pharmacist because there are flavours like cherry and butter, which have awful respiratory effects. And then also device safety because if you use a device that has an incompatible voltage for example, it can explode. So those protections are in place around nicotine vaping. And we should be utilising our pharmacist for that. That's probably another area that's even more underutilised compared to alcohol PharmaCare therapies. In terms of options, I've worked for peer psychiatrist who says it really nicely and succinctly. It's the nicotine that hooks you, but it's the tar that kills you. So really good to get on tobacco smoking. Yeah,

Annie Williams (01:03:41):

And I guess too, that would also help with his use of the bong if you'd moved him to the vape.

Dr Ferghal Armstrong (01:03:51):

Yes. Yes. Vaping, vaping. Cannabis is fraught, but it's probably safer than a bomb.

Annie Williams (01:04:03):

So we're nearly at time, so I would just invite you all to give your last thoughts and advice for Aidan and he, oh, beg your pardon, Vicky.

Dr Vicky Phan (01:04:16):

Yeah, I had one foot that we haven't sort of covered so far, but

(01:04:19):

I think one thing that there's an opportunity to do further here in terms of screening assessment is really looking at the gaming because we have to consider addictive behaviours as well. So he is the guy who's spending all his day on the computer at home. So I would really like to know if there's any internet gaming disorder that potentially is present here too, and making sure that we're drawing consideration to that gambling disorder and internet gaming disorder are the two addictive behaviours around that we really have good robust evidence for in terms of support and management. So we should be trying to provide treatment and support for that too, if that exists. And that's something that doesn't even fallen across every clinician's radar in terms of management strategy, assessment, strategy. That's one thing I think in his presentation that's interesting that's really to be curious about that we haven't discussed so far. And then I guess also looking at the broader family system, it's also sometimes good to see if there's other mental health and substance use need in families, particularly where the family members haven't identified it. I'm sort of history there about the mom having mood, potential anxiety issues, how she going with that? Is she getting support for that? Whether dad and sister have had any concerns there too because it's just, and again, that opportunity with a culturally and diverse family here to see if the needs are being met.

Annie Williams (01:05:39):

Could you give us a very quick synopsis of what treatment is available for gaming?

Dr Vicky Phan (01:05:47):

Yeah, so the mainstay is cognitive behavioural therapy and really working on the drivers and urges to use internet gaming. There's a bit you can do around contingency management and reinforcement schedules. I've heard of one fantastic case study that was out of the Flinders Gambling and Disorder unit in South Australia. They had a teenager who was spending hours and hours gaming in their bedroom all day and they worked out a contingency management schedule supported by the parents where they installed a different circuit breaker on the bedroom and the electricity was cut off until particular mile points were met in graduated succession like coming out for lunch and coming out for lunch and dinner, having a shower. And eventually that young person integrated really well back into family life and gave up the internet gaming. So it is just recognising that there are treatments and supports available for things like that.

(01:06:40):

And it's difficult because often those things don't get forward of as medical disorders because gaming is quite a healthy construct as well. And games can also actually be quite good for developmental and wellbeing and there's evidence that some particular games can help with, for example, orders and spectrum disorder and the like. So there's shades of grey there in terms of when gaming is an issue and when it isn't. But if there is an internet gaming disorder, if he's got things like neck and back pain and he

can't leave the computer and there's uncontrollable urges first thing in the morning to wake up to go and game, and if he's spending money on loot boxes and things in games and potentially going into debt with that, then we should definitely look into those things.

Annie Williams (01:07:18):

Well thank you very much for highlighting that. So if I move to you, Ben, have you got any last minute pearls of wisdom or thoughts that you'd like to share with us?

Ben Veenker (01:07:33):

I'm sure the true pearls will come when I put my head on the pillow tonight. Look, I think I just can't really stress the importance enough of having the nonclinical peer support roles alongside the clinical teams. You can't speak to the value enough around having both of those working together with em to support him on his journey wherever that he decides that needs to go. The lived experience brings the real life to the case, I suppose you could say, and brings the trust in the service where the lived experience can be that bridge between the clinical as well. So I think where possible, if we can have lived experience workforce embedded within clinical teams, fantastic. In the absence of that, that we have a good understanding of what peer services or groups are available in your local area to be able to at least inform AEM about. These are some groups you might want to connect with to help you decide on which direction you want to go.

Annie Williams (01:08:52):

Thank you. And Ferghal, apart from love first and love last, what other pearls do you have?

Dr Ferghal Armstrong (01:08:59):

I don't think you can beat that, but since you asked, I think don't forget the famous five, and I'm speaking to GPS and community practitioners now, it's don't try and do this on your own. There's no lone ranges in recovery. You've got to have a team and try and get as many people involved as possible so that AEM can ultimately increase his time spent with non-drug using peers and his time spent engaged in meaningful activity.

Annie Williams (01:09:28):

Thank you. And I'll throw to Alice,

Alice Frank (01:09:32):

I think it just really highlights the importance of taking a holistic view. So it's not just about addressing your substance use, it's not just about his mental health, it's taking that real holistic picture. And even though I am a pharmacist, it's not necessarily about medication in this case. It's taking that opportunity to sort of have a good view of the overall picture and providing the best support to Adrian as well and providing that positive interaction as well to ensure that even if he doesn't stay engaged with treatment this time, that he might again in the future when the time's right for him.

Dr Vicky Phan (01:10:06):

And Vicky, I'd really echo what everyone else has said and I think what's really important is to stay curious about the person and their support system around you. And I think this panel today, everyone's really brought a lot of curiosity and questions to the case. Everyone's wanted to learn more and it's provided a breadth of further roads that we could go down in terms of treatment support, exploration. That's all really key to understanding why AEM is presenting our views and how we can best support him. And just really making use of the services, the training, the support you can get around you as a clinician as well. My practise is certainly enhanced by having people on this excellent panel as colleagues, and I'm sure everyone joining in has got people that they can go to too. There's no sort of wrong question to ask when you're going to your workmates to find out what else could be done for a

Annie Williams (01:10:59):

Person. Thank you. And I'd like to thank you all too for reminding us to make AEM and people like a dem the centre of the solution and to remain curious about these people. I'd also like to thank the audience for joining us and for people who will be watching this recording. Thank you also for your time. There's opportunity for resources on both MHPN and Hamilton Centre websites around future webinars and in case of Hamilton Centre education modules and webinar content. Thank you very much for coming to this activity. I've really enjoyed moderating. Thank you to the panel again, and I hope you all have a lovely evening.