

Integrated treatment, care and support for people with co-occurring mental illness and substance use or addiction

Guidance for Victorian mental health and wellbeing and alcohol and other
drug services

OFFICIAL

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July 2022

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Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

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ISBN 978-1-76096-912-7 (pdf/online/MS word)

Except where otherwise indicated, the images in this document show models and illustrative settings only, and do not necessarily depict actual services, facilities or recipients of services.

In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people.

'Indigenous' or 'Koori/Koorie' is retained when part of the title of a report, program or quotation.

Available at the [Department of Health website](https://www.health.vic.gov.au/mental-health-reform/recommendation-35) <https://www.health.vic.gov.au/mental-health-reform/recommendation-35>

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Terminology and language

The language used in the *Integrated treatment, care and support for people with co-occurring needs: Guidance for Victorian mental health and wellbeing and alcohol and other drug services* (the Guidance) aims to be inclusive and respectful. Where possible it is aligned with preferred terms adopted by the Final Report from the Royal Commission into Victoria's Mental Health System¹ and the *Power of Words: Having alcohol and other drug conversations: A practical guide*.²

Two key phrases used in the Guidance are 'co-occurring needs' and 'integrated treatment, care and support'. These phrases are defined specifically in **figure 1** below. A full glossary is available at **appendix A**.

Figure 1: Definition of key terms

People with co-occurring needs	The term 'co-occurring needs' can be used to describe a range of different support needs that a person may experience at the same time. However, for the purposes of the Guidance, this term is used to refer to people who experience co-occurring mental illness (including people experiencing suicidal thoughts and behaviours) and substance use or addiction, with or without a formal diagnosis. This definition acknowledges the diversity of people's experiences with mental illness and alcohol and other drug use.
Integrated treatment, care and support	Treatment, care and support should be led by an individual's priorities, goals and preferences, empowering people with co-occurring needs, and their families and supporters, to achieve the outcomes that are important to them. Treatment, care and support is integrated if it: • offers a welcoming, hopeful, timely and coordinated response to a person's co-occurring mental illness and substance use or addiction, prioritising simplicity and continuity³ for the person and their family and supporters • provides choice and control for the person, offering simultaneous responses to both co-occurring needs as well as support for people who may not, at a given time, wish to engage with some or all available aspects of treatment, care and support.

¹ Royal Commission into Victoria's Mental Health System Final Report, 2021, Volume 1, Glossary, pp.652-677.

² The Power of Words: having alcohol and other drug conversations: A practical guide, 2021.

³ Often this will mean a person with co-occurring needs prefers to engage with a single worker, single provider contact, and/or single program of treatment, care and support. If this is not preferred by the person, or not otherwise possible, multiple workers or service providers may be involved, operating under a shared care framework.

Executive Summary

The Royal Commission into Victoria's Mental Health System (the Royal Commission) envisaged a future in which people with co-occurring mental illness and substance use or addiction (people with co-occurring needs) and their families and supporters have access to integrated treatment, care and support in a variety of settings, consistent with the intensity of their needs, strengths and preferences.

To achieve this, the mental health and wellbeing and the alcohol and other drugs (AOD) systems will remain distinct but will work more closely together, based on a shared understanding of best practice for integrated treatment, care and support.

Integrated treatment, care and support for people with co-occurring mental illness and substance use or addiction: Guidance for Victorian mental health and wellbeing and alcohol and other drug services (the Guidance) supports the implementation of the Royal Commission's recommendations. It will shape connected systems reforms and provides a shared vision and framework for the mental health and wellbeing and AOD systems to work more closely together to meet the expectations of people with co-occurring needs, and those of their families and supporters.

Delivering integrated treatment, care and support across multiple services and systems

People with co-occurring needs and their families and supporters will have access to integrated treatment, care and support that consists of six levels of service provision, across a spectrum of needs intensity.

Regardless of whether a person seeks support for their co-occurring needs in the mental health and wellbeing or AOD system, they will be met with a welcoming and compassionate approach, based on a 'no wrong door' approach and a philosophy of 'how can we help?' Once people are connected with support, services will respond flexibly to people's needs, strengths and preferences using trauma-informed practices.

In the future, work will be undertaken to further clarify the pathways and roles and responsibilities of services providers across the mental health and wellbeing and AOD systems, including how they relate to allied service systems (see further information at critical milestones).

Vision, principles and expectations of integrated treatment, care and support

The Guidance provides the overall concept and direction for how people with co-occurring needs and their families and supporters should experience integrated treatment, care and support:

- the **vision** briefly sets out the desired future state
- the **principles** describe key concepts to inform the implementation of integrated treatment, care and support
- the **statements of shared understanding** provide essential context about the rights, needs and experiences of people with co-occurring needs, and their families and supporters
- the **expectations** articulate service providers' broad obligations when supporting people with co-occurring needs and their families and supporters.

Making integrated treatment, care and support happen

Achieving the Royal Commission's recommendations for people with co-occurring needs, and their families and supporters, requires that integrated treatment, care and support is embedded across a wide range of system reforms. To this end, the [Workplan: Integrated treatment, care and support \(the Workplan\)](https://www.health.vic.gov.au/mental-health-reform/recommendation-35) <<https://www.health.vic.gov.au/mental-health-reform/recommendation-35>> describes how related system reforms intersect with, promote and contribute to the integrated treatment, care and support agenda. The Workplan is separate to the Guidance and should be read alongside it.

A range of forums will help to monitor progress on the delivery of integrated treatment, care and support and drive greater collaboration across the mental health and wellbeing and AOD sectors. To support the implementation of the Guidance, mental health and wellbeing and AOD services should strategically plan for the change ahead and learn from best practice approaches and related system reforms.

Critical milestones

As outlined in the Workplan, embedding the vision, principles and expectations of the Guidance is dependent on a range of system reform activities occurring over the coming months and years. Key early milestones of this work include: the establishment of new and reformed services that will better meet people's co-occurring needs, and those of their families and supporters; reforms to build the integrated care capability of workers; and a new approach to performance monitoring and accountability to understand whether our approach to integrated treatment, care and support is working.

In addition to whole of system reform work, ongoing effort is required to support the implementation of the Guidance. **Figure 2** summarises critical milestones to be led in collaboration with people with lived and living experience, workers and service providers.

Figure 2: Critical milestones to support the delivery of integrated treatment, care and support

Activity	Indicative timeline
The Department of Health to collaboratively lead work to operationalise the Guidance, including case studies on best practice approaches for how services should configure themselves, and work to further define the application of the Guidance across different service settings .	End 2022
The new statewide service for people living with mental illness and substance use or addiction to collaboratively lead a review of existing tools and identify a range of preferred integrated screening tools for use in different settings to inform preliminary needs assessment. This will be supported by work in 2022 to develop consumer vignettes that illustrate the intensity of people's needs.	Early 2023
The new statewide service for people living with mental illness and substance use to collaboratively develop practice guidelines that will support services and workers to deliver best practice integrated treatment, care and support.	Early 2024

Part one: reform context

1. Introduction

This section describes relevant findings and recommendations from the Royal Commission into Victoria's Mental Health System (the Royal Commission), outlines the purpose and scope of the *Integrated treatment, care and support for people with co-occurring mental illness and substance use or addiction: Guidance for Victorian mental health and wellbeing and alcohol and other drug services* (the Guidance), and describes how the Guidance interacts with concurrent reform initiatives.

The Royal Commission's findings regarding people with co-occurring needs

Consistent with a long-established evidence base, the Royal Commission found that many people experience co-occurring mental illness and substance use or addiction, with some leading international experts considering this 'the expectation, not the exception.'⁴

Despite this relationship, many people with co-occurring substance use or addiction (people with co-occurring needs), and their families and supporters experience siloed approaches to service delivery that treat their interrelated needs separately. A common experience is that people 'fall through the gaps' and are referred back and forth, having to retell their story to different workers in different services; in some cases, people are excluded from services altogether.⁵ The impact of this can be exacerbated for those who also have social and other support needs, such as housing.

People with co-occurring needs consistently report experiences of compounded forms of stigma⁶ and discrimination, in both service provision and wider community contexts. Some commonly held misbeliefs about people with co-occurring needs are that they are dangerous or unpredictable, lack motivation to change, cannot make decisions and are to blame for their experiences. Diagnostic labels can also perpetuate and reinforce stigma, as can the use of particular substances or consumption practices. These experiences can have profound and enduring impacts on the lives of people with co-occurring needs, and their families and supporters. Such beliefs can discourage people from seeking support in the first place, and undermine and negatively influence the treatment, care and support they receive.⁷

Experiences of trauma among people with co-occurring needs are also common. These experiences of adversity, both in childhood and later in life, can be harmful to people's health and wellbeing, and that of their families and supporters.

⁴ Kenneth Minkoff and Christie A. Cline, Developing Welcoming Systems for Individuals with Co-Occurring Disorders: The Role of the Comprehensive Continuous Integrated System of Care Model, *Journal of Dual Diagnosis*, 1.1 (2005), 65–89, p. 71.

⁵ The Royal Commission into Victoria's Mental Health System Final Report, 2021, Volume 3, chapter 22, pp. 310-311 and 316.

⁶ There are four different types of stigma that are related and mutually reinforcing: self-stigma (the process whereby a person internalises negative attitudes and applies these views to themselves), public stigma (publicly held attitudes or behaviours towards people with co-occurring needs), structural stigma (exclusionary policies, practices or systems) and stigma by association (stigma experienced on the basis of association to a person with co-occurring needs). The Royal Commission into Victoria's Mental Health System Final Report, 2021, Volume 3, Chapter 25, p.520-521; Witness Statement of Dr Chris Groot, 4 September 2019; Witness Statement of Dr Michelle Blanchard, 27 June 2019.

⁷ The Royal Commission into Victoria's Mental Health System Final Report, 2021, Volume 3, chapter 22, pp. 317-318.

Evidence suggests that integrated treatment, care and support results in better outcomes for people with co-occurring needs, and their families and supporters. While there are examples of good integrated practice across the mental health and wellbeing and alcohol and other drug (AOD) systems, the Royal Commission found that comprehensive and integrated treatment, care and support is not readily available to all who need it.⁸

The Royal Commission's recommendations for people with co-occurring needs

The Royal Commission envisaged a future in which people with co-occurring needs and their families and supporters have access to integrated treatment, care and support in a variety of settings, consistent with the intensity of their needs, strengths and preferences. It also made clear that no person should be excluded from mental health and wellbeing services because of their co-occurring substance use or addiction (see **appendix B** for further detail on the Royal Commission's recommendations). In this way, equitable access to integrated treatment, care and support will help people to realise their fundamental human right to enjoy their best possible health, free from stigma and discrimination.

The Royal Commission's recommendations are focused on delivering an integrated experience of treatment, care and support for people with co-occurring needs and their families and supporters, while maintaining the unique strengths of both the mental health and wellbeing and AOD systems. For this reason, rather than recommending system integration, the Royal Commission envisaged a future where both systems remain distinct and consistently offer welcoming, compassionate and capable responses to people with co-occurring needs and their families and supporters.

Purpose and scope of the Guidance

The purpose of the Guidance is to establish a shared vision for integrated treatment, care and support that will meet the expectations of people with co-occurring needs, and their families and supporters. The Guidance will also inform, shape and contribute to related system reforms.

This will support the Department of Health and its funded services to be in the best position to support people with co-occurring needs and their families and supporters, whether that care is experienced in the mental health and wellbeing or AOD systems. Substantial effort will be required to ensure that people with co-occurring needs, and their families and supporters remain at the centre of these efforts.

The Guidance:

- provides clear directions to leaders on how to deliver integrated treatment, care and support and provides a framework for the mental health and wellbeing and AOD systems to work more closely together
- will be used as the basis to inform the design and implementation of a range of related system reforms, ensuring that people with co-occurring needs and their families and supporters are front and centre across the reform agenda
- is targeted to leaders across the mental health and wellbeing and AOD systems who are responsible for shaping service design, delivery and implementing reform

⁸ The Royal Commission into Victoria's Mental Health System Final Report, 2021, Volume 3, chapter 22, p.285.

- complements, rather than replaces, existing policies and frameworks that support the delivery of integrated treatment, care and support.⁹

This Guidance applies to Victorian Department of Health-funded mental health and wellbeing services, AOD services and emergency department mental health and AOD hubs supporting people with co-occurring needs and their families and supporters. This includes people with co-occurring needs accessing treatment, care and support in the community as part of a court order. In the future, work will be undertaken to further define and articulate the application of the Guidance in practice across different service settings (see **appendix A** for further detail on services that are in scope of the Guidance).

The Department of Health is committed to ensuring that all mental health and wellbeing and AOD services, irrespective of how they are funded or commissioned, are aware of the Guidance, and will work collaboratively to encourage alignment with the principles and expectations of the Guidance to support better outcomes for people with co-occurring needs and their families and supporters.

A summary of the Guidance is available on the [Department of Health's website](https://www.health.vic.gov.au/mental-health-reform/recommendation-35) <<https://www.health.vic.gov.au/mental-health-reform/recommendation-35>>.

Process for developing the Guidance

In developing the Guidance, the Department of Health has consulted widely with people with co-occurring needs, families and supporters, workers and services providers across the mental health and wellbeing and AOD sectors. For details on the Department of Health's engagement approach see the [What we Heard \(2021\) and What we Learned: Integrated treatment, care and support \(2022\) publications](https://www.health.vic.gov.au/mental-health-reform/recommendation-35) <<https://www.health.vic.gov.au/mental-health-reform/recommendation-35>>.

The Department of Health has also been informed by leading integrated care policies and programs, including Victoria's [Dual Diagnosis: Key Directions and Priorities for Service Development](https://www.health.vic.gov.au/publications/dual-diagnosis-key-directions-for-service-development) <<https://www.health.vic.gov.au/publications/dual-diagnosis-key-directions-for-service-development>> and the influential work of Christie Cline and Kenneth Minkoff in developing the [Comprehensive Continuous Integrated System of Care model](http://www.ziapartners.com/resources/comprehensive-continuous-integrated-system-of-care-ccisc-2/) <<http://www.ziapartners.com/resources/comprehensive-continuous-integrated-system-of-care-ccisc-2/>>.

It has also drawn on early learnings from the Victorian Department of Health Integrated Care Pilot, which is piloting the Comprehensive Continuous Integrated System of Care model. As the lead agency, First Step is working alongside ten partner organisations from the mental health and wellbeing, AOD and allied sectors that respond to issues such as homelessness, disability, child and family support and primary health care, to improve services shared capability to support people with co-occurring needs,¹⁰ and their families and supporters (see **section 5** for further information on early learnings from the pilot).

⁹ For example: the [AOD Program Guidelines](https://www.health.vic.gov.au/aod-service-standards-guidelines/alcohol-and-other-drug-program-guidelines) <<https://www.health.vic.gov.au/aod-service-standards-guidelines/alcohol-and-other-drug-program-guidelines>> the Royal Commission's guiding principles for Victoria's mental health and wellbeing system, the [Dual Diagnosis: Key Directions and Priorities for Service Development](https://www.health.vic.gov.au/publications/dual-diagnosis-key-directions-for-service-development) <<https://www.health.vic.gov.au/publications/dual-diagnosis-key-directions-for-service-development>> [Korin Korin Balit-Djak](https://www.health.vic.gov.au/health-strategies/korin-korin-balit-djak-aboriginal-health-wellbeing-and-safety-strategic-plan-2017) <<https://www.health.vic.gov.au/health-strategies/korin-korin-balit-djak-aboriginal-health-wellbeing-and-safety-strategic-plan-2017>> and [Balit Murrup](https://www.health.vic.gov.au/publications/balit-murrup-aboriginal-social-emotional-wellbeing-framework-2017-2027) <<https://www.health.vic.gov.au/publications/balit-murrup-aboriginal-social-emotional-wellbeing-framework-2017-2027>>

¹⁰ In the context of the Integrated Care Pilot, 'co-occurring needs' refers to a range of support needs that a person may experience at any one time, including mental health, substance use or addiction, physical health, housing, legal support, and family and child services.

Integrated treatment, care and support across all reforms

The Guidance provides the concept and foundations for a new approach to integrated treatment, care and support. It is, however, only the first phase of the reform journey. Achieving the Royal Commission's vision for people with co-occurring needs, and their families and supporters requires that their needs and perspectives are embedded across all aspects of the reform agenda.

This means that the Guidance must be used to inform the design and implementation of all relevant reforms – whether they be new service models, governance and accountability structures, leadership or workforce changes, or efforts to ensure ongoing excellence in meeting community mental health and wellbeing needs.

Information on how integrated treatment, care and support will be implemented through related system reforms is described at **section 4** of the Guidance. The Guidance should also be read alongside the [Workplan: Integrated treatment, care and support](https://www.health.vic.gov.au/mental-health-reform/recommendation-35) <<https://www.health.vic.gov.au/mental-health-reform/recommendation-35>>.

2. Delivering integrated treatment, care and support across multiple systems

This section describes the continuum of care for people with co-occurring needs and their families and supporters based on a 'no wrong door' approach. It also describes the different ways mental health and wellbeing services may configure themselves to deliver integrated treatment, care and support.

Continuum of care for people with co-occurring needs

As illustrated in **figure 3**, people with co-occurring needs and their families and supporters will have access to integrated treatment, care and support across six levels of service provision, consistent with their preferences, strengths and the intensity of their needs. The primary focus of the Guidance is on Levels three to six of service provision, which illustrates distinct but interconnected roles for the mental health and wellbeing and AOD systems.

Figure 3 also highlights the important role that crisis and emergency services play in supporting people with co-occurring needs, their families and supporters. Noting that further work is planned to operationalise the Guidance in practice across different service settings, emergency department mental health and AOD hubs will provide integrated treatment, care and support to people who are experiencing a mental health and/or substance use or addiction related crisis or emergency, consistent with the Guidance. AOD expertise will be embedded in each of the hubs as part of a multidisciplinary team, delivering integrated assessments, brief interventions, peer support, short-stay bed crisis services, referrals, post discharge planning and continuity of care (see **appendix A** for further detail).

The Guidance broadly describes the continuum of care for people with co-occurring needs and their families and supporters, consistent with recommendations from the Royal Commission. In the future, the Department of Health will lead collaborative work on related system reforms that will help to further define people's access to and pathways between services. The new statewide service for people living with substance use or addiction (the Statewide Service) will also work collaboratively to review and identify preferred integrated screening tools that will inform preliminary needs assessment, including the 'intensity of people's needs.' For further information please refer to **section 5** of the Guidance and the [Workplan: Integrated treatment, care and support](https://www.health.vic.gov.au/mental-health-reform/recommendation-35) <<https://www.health.vic.gov.au/mental-health-reform/recommendation-35>>.

Whole of system reform on improving connections between the mental health and wellbeing and AOD systems, and other related service systems (for example, housing) will also be required to ensure that people receive holistic treatment, care and support.

Collectively, this work will help to clarify the pathways and roles and responsibilities of service providers across the mental health and wellbeing and AOD systems, and how they relate to and work alongside allied service systems.

No wrong door

Regardless of whether a person seeks support for their co-occurring needs in the mental health and wellbeing or AOD systems, they will be met with a welcoming and compassionate approach, based on a 'no wrong door'¹¹ approach and a philosophy of 'how can we help?'

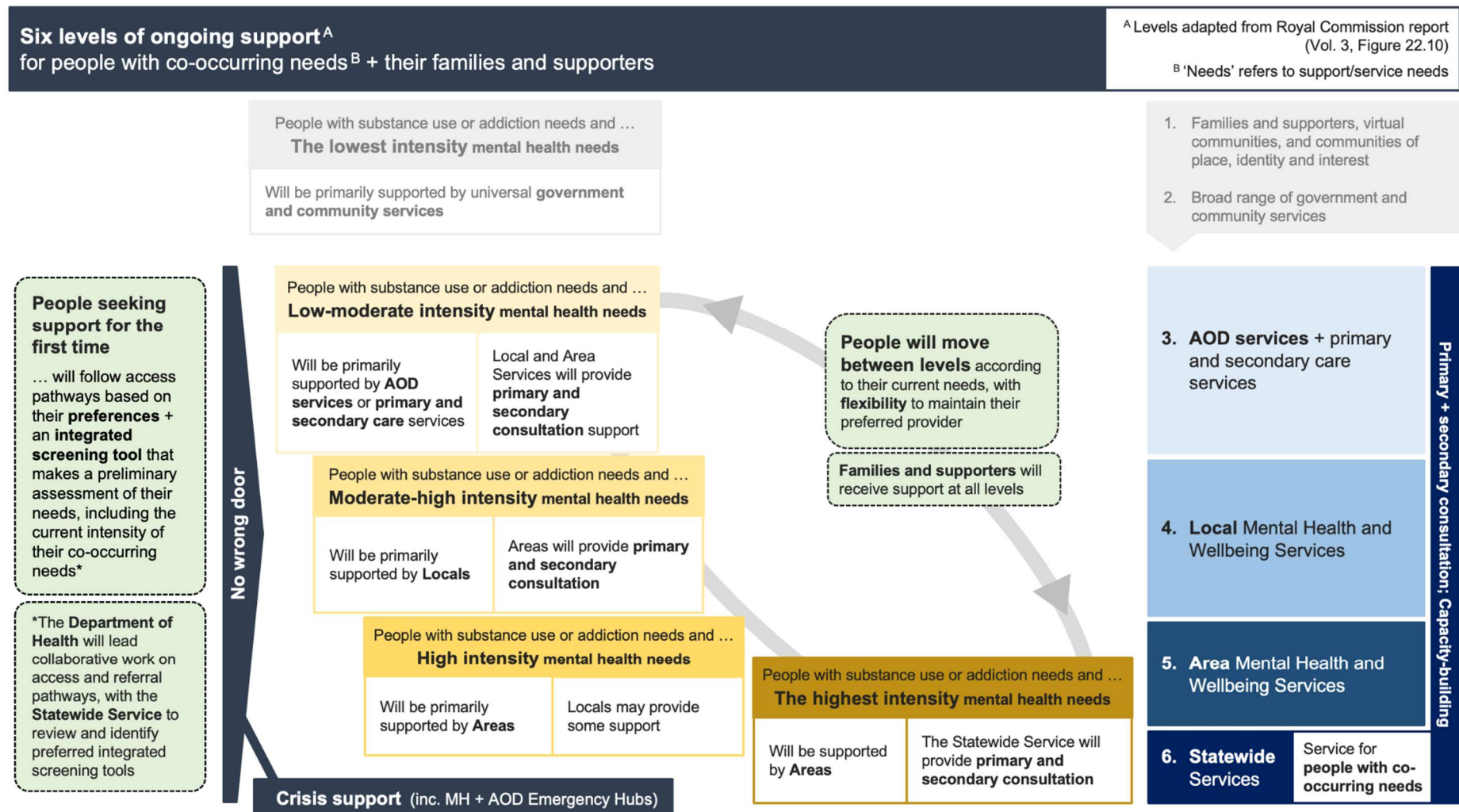
Substance use or addiction will not be a barrier to accessing treatment, care and support from the mental health and wellbeing system (this includes recognising that people who do not wish to reduce or eliminate substance use are just as entitled to treatment, care and support). Mental illness will not be a barrier to accessing treatment, care and support from the AOD system. People with co-occurring needs, their families and supporters will not be turned away or excluded from services. Instead, they will receive comprehensive and equitable access to treatment, care and support that can help them live a life they value.

Once people are connected with support, services will respond flexibly to their needs, strengths and preferences using trauma-informed practices. Integrated treatment, care and support will be provided either through direct service delivery or supported referral processes. People with co-occurring needs and their families and supporters will have choice and control over their treatment, care and support. While most people will generally follow the service pathways according to the continuum of care in **figure 3**, they will be able to maintain relationships with their preferred service providers and workers wherever possible.¹² This also means people will have the flexibility to move between different services and systems in line with their changing needs, strengths and preferences.

¹¹ See **appendix A** for a definition of 'no wrong door.'

¹² Where this can be safely and effectively facilitated in a given service setting.

Figure 3: Continuum of care for people with co-occurring needs, and their families and supporters



The 'levels of support' explained

Level 1: Families, supporters and communities

The first level on the continuum of care recognises the important role that families, supporters and communities play in supporting the health and wellbeing of people with co-occurring needs. When people start to experience co-occurring needs, the first place they often turn to for support is their family, friends and community.

Level 2: Broad range of government and community services

At the next level, there is a broad range of universal and government services that sit outside of the mental health and wellbeing and AOD systems. These include universal services such as health or education and community services responding to issues like homelessness, housing, legal assistance, and child and family safety.

These services support people with substance use or addiction needs and the lowest-intensity mental health needs, alongside their families and supporters. They help them to live well in the community and also play an important role in primary prevention and early intervention of co-occurring needs.

As the intensity of a person's co-occurring needs increases, and they access support from the mental health and wellbeing and AOD systems, they may also continue to experience a range of other health, social and legal issues that require a coordinated and holistic service response in partnership with the person. Mental health and wellbeing and AOD services will proactively and routinely engage with a broad range of government and community services, including criminal justice services like police and corrections, to ensure that people's co-occurring needs are met in a holistic and integrated way.

Level 3: AOD services and primary and secondary care services

AOD services and primary and secondary care services comprise the third level of the continuum of care. They are responsible for supporting people with substance use or addiction needs and co-occurring low to moderate intensity mental health needs, as well as their families and supporters.

AOD services include prevention, early intervention, harm reduction, treatment and ongoing support programs. This includes AOD services available to all Victorians, targeted services such as Aboriginal and youth services, and AOD services provided to people in the community as part of a court order.

People accessing treatment, care and support from AOD services are primarily doing so to address their substance use or addiction needs, however, many also experience co-occurring low to moderate intensity mental health needs. The AOD system will continue to support people to meet both needs in an integrated way, consistent with the principles and expectations outlined in the Guidance, while having new support from:

- Local Mental Health and Wellbeing Services (Local Services) and Area Mental Health and Wellbeing Services (Area Services), via primary and secondary consultation

- the Statewide Service, which will provide capacity building to AOD services via secondary consultation and primary consultation to a small number of people with the highest-intensity substance use or addiction needs and co-occurring mental health needs.¹³

The third level also comprises primary and secondary care services. Primary care services are highly accessible services where people can receive treatment, care and support without a referral or meeting eligibility criteria. For example, general practitioners (GPs) and allied health professionals, such as social workers or nurses. Secondary care services are generally only accessed through a referral from a GP, such a psychologist or psychiatrist providing treatment, care and support via fee-for-service, federal subsidies, health insurance or workplace programs.

Primary and secondary care services are predominantly Commonwealth-funded services and play an important role in supporting people with co-occurring needs and their families and supporters. Primary and secondary care services are where most Victorians access support for their mental health and wellbeing, providing holistic service responses and proactively connecting people to supports and services in their local community. Primary and secondary care services will be supported by Local and Area Services via primary and secondary consultation. While the Guidance does not apply to these services, in the future the Department of Health will work with providers to explore opportunities for alignment.

See **appendix C** for an illustration of:

- Alex and their friend Kristy's experience of integrated treatment, care and support for co-occurring use of pain medication and experiences of anxiety and trauma, via AOD services (with secondary consultation from a Local Service), and some support via primary and secondary services.
- April and her brother Gary's experience of integrated treatment, care and support for co-occurring alcohol use and suicidal behaviour, via AOD services and suicide prevention and response supports, with some support via an emergency department.

Level 4: Local Mental Health and Wellbeing Services

At the fourth level of the continuum of care are new **Local Youth** and **Adult and Older Adult** Services. Local Services will support people with substance use or addiction needs and co-occurring moderate-to-high intensity mental health needs, as well as their families and supporters.

People accessing treatment, care and support from Local Services are primarily doing so to address their moderate-high intensity mental health needs; however, many also experience co-occurring substance use or addiction. Local Services will support people to meet both needs in an integrated way, with primary and secondary consultation support from Area Services and capacity building support via secondary consultation from the new Statewide Service. This includes primary consultation to a small number of people with the highest-intensity substance use or addiction needs and co-occurring mental health needs.¹⁴

The Royal Commission recommended the establishment of 50-60 new **Local Adult and Older Adult** Services across Victoria by end of 2026, with the first six scheduled to open by the end of 2022. Local Adult and Older Adult Services will deliver integrated treatment, care and support in line with the principles and expectations of the Guidance. They will be networked with Adult and Older Adult Area Services in their service catchment and will work collaboratively with local AOD

¹³ Initially the Statewide Service will provide primary consultation to Area Services, over time capacity will be expanded to enhance access for AOD services.

¹⁴ Initially the Statewide Service will provide primary consultation to Area Services, over time capacity will be expanded to enhance access for Local Services.

service providers, facilitating smooth referral pathways. **Local Adult and Older Adult Services** will provide primary and secondary consultation to AOD services and primary and secondary care services, to ensure people can continue to get treatment, care and support without having to be referred or 'handed over' to a different provider.

Headspace centres are currently fulfilling the role of **Local Youth Services**. Headspace centres are Commonwealth funded and commissioned by Primary Health Networks. The Guidance does not formally apply to headspace centres; however – recognising these services represent a critical part of the continuum of care for young people with co-occurring needs and their families and supporters – the Department of Health will ensure headspace centres are aware of the Guidance and we will work together on how the Guidance applies to young people with co-occurring needs, and their families and supporters.

See **appendix C** for an illustration of Anh's experience of integrated treatment, care and support for co-occurring experiences of grief, low mood and substance use via a Local Service, with some support via primary care and AOD services.

Level 5: Area Mental Health and Wellbeing Services

At the fifth level of the continuum of care are **13 Infant, Child and Youth** and **22 Adult and Older Adult Area Services**. These existing services are being reformed, with their capacity and scope of practice expanded to support people with substance use or addiction needs and co-occurring high-to-highest intensity mental health needs, as well as their families and supporters.

Area Services provide tertiary-level, high-intensity and complex support responses, with multidisciplinary teams. They will also deliver a centrally coordinated 24 hour, seven-day-a-week telephone and telehealth crisis response service, providing crisis assessment, immediate support, and mobilisation of a crisis outreach team. People accessing treatment, care and support from Area Services are primarily doing so to address their high-to-highest intensity mental health needs, however, many also experience co-occurring substance use or addiction needs.

Area Services will support people to meet both needs in an integrated way, consistent with the principles and expectations outlined in the Guidance. Some support may be provided via Local Services. The new Statewide Service will also provide capability building support, including primary consultation to a small number of people with the highest-intensity substance use or addiction needs and co-occurring mental health needs.

Area Services will provide primary and secondary consultation to AOD services, primary and secondary care services and Local Services, to ensure people can continue to get treatment, care and support without having to be referred or 'handed over' to a different provider.

See **appendix C** for an illustration of :

- Jarrah and his mother Keira's experience of integrated treatment, care and support for co-occurring experiences of emotional distress, psychosis and substance use via an Adult and Older Adult Area Service, Local Service and a family carer-led centre.
- Ahmed and his parent's Yasmin and Amir's experience of integrated treatment, care and support for co-occurring experiences of early psychosis, trauma and substance use via an Infant, Child and Youth Area Service, with some support via a headspace centre.

Level 6: The statewide service for people living with mental illness and substance use or addiction

Statewide services comprise the sixth level of the continuum of care, supporting a small number of people with the highest-intensity needs and their families and supporters. Statewide services require a high degree of specialisation and play an important role in sharing skills and expertise to build the capability of related services and workers.

The new statewide service for people living with mental illness and substance use or addiction (the Statewide Service) is being established in collaboration with people with lived and living experience, service providers and workers. The new Statewide Service will comprise Turning Point as the lead organisation, and a network of addiction service Partner Providers.

The key role of the Statewide Service is to provide support to, and build the capability of, the mental health and wellbeing and AOD systems to deliver integrated treatment, care and support.

As the Statewide Service lead, Turning Point will:

- develop and deliver an education and training program that will increase the integrated care capability of mental health and wellbeing and AOD workers
- lead research into co-occurring mental illness and substance use or addiction
- provide brief centralised secondary consultation to AOD services, Local Services and Area Services
- coordinate access to the statewide network of Partner Providers across AOD services, Local Services and Area Services, providing specialised support for people with the highest-intensity substance use or addiction needs and co-occurring mental health needs, and their families and supporters.

The Statewide Service will deliver these core functions in line with the principles and expectations outlined in the Guidance.

A statewide network of Partner Providers will facilitate access to addiction specialists via primary and secondary consultations across metropolitan and regional Victoria. Partner Providers will offer a mix of face-to-face, telehealth and outreach support, ensuring care is provided closer to home.

Turning Point will commence operations as the Statewide Service by end 2022. The first four Partner Providers will be established by January 2023, with additional Partner Providers established by mid-2025. Initially the Statewide Service will prioritise building the capability of Area Services, over time capacity will be expanded to enhance access for AOD services and Local Services, with primary and secondary care services to follow in future years.

See **appendix C** for an illustration of how Partner Providers may facilitate access to addiction specialists via primary and secondary consultation to Area Services.

How Local and Area Services can configure themselves to deliver integrated treatment, care and support

In line with the shared vision, principles and expectations of the Guidance (see **section 3**), all people working in roles in the mental health and wellbeing sector need to develop capability in substance use and addiction. The [Mental Health and Wellbeing Workforce Capability Framework](https://www.health.vic.gov.au/strategy-and-planning/mental-health-workforce-strategy) <<https://www.health.vic.gov.au/strategy-and-planning/mental-health-workforce-strategy>> identifies

“understanding and responding to substance use and addiction”¹⁵ as one of 15 capabilities outlining the knowledge and skills required to deliver safe and effective treatment, care and support in the Victorian mental health and wellbeing system.

In addition – consistent with the Royal Commission’s findings – multidisciplinary teams, co-location, and service delivery partnerships are some of the ways Local and Area Services might choose to configure themselves to develop specialised capability in supporting people with co-occurring needs and their families and supporters (refer to **figure 4**).

Local and Area Services will have the flexibility to determine which approach, or combination of approaches, best meets the needs of their local communities.¹⁶ Regardless of the approach adopted, all Local and Area Services will deliver integrated treatment, care and support that comprehensively meets the needs and preferences of people with co-occurring needs, and their families and supporters, in those services specifically.

Figure 4: How Local and Area Services can configure themselves to develop capability in and deliver integrated treatment, care and support¹⁷

Multidisciplinary teams	Workers of different disciplines provide integrated treatment, care and support in a single service setting. There is a high degree of collaboration and coordination to deliver person-centred care.
Co-location and care coordination partnerships	A Local or Area Service physically co-locates with an AOD service to deliver coordinated treatment, care and support. Through care coordination and single care planning, they deliver integrated treatment, care and support needed to meet the person’s co-occurring needs. Regular case conferencing and shared records and information enable seamless and coordinated care, where both providers work towards joint care goals. Care coordination and shared information systems are critical components in this model.
Service delivery partnerships	A Local or Area Service partners with an AOD service to deliver some aspects of a person’s treatment, care and support within the mental health and wellbeing service.

¹⁵ Capability – Understanding and responding to substance use and addiction: “Care, support and treatment recognises that experiencing psychological distress or mental illness places a person at increased risk of also experiencing a diversity of other concerns and intersecting care, support and treatment needs and preferences. Services, teams, and practitioners recognise the prevalence of co-occurring substance use and addiction amongst people experiencing mental health needs and ensure an integrated approach to mental health and substance use or addiction treatment.” [Mental Health and Wellbeing Workforce Capability Framework](https://www.health.vic.gov.au/strategy-and-planning/mental-health-workforce-strategy) <<https://www.health.vic.gov.au/strategy-and-planning/mental-health-workforce-strategy>>

¹⁶ As the Royal Commission noted, Local Services and Area Services will be assisted by Regional Mental Health and Wellbeing Boards to determine the most appropriate approach. Royal Commission into Victoria’s Mental Health System Final Report, 2021, Volume 3, Chapter 22, p. 331.

¹⁷ Royal Commission into Victoria’s Mental Health System Final Report, 2021, Volume 3, Chapter 22, p. 332.

Part two: understanding and implementing integrated treatment, care and support

3. Vision, principles and expectations of integrated treatment, care and support

This section articulates the overall concept and direction for how people with co-occurring needs and their families and supporters should experience integrated treatment, care and support:

- the **vision** briefly sets out the desired future state
- the **principles** describe key concepts to inform the implementation of integrated treatment, care and support
- the statements of **shared understanding** provide essential context about the rights, needs and experiences of people with co-occurring needs, and their families and supporters
- the **expectations** articulate service providers' broad obligations when supporting people with co-occurring needs and their families and supporters.

Appendix C illustrates how people with co-occurring needs, and their families and supporters will experience integrated treatment, care and support in the reformed system. These descriptions are intended to bring to life the vision, principles and expectations of the Guidance from the perspective of those who use services.

A shared vision for people with co-occurring needs

A future in which all people with co-occurring needs enjoy their best health and wellbeing, with equitable access to integrated treatment, care and support that meets their needs and preferences and proactively involves families and supporters.

Achieving this vision is a shared responsibility across the mental health and wellbeing and AOD systems and the Victorian Government.¹⁸ Other health, social and justice service systems also play a critical role in supporting people with co-occurring needs and their families and supporters to achieve better outcomes.

¹⁸ As represented by the Department of Health.

Principles and expectations of mental health and wellbeing and AOD services

Figure 5: Principles and expectations of mental health and wellbeing and AOD services supporting people with co-occurring mental illness and substance use or addiction and their families and supporters

Note on terminology: In figure 5, 'People with co-occurring needs' refers to people experiencing co-occurring mental illness and substance use or addiction. See the Glossary at **appendix A** for more information on the terms used in this Guidance.

Principles	Expectations
1 Inclusion All mental health and wellbeing and AOD services welcome people with co-occurring needs, and their families and supporters	A. Welcome people with co-occurring needs and their families and supporters. Take every opportunity to ensure they feel and are safe, and feel accepted and free to be themselves.
Shared understanding People with co-occurring needs have a right to enjoy their best possible health and wellbeing, and are entitled to respect, dignity and equity in the provision of treatment, care and support. People with co-occurring needs and their families and supporters may have low trust in services as a result of experiences such as stigma, poor worker knowledge, discrimination, trauma, or involuntary, punitive and custodial interventions (either in service provision or wider community contexts). Building and maintaining trust and engagement requires a compassionate, empathetic service response that is relationally-based and fosters hope.	B. Offer hope, respect and non-judgement. Do not judge people for: • their co-occurring needs, substance use, or mental health symptoms • not following, or circumstances not supporting them to follow, treatment, care and support recommendations • their relationship to a person with co-occurring needs ... or for any related harm or consequence (including contact with the criminal justice system). Establish a sense of safety, connection and trust and inspire hope in the possibility for positive change. Proactively and systematically address stigmatising language and practices across all aspects of service delivery.

Principles	Expectations
2 Access People with co-occurring needs, and their families and supporters, have equitable access to treatment, care and support Shared understanding Co-occurring needs are common (the ‘expectation, not the exception’²⁰ for service providers) and should be anticipated as part of core business. A person’s co-occurring needs should not exclude them from access to treatment, care and support. A wide range of populations and communities may require tailored approaches to accessing integrated treatment, care and support (and may also be more likely to have co-occurring needs), including: • people who have already experienced the negative impact of access inequities • Aboriginal people who have disproportionately experienced exclusionary policies and practices • people whose individual circumstances, such as the intensity of their needs, influence their ability to engage with services or maintain engagement with services over long time periods • people who may be at higher risk of suicide.²¹	C. Ensure there are ‘no wrong doors’¹⁹ and viable support pathways. Ensure people with co-occurring needs, and their families and supporters, have access to integrated treatment, care and support (including harm reduction), no matter which point of entry they have taken. Use intake, assessment and referral flexibly and judiciously, ensuring these processes unconditionally welcome people with co-occurring needs and their families and supporters, and result in an increase (rather than a decrease) in access to the services they value. Maximise coordination, effective navigation and continuity of care throughout a person’s experience, especially at transition points and for people who may need to engage with services over a long period of time. When service transition or referral is necessary and the person agrees, ensure the experience is proactive, practical and as seamless as possible, minimising the need for people to retell their stories. D. Maximise accessibility. Via local engagement, relationships and research, maximise accessibility, safety and capacity to respond to the specific needs of: women, people from culturally and linguistically diverse backgrounds, older and younger people, the LGBTIQ+ community, gender diverse people, people with disabilities, neurodiverse people, survivors of family violence, and people in contact or at risk of contact with the criminal justice system. Welcome all people and support them as a whole person with unique, often intersecting experiences and needs.

¹⁹ See **appendix A** for a definition of a ‘no wrong door approach.’

²⁰ Minkoff and Cline, “Developing Welcoming Systems for Individuals with Co-Occurring Disorders: The Role of the Comprehensive Continuous Integrated System of Care Model”, *Journal of Dual Diagnosis*, 1.1 (2005), 65–89, p. 71.

²¹ For example, people living in rural and remote communities, veterans and people working in higher-risk industries (agricultural workers and construction workers, police, emergency services and workers in the transport industry).

People with co-occurring needs may also have a range of other needs alongside their mental illness and substance use or addiction.

E. Ensure Aboriginal cultural safety and self-determination.

Build cultural safety to ensure Aboriginal people feel safe to access your service in a manner that validates their identity and experience. This may be underpinned by local or organisational partnerships with Aboriginal community-controlled organisations and Elders, facilitating First Peoples' right to make decisions on matters that affect their lives and communities.

Principles	Expectations
3 Capability Services and workers have the skills, knowledge and attitudes to meet people's co-occurring needs and the needs of their families and supporters – enabled by individual, practice, organisation and system-level supports²² Shared understanding Mental health and substance use can influence each other.²⁶ They can create complex interactions and – while individual experiences vary – may significantly exacerbate each other, increasing the risk of poor health and wellbeing. The likelihood of experiencing harm is shaped by a person's physical, social, economic and policy environment.²⁷ Treatment, care and support that addresses both mental illness and substance use or addiction in an integrated way can offer benefits for	F. Meet both co-occurring needs. Respond to a person's co-occurring needs in a timely and coordinated way, consistent with their priorities and preferences, using trauma-informed practices. Offer evidence-informed integrated treatment, care and support options that are: • inclusive of biological, psychosocial, peer-based support and family-inclusive offerings (for example, talking therapies, care coordination, harm reduction, single session family work, group-based peer support and mutual aid, and/or medication) • responsive to all substances (including poly-substance use) and routes of administration (including injecting) • appropriate to the person's age, development, stage of change, and risk and protective factors • informed by the person's self-determined identity, experiences, and any other relevant social and cultural factors • for Aboriginal people, aligned with Aboriginal concepts of social and emotional wellbeing²³

²² This capability could be held by a single worker, a team of workers in a multidisciplinary team or organisations from different disciplines and settings working collaboratively to deliver integrated treatment, care and support.

²³ See **appendix A** for a definition of 'social emotional wellbeing.'

²⁶ Mental illness and substance use are complex human phenomena, requiring an ongoing global research effort to further advance our understanding of causes, mechanisms, effective service offerings, and opportunities to protect and enhance human health and wellbeing.

²⁷ Rhodes, "The 'risk environment': a framework for understanding and reducing drug-related harm", *International Journal of Drug Policy*, Volume 13, Issue 2, 2002, Pages 85-94.

people with co-occurring needs, and their families and supporters, to help them live a life they value and support enjoyment of human rights.

Even when it also introduces harm or risk, substance use typically offers a range of compelling desirable effects for individuals, including functional and therapeutic benefits and pleasurable rewards.

Some people may not wish to reduce or eliminate substance use at a given time, or perhaps ever. Similarly, some people may not wish, or may not be in a position, to access recommended medications or therapies. This does not reduce their, or their families', entitlement to treatment, care and support; rather, the support provided should match their priorities and preferences at that time.

Families and supporters often experience particular stressors and harms related to the intensity of a person's co-occurring needs, and must have their own needs met for them to continue their varying support roles. They may also have past experiences of stigma, shame and inadequate system responses to their own or their loved one's needs.

- provided via a diversity of delivery modes and disciplines, including lived and living experience workforces.

G. Take a person-led approach.

Take active steps to understand how a person self-defines their experiences, including why they may use substances and the extent and interaction of their co-occurring needs. Focus on a person's strengths and work with them where they are (not where you think they should, or could, be), being prepared for these circumstances to change often.

Support people to determine their own goals, needs, strengths and preferences. Empower them to access information and make decisions about their treatment, care and support and make positive changes, including learning new skills to help them meet their goals.

H. Promote and support harm reduction.

Approach mental illness and substance use from a health and wellbeing and strengths-based perspective. Provide practical opportunities to promote wellbeing and reduce associated risks, especially where a person with co-occurring needs continues to use substances, for example safer consumption practices and overdose prevention.

I. Support and involve families and supporters.

Listen to, recognise and respond to the needs of families and supporters, understanding their relationship of care with the person with co-occurring needs and aligning with the principles and obligations in the *Carers Recognition Act 2012* (Vic). This may include providing practical self-care strategies, information about co-occurring needs and linkages to support services and programs (both internal and external to your organisation).

Proactively involve families and supporters in decision-making and information-sharing about the person with co-occurring needs' treatment, care and support, consistent with the person's preferences. Check in regularly with the person with co-occurring needs to ensure that family and supporter involvement reflects their current preferences.²⁴

²⁴ The Victorian Office of the Chief Psychiatrist publishes the *Working together with families and carers* guideline. While this resource is specific to Victoria's publicly funded clinical mental health and wellbeing services, it may be useful for a range of mental health and wellbeing and AOD services providing support to people with co-occurring needs <<https://www.health.vic.gov.au/key-staff/working-together-with-families-and-carers>>

J. Collaborate and learn.

In collaboration with people with lived and living experience, implement sustainable local strategies to increase cross-sector collaboration, communication, learning and development to continuously improve support for people with co-occurring needs and families and supporters.²⁵

Principles

4 Participation

People with co-occurring needs and their families and supporters are empowered to influence and improve the services that work to support them

Shared understanding

People with co-occurring needs – as well as their families and supporters – have distinct lived and living experiences which have inherent value and should be considered as expertise.

Respecting, listening to, and acting on these experiences and expertise can improve service delivery and outcomes of treatment, care and support – especially during times of service and system reform.

People's individual circumstances and experiences of stigma, shame, trauma and/or criminalisation may impact their ability to meaningfully engage and participate.

Expectations

K. Create meaningful participation and leadership opportunities.

Provide opportunities for participation and leadership in service design, development, delivery and evaluation – including connections with allied health, social and other services (noting that different participation approaches will be required to meet people's individual needs and circumstances). This may include co-production processes and the employment of the lived and living experience workforces.

Create regular and accessible opportunities to ask people with co-occurring needs and their families and supporters, who may not be engaged with treatment, care and support, what they may want from your service. Listen to their answers and take meaningful action. This may include sharing results with the Department of Health or other commissioning bodies.

Partner and communicate with a diversity of peer-based lived and living experience organisations that consist of, support and represent people with co-occurring needs, and their families and supporters and the lived and living experience workforces.

²⁵ See **section 5** of the Guidance for further information on opportunities for cross-sector collaboration.

4. Making integrated treatment, care and support happen

This section describes how integrated treatment, care and support will be embedded across a wide range of system reforms. It also outlines governance, leadership and collaboration arrangements to support integrated treatment, care and support and shares early reflections from the Victorian Department of Health Integrated Care Pilot on how to achieve change.

Embedding integrated treatment, care and support in system reforms

Achieving the Royal Commission's recommendations for people with co-occurring needs, and their families and supporters, requires that integrated treatment, care and support is embedded across a wide range of reforms.

To support the application of the principles and expectations of the Guidance across the broader system reform agenda, the Department of Health has developed the [Workplan: Integrated treatment, care and support \(the Workplan\)](https://www.health.vic.gov.au/mental-health-reform/recommendation-35) <<https://www.health.vic.gov.au/mental-health-reform/recommendation-35>>.

The Workplan describes how integrated treatment, care and support will be delivered via related system reforms. The Workplan is separate to, but related to the Guidance, and should be read alongside it. A summary is available at **figure 6**.

The Workplan organises reform initiatives across five enabler categories, reflecting the highly complex reform environment that people with lived and living experience, workers, services providers and the Department of Health are operating in. It identifies key activities across related reform initiatives, and describes how they intersect with, promote and contribute to the integrated treatment, care and support agenda.

The Workplan represents a point in time and will continue to evolve in line with the design and implementation of related reforms. The Department of Health will monitor its implementation to ensure integrated treatment, care and support is embedded across relevant reforms. It will also work with relevant departmental advisory groups and advise system leaders on the impacts of reforms on the specialist AOD system.

Figure 6: Summary of the *Workplan: Integrated Treatment, Care and Support*

Enabling effort	Intersections with integrated treatment, care and support	Reform activities
1. Collaboration and governance	Cross-sector relationships, collaborative spaces and new structures to support implementation and oversight of integrated treatment, care and support.	Governance and leadership of the mental health and wellbeing system and strategic connections with the AOD system, including the establishment of new entities such as the Collaborative Centre for Mental Health and Wellbeing.
2. New and reformed services	New and reformed services providing integrated treatment, care and support to people with co-occurring needs and their families and supporters.	Transformation and expansion of existing services, such as Area Services and social and emotional wellbeing teams, and the establishment of new services, such as Local Services , the new Statewide Service , and lived and living experience-led services.
3. System coherence	Clear pathways and information sharing within and across the mental health and wellbeing and AOD systems.	Establishment of new access and referral approaches, and development of policies, protocols and systems that enable safe and effective collection and sharing of information .
4. Capability	Capability planning to ensure all workers and services can offer integrated treatment, care and support that is valued by people with co-occurring needs and their families and supporters.	Expanding the size and capability of the workforces and articulating the service offering , workforce profile , infrastructure and governance arrangements of mental health and wellbeing services and their interaction with AOD services.
5. Resourcing, performance and accountability	Sufficient resourcing and outcomes-oriented funding and performance monitoring to ensure people with co-occurring needs and their families and supporters experience high quality services.	Modelling the demand , service and capital needs of the mental health and wellbeing and AOD systems and reforming mental health and wellbeing funding and monitoring approaches.

Governance, leadership and collaboration to enable the delivery of integrated treatment, care and support

A range of ongoing forums will help monitor progress on the delivery of integrated treatment, care and support reforms and support collaboration between the mental health and wellbeing and AOD sectors.

The **Mental Health Ministerial Advisory Committee** (MHMAC) helps guide Victoria's 10-year mental health and wellbeing reform journey, identifying and providing advice on emerging issues and best practice nationally and internationally in mental health and wellbeing, shaping reforms, and identifying opportunities for further collaboration and innovation. The MHMAC reports to the Minister for Mental Health and includes representatives from mental health and wellbeing sector leaders and peak bodies, including Turning Point, a major AOD service provider and the lead for the new Statewide Service.

The **Interdisciplinary Clinical Advisory Group** (ICAG) is a subcommittee of the MHMAC, comprising some of Victoria's leading mental health clinicians, specialising in culturally and linguistically diverse and Aboriginal Victorian health, LGBTIQ+, disability and homelessness, and includes representation from Odyssey House. The ICAG provides expert advice on systems, services and processes and ensure the needs, strengths and interests of Victoria's diverse communities are represented.

The ICAG works alongside the **Lived Experience Advisory Group** (LEAG), which is made up of people who have lived experience of mental illness and psychological distress, and family members and supporters of people with lived experience. The LEAG ensures that people with lived experience are partners in policy development, service design and delivery.

The **AOD Expert Advisory Group** and **AOD Lived and Living Experience Advisory Group** will continue to be forums for AOD stakeholders, including people with lived and living experience of substance use or addiction and their families and supporters, to advise the Department of Health on issues affecting the AOD sector and people with lived and living experience. This includes advice on the implementation of integrated treatment, care and support and the impacts of system reforms on the specialist AOD sector.

The newly established **Interim Regional Bodies**²⁸ will commence building relationships with AOD service providers and commissioners within each mental health and wellbeing region.

The **Statewide Service**, building on the foundations established by the **Victorian Dual Diagnosis Initiative**, will lead research and develop education and training initiatives to enhance the integrated care capability of the mental health and wellbeing and AOD sectors. In addition, a network of Partner Providers will provide access to expert advice (primary and secondary consultations) and deliver communities of practice (or other continuing professional development models) to support and build the capacity of the mental health and wellbeing and AOD workforces to provide integrated treatment, care and support across Victoria.

The **Department of Health** will lead oversight of the implementation of the Guidance, including monitoring its application and impact. It will also engage with allied service sectors and the Commonwealth about the application of the Guidance across different service settings.

²⁸ See **appendix A** for definition of 'interim regional bodies.'

The Department of Health will continue to review these forums to ensure the right governance, leadership and collaboration arrangements are in place to deliver integrated treatment, care and support for people with co-occurring needs, and their families and supporters.

Enabling change through organisational culture

Implementation of the Guidance will require significant changes across the mental health and wellbeing and AOD systems. Change of this scale must be strategically planned for, so that it can be sustained over the long term, with improvements and adaptations made along the way.

To prepare, plan for and implement the Guidance, all relevant mental health and wellbeing and AOD services should consider:

- identifying **relevant leaders** to drive change and build collective ownership and responsibility for integrated practice
- adopting the principles and expectations of the Guidance into **existing policies, plans, models of care and processes**
- developing **staged implementation plans** by which programs and services become more integrated care capable, aligned with the principles and expectations of the Guidance.

The new Statewide Service will also play an important role in enabling change, by supporting services to continuously improve and deliver best practice integrated treatment, care and support. It will work alongside the Collaborative Centre for Mental Health and Wellbeing,²⁹ leading translational research³⁰ into co-occurring needs that can be applied in practice to support high quality service delivery.

Leaders across the mental health and wellbeing and AOD systems responsible for implementing the Guidance should also learn from related system reforms both in Australia and internationally. For example, the case study at **figure 7** provides early insights and learnings from the Victorian Department of Health Integrated Care Pilot about the transformation process.

Implementation of recommendations from the Royal Commission into Family Violence (Victoria) is another pertinent example. These reforms have demonstrated the value of the Specialist Family Violence Advisor capacity building program in driving system and practice change. Advisors embed specialist family violence expertise within the mental health and wellbeing and AOD systems and build cross-sector collaboration, capacity and capability to identify, assess and respond to family violence.

Figure 7: Early insights from the Victorian Department of Health Integrated Care Pilot

The Victorian Department of Health-funded Integrated Care Pilot, which is being led by First Step and ten partner organisations, is testing the implementation of the Comprehensive Continuous Integrated System of Care (CCISC) model.

Participating organisations are implementing the CCISC model, building communities of practice, undertaking self-structured assessments, participating in training and implementing action plans to increase their capacity to:

²⁹ Recommendation 1 from the Royal Commission's interim report: Establish the Victorian Collaborative Centre for Mental Health and Wellbeing to: drive exemplary practice for lived experience, conduct interdisciplinary, transitional research and educate the mental health workforce.

³⁰ 'Translational research involves testing and applying new treatments and models of care in service delivery environments.' The Royal Commission into Victoria's Mental Health System Final Report, 2021, Volume 5, Chapter 36, p.130.

- engage and support people with co-occurring needs, and their families and supporters
- provide a strength-based and trauma-informed approach to treatment, care and support
- support person-centred care within an operational, administrative and compliance framework
- engage in data-driven quality improvement process at all levels of each participating organisation
- engage in clinical practices consistent with the values and vision of each participating organisation
- consistently provide an environment that is welcoming, empathetic and hopeful.

Based on the implementation of the pilot to date, participating organisations shared some early learnings and insights about their work, including:

- Participating organisations consider that the CCISC model appears to work well in Victoria. They report that the CCISC model is **capable of flexibly supporting organisations** with different objectives and programs, from across different sectors, to work together using common tools and language. Participating organisations consider that, for the model to be successful, it should be built into policies, procedures, practice supports and funding models.
- Participating organisations noted that the pilot has demonstrated the **individual and collective capacity** of services from different sectors to **improve the delivery of integrated treatment, care and support**:
 - Through self-assessment, participating organisations have identified strengths and opportunities to improve their integrated care capability within existing resources.
 - All participating organisations report that the process has been energising which helps them maintain a strong desire to keep going (despite some initial concerns about the potential for the pilot to increase workload and burnout among workers).
 - Participating organisations are much more integrated care capable than they initially realised even where this is not recognised or supported via funding models, service descriptions and administrative arrangements. All participating organisations are now working to improve this within existing resources.
- Participating organisations highlight the value of the pilot in creating a **culture shift of new partnerships** within which workers, services and the Department of Health improve together to achieve a common vision. Participating organisations report they are learning that they need to work in partnership with the Department of Health, to ensure system processes and structures are set up to enable integrated treatment, care and support, including:
 - appropriate data systems to collect, report and measure progress
 - simple and flexible administrative arrangements to support integrated practice
 - true integrated teamwork that prioritises simplicity, rather than requiring people with co-occurring needs, families and supporters to engage with multiple workers, from multiple services operating under different funding arrangements.

While the change process is still in the early stages, participating organisations have valued the opportunity to work at all system levels to reform culture and practices. The Integrated Care Pilot has provided an important opportunity to translate familiar words into meaningful action and change.

The Integrated Care Pilot, once evaluated, will have important findings for future system design and best practice approaches for integrated treatment, care and support in Victoria.

5. Critical milestones

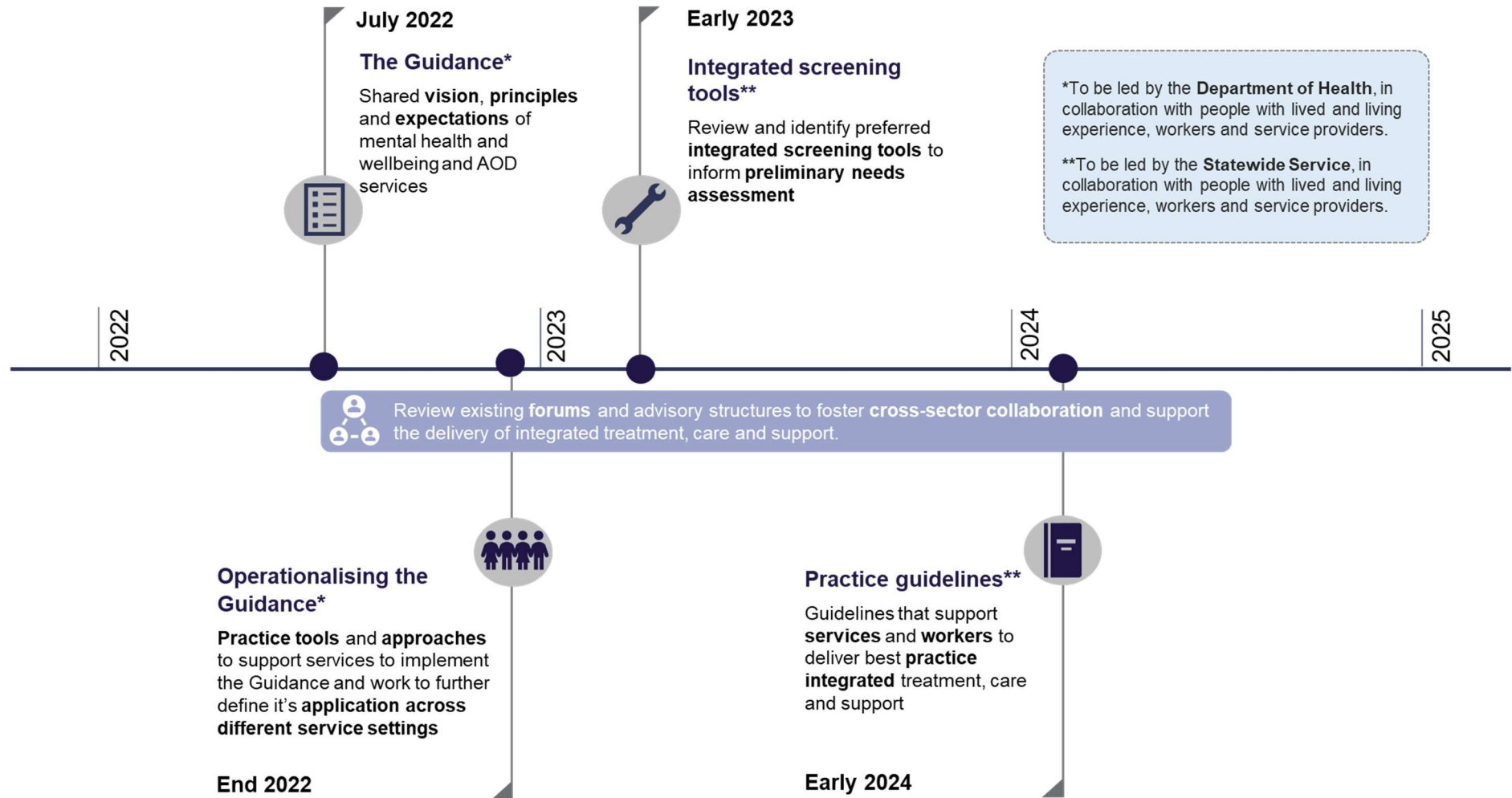
Achieving the best possible health and wellbeing outcomes for people with co-occurring needs and their families and supporters will take time and focus. While the Guidance represents an important milestone, it is only one step in the reform journey. As outlined in the Workplan, embedding the vision, principles and expectations of the Guidance is dependent on a range of interdependent system reform activities occurring over the coming months and years.

Figure 8 provides an overview of some critical milestones with indicative timelines, that will support mental health and wellbeing and AOD services on the journey to integrated practice. These activities will involve collaboration with people with lived and living experience, workers and service providers:

- by **end 2022**, the Department of Health will collaboratively lead work to **operationalise** the Guidance. This may include developing case studies on **best practice tools** and approaches for how services should configure themselves, and work to further define the **application of the Guidance in practice across different service settings**.
- by **early 2023**, the Statewide Service will collaboratively review existing tools and **identify a range of preferred integrated screening tools for use in different settings** that inform preliminary needs assessment, including the current intensity of a person's co-occurring needs. This will be supported by work in 2022 to develop consumer **vignettes** that aim to illustrate the intensity of people's needs and their treatment, care and support journey.
- in **early 2024**, the Statewide Service will collaboratively develop **practice guidelines** that will support services and workers to deliver best practice integrated treatment, care and support.

Alongside these activities, the Department of Health will continue to review existing forums and advisory structures to ensure the right governance, leadership and collaboration arrangements are in place to foster cross-sector collaboration and support the delivery of integrated treatment, care and support.

Figure 8: Critical milestones to support the delivery of integrated treatment, care and support



Appendices

A. Glossary

Language and words are powerful and have different meanings to different people. There are many words that people use to describe their experiences of mental health and the use of substances. The language used in this document aims to be inclusive and respectful, however it is acknowledged that not all people will identify with the terminology used.

Where possible, the language used in this document aligns with the terms adopted by the Royal Commission into Victoria's Mental Health System³¹ and preferred terms outlined in the *Power of Words: Having alcohol and other drug conversations: A practical guide*³² which aims to reduce stigma and improve health outcomes for people who use substances through welcoming and inclusive language. **Figure 9** provides a definition of key terms used throughout the Guidance.

Figure 9: Glossary of key terms used throughout the Guidance

Addiction	A medical term used to describe a condition where someone continues to engage in a behaviour despite experiencing negative consequences. ³³
Addiction specialists	Addiction specialists are medical doctors (both physicians and psychiatrists) who have advanced training in addiction, including drug and alcohol addiction.
Adult and Older Adult Area Mental Health and Wellbeing Services (Adult and Older Area Services)	Existing services that are being reformed to provide tertiary-level, high-intensity and complex support responses via multidisciplinary teams to people aged 26 years or older in both community and bed-based settings. The delivery of integrated treatment, care and support to people with co-occurring needs is a core function of all Adult and Older Adult Area Services. The Guidance applies when Adult and Older Adult Area Services are supporting people with co-occurring needs and their families and supporters.
AOD services	A collective term for all AOD services funded by the Victorian Department of Health and covered by the AOD Program Guidelines, including prevention, early intervention, harm reduction, treatment and ongoing support programs. ³⁴ This includes AOD services available to all Victorians, targeted services such as Aboriginal and youth services, and AOD services provided to people in the community as part of a court order. The Guidance applies when AOD services are supporting people with co-occurring needs and their families and supporters. ³⁵
Co-occurring needs	The term 'co-occurring needs' can be used to describe a range of different support needs that a person may experience at the same time. However, for the purposes of the Guidance, this term is used to refer to people who experience co-occurring mental illness (including people

³¹ Royal Commission into Victoria's Mental Health System Final Report, 2021, Volume 1, Glossary, pp.652-677.

³² The Power of Words: Having alcohol and other drug conversations: A practical guide, 2021.

³³ The Power of Words: Having alcohol and other drug conversations: A practical guide, 2021, p.4.

³⁴ Victorian AOD Program Guidelines, <<https://www.health.vic.gov.au/aod-service-standards-guidelines/alcohol-and-other-drug-program-guidelines>>

³⁵ AOD services are primarily responsible for supporting people with substance use or addiction needs and co-occurring low-to-moderate intensity mental health support needs, and their families and supporters.

	experiencing suicidal thoughts and behaviours) and substance use or addiction, with or without a formal diagnosis. This definition acknowledges the diversity of people's experiences with mental illness and alcohol and other drug use.
Discrimination	Discrimination refers to the prejudicial treatment of people based on their individual or collective characteristics.
Emergency department mental health and AOD hubs	Hubs located in emergency departments designed to support integrated responses to mental health, substance use and physical health needs. The hubs deliver integrated assessments, brief interventions, peer support, short-stay bed crisis services, referrals, post discharge planning and continuity of care. The Guidance applies when emergency department mental health and AOD hubs are supporting people with co-occurring needs and their families and supporters.
Family	Refers to family of origin and/or family of choice.
Harm reduction	Harm reduction empowers people to reduce the harms associated with substance use, without necessarily requiring a reduction in use. Harm reduction strategies support safer decision making about the use of substances, modify risk factors that can lead to AOD-related harm, and contribute to better health and wellbeing outcomes for individuals and the community. Harm reduction strategies may include (for example) safer consumption practices and overdose prevention and response and can be used by people with co-occurring needs as well as their families and supporters. While applicable in all contexts, harm reduction practice is a discipline of its own and may require referrals or secondary consultations as the need for specialisation increases.
Infant, Child and Youth Area Mental Health and Wellbeing Services	Reformed services that will provide tertiary-level, high-intensity and complex support responses via multidisciplinary teams to people aged 12–25 years (until a person's 26th birthday) in both community and bed-based settings. The delivery of integrated treatment, care and support to people with co-occurring needs is a core function of all Infant, Child and Youth Area Services. The Guidance applies when Infant, Child and Youth Area Services are supporting people with co-occurring needs and their families and supporters.
Integrated treatment, care and support	Treatment, care and support should be led by an individual's priorities, goals and preferences, empowering people with co-occurring needs, and their families and supporters, to achieve the outcomes that are important to them. Treatment, care and support is integrated if it: • offers a welcoming, hopeful, timely and coordinated response to a person's co-occurring mental illness and substance use or addiction, prioritising simplicity and continuity³⁶ for the person and their family and supporters

³⁶ Often this will mean a person with co-occurring needs prefers to engage with a single worker, single provider contact, and/or single program of treatment, care and support. If this is not preferred by the person, or not otherwise possible, multiple workers or service providers may be involved, operating under a shared care framework.

	provides choice and control for the person, offering simultaneous responses to both co-occurring needs as well as support for people who may not, at a given time, wish to engage with some or all available aspects of treatment, care and support.
Interim regional bodies	Through local engagement, interim regional bodies provide advice to the Department of Health as it plans, develops, coordinates, funds and monitors a range of mental health and wellbeing services in each region.
Local Adult and Older Adult Mental Health and Wellbeing Services (Local Adult and Older Adult Services)	New services that will deliver treatment, care and support to people aged 26 years or older. They will be delivered in a variety of settings where people first access services from the public mental health and wellbeing system and receive most of their treatment, care and support. The delivery of integrated treatment, care and support to people with co-occurring needs is a core function of all Local Adult and Older Adult Services. The Guidance applies when Local Adult and Older Adult Services are supporting people with co-occurring needs and their families and supporters.
Local Youth Mental Health and Wellbeing Services (Local Youth Services)	Services that will deliver treatment, care and support to people aged 12–25 years or older. The delivery of integrated treatment, care and support to people with co-occurring needs is a core function of all Local Youth Services. Headspace centres are currently fulfilling the role of Local Youth Services. Headspace centres are Commonwealth funded and commissioned by Primary Health Networks.
Mental health and wellbeing services	A collective term for the following mental health and wellbeing services funded by the Victorian Department of Health: - New Local Adult and Older Adult Mental Health and Wellbeing Services (Local Adult and Older Adult Services) - Reformed Adult and Older Adult Area Mental Health and Wellbeing Services (Adult and Older Adult Area Services) - Reformed Infant, Child and Youth Mental Health and Wellbeing Services (Infant, Child and Youth Area Services) - Suicide prevention and response services - Aboriginal social and emotional wellbeing teams - The new statewide service for people living with mental illness and substance use or addiction. This Guidance applies when mental health and wellbeing services are supporting people with co-occurring needs and their families and supporters.³⁷
Mental illness	Refers to a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory, as defined in the <i>Mental Health and Wellbeing Bill 2022</i> (Vic). ³⁸
No wrong door approach	A no wrong door approach provides people with appropriate treatment, care and support that is accessible from multiple points of entry. Both mental health and wellbeing and AOD services must welcome all people with co-occurring needs, and their families and supporters based on the philosophy of ‘how can we help?’ They must meaningfully and actively

³⁷ Mental health and wellbeing services are primarily responsible for supporting people with substance use or addiction needs and co-occurring moderate-to-highest intensity mental health support needs, and their families and supporters.

³⁸ *Mental Health and Wellbeing Bill 2022* (Vic), sec. 4

	respond to people's co-occurring needs using trauma-informed practices, either through direct service provision or supported referral processes.
Primary consultation	A consultation between a worker or multidisciplinary team and a person with co-occurring needs (as well as their families and supporters) that may be conducted in person or through teleconferencing or phone.
Primary care services	Highly accessible services where people can access treatment, care and support without a referral or meeting eligibility criteria. For example, GPs and allied health professionals, such as social workers or nurses.
Secondary consultation	Secondary consultation involves workers or multidisciplinary teams providing information, advice and expertise to another service provider about a person with co-occurring needs. Secondary consultation can be given either in relation to a specific person on a case by case basis, or as regularly scheduled group consultations/meetings in relation to multiple people with co-occurring needs and/or issues. Secondary consultation can occur in person or through teleconferencing or phone.
Secondary care services	Refers to services that people can only generally access through a referral from a GP, such as a psychologist or psychiatrist, providing treatment, care and support via fee-for-service, federal subsidies, health insurance or workplace programs.
Social and emotional wellbeing	The Aboriginal concept of social and emotional wellbeing is 'an inclusive term that enables concepts of mental health to be recognised as part of a holistic and interconnected Aboriginal view of health which embraces social, emotional, physical, cultural and spiritual dimensions of wellbeing.' ³⁹
Stigma	The World Health Organization defines stigma as a 'mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society.' ⁴⁰
Substance use	Substance use refers to the use of alcohol or other drugs. In some cases, substance use may become harmful to a person's health and wellbeing or can have other impacts on someone's life and/or that of their family and supporters.
Supported referral	A process that ensures the person understands the referral process, reassuring them before the first appointment, accompanying the person to the first appointment, talking to them about the experience afterwards and providing follow up support as required.
Supporter	Refers to the full range of relationships, social connections and supports that many people have in their lives.
Trauma-informed practices	Trauma-informed practices recognise the high prevalence of experiences of trauma among people who access mental health and wellbeing and AOD services and takes care to avoid practices or discussions that may trigger memories of previous experiences of trauma. ⁴¹
Treatment, care and support	This phrase is used to represent the different types of treatment, care and support that a person with co-occurring needs, and their families and supporters may require, depending on their goals, needs, strengths and preferences. This includes prevention, early intervention, harm reduction,

³⁹ Balit Murrup, Aboriginal social and emotional wellbeing framework, 2017-2027, 2017, p.10.

⁴⁰ Witness Statement of Associate Professor Nicola Reavley, 3 July 2019, para. 8; World Health Organization, The World Health Report 2001. Mental Health: New Understanding, New Hope, 2001, p. 16.

⁴¹ Victorian Department of Health, <<https://www.health.vic.gov.au/practice-and-service-quality/trauma-understanding-and-treating>>

	treatment (inclusive of wellbeing supports that focus on community connection and social wellbeing) and ongoing support. Treatment, care and support will be delivered in a range of ways and will be accessible to the diverse needs of people with co-occurring needs, and their families and supporters.
Wellbeing	The Better Health Channel defines wellbeing as, 'not just the absence of disease or illness. It's a complex combination of a person's physical, mental, emotional and social health factors. Wellbeing is strongly linked to happiness and life satisfaction. In short, wellbeing could be described as how you feel about yourself and your life.'⁴²
Worker	A collective term used to describe the diversity of workers, across different professions, disciplines, backgrounds and experiences, that provide integrated treatment, care and support to people with co-occurring needs and their families and supporters. This includes the lived and living experience workforces who utilise their lived or living experience, alongside discipline-specific training in service delivery and development. These workforces include lived and living experiences of mental illness or psychological distress and/or substance use or addiction⁴³ and lived or living experience as a family or supporter. Lived and living experience workforces may be employed in direct support roles such as peer support and education, individual and system advocacy, as well as indirect roles such as leadership, consultation, training, and research.

⁴² Better Health Channel, <<https://www.betterhealth.vic.gov.au/health/healthyliving/wellbeing>>

⁴³ This includes people who have current living experience of alcohol and drug use.

B. The Royal Commission into Victoria's Mental Health System

In March 2021, the final report of the Royal Commission was tabled in parliament. The report contains 65 recommendations, set over a 10-year reform vision, in addition to nine recommendations from the Royal Commission's interim report. The Victorian Government has committed to implementing these recommendations in full.

The Royal Commission's recommendations include specific reforms to improve outcomes for people with co-occurring needs and their families and supporters. These are described in **figure 10**.

Figure 10: The Royal Commission's recommendations to improve the outcomes of people with co-occurring needs, and their families and supporters

Recommendation 35	1. That the Victorian Government, by the end of 2022, in addition to ensuring there is at least one highest-level emergency department suitable for mental health and alcohol and other drug treatment in every region (refer to recommendations 3(3) and 8(3)(c)), ensure that all mental health and wellbeing services, across all age-based systems, including crisis services, community based services and bed-based services: a. provide integrated treatment, care and support to people living with mental illness and substance use or addiction; and b. do not exclude consumers living with substance use or addiction from accessing treatment, care and support.⁴⁴
Recommendation 36	1. That the Victorian Government establish a new statewide specialist service, built on the foundations established by the Victorian Dual Diagnosis Initiative, to: a. undertake dedicated research into mental illness and substance use or addiction; b. support education and training initiatives for a broad range of mental health and alcohol and other drug practitioners and clinicians; c. provide primary consultation to people living with mental illness and substance use or addiction who have complex support needs; and d. provide secondary consultation to mental health and wellbeing and alcohol and other drug practitioners and clinicians across both sectors. 2. That the Victorian Government, as a matter of priority, increase the number of addiction specialists (addiction medicine physicians and addiction psychiatrists) in Victoria. 3. That the Victorian Government, work with the Commonwealth Government to explore opportunities for funded addiction specialist trainee positions in Victoria.⁴⁵
Recommendation 8(3)(c)	a) That the Victorian Government improve emergency department's ability to respond to mental health crisis by: a. ensuring there is at least one highest-level emergency department suitable for mental health and alcohol and other drug treatment in each region.⁴⁶

⁴⁴ Royal Commission into Victoria's Mental Health System, Final Report, 2021, Volume 3, Chapter 22, p.283.

⁴⁵ Royal Commission into Victoria's Mental Health System, Final Report, 2021, Volume 3, Chapter 22, p.284.

⁴⁶ Royal Commission into Victoria's Mental Health System, Final Report, 2021, Volume 1, Chapter 9, p.505.

C: Future experiences of integrated treatment, care and support

The stories on the following pages are intended to bring to life the future experiences of people with co-occurring needs, and their families and supporters, in line with the principles and expectations outlined in the Guidance (**figure 11**). This series of brief illustrative stories are also available on the [Department of Health's website](https://www.health.vic.gov.au/mental-health-reform/recommendation-35) <<https://www.health.vic.gov.au/mental-health-reform/recommendation-35>>.

The stories below are fictional and do not represent the experiences of any one person. They illustrate the ideal future state, including references to new services that are being established and existing services that are being reformed, envisaged over a 10-year reform journey.

It is important to note that the final model of care and workforce composition will vary in each given service,⁴⁷ depending on the service setting and context, including local demand and need. Each person's needs, strengths and preferences are different and will require different treatment, care and support.

The descriptions do not illustrate the diversity or complexity of people's experiences, including for example the many barriers and challenges that people may face when attempting to access treatment, care and support. They are primarily focused on mental health and wellbeing and AOD services that are in scope of the Guidance, rather than broader universal and community services.

In the future, the Statewide Service, in collaboration with people with lived and living experience, workers and service providers, will build on these stories to develop consumer vignettes that will provide more practical and operational advice about the capabilities required of mental health and wellbeing and AOD services.

Please note that some of these stories contain content that may be distressing, including references to suicidal thoughts and behaviour. If you are distressed by any of the content in this document, the [Better Health Channel](https://www.betterhealth.vic.gov.au/timetotalkvic#where-to-get-help) has a list of services that are available to support you: <https://www.betterhealth.vic.gov.au/timetotalkvic#where-to-get-help>.

Figure 11: Future experiences of integrated treatment, care and support

Jarrah and his mother Keira's experience of integrated treatment, care and support

Main supports: Adult and Older Adult Area Service (with primary consultation from an addiction specialist), Local Service and a family carer-led centre

Jarrah is a 29-year-old Aboriginal man. Since he was a teenager, he has used illicit drugs in social contexts, usually a few days a month. In the past Jarrah has experienced frequent and prolonged periods of emotional distress, but he is not currently in touch with any services.

Recently Jarrah has been having thoughts that disturb him, including thoughts about harming himself. He's also started to see things that aren't there. This is causing him significant emotional distress and is interfering with his day-to-day life. Jarrah has also increased his use of illicit drugs from occasionally to daily. Using drugs provides Jarrah with some relief, but his daily use is also affecting his sleep and finances, and he feels ashamed that his drug use has increased so much.

Understanding needs, strengths and preferences

⁴⁷ In this context service refers to: Adult and Older Area Mental Health and Wellbeing Services (Area Services), Infant, Child and Youth Area Mental Health and Wellbeing Services (Infant, Child and Youth Area Services), Local Adult and Older Adult Services (Local Services), headspace (currently fulfilling the role of Local Youth Mental Health and Wellbeing Services), Alcohol and Other Drug (AOD) services, family carer-led centres and the Hospital Outreach Post-suicidal Engagement (HOPE) program.

Jarrah's mother, Keira, is very concerned about her son and worried he will harm himself. Keira's own social and emotional wellbeing is also being significantly affected. Jarrah and Keira seek advice through 13 YARN, who recommend they contact their Local Service for support. Together Jarrah and Keira walk into the Local Service and are connected with a support worker with lived experience, Nadine, to discuss Jarrah and Keira's situation and how they want to be supported.

Access to integrated treatment, care and support

Based on this discussion and an initial needs assessment, Nadine suggests that Jarrah may benefit from some support available from an Area Service. Nadine offers a supported referral option to Jarrah, which he accepts. Nadine helps Jarrah to organise an urgent appointment and accompanies Jarrah and Keira to their first appointment at the Area Service.

Nadine also works with Keira to understand her own social and emotional wellbeing needs and how she would like to be involved in Jarrah's treatment, care and support. Keira meets with a family-peer worker who has experience supporting family members with co-occurring needs. Hearing these similar experiences helps Keira to feel welcome and supported, and she is invited to a family-peer support group which provides her with relational support, as well as information and education. The family-peer support group also assists her to access the local family and carer-led centre. The centre provides brokerage funding to help her address her immediate practical needs. Nadine remains a point of contact for Keira, providing information about Jarrah's treatment, care and support (with Jarrah's consent). Nadine continues to regularly check in with Jarrah to ensure that Nadine's level of involvement reflects his preferences.

At the Area Service, Jarrah, with support from Keira, is asked about his needs, strengths and preferences. An Aboriginal Liaison Officer is also present to provide emotional, social and cultural support. Together the Area Service, Jarrah and Keira co-design a care plan, involving a short stay in a bed-based acute inpatient unit at the Area Service, followed by treatment, care and support in the community.

Experience of integrated treatment, care and support

While in the acute inpatient unit, Jarrah is supported by a culturally competent, multidisciplinary team, including an Aboriginal health worker and an addiction specialist. The multidisciplinary team works together to support Jarrah and better understand his feelings of emotional distress and his range of motivations for using substances, respecting his preferences around what goals he would like to achieve.

The addiction specialist supports Jarrah to safely withdraw, and he is prescribed new medication to help improve his mood stability and alleviate disturbing thoughts and visual hallucinations. The Aboriginal health worker supports Jarrah to develop new skills to manage stressful situations and navigate social settings where people may be using substances.

The addiction specialist also provides Jarrah with harm reduction advice to reduce the risk of overdose in case Jarrah uses drugs again after he has withdrawn. Jarrah mentions that he has witnessed accidental overdoses in the past, which he found confronting and distressing because he was unsure how to help. The Area Service organises a peer education session focused on preventing and responding to overdose, which Jarrah and Keira attend together.

After a few weeks, Jarrah's mood stabilises, and he is no longer seeing things that aren't there. Consistent with the goals in his care plan, Jarrah feels he is ready to leave the acute inpatient unit and agrees to continue to be supported by the Area Service for six months or so, with a view to eventually transitioning back to his Local Service for further treatment, care and support.

Jarrah continues accessing day support from the Area Service, focused on building his confidence to manage occasional unwelcome thoughts. His original support worker in the Local Service, Nadine, checks in regularly with Jarrah and, with support from Keira, they decide to organise a referral back to the Local Service after a few months. Jarrah and Keira are pleased with the outcome and feel supported throughout the process.

Through the Local Service, Jarrah is supported to access one-to-one culturally and trauma informed psychological therapy, where he reflects on his experiences and learns new techniques to manage painful memories and unwelcome thoughts about himself. He also checks in with Nadine about his drug use goals, using the skills he learned during his inpatient stay.

Health and wellbeing outcomes

After six months, Jarrah's social and emotional wellbeing improves, and his use of substances reduces to levels he is satisfied with. He continues to access psychological therapies and group-based recovery orientated programs facilitated by the Local Service. Jarrah's support worker, Nadine, continues to check in on him and Keira to see how they are going. Keira continues to attend meetings at the family-peer support group.

Ahmed and his parents Yasmin and Amir's experience of integrated treatment, care and support

Main supports: Infant, Child and Youth Area Service (with secondary consultation from an addiction specialist), with some support via a headspace centre

Ahmed is 16 years old. He and his family arrived in Australia ten years ago as refugees.

Ahmed is fluent in English; however, his parents Yasmin and Amir prefer to speak Arabic.

As a young child, the experience of fleeing his home country had a profound impact on Ahmed's mental health and wellbeing. To help him process the trauma associated with his migration experience, Ahmed has been engaged with his local headspace for almost three years.⁴⁸

Through headspace he has participated in a range of individual and group trauma-informed counselling sessions, including sessions that involve his parents Yasmin and Amir. Ahmed has occasionally used drugs in the past. While his local headspace has offered to connect him with an AOD worker, he has been reluctant to take up this referral, as substance use is common in his peer group, and he does not want to jeopardise his connection with his friends.

Over the last few months, Ahmed has started to experience increased and prolonged periods of significant distress. This has been accompanied by hearing voices – a new experience for Ahmed which he has found distressing. Ahmed has also increased his substance use and is now using drugs most days, and more often on his own. Ahmed does not feel well enough to go to school despite efforts from the school to engage Ahmed and his family. His parents, Yasmin and Amir, are concerned that he is becoming increasingly withdrawn and isolated.

Understanding needs, strengths and preferences

Yasmin and Amir offer to support Ahmed at this regular meeting with his headspace counsellor. With support from his parents, Ahmed opens up about how he is feeling, and together they agree that he may benefit from more intensive integrated support from an Infant, Child and Youth Area Service. Following an initial assessment, they discuss the benefits of a short stay in a Youth Prevention and Recovery Centre (YPARC) that may support Ahmed in this time of acute distress. Ahmed is apprehensive about staying outside the family home, but also relieved by the idea that his wellbeing could improve. The Infant, Child and Youth Area Service explains the types of supports available at the YPARC and the referral processes. Ahmed is comfortable in a mixed-gender service but notes that his parents may prefer to engage with female workers.

Access to integrated treatment, care and support

The Infant, Child and Youth Area Service accompanies Ahmed to his first appointment at the YPARC and provides a detailed handover to the YPARC team, including articulating his parents' preference to engage with female workers, so that Ahmed does not have to retell his story.

Ahmed asks for Yasmin and Amir to participate in his treatment, care and support planning at the YPARC. On Yasmin and Amir's request, the YPARC arranges for an interpreter to be part of the planning process. With the help of the interpreter, Yasmin and Amir share their concerns for their son, as well as the impacts on their own wellbeing. The YPARC provides them with family-specific supports to meet their own needs, including a family peer support worker and a group

⁴⁸ Filling the role of a Local Youth Mental Health and Wellbeing Service (Local Youth Service)

education program. The YPARC continues to check in with Yasmin and Amir to update them on Ahmed's progress and see how they are going.

Experience of integrated treatment, care and support

Ahmed stays at the YPARC for just over a month and is supported by a multidisciplinary team of workers, including workers who are skilled in trauma-informed care, and understand his migration experiences and the impacts on his mental health and wellbeing. An addiction specialist works with the YPARC treating team, improving the capability of the YPARC to meet Ahmed's co-occurring needs in an integrated way.

Throughout his stay at the YPARC, Ahmed accesses clinical supports, including medical oversight for mild withdrawal symptoms and a short course of medication to help reduce Ahmed's experiences of hearing unwelcome voices. He is also provided with wellbeing supports, including family therapy that involves his parents. The therapy sessions are led by a female worker with an interpreter present, helping Yasmin and Amir to feel safe to engage and contribute.

Ahmed is supported to work towards his goals to strengthen his relationships with his parents and friends, and his levels of distress and the voices he was hearing start to reduce in the YPARC. He also learns new skills to support his day-to-day life, including practical harm reduction strategies to reduce risks associated with substance use.

The YPARC works with Yasmin and Amir to help them prepare for Ahmed's transition home. His parents are looking forward to his return. With his discharge supports in place, Ahmed feels well enough to leave the YPARC and re-engage with school.

Health and wellbeing outcomes

Ahmed continues to receive ongoing support from a program offered via the Infant, Child and Youth Area Service which supports young people who have experienced early symptoms of psychosis. The Infant, Child and Youth Area Service also links Ahmed with a youth peer support group.

Over time, Ahmed makes new friends and establishes cultural connections with young people who have shared similar experiences. Yasmin and Amir remain connected with and continue to receive ongoing support from their family peer support worker, including relational support, boundary setting strategies and information and referral to culturally specific supports.

April and her brother Gary's experience of integrated treatment, care and support

Main supports: AOD services and suicide prevention and response supports, with some support via an emergency department

April is a 54 year old woman experiencing mental health challenges related to ongoing alcohol use. In times of distress April has suicidal thoughts. Living in regional Victoria means that April has limited services available in her local area and often must travel to access support. Recently, she has been drinking more heavily and feeling like her life isn't worth living.

Understanding needs, strengths and preferences

April's brother Gary is concerned and, when he goes to visit her, finds that April has attempted to take her own life.

April is treated at her local emergency department. While she has attended emergency several times before, she has not been offered follow up support and so has been reluctant to engage in ongoing treatment, care and support.

Access to integrated treatment, care and support

After leaving the emergency department, April is contacted within 24 hours by the Hospital Outreach Post-suicidal Engagement (HOPE) program. Initially she is hesitant to engage as she

does not want to spend time travelling to access support. However, when she realises that the program is available in her local area she agrees to participate.

Experience of integrated treatment, care and support

Through the HOPE program, April is connected with her key worker, Zoe, who remains a consistent point of contact and helps her to feel safe and supported. Over the next few months, the HOPE program works with April to provide individualised support that takes an integrated approach to her mental health, alcohol use and suicidal thoughts and behaviours. She learns new ways to identify and respond to changes in her mood and stressful situations. Together, with her brother Gary, April co-designs a safety plan that identifies key strategies to help her feel safe and supported when she is feeling distressed. Consistent with her goals, the HOPE program also supports April to find casual employment, which April feels has improved her sense of purpose.

While co-designing the safety plan, Gary expresses feelings of emotional distress associated with finding April after she attempted to take her own life. The HOPE program works with and provides individualised support to Gary, including trauma-informed counselling that helps him work through painful memories. Gary is also assisted to access local family peer support groups, where he speaks to people who have shared similar experiences and participates in a family focussed psychoeducational program.

In one of her regular meetings with her support worker Zoe, April shares her long-term goals around wanting to reduce her alcohol use. In partnership with April, Zoe arranges a supported referral to a local AOD service, providing a handover of information (with April's consent). At the AOD service, April is supported by a counsellor who empowers her to set goals about her alcohol use and mental health and wellbeing. She also joins a peer support group where she establishes new relationships and can give and receive practical and emotional support.

Health and wellbeing outcomes

With the help of her peers, and access to counselling through the AOD service which involves her brother Gary, April's use of alcohol reduces to levels that are in line with her goals. While April still has suicidal thoughts from time-to-time, she can draw on the skills she has learnt through the HOPE program and implement strategies from her safety plan. April and Gary's peer support groups continue to be a source of ongoing support.

Alex and their friend Kirsty's experience of integrated treatment, care and support

Main supports: AOD services (with secondary consultation from a Local Service), and some support via primary and secondary services

Alex is 46 years old and identifies as non-binary. They drink socially and use drugs occasionally. Two years ago, Alex had an accident at work and was prescribed medication to help manage the pain. While Alex's physical pain has improved, they still have traumatic memories of the accident and have continued to take their prescribed medication at increasingly higher-than-recommended doses. This is having a negative impact on Alex's daily functioning – they don't feel confident about re-entering the workforce and are finding it hard to engage in the social activities they used to enjoy.

Understanding needs, strengths and preferences

Alex is nervous about sharing their experiences with their general practitioner (GP) – they worry that they will be judged and refused prescription medications in the future. Instead, Alex reaches out to their friend Kirsty who reassures them and offers to come along to their GP appointment.

With Kirsty's support, Alex explains how they are feeling to their GP. Together they agree that Alex would benefit from a safe place to withdraw from their pain medication. Alex explains that they want to go to a service that will accept and respect their non-binary identity. Alex's GP contacts the local residential AOD withdrawal service to ensure it has gender neutral private

bedrooms and bathrooms, that there are peer workers at the service, and that staff have undertaken relevant training and accreditation to offer inclusive and respectful support.

Alex feels reassured and their GP provides a handover of information to the AOD withdrawal service. Alex is unable to access the withdrawal service immediately but is provided with some bridging support and continued care from their GP while they wait.

Access to integrated treatment, care and support

Kirsty comes along to Alex's initial discussion at the AOD withdrawal service. Alex is asked about the pronouns they use, and about their goals and preferences, which helps them feel safe, accepted and empowered. Together with their treating team and GP, Alex co-designs a treatment plan that addresses their mental health and substance use needs, with the aim of facilitating withdrawal and enabling Alex to work toward their long-term goals of reengaging in social activities and commencing retraining in a new industry.

The AOD withdrawal service suggests that Alex may benefit from a therapeutic day rehabilitation program run by an AOD service provider. After meeting a visiting case worker during their residential withdrawal stay, Alex agrees this could be a good next step, and they are looking forward to starting the program after completing withdrawal.

Experience of integrated treatment, care and support

Alex likes the day rehabilitation program workers, but a week after withdrawing, Alex starts to experience acute anxiety and finds it hard to talk about the accident in counselling and group sessions. Alex is concerned that things aren't getting better and tells their lead worker, Monica. Together they develop a plan which prioritises helping Alex to manage their anxiety before restarting talking therapy focused on trauma. Monica and her supervisor also consult with the Local Service, which supports them to co-design an after-hours safety plan with Alex. The Local Service also works with Monica via secondary consultation to jointly reflect and collaborate on a best-practice approach to trauma-informed treatment, care and support.

Health and wellbeing outcomes

After a few weeks, Alex has started to rebuild their confidence and is feeling well enough to engage in everyday activities and take some steps toward their goals. They complete the rehabilitation phase of the program and, with Alex's consent, Monica provides a handover of information back to Alex's GP. To help Alex continue to work towards their goals, their GP arranges a supported referral to a psychologist who is trained and accredited in supporting non-binary people, allowing Alex to continue their talking therapy.

Anh's experience of integrated treatment, care and support

Main supports: Local Service, with some support via primary care and AOD services

Anh is a 72 year-old woman who is experiencing significant levels of distress after the death of her sister, who she lived with. Anh has not previously been diagnosed with a mental illness; however, she has started to experience mood swings and is not feeling safe when she's on her own. Anh has also been using drugs for many years and doesn't want to modify her substance use.

Understanding needs, strengths and preferences

Anh has a good relationship with her GP, who also has a Vietnamese background and cares for many other people in Anh's community. Anh has never disclosed her drug use to her GP because she has never considered it a problem, and because of a fear of stigma if it somehow became known in her community.

Anh's GP asks her if she has a family member or friend who may be able to support her during this time. Anh explains that the loss of her sister has made her feel alone and isolated, and she doesn't feel like she has anyone to turn to. Anh's GP reassures her and offers to support her to

access care for her mental health via a Local Service. Anh agrees; however, she knows of people who have reported feeling judged for drug use by mental health and wellbeing services in the past. She is still concerned that if she mentions her substance use to the Local Service, she will be made to stop using substances or be judged for her choices.

Access to integrated treatment, care and support

At her initial support discussion with her Local Service, Anh is made to feel safe and welcome and is asked about her concerns and needs. Workers at the Local Service also explain that the service takes a health and wellbeing approach to substance use for all people. Anh feels safe and supported, but decides she wants to focus on her mental health and does not mention her drug use during her initial support and assessment discussions.

Experience of integrated treatment, care and support

The Local Service provides Anh with a suite of wellbeing supports and clinical therapies that assist her with the grief she feels after her sister's death and plan for her future housing needs. After forming a good connection with her support worker, Anh also chooses to disclose her substance use but explains that she does not wish to stop using substances.

Anh's lead worker does not judge her and respects her decision. While Anh already takes harm reduction measures when she uses drugs, together they agree that Anh may benefit from talking to someone who has shared similar experiences. Anh is linked with a harm reduction peer educator from the local Needle and Syringe Program who provides relational support through shared lived and living experience. This relationship helps her to feel comfortable and stay engaged.

Health and wellbeing outcomes

Over time, Anh feels that her mental health and wellbeing has improved, and she knows that she can return for further support at the Local Service at any time if needed – including if she feels that she needs support for her substance use. Anh continues to access ongoing support from the local Needle and Syringe Program. She also continues to receive occasional follow up from her support worker at the Local Service, who checks in with Anh on how she is going and if she needs further support.

A few months after discharge, Anh is contacted to become a member of the Local Service's consumer and family advisory group, which supports executive decision making for the service. By sharing her lived and living experience, Anh ensures the Local Service is meeting the needs and expectations of the communities it serves. Anh's participation in the group helps grow her social connections and sense of meaning after the loss of her sister.