

Summary: Integrated treatment, care and support guidance

Principles and expectations for mental health
and wellbeing and alcohol and other drug services


In Victoria, all people who experience co-occurring mental illness and substance use or addiction, and their families and supporters, are entitled to treatment, care and support that meets their needs in an integrated way.

Working in partnership with people with lived and living experience and service providers, the Department of Health has developed 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 (AOD) services*** (the Guidance).

The Guidance contains **11 expectations for service providers** – underpinned by **four principles** – to guide the delivery of integrated treatment, care and support.

The principles and expectations are summarised on page 3 and fully described on pages 4–8.

Summary of principles and expectations

Principles	Expectations
1. Inclusion 	A. Welcome people with co-occurring needs and their families and supporters B. Offer hope, respect and non-judgement
2. Access 	C. Ensure there are 'no wrong doors' and viable support pathways D. Maximise accessibility E. Ensure Aboriginal cultural safety and self-determination
3. Capability 	F. Meet both co-occurring needs G. Take a person-led approach H. Promote and support harm reduction I. Support and involve families and supporters J. Collaborate and learn
4. Participation 	K. Create meaningful participation and leadership opportunities

Service providers are expected to implement the principles and expectations when supporting people with co-occurring mental illness and substance use or addiction and their families and supporters. Services are encouraged to consider **identifying leaders** to drive change and build collective ownership and responsibility for integrated practice, **incorporating the principles and expectations** into existing policies, plans, models of care and processes, and developing **staged implementation plans** by which programs and services become more integrated care capable, aligned with the principles and expectations of the Guidance.

The Guidance, which provides more information and context about Victoria's approach to integrated treatment, care and support, 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>>.

Principles and expectations of mental health and wellbeing and AOD services

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: 'people with co-occurring needs' refers to people experiencing co-occurring mental illness and substance use or addiction.

Principles	<h2>1. Inclusion</h2> <p>All mental health and wellbeing and AOD services welcome people with co-occurring needs, and their families and supporters</p> 
Shared understanding	<p>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.</p> <p>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).</p> <p>Building and maintaining trust and engagement requires a compassionate, empathetic service response that is relationally-based and fosters hope.</p>
Expectations	<h3>A. Welcome people with co-occurring needs and their families and supporters</h3> <p>Take every opportunity to ensure they feel and are safe, and feel accepted and free to be themselves.</p> <h3>B. Offer hope, respect and non-judgement</h3> <p>Do not judge people for:</p> <ul style="list-style-type: none"> • 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 <p>... or for any related harm or consequence (including contact with the criminal justice system).</p> <p>Establish a sense of safety, connection and trust and inspire hope in the possibility for positive change.</p> <p>Proactively and systematically address stigmatising language and practices across all aspects of service delivery.</p>

Principles	<h2>2. Access</h2> <p>People with co-occurring needs, and their families and supporters, have equitable access to treatment, care and support</p> 
Shared understanding	<p>Co-occurring needs are common (the 'expectation, not the exception'¹ for service providers) and should be anticipated as part of core business.</p> <p>A person's co-occurring needs should not exclude them from access to treatment, care and support.</p> <p>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:</p> <ul style="list-style-type: none"> • 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.² <p>People with co-occurring needs may also have a range of other needs alongside their mental illness and substance use or addiction.</p>
Expectations	<h3>C. Ensure there are 'no wrong doors'³ and viable support pathways</h3> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <h3>D. Maximise accessibility</h3> <p>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.</p> <p>Welcome all people and support them as a whole person with unique, often intersecting experiences and needs.</p> <h3>E. Ensure Aboriginal cultural safety and self-determination</h3> <p>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.</p>

1 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.

2 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).

3 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 respond to people's co-occurring needs using trauma-informed practices, either through direct service provision or supported referral processes.

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 supports⁴

Mental health and substance use can influence each other.⁵ 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.⁶

Treatment, care and support that addresses both mental illness and substance use or addiction in an integrated way can offer benefits for 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.

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 wellbeing⁷
- provided via a diversity of delivery modes and disciplines, including lived and living experience workforces.

4 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.

5 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.

6 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.

7 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, *Balit Murrup*, Aboriginal social and emotional wellbeing framework, 2017–2027, 2017, p. 10.

3. Capability

Expectations

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.⁸

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.⁹

⁸ The Victorian Office of the Chief Psychiatrist publishes the *Working together with families and carers* guideline <<https://www.health.vic.gov.au/key-staff/working-together-with-families-and-carers>>. 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.

⁹ See section 5 of the Guidance for further information on opportunities for cross-sector collaboration, 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>>.

Principles	<h2>4. Participation</h2> <p>People with co-occurring needs and their families and supporters are empowered to influence and improve the services that work to support them</p> 
Shared understanding	<p>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.</p> <p>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.</p> <p>People’s individual circumstances and experiences of stigma, shame, trauma and/or criminalisation may impact their ability to meaningfully engage and participate.</p>
Expectations	<h3>K. Create meaningful participation and leadership opportunities</h3> <p>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.</p> <p>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.</p> <p>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.</p>

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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's website <https://www.health.vic.gov.au/mental-health-reform/recommendation-35>](https://www.health.vic.gov.au/mental-health-reform/recommendation-35)