Synthesis and Insights Report

Statewide Centre for Addiction and Mental Health Consultation

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Monash University Design Health Collab and Turning Point acknowledge the First Nations peoples of Australia, the traditional custodians of the lands on which this research was conducted. We pay our respects to ancestors and Elders, past, present and emerging.

Monash University Design Health Collab and Turning Point are committed to honouring First Nations peoples' unique cultural and spiritual relationships to the land, waters and seas and their rich contribution to health and wellbeing.

Our respect also extends to all Traditional Custodians of the lands, waters, animals, forest and skies where this report is read, and we are grateful for the cultural wisdom that may teach us in guiding our shared health futures.

We extend this acknowledgement to people with lived and living experience of co-occurring mental illness, addiction and their recovery journey. We also acknowledge the experience of people who have been carers, families, or supporters. We recognise their vital contribution to this research, and value the courage of those who shared their unique perspectives for the purpose of this project.

"Statewide Centre for Addiction and Mental Health Consultation: Synthesis and Insights Report"

Completed by Monash University Design Health Collab, in collaboration with Turning Point.

Design Health Collab
Design Health Collab uses a people-centred design approach to understand and activate significant, high-impact healthcare services and products in the world.

Read more about the Monash Design Health Collab work and research at monash.edu/mada/research/labs/health-collab.

Turning Point
Turning Point is an Australian addiction research and education centre that provides treatment for people adversely affected by alcohol, drugs and gambling.

Read more about Turning Point's work at turningpoint.org.au/.

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A note on content

This research acknowledges the strength of people living with co-occurring mental illness and addiction, their families, carers, supports and the staff who care for them. We thank the people who have contributed their lived and living experience to this research.

This report contains information that could be distressing. The report explores and discusses aspects of mental health and addiction that includes substance use and addiction to alcohol and other drugs, trauma, sexual assault and harassment and complex clinical mental health presentations that include suicide and psychosis. These discussions are important to ensure that integrated care service delivery meets the diverse needs of the Victorian community. You may want to consider how and when you read this report. Please read with care.

If you are upset by the content of this report, or if you or a loved one need support, the following services are available to support you:

- For crisis support, contact **Lifeline** on 13 11 14.
- **Beyond Blue** on 1300 224 636
- **National Suicide Callback Service** on 1300 659 467 or visit their website suicidecallbackservice.org.au/
- For alcohol and other drug support contact the **National Alcohol & Drug Hotline** 1800 250 015
- For assistance in an emergency or life-threatening situation, contact emergency services immediately on Triple Zero (000).

Executive Summary

Between 70–90% of people living with addiction also experience co-occurring mental illness. The complexity of this cohort's presentations is compounded by the difficulty they experience having to navigate alcohol and other drug (AOD) and mental health services across multiple, fragmented service systems. To fix this broken system and provide people living with substance use or addiction and mental illness the high-quality integrated treatment they need and deserve, the Royal Commission into Victoria's Mental Health System recommended that all mental health and wellbeing services provide integrated treatment, care and support to people living with mental illness and substance use or addiction so that they do not exclude individuals living with substance use or addiction from accessing treatment. The Royal Commission also recommended the establishment of a new Statewide specialist service to support this work. The Victorian Government appointed Turning Point as the Statewide Service Lead in March 2022, which will provide primary consultation for consumers, secondary consultation, education and training for health practitioners, and interdisciplinary research.

This report outlines two sets of interrelated online co-design workshops conducted by Monash University's Design Health Collab, in collaboration with Turning Point, to support their work in the establishment of the Statewide Centre. These workshops brought together more than forty stakeholders from across Victoria, that included mental health practitioners, Alcohol and other drug (AOD) practitioners, clinical leaders, peer workers and lived experience advocates to discuss the design of a best practice model of integrated care to support individuals with co-occurring mental illness and addiction. This research and the contributions of participants, will support the Statewide Centre as they work toward developing a best practice model of integrated care for people with co-occurring substance use or addiction and mental illness.

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1.1 Background context

1.1 Background context

Between 70–90% of people living with addiction also experience co-occurring mental illness. The complexity of this cohort's presentations is compounded by the difficulty they experience having to navigate alcohol and other drug (AOD) and mental health services across their multiple, fragmented service systems. The Victorian Dual Diagnosis Initiative (VDDI) was established in 2002 to support this vulnerable cohort, but philosophical differences between mental health and AOD practitioners, the absence of a shared understanding of integrated care, limited key performance measures or monitoring, a governance structure lacking accountability, and a lack of coordination between services, have meant that in two decades the VDDI has yet to make any significant inroads. As a result, people with co-occurring addiction and mental illness are often bounced between services and receive suboptimal care.

To fix this broken system, the Royal Commission into Victoria's Mental Health System recommended that all mental health and wellbeing services provide high quality integrated treatment, care and support to people living with mental illness and substance use or addiction, The Royal Commission also recommended the establishment of a new Statewide Centre to support this work (State of Victoria 2021, p72). The Statewide Centre's functions are primary consultation for consumers, secondary consultation, education and training for health practitioners, and interdisciplinary research.

The Victorian Government appointed Turning Point as the Statewide Service Lead in March 2022. This report outlines a synthesis of findings from the co-design workshops and stakeholder consultation that was facilitated by Monash University's Design Health Collab that brought together community AOD services, Local and Area Mental Health and Wellbeing Services, and new tertiary Addiction Services.

2 Methodology

2.1 Overview

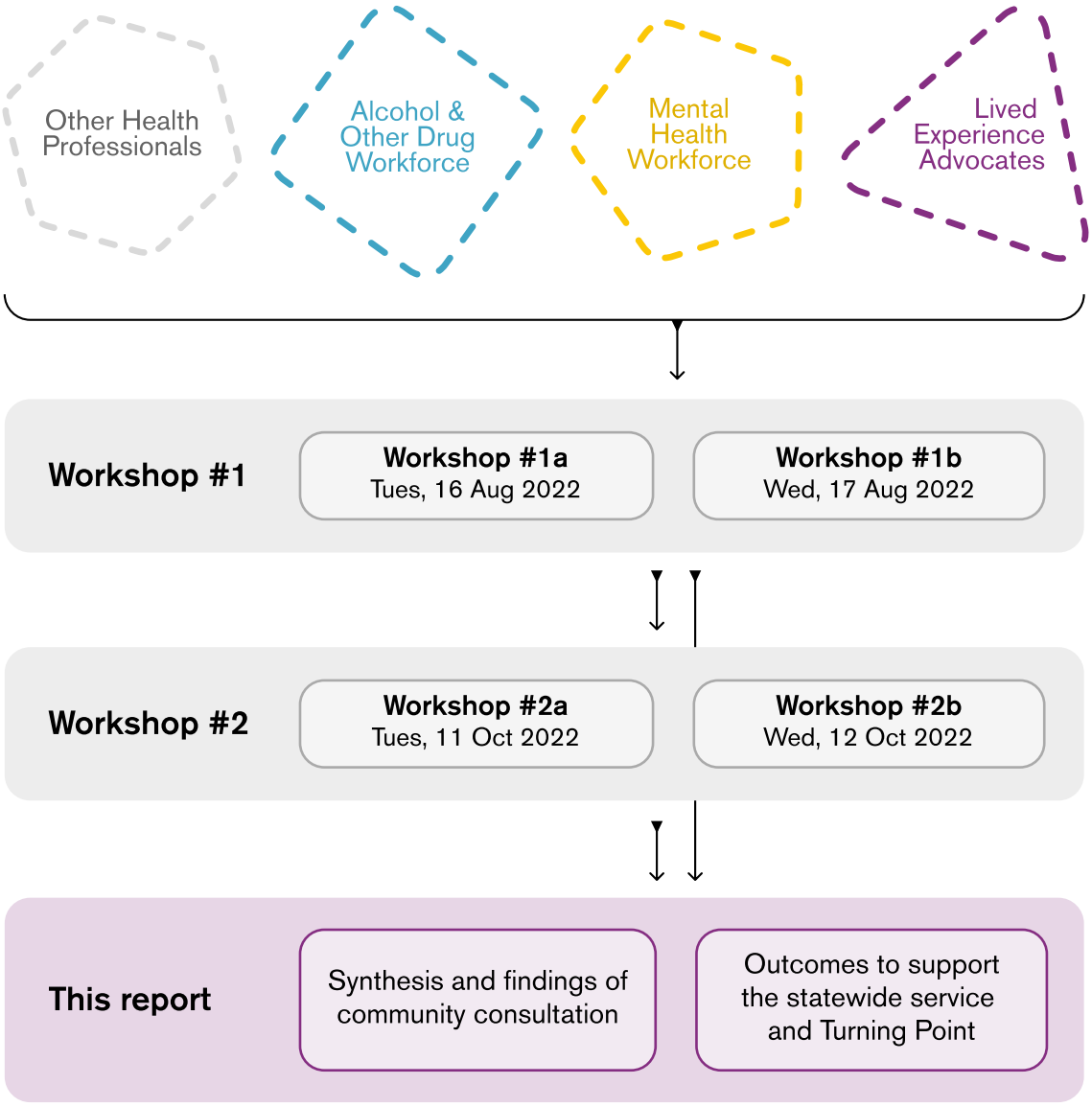

Figure 1 Diagram to illustrate the two sets of workshops that were conducted with AOD, MH workforces, lived experience advocates and other health professionals that led to the findings described in this report.

This report outlines two sets of interrelated online co-design workshops conducted by Monash University's Design Health Collab, in collaboration with Turning Point. These workshops brought together more than forty stakeholders from across Victoria that included mental health practitioners, alcohol and other drug (AOD) practitioners, clinical leaders, peer workers and lived experience advocates to discuss the design of a best practice model of integrated care to support individuals with co-occurring mental illness and addiction. Both sets of workshops were anchored upon four persona users that aimed to represent some of the different individuals who might seek help for co-occurring mental illness and addiction.

The workshop activities and these four personas were crafted in collaboration between Monash researchers and Turning Point, utilising client-facing clinical experience. These personas build upon fictional stories developed previously, as detailed in the summaries published following the Royal Commission (State of Victoria, 2022 p39). The personas used in this research were:

- **Mary:** (She/Her) a young Sudanese woman living in public housing in Flemington, Victoria who has a history of using multiple substances. Mary is receiving treatment for her psychotic symptoms and post-traumatic stress disorder.
- **Johan:** (He/Him) an unemployed and homeless 42-year-old man who is addicted to heroin and is experiencing suicidal thoughts. Johan seeks support for the first time at Pakenham, Victoria.
- **April:** (She/Her) a 54-year-old woman living in Euroa, Victoria and experiencing suicidal thoughts. April is using alcohol to manage her intense emotions.
- **Jarrah:** (He/Him) a single, unemployed 29-year-old First Nations Australian man living in Morwell, Victoria and experiencing anxiety and using cannabis to manage his negative emotions. Jarrah has never sought professional mental health services previously.

2.2 Tactile Tools

Both sets of workshops used the Tactile Tools digital workshop method, which was adapted by researchers from the Monash Design Health Collab as a collaborative process to gather input from workshop participants in relation to how integrated care should be experienced and delivered in the future. The Tactile Tools design thinking method has been used with over 450 experts from healthcare, education, engineering and the public service to collaboratively iterate solutions to complex problems. The approach excels at helping interdisciplinary teams find common ground and build cross-sector relationships (Heiss and Kokshagina, 2021; Heiss, Bush and Foley, 2020; Heiss et al., 2021).

Workshop participants used video conference software Zoom and Miro, a digital whiteboard tool, during the two workshops. Participants were organised into small groups that included a mix of stakeholders with a diversity of lived experiences and professional backgrounds. Each group then completed a series of activities on Miro ‘boards’ that were anchored upon four persona users that aimed to represent some of the individuals who would seek integrated care services in the future. The Miro boards and associated activities aim to scaffold a focussed conversation on an aspect of integrated care, using prompts that were co-developed between Monash Design Health Collab and Turning Point.

Following the workshops, researchers from Monash Design Health Collab synthesised the conversations that emerged to help inform the ongoing development of a best practice model of integrated care. This model aims to improve the health and wellbeing of people with co-occurring addiction and mental illness.

2.3 Workshop #1 activities

In the first set of workshops in August 2022, participants discussed integrated care for co-occurring mental illness and addiction through the experience of their persona user, who aimed to represent a group of people seeking care in the existing system. Participants were asked to discuss how this user and their story could be improved to better reflect the complexity of their experience and care journey. Participants then explored the experience of their persona and integrated care in relation to the principles of inclusion and access as detailed in Recommendation 35 of the Victorian Royal Commission into Mental Health (State of Victoria, 2021, p 71).

The activities in the first workshop ran for approximately 90 minutes and were focussed around three activities:

1. The **first** Miro activity asked participants to deeply engage with the Persona user and interrogate whether the story that was presented was realistic based on the lived experience of participants, as well as an exploration into the hopes, fears and needs that persona may have.
2. The **second** Miro activity asked participants to discuss how integrated care could be provided inclusively, focussing on the specific experience of their persona. Participants specifically focussed on how individuals should be 'welcomed' in an ideal state model of integrated care, how their families or supporters should be included, as well as the attributes of high quality integrated care.
3. The **third** activity focussed on how the individual persona and their families and chosen supporters might access integrated care, and how individuals with co-occurring addiction and mental illness might have equitable access to treatment, care and support. During this activity, entry points to the future integrated service system were discussed, including what can be done to maximise accessibility. Specific attention was also paid towards considerations for cultural safety and health inequalities.

Following these activities, participants then returned to the larger group and shared back a high level summary of the key takeaways that emerged from the work.

2.4 Workshop #2 activities

In the second set of workshops in October 2022, participants discussed the principle of capability as detailed in the Royal Commission recommendation (State of Victoria, 2021, p71), as well as the many interrelated barriers and opportunities of integrated care delivery. Participants then highlighted the necessary learning, knowledge, skills and training needed of the existing MH and AOD workforce to enable integrated care delivery in the future, as well as the change process required to shift organisational culture.

This workshop introduced two new characters into the care journey as archetypes to focus conversation on the mental health and AOD workforce. While fictional, these

characters aimed to provide a scaffolding for participants to focus their ideas and conversations at the level of person-to-person interaction. These characters were:

- **Kish:** (They/Them) is a mental health clinician. They have worked across a range of mental health settings, including a forensic mental health inpatient unit and as a case manager in a metropolitan Area Mental Health service.
- **Ben:** (He/Him) is an alcohol and other drug clinician. He has previously worked on an alcohol and drug helpline (Directline), and as an intake clinician in a counselling service.

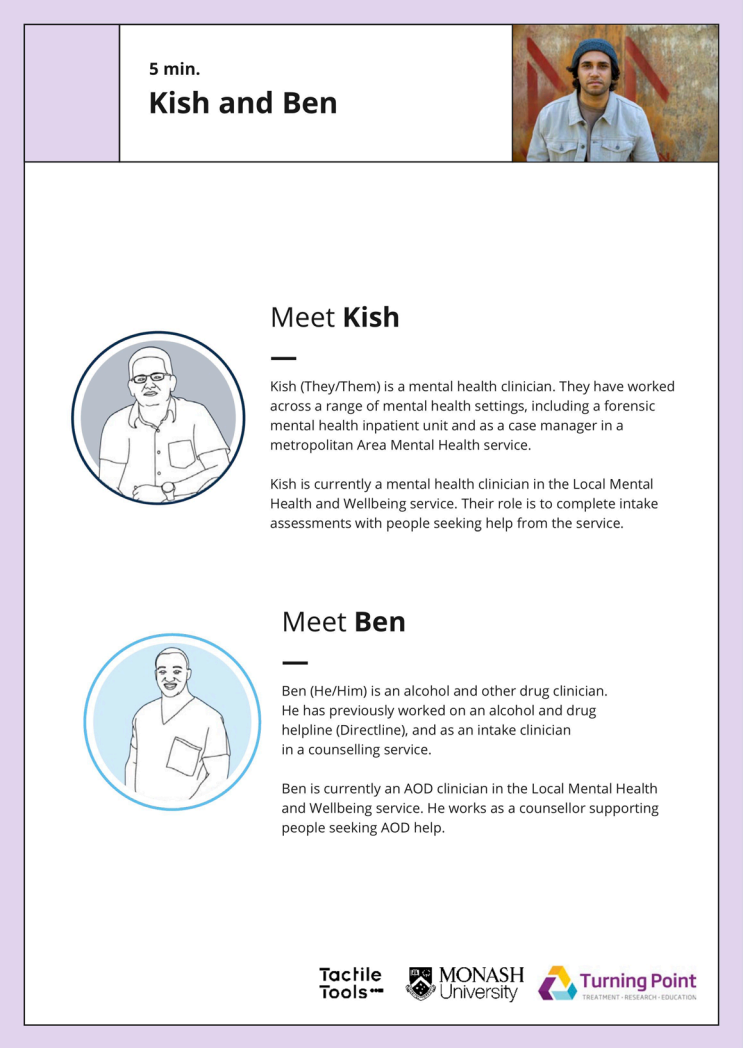

Figure 2 A screenshot of the stories provided to give context to the Kish and Ben characters, focussed on the experience of the Jarrah persona.

The stories for Kish and Ben were slightly altered for each workshop group, based on the persona that group was working with, in order to maintain narrative consistency. In all stories provided to participants, Kish represented part of the mental health workforce, and Ben represented part of the AOD workforce. The full set of stories for Kish and Ben that were provided to participants are visible in the blank Miro activities that are attached to this report as Appendix B.

The activities in the second workshop ran for approximately two hours and were focussed around five activities:

- The **first** activity asked participants to discuss capability in relation to integrated care, as presented in Recommendation 35 of the Mental Health Royal commission. Participants discussed if it was likely AOD and MH practitioners had a shared understanding of integrated care, what integrated care delivery looks like, and how the two workforce groups collaborate.
- In the **second** activity, participants then discussed the enablers and barriers to integrated care in respect to the people, systems, processes, and organisations that make providing integrated care possible. Specific attention was given to what makes things hard for Kish and Ben, what should happen when someone is referred to another service, as well as what helps integrated care systems operate smoothly.
- The **third** activity then focussed on the knowledge, skills and learning needs of the AOD and mental health workforces involved in integrated care delivery. While this activity focussed on Kish and Ben specifically, the discussion had by participants examined what learning is required of the two workforces generally, as well as what learning is needed for all stakeholders involved in integrated care.
- The **fourth** activity addressed the future of workforce training to support integrated care delivery, focussing on what support is needed for AOD and MH workforces to continually develop their skills across their careers.
- The **fifth** activity focussed on the process of organisational change and change management. This activity identified what service providers and organisations needed to do to ensure that integrated care is part of their core business, and what behaviours, attitudes and mindsets needed to change across sectors to enable integrated care delivery.

Following these activities, participants then returned to the larger group and shared back a high level summary of the key takeaways that emerged during the workshop.

2.5 Approach to synthesis

Following the workshops, researchers from Monash Design Health Collab conducted a qualitative thematic analysis and coding of the data collected through these workshops using Nvivo. Thematic analysis is a flexible method of data analysis, used in this research to synthesise workshop data and to provide actionable design insights that will inform operations of the Statewide Centre. Multiple groups across both sets of workshops enabled researchers to validate findings through a process of qualitative triangulation (Patton 1999 in Carter et al. 2014), where findings are supported by topics, ideas or themes that were repeatedly raised by participants across separate workshop groups. Recurrent findings are presented in this report, alongside summaries that capture the direct responses from participants during each activity.

The following section provides an overview of the major themes that emerged across both sets of workshops. Each of these key themes will be introduced and then followed by an examination of important sub themes.

3 Themes and insights

Major themes that were recurrent across both sets of workshops and multiple groups are first detailed in this section, before drilling down on specific elements and trends. Some of these themes focus on the AOD and MH system itself, while others reflect on individual experiences across peer support workers and lived experience advocates, as well as healthcare providers at the frontlines of providing AOD and MH care. Others include how people can be supported to navigate the system, and the importance of community and resourcing to support integrated care delivery.

The **major themes** generated by this research include:

1. Understanding integrated care
2. Understanding client needs
3. Barriers, caps, & limitations to integrated care
4. Enablers of integrated care
5. Training & education requirements
6. Change management & organisational culture

The following section presents brief summaries as well as the themes that emerged during each workshop activity.

3.1 A lack of integrated care understanding

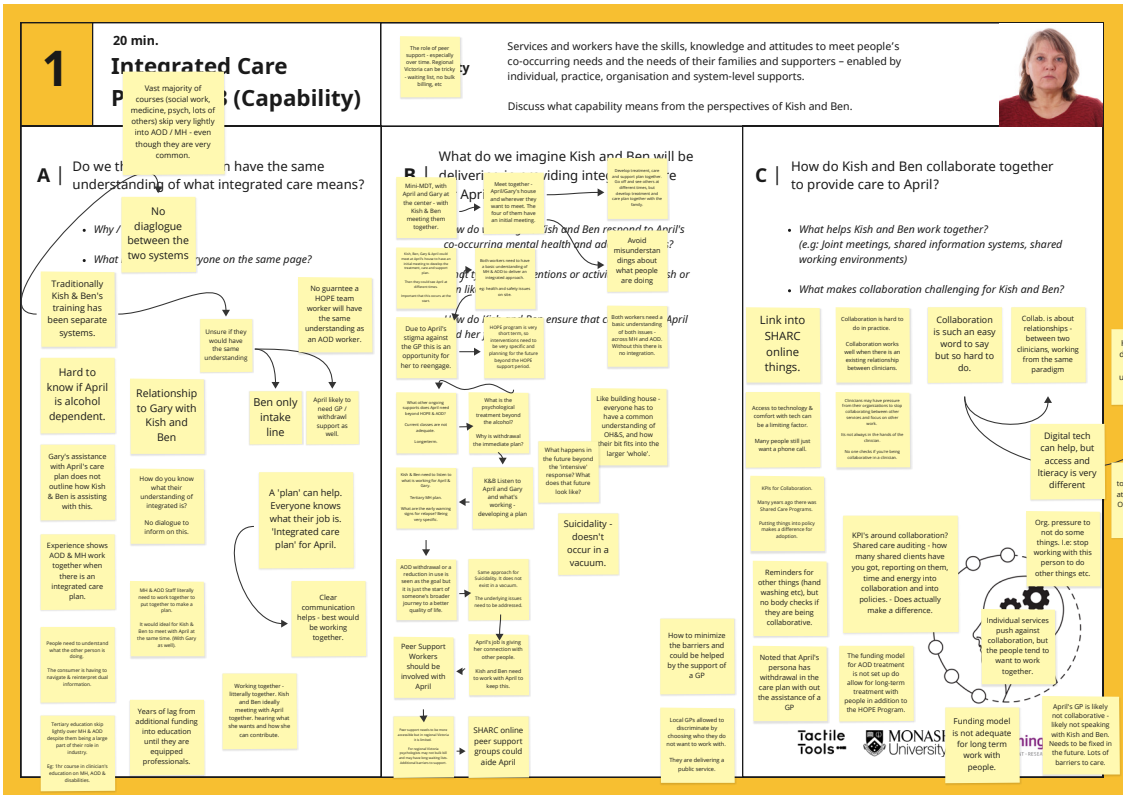

Figure 3 A screenshot of Activity #1 from Workshop #2, focussed on the experience of the April persona.

This research surfaced that there is a lack of shared meaning as to what 'integrated' care in practice means at individual, service, organisational and institutional levels. Contributions to this research called out the tension between collaborative and integrated care, and the need for all stakeholders, from frontline service providers to government departments, to be integrated in their thinking. This misunderstanding across healthcare silos can lead to a lack of clarity of roles and responsibilities, the duplication of service provision, and the absence of a shared vision of what success looks like for each individual client. To enable such a shared understanding of what integrated care is, additional work needs to be conducted to ensure that everyone is working from "the same page of the book".

While it was difficult to ascertain a common definition of 'integrated care' across the project, research participants recurrently described it as requiring shared values. As an AOD clinician articulated, "enabling integrated care is being able to have those shared values at the outset", where the values that underpin integrated care are understood by all those involved. Not having such shared values about what care should be can cause clients to fall through gaps as they transition across providers. As a psychiatrist articulated in regards to the Mary persona as they transition across services:

> *The gaps in services are what are more worrisome for me. I mean when you ask what's missing, I think, there are so many services and we appear to be good at, you know, making a plan for Mary to meet 200 people when she leaves the hospital.*

[...] which is exactly what I feel is happening here and which we have been doing very well for the past 20 years in Victorian mental health services is to make it somebody else's problem. I think that integration is what is missing for me in that scenario.
– Psychiatrist, Workshop #1

Beyond the individual level, there is a need to create aligned values at the organisational level. As a Dual Diagnosis clinician pointed out "[...] these [integrated care] principles are important. This needs to be in their position descriptions, that it is expected that they will provide a certain kind of care, the vision and mission statements of the organisation need to reflect this". Understanding what 'values' underpin integrated care at an organisational level is important to create alignment across the whole organisation - which enables genuine integration at the level where care is actually provided.

3.1.1 Collaborative vs integrated Care

Participants highlighted the important, yet misunderstood terms of collaborative and integrated care are often conflated across both mental health and AOD sectors. Genuine integration of care teams - shared visits, sharing of case notes, and multidisciplinary decision making - only tends to happen in moments of extreme acuity or within inpatient settings. Outside of these acute settings, integrated care only happens when a patient is in a critical state, or the prognosis of that client is poor.

It takes that level of acuity and threat for the two systems to come together in general, and it takes a lot of work. You know, if you are managing a caseload of 35 to 40 people, it takes a lot of time, effort, coordination to ring up an AOD worker or ring up a mental health worker and organise a time to discuss, you know, or if there's more than two workers involved, even more effort, you know [...] And most often that is the most viable response given the restrictions on the limitations of our workforce and its capabilities and the numbers, particularly in a regional area like Euroa or where that's not possible. The two workers collaborate on one treatment thing, develop collaboratively with the person. That's a clear achievable definition of integrated treatment. [...] you really need a clear, achievable definition of integrated treatment for AOD and mental health workers to come around together, and most often it's not gonna be collaboration between the sectors. Everyone thinks, you know that's great. It's most often not achievable.
– Dual Diagnosis Clinician, Workshop #2

In regards to a shared language and definitions of key terminology, a Mental Health provider articulated:

Mental health and [AOD] are very different beasts. So, you know the language, the terminology, even down to what a mental health service might call an assessment and we call an intake. You know, I'm noticing that with our work, trying to work closely with our mental health team at [Regional Victoria] community health is just around, somebody says, well, I've done an assessment and I look at it and go, well, no, that's just an intake or, you know, vice versa. So there's lots to like work out and work on so that we understand each other.
– AOD Practitioner, Workshop #1

Despite the logistical hurdles, participants highlighted that the coming together of care teams was both beneficial for patients and providers alike.

> *I do find the meetings, the multidisciplinary meetings, different clinicians, very helpful. Because there you have the opportunity to speak about what the next step is and what the plan is, and everybody makes decisions together. It's very clear, and one can do quite good planning in those meetings, and then somebody can be nominated to have that discussion with the patient and their family, just in terms of effective handovers and, you know, planning for the next step in their care. I find the case conference is really helpful in the clinical meetings.*
> *– Psychiatrist, Workshop #1*

The focus on collaborating with other healthcare providers - rather than working with them directly - is perhaps most evident with examples provided by participants that suggest that care is too centralised at present. Some stories provided by participants included clients who walk into a hospital but are then sent to another provider via a phone call. As a mental health nurse articulated: "hey I need help' and we go, 'here's a number and they'll organise three appointments for you, and three months down the line you'll do an assessment and then maybe come back to us one day". As an AOD nurse suggested in regards to intake at an Emergency Department:

> *What they've really done is had to create a resource to fix the problem with access. So they've had to create a resource to help the client navigate how to get in. So we've got this idea of no wrong door, but actually there is only one door now.*
> *– AOD Nurse, Workshop #1*

To move beyond just collaborative care - which involves a client seeing different providers - genuine integration requires sharing of expertise, resources, information, clinical notes and approaches across providers, and the alignment of values about what integration is. This sharing should be underpinned by professional relationships, where different service providers regularly speak, are in contact, and work together. As an AOD clinician articulated: *"Just ensuring that they have shared everything. And you have got shared information systems [...], And I think that's probably something really important that helps collaboration, is that everybody's reading from the same book."* As a Dual Diagnosis clinician underscored: *"But when we're talking about integrated care, the second you send someone to another organisation with another data system with, you know, an emailed referral, you can start forgetting about anything that you can really call integration."*

Clients shouldn't feel as if they are 'being bounced' around or are in care silos. Instead, clients should feel that providers are united in supporting their overall health and recovery. Participants suggested that shared assessment or intake templates - that encourage providers to document the story of their clients in their own words, along with their hopes and fears - may improve the handover experience when a client needs support from other providers. Ideally, this information should be accessible through a central database - such as MyHealthRecord. Participants continually highlighted the barriers presented by multiple or overlapping recording systems.

3.1.2 Distinctions between mental health and AOD addiction services

A lack of shared understanding of what integrated care means across AOD and MH workforces presents a significant challenge to genuine integration. Both workforces lack a shared language, with different definitions of the same concepts (e.g: entry vs. intake), or understanding of the entire patient journey across their lifecourse. For example, some participants suggested that from the point of view of an AOD practitioner, getting through withdrawal is just the start of recovery, while mental health providers can sometimes see this as the end of the recovery journey. Beyond terminology, there is also a lack of knowledge across MH and AOD service providers, with MH and AOD providers not necessarily having a basic knowledge of the other, and vice versa. As a Dual Diagnosis clinician articulated:

> *There's broader issues here about the AOD worker's understanding of integrated treatment and mental health worker's understanding of what constitutes integrated treatment. As strong as it is, you know, the recent guidelines with the definition they proposed of integrated treatment, I don't think it does a lot to shed light there. You know, there's background issues. If you work in mental health and you work in AOD, people with both issues are highly prevalent, you know, nearly everybody who comes through the door of mental health and nearly everybody who comes through the door of AOD is carrying mental health and AOD issues. But there's a great huge variability in what those issues are and in the severity of those issues. [...]*
>
> *You know, traditionally, both sectors are populated by fantastic people who love working with people who love contributing to better outcomes. They work in highly pressured environments, often when they've come together due to misunderstandings about the role and function and capabilities and restrictions of the other sector. There's been lots of, I guess rock tossing and frustration with the other sector. You know, one sector not understanding what the other sector does, what it can offer, what it can't, etc.*
> *– Dual Diagnosis Clinician, Workshop #2*

Both sectors bring specialist skills that are required for the care of individuals with multiple needs. This lack of shared understanding and knowledge can create challenges in regards to role clarity, especially in relation to who provides clinical and non-clinical support. As participants suggested:

> *I think it's good to be clear. I don't really care about who's clinical or not clinical, but believe me, we people in mental health care about these distinctions and technically, you know, a mental health nurse can certainly be regarded as a clinician, but I wouldn't think that a counsellor, you'd use that same piece of terminology. [...] It's not about hierarchy. The only reason I mention it is that one of the key principles of co-occurring care is that there's a balance of the clinical and non-clinical perspective.*
> *– Dual Diagnosis Clinician, Workshop #2*

I think just being really concrete in the language about area mental health, inpatient clinician, mental health nurse, and not to throw around too many titles.
– Mental Health Nurse, Workshop #2

Participants articulated that the ideal 'future-state' for integrated care doesn't necessarily mean that all parts of the workforce become experts across multiple disciplines. Instead, all parts of the workforce would need to become 'dual diagnosis capable'. This could be achieved through a combination of fostering shared understandings across both workforces and targeted training. As participants articulated:

The future is how you actually broaden that understanding and people working in the system so that they're able to deal better with people coming at it from different areas. So if someone's got a mental health issue, then if you've got a dual diagnosis, competent individual working there, they should be able to work both AOD and mental health. But that's sort of a future state. I'd say at the moment the professional frame is separate."
– AOD Executive, Workshop #2

See, looking at what model we use here for training? Because if we use a deficit model saying that these are your weak areas, this is what you don't know, and let us make you aware of it. In that model, it's helpful to understand that I'm looking at some basic skills and [Mental Health worker] might never be able to match [AOD worker] in alcohol and drug skills and vice versa. So this is called like in the field of dual diagnosis. Instead of saying that everybody will become a dual diagnosis expert, you will become dual diagnosis capable. Defining those basic skills will help.
– Psychiatrist, Workshop #2

Participants also discussed how the friction between the two workforces might be overcome with structured ways to build and nurture professional relationships between workforces, especially those workforces who are unable to be co-located in the same building. As a Policy Advisor articulated:

Just say that there needs to be time that is funded to facilitate and nurture those new partnerships and relationships and to develop a deep understanding of what each other do and capabilities.
– Policy Advisor, Workshop #2

3.1.3 Actionable insights: Enabling a shared understanding of integrated care

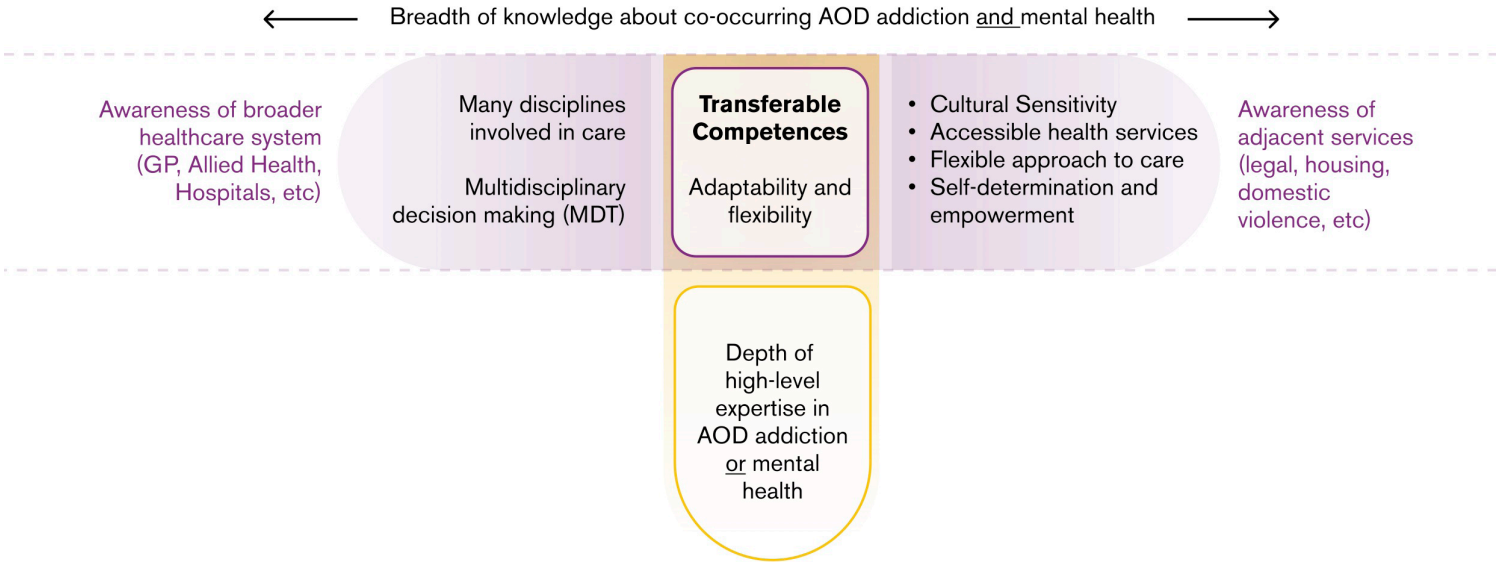

Figure 4 Diagram to communicate a transition towards a T-Shaped workforce in AOD and MH, that have 'generalist' skills and specialist skills in their discipline area. Adapted from SCRUM/AGILE methodologies.

Actionable insights that emerged in relation to enabling, fostering and promoting a shared understanding of integrated care are:

- There is a need to get everyone 'reading' from the same book. Articulate and communicate what integrated care means - and what it doesn't - for treating individuals with co-occurring mental illness and addiction across the MH and AOD workforces. Support this by creating training that explains what integrated care means for the system, organisations, executives, managers, team leaders and frontline providers.
- Create and encourage the use of common templates for shared clinical notes and clinical meetings in community care settings. Ensure training for providers to underscore the benefits of using such shared templates and approaches to clinical documentation.
- Participants recommended that AOD and MH service providers create a 'Dual Diagnosis portfolio' to be held by an individual within their team with training across both specialities. Alternatively,support can be provided to an individual who undertakes training in the other speciality. This portfolio should act as a 'champion' of integrated care within the organisation and work to foster relationships across AOD and MH at the local level.
- There is a need to develop service providers who are a blend of both a 'generalist' and 'specialist'. These individuals have deep clinical expertise in one area, but also a general interest in the Victorian mental health system and knowledge of how this fits within the larger context of the Australian healthcare system. This is visualised in the diagram below, and discussed further in the 3.5 Training and Education section.

3.2 Understanding client hopes, goals, and needs to enable integrated care

Figure 5 Images of the persona posters that were printed on A2 paper and posted to workshop participants. Each persona aimed to reflect a different kind of client with co-occurring addiction and mental health needs.

Understanding the individual with co-occuring mental health and addiction and their needs is the first step in ensuring holistic healing and recovery. This research confirmed that best-practice integrated care should be led by the client and their needs and informed by their hopes, goals and dreams for the future. Important considerations relate to the inclusion of traditionally marginalised groups and communities, how individuals involved in care communicate (this includes the client, their family, carers and providers), and the overall support structures that enable care to be delivered. Participants described that high quality care should focus on clients holistically and as "3-dimensional, complex" people while focussing on their backgrounds, strengths and successes instead of focussing solely on deficiencies such as illness, challenges or problems.

In addition to a focussed discussion upon the principles that emerged from the Mental Health Royal Commission (Access, Inclusion and Capability), participants continued to reinforce the importance of social inclusion during successful integrated care delivery. Specific examples included strategies to support LGBTIQA+ communities, establishing cultural safety at the point of care, and creating active partnership with traditionally marginalised groups and communities.

3.2.1 Engaging and supporting LGBTIQA+ communities

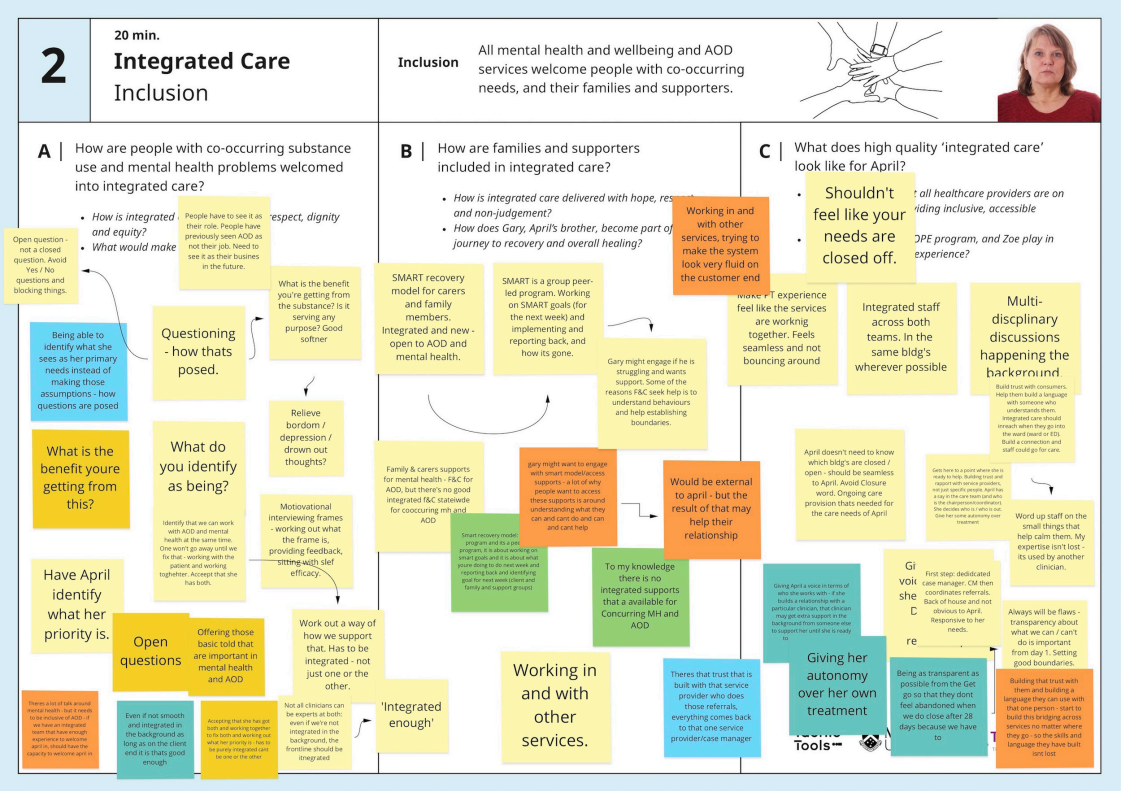

Figure 6 A screenshot of Activity #2 from Workshop #1, focussed on the experience of the April persona as a lesbian living in regional Victoria.

Participants highlighted that persistent social stigma can make individuals of diverse genders and sexualities feel isolated due to their identity, which can be further exacerbated by stigma that surrounds mental health and addiction. To overcome this barrier, participants highlighted the benefit of having peer mentors from the LGBTQIA+ community to support individuals from the same community to feel comfortable, as well as creating a safe space to discuss any concerns. Other strategies included having visible symbols of LGBTQIA+ 'pride', such as visible pronouns or rainbow lanyards, as well as staff training on the barriers that individuals with diverse genders and sexualities can face when seeking care.

> *[...] It's really important that any of the public materials that the centre presents, and when they talk about themselves in any kind of publicity, make it very clear that people with co-occurring needs - and that may not be the phrase you use to the general public - can find support there.*
>
> *So you have to be really proactive, loud and proud, about that spirit of welcome at that centre [...] You need help with anything else. You are welcome here. This is a safe place for you. And you know, positive statements about, sexuality, positive statements about, first nations people being welcome [...], the welcome starts, you know, really, really early.*
> *– Addiction NGO Professional, Workshop #1*

As discussed, stigma surrounding LGBTIQA+ communities can be exacerbated in regional or rural contexts, which can place a further barrier to seeking support or care. As a lived experience advocate articulated in response to the April persona:

> *Well, she may be further isolated by that identity within a rural community. Depending on her feeling of the levels of acceptance. It may be really important to ask her about whether that's part of what she would like, navigation towards supports for and within the LGBTQI community and links into those communities [...].*
>
> *Just discussing, you know, whether she wants to talk about how that part of her identity has impacted her health, you know, navigating that and losing relationships I think is a pretty strong trigger for anyone in terms of depression and addictive behaviours. [...] She may be more comfortable talking to someone from the LGBTQI community or a support person from that community around those issues.*
> *– Lived Experience Advocate, Workshop #1*

3.2.2 Fostering cultural safety in integrated care

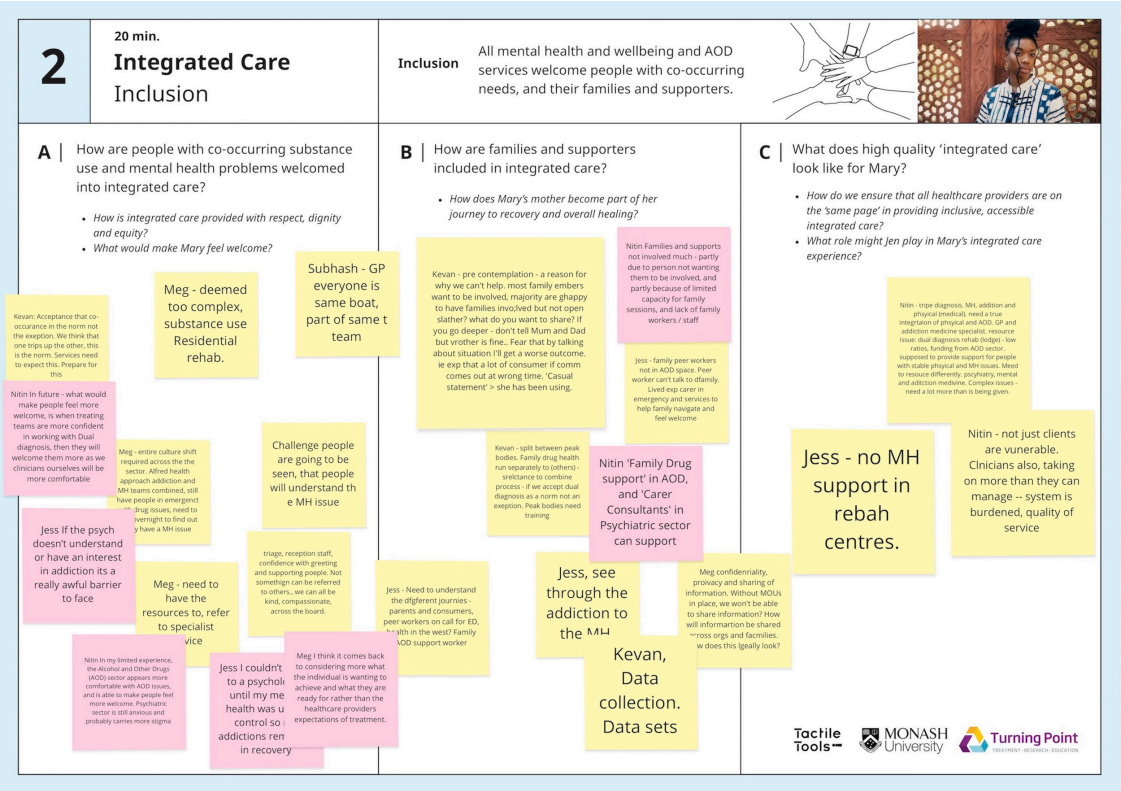

Figure 7 A screenshot of Activity #2 from Workshop #1, focussed on the experience of the Mary persona.

Participants raised the importance of cultural safety as an important element in ensuring that all clients felt included in care:

> *[...] there needs to be culturally specific advocacy. So the peer not only has there to be a kind of disease, specific advocacy as on peer support workers, but also,*

you know, if we're talking culturally specific advocacy as well, we have it for patients of Aboriginal entire Strait Islander or origin, but we don't have it for other cultural groups."
– GP, Workshop #1

I think cultural safety should be kept in mind every time when we are with the patient. And that would be answered by just simply understanding three questions about where, who, and what are we discussing.
– Psychiatrist, Workshop #1

So when we talk about cultural safety it's about people being able to access services without feeling that their cultural identity is being a factor in the way people interact with them. Yep. So whether it's unconscious biases, whether it's systemic racism, all of those aspects. So when we talk about cultural safety, we talk about one of the things that create people to make them feel culturally unsafe. So it is, racism and discrimination and not being able to bring your whole self to whether it's to a workplace, whether it's to a community space, whether it's to service access in [...]. So being able to create spaces that address that from a whole of service point of view, like there's a whole method and kind of framework on what needs to occur in services for that to happen.
– Mental Health Clinician, Workshop #1

Establishing cultural safety at the point of service provision means providing access to interpreters at the place where care is being sought, understanding or awareness of intergenerational trauma and how this might affect addiction and mental health, an expanded notion of family, the cultural stigmas and shame around mental health and addiction, as well as local services available to CALD communities - if clients choose to access them. As one participant noted: "Cultural safety is access to services without feeling that their cultural identity is a factor in the way that people interact with them. Can their whole self be brought to that situation? Can spaces be created that address these issues?" A psychologist suggested that cultural sensitivity and awareness training may be beneficial:

I think some cultural training, sensitivity training is important. We're doing a project with the African communities at the moment and just the awareness that's come out of one of how diverse they are, the different communities. And so often you have to be specific, but even just better understanding the role of, you know, shame and family and and the experiences that are common to people, I think would absolutely help a better empathy and understanding, which without needing Mary to go through all the details of what happened, there would be a background there that would already give some context to that work. So some cultural awareness training I think would go a long way.
– Psychologist, Workshop #2

Understanding the cultural dimension that can shape feelings of shame and stigma is important for service providers to be aware of when providing care. As a lived experience advocate articulated: "with Sudanese [individuals], there are people who are [diverse religions], where there's kind of that shame and stigma around substance use, more severe than there is just in everyday life. It can make a massive difference to that person's recovery journey."

3.2.3 Engaging with First Nations communities

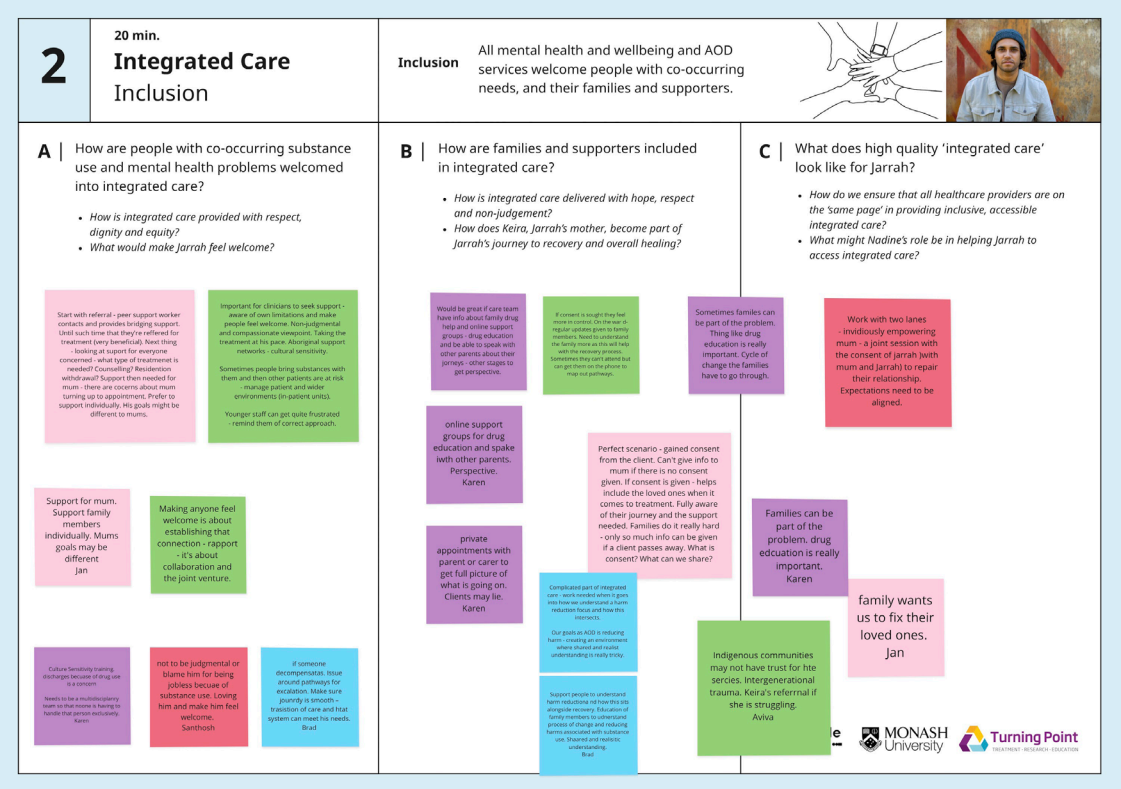

Figure 8 A screenshot of Activity #1 from Workshop #1, focussed on the experience of the Jarrah persona.

Participants called out important insights to ensure the inclusion of first nations people when receiving care, acknowledging that first nations peer mentors and Aboriginal Services liaisons have an important role to play in service delivery. However, participants also recognised that not all Indigenous clients want support from Indigenous services. As one participant noted: "Cultural safety can only be defined by a person's experience. To aid in cultural safety you need to look at two aspects - individual and systems. Individual: training, experiences, skills and knowledge. Systems: Structures, policies and practices". Participants indicated that for Indigenous communities to have access, there needs to be better "cross pollination" across the sectors (AOD and MH). For example, active partnership development, supporting families in their homes for older generations if requested, telehealth for younger clients, and provision of interpreter services.

> *We know that about 4% of the Australian population identifies itself as Aboriginal, but it's nowhere near 4% of the workforce that I've got here [...] identifies itself as Aboriginal. And I think an organisation probably needs to have a vision that goes on the lines of 4% of our workforce would probably need to be Aboriginal identity. [...] I think a service needs to have Aboriginal liaison officers who are a point of trust for an Aboriginal person coming into the service, to help them feel culturally safe.*
> *– Psychiatrist, Dual Diagnosis, Workshop #1*

I think we also need to be mindful that not all indigenous clients want support from indigenous services. There's a lot of shame there and, you know, there's a lot of family relations and they'd rather their story be kept private. So I think we need to be aware of that as well.
– Mental Health Practitioner, Workshop 1

3.2.4 Communication with and for clients in recovery

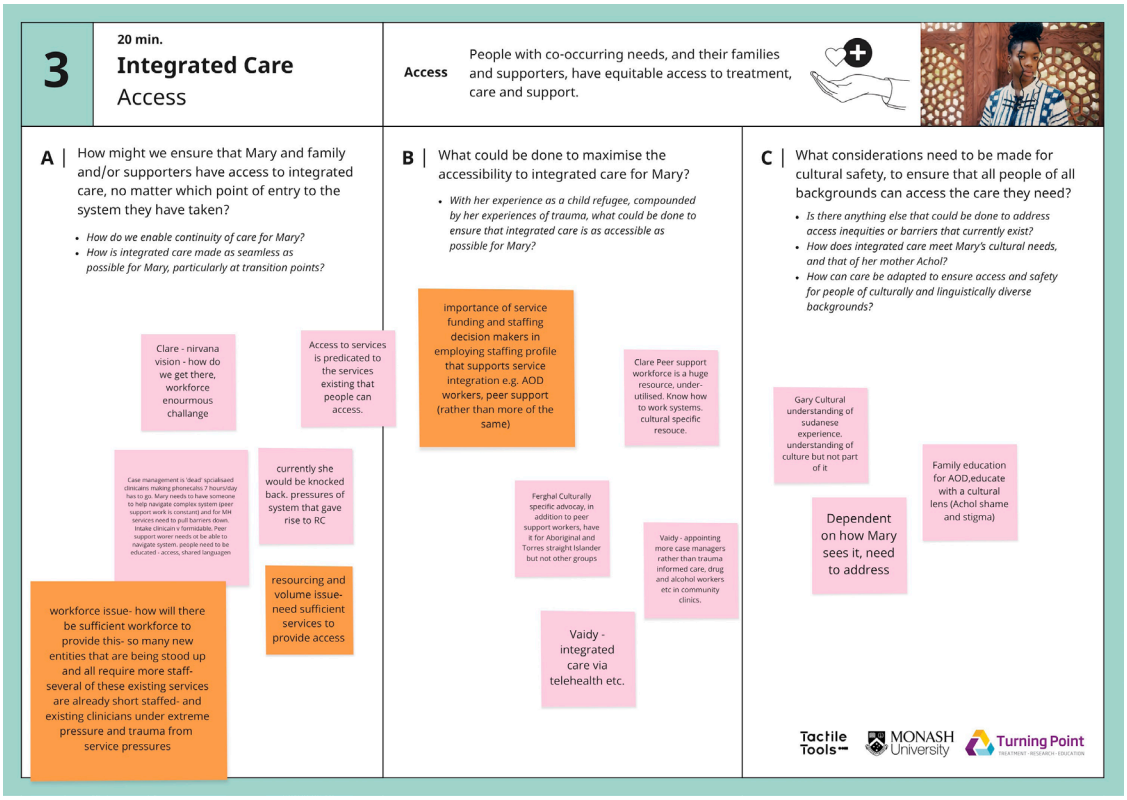

Figure 9 A screenshot of Activity #3 from Workshop #1, focussed on the experience of the Mary persona.

How an individual first enters the healthcare system, and the experience that they have being welcomed into care, can have a profound impact on their overall healing and likelihood to remain in care. Stigma - perceived or actual - within the healthcare system can impact both how care is delivered and experienced. Being 'kept in the loop' and understanding what is happening at each stage of care delivery can improve the overall comfort of the individual patient. As a lived experience advocate articulated:

I spent 19 hours in a psych ward once after an overdose, and I was completely ignored. Every other person with a mental health issue was seen before me, obviously, I don't know all their stories, but there is a general feeling amongst people with lived experience that you will be judged if you go into hospital, in any kind of setting. So I feel like that's gonna be a really big challenge for us to make this very welcoming service, to make people know that they're not just gonna be ignored, they are gonna be seen correctly. And that we will see through the addiction to understand the mental health issue, which is the most important thing.
– Lived Experience Advocate / Peer Support Worker, Workshop #1

Client story

Asking an individual with co-occurring mental illness and substance use to tell their story is an important moment in their journey to recovery, but can be a distressing experience. It's important that clients are treated with respect when asked to do this and that a feeling of safety is created. Asking patients to retell their stories again to other providers - stories that are often layered with trauma in relation to criminal justice, housing, domestic violence or more - can further exacerbate this trauma and make the health encounter even more distressing. As explained by an AOD team leader:

> *The retelling of the story is very traumatic, for the people that we see. And we'll come in and do the AOD comprehensive assessment, which is very thorough. And then, you know, refer them to mental health and they have to do their mental health assessment, which again, is very thorough. And this, I think this has turned into a barrier.*
> *– AOD Team Leader, Workshop #2*

> *This is someone potentially for the first time opening up, sharing their journey and [...] [this] can potentially be the very start of their journey and thinking that this is where I've come. [...] but it actually we're just taking your information and gonna flick you on to where we think you should go. And that I find that can be, I don't know, very harmful I suppose. So for most, I won't send most of my clients to intake cause I just think it's too difficult.*
> *– AOD Clinician, Workshop #2*

Retelling the story can also be a barrier to clients accessing specialist services and help, as well as a barrier for clinicians to refer a client to another service. As a psychologist and AOD clinician discussed in regards to intake:

> *One of the current challenges working between the two systems. I mean, if someone's presenting for the first time to share their story, going through an intake makes good sense to get the picture of what's going on and where, where they're best suited. But if they're already engaged with one part of the system, let's say it's mental health, and you are really clear that you want to add something from drug and alcohol, you know, to guide their journey over the longer term the flexibility to be able to just access that part of the system without saying, oh, sorry, but you have to go all the way through the intake of the drug and alcohol system and then do an assessment and then you'll get allocated to someone is just such a barrier that's unnecessary and would be horrible to experience.*
> *– Psychologist, Workshop #2*

> *This is retelling the story, it's not just for Mary, it's for the clinicians as well. And if I'm referring into detox and then especially referring into ongoing rehabilitation, it's presented to an intake, another intake worker, then that other intake worker, I've gotta get them up to speed, then they'll take it to the intake meeting, the intake worker won't be able to answer the questions that comes back again. [...] So as a clinician, I should be able to go to the intake meeting and present the client, answer all the questions and cut out all the middlemen. Not to join their entire meeting, but to be able to present the consumer and be able to, it would just streamline things a lot easier.*
> *– AOD Clinician, Workshop #2*

Communication between services and service providers

Communication between services and service providers can also prove challenging, which can further complicate the extent to which an individual client is involved and understands what is happening on their journey of care. As participants stated:

> *NDIS is a black hole to every other service provider. Like there's no communication in and out of that system.*
> *– GP, Workshop #1*

> *Effective communication, I think, and collaboration between all the people involved in [...] care is probably the most important thing. And then planning the transition stages and seeing what the, you know, the risk points are [...] and effective and ongoing communication and collaboration between people [...] at all the important times throughout his process and explaining, and, you know, what's gonna happen from one stage to the next and planning things. So there are no surprises for them.*
> *– Psychiatrist, Workshop #2*

3.2.5 Family engagement and support

Participants discussed the benefit of having family involved in care to support the individual client, but recognised that providers need to understand a family's own capacity to support. This includes considering their own healthcare, addiction or mental illness needs, potential triggers or risks and their own health literacy. Providers should, therefore, recognise and provide support to family or chosen supports as they need. As participants articulated:

> *I think a family peer support worker or a family education program would be really good for the mum. Cos if the mum got back on board with the support, it would benefit the client in a massive way. I mean, it said in Mary's file that she had a good relationship with her mum until she started using substances and that's when it broke down. If we got the mother back on board, it would benefit the client massively, I think.*
> *– Peer Support Worker, Workshop #2*

Indigenous families and CALD communities

Providers should also consider the complex dynamics of Indigenous families and CALD communities, as well as the individual and collective Aboriginal values that may influence their feeling of inclusion. As one participant noted: "The chief goal should be a therapeutic alliance with individual and family or broader support network". As highlighted by a GP:

> *I think there's also an issue about family education. I mean, there are organisations to do family support for, and part of that role is to educate the family on what the AOD issue is. And then also to try and explain and reduce the stigma around that. [...] Putting a cultural lens on that because you know, the mother is full of shame and stigma of the fact that her daughter has [co occurring addiction and mental illness].*
> *– GP, Workshop #1*

Associated risk

Participants called out that supporting someone in crisis can also predispose them to psychological risks themselves through vicarious trauma. As a Dual Diagnosis nurse explained in regards to April's brother finding her after a suicide attempt:

> *I'll also see that Gary was the one that found her. So there's probably quite an important need to assess Gary's state of mind. We know that there's a huge risk factor for suicidality if somebody else, you know, has attempted. So we need to see where, where he's at. And then also, perhaps just asking the question about what would it take for you to be able to feel comfortable providing this support, if that was to happen. And if, you know, he's willing to, or interested in connecting with, mental health care and family support for himself.*
> *– Dual Diagnosis Nurse, Workshop #1*

3.2.6 Informed consent

The client should decide and consent when and where to involve their family or chosen supports in their care and recovery. As a psychologist articulated in regards to the experience of the Mary persona:

> *I think, you know, she needs to be empowered to have some control over her information and what's shared with who. I know there's a whole lot of things in the system that could make, you know, sharing of her file and information easier. But it's not as nuanced as when she's going to TAFE and seeing a counsellor there. Does she wanna share all of that clinical information with them or only some of it? Is she gonna do that, you know, deep work around her trauma there, or is it just focusing on helping her manage, you know, managing her studies there? So there's something about the information sharing and how much control Mary has and what's going to support her to be able to, easily say, Yes, I'm happy for this to be shared with this person. And no, I don't want that full file shared with that person.*
> *– Psychologist, Workshop #2*

And as other participants highlighted:

> *First of all, consent is everything right? So you've got to invite April to consider bringing her family in and then family can be incredibly helpful, even from the very first get go in terms of creating that safety plan. Often safety plans include the person's best connections in the community, the ones that actually work, because people are more likely to reach out to someone that they know.*
> *– GP, Workshop #1*

> *Reach out and ask April whether she'd like family there or family involved, it's then a question of asking family, or having that conversation as well with family. And that might be a shared conversation, or it might be one that is had outside of that. It's interesting to think about how you frame that in relation to the consent, but you can still inform and you can discuss stuff that's outside the treatment*

frame with family to ensure that they don't need some support before they step into this support space. They might be carrying some distress around what's been happening. They might feel they might be frustrated and angry at the sorts of behaviours they've been seeing.
– Lived Experience Advocate, Workshop #2

3.2.7 Additional support structures

While this report focuses on the mental health and AOD workforces, participants felt that other parts of the system have an important role to play in successful integrated care. This includes the role of dedicated support, the role of the peer support workforce, support structures needed for clients as they step down from care as well as support for their family and loved ones.

Peer support workers

The role of peer support workers to ensure a balance of clinical and non-clinical supports, and to support clients in navigating the system was also raised. Some participants felt that case management in public mental health services is "literally dead" and that specialised clinicians should not be responsible for "making phone calls seven hours a day". When discussing the persona Mary, participants stated:

I am actually thinking that Mary would really want somebody with whom she can actually identify such as the peer support worker to help her navigate this very complex system. So I would actually see that peer support worker as the constant through a journey, across this and for the mental health services. The challenge will be to actually, kind of make it easy for people to access services, you know, pull the barriers down.
– Psychiatrist, Workshop #1

I just, in terms of what it looks like for her, I think maybe for her, she needs a personal advocate that can help her walk through the system and navigate the choppy waters of the interfaces between different services. Yep. Case worker, whatever personal advocate, peer support worker, you know, someone who can walk with her.
– GP, Workshop #1

As one participant explained, the role of peer support workers is already happening in parts of regional Victoria:

The first telephone call comes from a peer support worker and that peer support worker provides bridging support and just keeps the person motivated and going, doing an outreach with them in their home and things like that and gathering information until such time as they're referred to treatment, which we found very beneficial. We have a lot more [clients] failed to attend, with people that don't have that bridging support peer support worker.
– Mental Health Nurse, Workshop #1

Transitioning from acute care back into the community

Participants also highlighted the need for services to support clients as they 'step down' from acute care and back into the community, potentially including the need to link clients to other services. For example, participants discussed how you may be able to navigate into the NDIS, but assistance is needed to manage this process if psychosocial support is needed on a daily basis. As further explained by a lived experience advocate:

> *It's not that people in crisis don't mean higher levels of support, but they need high levels of particular support. Whereas I would say when people are slowly emerging back into their life, that can be the most vulnerable time. And it also is, they need a lot of support at that point, different kinds of supports, but we have that step up step down. And so when they're in crisis, they need a lot. And when they're doing a bit better, then those supports can shift away. [...] So people have reasons to stay well and have support to do that. And we get that wrong often or a lot, most of the time, I think.*
> *– Lived Experience Advocate, Workshop #1*

Participants also discussed referring clients and their family or chosen supporters to online services to assist in the client's transition back into the community:

> *It would be great if the care team have information about [...] family drug help, for instance, and online support groups for her, where she can get drug education and also be able to speak with other parents, about their journeys and, people who are at different stages with their kids on that recovery journey to get perspective.*
> *– Lived Experience (Addiction), Workshop #1*

Psychosocial support

It's also likely that individuals with co-occurring addiction and mental illness will have other overlapping and coccurring needs - which might range from criminal justice, social welfare, disability to housing. It's important that these needs are addressed, as resolving these areas are usually determinants in the overall recovery of a client.

Diversity, equity, and accessibility

Participants articulated that ensuring access for all in the community can be attributable to workplace culture. Service providers should reflect the diversity of clients they aim to serve, and should actively seek to recruit a diverse workforce wherever possible. Service providers should also be distributed across Victoria, rather than just centralised in Melbourne, to ensure that individuals in regional locations don't need to travel long distances to receive relatively routine care. Participants highlighted the importance of "boots on the ground" in rural areas, and local service providers who are familiar with local problems and know how to access the resources in their communities. At the same time, the community needs to know which services are available and how to access them.

3.2.8 Actionable insights to support client needs in integrated care

To enable best-practice integrated care that is led by the client and their needs, while informed by their hopes, goals and dreams for the future:

- Create templates to capture the client's story in clinical notes so that they don't have to repeat themselves as they move between service providers. This strategy aims to reduce the impact and trauma that retelling can create for both clients and service providers, while also addressing barriers to accessing multiple service providers.
- Implement strategies to address stigmas across service providers that can prevent individuals from seeking support. This can include visible symbols of LGBTQIA+ 'pride', visible pronouns or rainbow lanyards, and staff training on the barriers that individuals with diverse genders and sexualities can face when seeking care. Also consider strategies to support First Nations communities and culturally diverse groups to feel safe as they transition across providers.
- Ask peer workers with lived experience of co-occurring mental illness and addiction to make initial contact with clients seeking help for the first time, and provide ongoing throughout their care journey as a kind of 'bridge' across and between clinical supports and treatments.
- Encourage meetings between clinical and nonclinical supports involved in a client's care to enable multidisciplinary decision making across the mental health and AOD workforces. Virtual tools such as Zoom or MS teams can be useful here, as these providers may not be co-located.

3.3 Barriers, gaps, & limitations to integrated care

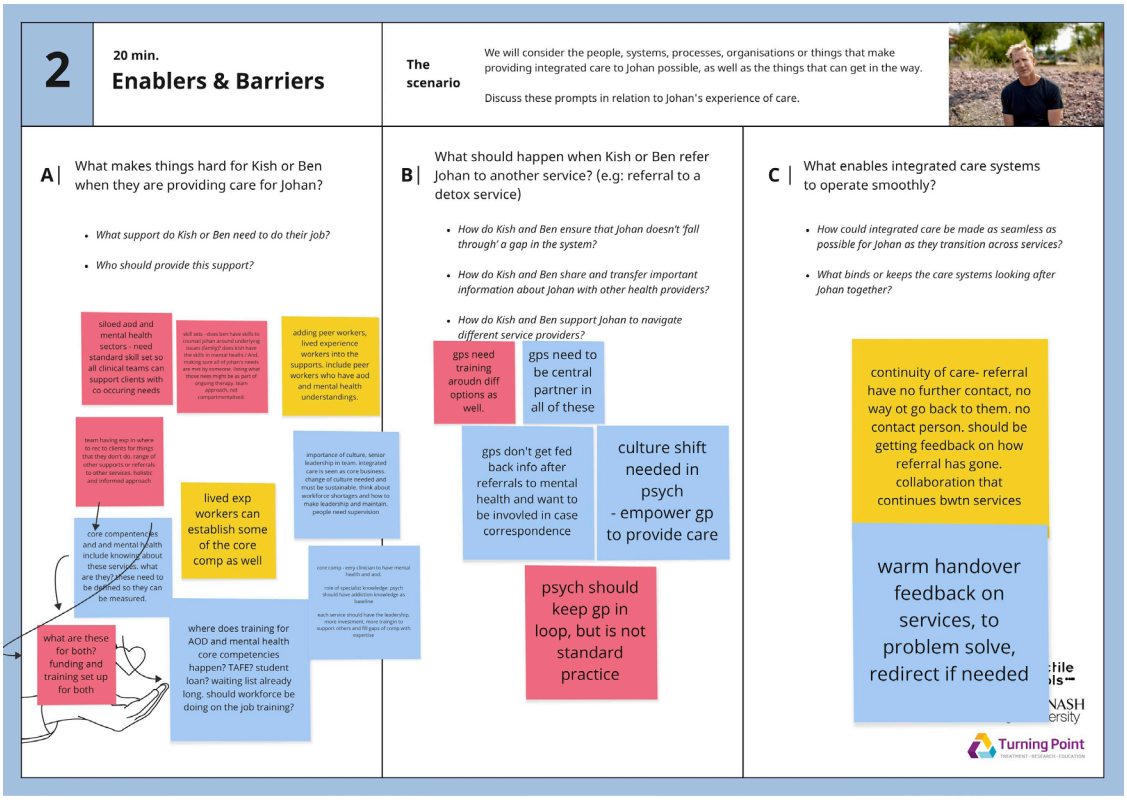

Figure 10 A screenshot of Activity #2 from Workshop #2, focussed on the experience of the Johan persona.

Themes that make implementing integrated care difficult include a variety of organisational and system-level constraints, inadequate resources and funding, limited workforce capabilities and capacity in certain settings, as well as the challenges faced within regional contexts. Attitudes, behaviours, and mindsets also pose significant challenges, with participants emphasising the entrenched stigma existing at individual, clinical, and community levels.

As foreshadowed in the previous sections, establishing a shared understanding of integrated care is essential before addressing any other barriers, gaps, or limitations.

3.3.1 Governance, policy, and leadership

Mental health and AOD sectors currently lack integrated governance policies, with participants emphasising the absence of clear structures or procedures. Different parts of the workforce are operating from 'different books', which makes any form of cooperation challenging. This includes ambiguity regarding who will be responsible for what part of care, and who is ultimately responsible for making decisions during different stages of a client's treatment plan.

If you haven't got agreement and buy-in and a policy structure and overall governance environment to support that [integrated care], then you're relying on the will and skill of individuals, which will vary.
– AOD Clinician, Workshop #2

These systems are still separate and AOD is sprinkled across the mental health wellbeing division (state funding). It's not going to be an integrated system because the governance structure isn't integrated.
– CEO, AOD NGO, Workshop #2

3.3.2 Intake, assessment, and treatment

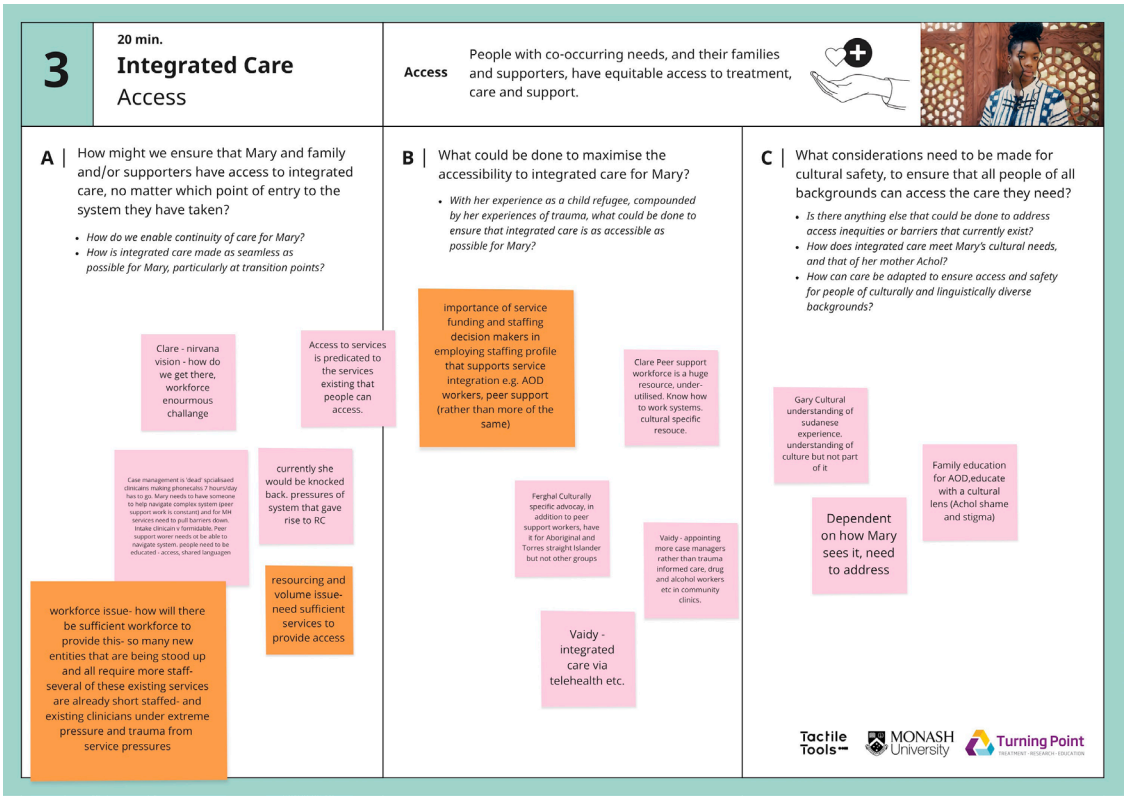

Figure 11 A screenshot of Activity #3 from Workshop #1, focussed on the experience of the Mary persona.

Intake is one of the most important parts of the recovery journey for clients, and can frame their overall perception of the entire service system. Participants suggested that, ideally, this should be a low stimulus environment that is led by the client, with space for the client to 'tell their story'. Any questions that are posed by providers need to be open ended - and not read off a sheet - to clarify the client's goals about substance abuse and recovery.

Current approaches to care at intake can be fragmented and siloed due to a lack of shared understanding, language, resources and stigma to provide care for individuals with co-occurring mental illness and addiction. Clinical government risk management processes further compound these barriers.

As participants articulated:

> *Yeah, but the first thing for me is the acceptance that co-occurring substance use to mental health issues are the norm rather than the exception.*
> *– Mental Health Nurse, Workshop #1*

> *If a person's got a mental health issue and they use substances, they're automatically referred to us because the mental health team finds them too complex and they have to get a hold on their addiction before they can actually look at the mental health. And we see the opposite where, you know, they need help with their mental health because they're actually using the substances that they use for their mental health. So it's a bit of a, you know, a catch 22 when what came first, the chicken or the eggs.*
> *– AOD Team Leader, Workshop #2*

> *The assumption that somebody would end up in the mental health unit being seen is not the common scenario. A lot of people won't actually get through that process because this will be seen as mainly a drug and alcohol issue, not a psychosis issue. There's also often a delay between being seen for both conditions from an emergency department scenario. If you are brought in by the police, for example, there can be a level of anxiety and distress and under some circumstances, people might actually leave before they get seen by either mental health or social use. And we tend to still see the person in terms of two separate streams rather than being mutually influential conditions.*
> *– Psychiatrist, Dual Diagnosis, Workshop #1*

Short time limits mean that intake assessments are only valid for three months before a review is needed, placing undue pressure on the client. Participants also spoke to the rigidity and inflexibility of these systems, including the detrimental effects these qualities can have on clients first entering, or those attempting to re-enter, MH or AOD systems.

> *This is where I think things like these referrals or suggestions of follow up in the community, the people that have been on the ward have already made some kind of a link they've told their story and then to have to go to intake and tell their story. And unfortunately, I think that when we had the reform of the drug and alcohol sector, the centralising of all of the intake services in some instances has actually become a barrier to people.*
> *– AOD Nurse, Workshop #1*

> *I have just taken it back a step, I guess, notice that this is all happening after apparently she was treated in an emergency department and absolved of her suicidal ideation, <laugh> miraculously and then sent home with 24 hour follow up afterwards. I think [...] from a welcoming perspective and an inclusion perspective, it's actually about your first point of contact. That makes a difference. If April had gone to this ED and had a negative experience, she would be less likely to follow up with a concurrent service offer.*
> *– Dual Diagnosis Nurse, Workshop #1*

> *I don't know if we ever looked at when we created the centralised intake system, whether that was ever evaluated and looked at the impact that it's had on service*

provision. And I think it did silo everything into [...] you've got all these people coming into one point trying to get them into one point and then trying to get them back out again.

[...] I'm not saying that there's not other people who it works incredibly well for. So if they pick up the phone, they're in local Melbourne or they're in Port Melbourne and [health provider] is around the corner and all of a sudden they're off and running cos that is there at their door.
– AOD Clinician, Workshop #1

Even when an individual does make it into the system, participants highlight the missed opportunities for conversations, actions or interventions that can make a difference in the holistic healing of those seeking care. As one participant highlights in regards to hospital settings:

So that's one thing which is missing formulation of alcohol and drug formulation of psychosocial presentation along with mental health. And the second thing is what is not written here is those multiple, multiple missed opportunities. When a person interacts with the system when she is in the mental health ward, in this case, she's getting treatment for psychotic symptoms. But this is an opportunity where we can look at it as a detox, link it up with some sort of a daily rehab or residential rehab, depending on her motivation.
– Psychiatrist, Dual Diagnosis, Workshop #1

When determining treatment approaches, expectations from MH and AOD clinicians will "always be underpinning conversations", with the misalignment between typical treatment models within these sectors potentially resulting in negative impacts for the client. As explained by a psychiatrist during workshop two:

Let's say, hypothetically, that I'm depressed and you are my doctor admitting me to the hospital. Would you impose a condition that if you come in and if you cry, even once, if you talk about depression once, you see…but we use a very similar model for a person with addiction. [We say] immediately stop all your substance [use] as if it is completely within your control so [this is an] abstinence model. So the models which we are using and the technical skills which we use may be lacking.

3.3.3 Challenges with shared information systems and referrals to adjacent services

Shared Information Systems

A lack of shared information systems can currently be observed as a significant gap within both MH and AOD sectors as well as within the wider healthcare network. This gap can result in limited or fragmented communication between sectors, with service providers sometimes relying on fax machines to convey information. Participants stated that it is the responsibility of the government to fund the creation of a central electronic shared information system. Although the 2016 reform saw the introduction of a suite of tools to address this challenge, participants noted that these did not improve access or communication to a large extent. It was also noted that if work can not be done to

improve this area, then the onus will fall on clinicians to do some of this work, filling in documentation gaps during the referral process. As explained by an AOD clinician:

> *I think shared information systems would be key. Information is just put in once by one person and people can access it, making communication so much better when you've got different organisations using their own tools. You've got to get the patient's consent to have the information released, it takes a while, it's a paper based system, they've gotta photocopy it. Having a central electronic shared information system would be super easy for everyone to access. That includes primary care as well, so I'm throwing in the patient's GP and his other caregivers, I think that would really help with providing coordinated care.*
> *– AOD Clinician, Workshop #2*

Referrals

Further challenges can be observed in reference to the current referral process. Delays between service providers can have profound impacts on the overall health of clients. Difficulties and delays caused by navigating the referral process can even culminate in individuals deciding to leave the system before receiving care. Clients are often required to make multiple appointments with different services, with many of these providers working in silos. The priorities of a client can also shift between appointments over time, which can pose significant challenges. As an AOD clinician emphasised during workshop two:

> *From one week to the next, even one day to the next, their priorities and their crisis might be different, and that could be related to their mental health or their substance use. It could be either but things will change very quickly for our clients. And they don't always remember appointments or something happens and they don't always make appointments. And [it's important to] have an understanding of that.*
> *– AOD Clinician, Workshop #2*

This challenge can be exacerbated when services themselves are already stretched thin and have a lack of resources to conduct timely follow ups with their clients. In reference to April's experience of care in regional Victoria, participants noted that "April's lucky she's been followed up by HOPE, but there will be plenty of people that go through the ED that won't be."

Emergency Department

Participants also highlighted barriers at entry via the Emergency Department. For example, some hospitals only allow triage nurses to record a single diagnosis (e.g. broken leg, suicidality, etc.) meaning that there is no deeper investigation into comorbidities or potential mental health or addiction issues. The KPIs of an ED also encourage staff to move people through the system as quickly as possible, which translates to these KPIs not supporting a deeper exploration into areas of addiction or mental illness. This is a significant challenge for integrated care delivery, when acute care staff are not encouraged to investigate whether substance abuse or mental illness contributed to the reason a client might be presenting at the ED.

As a Dual Diagnosis practitioner articulated:

> *We get, for example, someone who's been using speed or alcohol, but we don't go deeper. That then impacts on the care [received] because if people are actually counting and looking for that and reporting on that, more importantly, what have they done about those issues? So if you're not looking for it and you're not actually being encouraged to actually do something about it, then eventually that will have an impact on care.*
> *– Dual Diagnosis Practitioner, Workshop #2*

General Practitioner

Participants also highlighted barriers to care when GPs are able to discriminate against particular clients by choosing who they do and do not want to work with. As a Dual Diagnosis practitioner highlighted in regards to people with addiction:

> *It never made sense to me that publicly trained individuals in health get a choice about whether they provide treatments depending on their own prejudice. Well, that's a bit inflammatory for some people, but if you're a local GP and you are saying, I don't want to work with these people because I'm not sure why we allow that, you shouldn't have the right to say I don't want to work with people with diabetes. I don't want to work with people who are IV drug users. They're providing a public service and that's another KPI that I'd like to raise.*
> *– Dual Diagnosis Practitioner, Workshop #2.*

Although integrated care may be better delivered with the support of a GP, participants felt that, at present, certain GPs do not work collaboratively with the MH and AOD sector.

3.3.4 Resources and funding

When referencing the AOD sector, participants explained that funding is often not adequate when considering long-term care planning. Although participants were in agreement that primary care is under-resourced, an underlying sentiment also included perceived distinctions between sectors, with AOD likened to the "poor cousin" of MH.

> *What I've never seen in mental health is fixed term funding, for example. No, we get growth funding, well we've never got any for years and now we're getting a lot, but it's recurrent funding and then in the AOD sector […] we'll get, you know, 18 months and then it stops. I mean it's impossible [...] People would be outraged if there was fixed term funding in mental health. You know, we'll fund a psychiatric nurse in an acute setting for 12 months and then no more. That just wouldn't happen.*
> *– Mental Health Clinician, Workshop #2*

Although ideas around joint consultations, multidisciplinary decision making (MDT), and external supervision were discussed, participants felt that further resources - in terms of people and funding - is required to support such initiatives. Given workforce shortages, questions were also raised in reference to the health sector's ability to foster and maintain new leaders in these settings.

Participants also highlighted that the healthcare sector lags behind the corporate sector when it comes to staff resourcing, with human resource managers being scarce within these settings. As a psychiatrist articulated during workshop 2:

> *Say in a hospital, if you want to do a team building activity, you can talk to your HR manager or there'll be somebody who can assist you with that. Hopefully in our sector for a 10,000 person sized organisation, there'll be one human resource manager sitting somewhere. And if you ask them, you know, we need something for a team management, team building activity, they'll say 'what is that? I don't have any money for that.*
> *– Psychiatrist, Workshop #2*

3.3.5 Workforce capabilities and capacity

Participants described a general lack of knowledge when it comes to areas outside of individual expertise, emphasising the need for further dual diagnosis capabilities. A number of other factors also present barriers to integrated care, which include collaboration, the role of technology and recruiting staff. Increasing knowledge and understanding also relies on the necessary training and education to adequately support clinicians and this will be discussed in depth within section 3.5.

Collaboration and coordination across workforces

Capacity constraints, different caseloads, and time pressures can have detrimental impacts on coordination and collaboration between sectors.

> *I think in terms of collaboration, the thing that would make it hard is that they're working in different organisations. They've probably got different caseloads and they've probably got different time pressures as well. So say meeting each other, they'd have to set up an appointment time where they can meet with [the client]. It can kind of put a few barriers in place if say Ben's workload is so bad that he can't meet for four or five days with Kish. So just the logistics of being in different organisations, different time pressures, different KPIs, different things that they have to try and accomplish will probably make it difficult for them to provide that collaborative care.*
> *– Addiction Medicine Trainee, Workshop #2*

Current system limitations also result in interdisciplinary collaboration often only happening when a crisis has or is about to happen. Participants noted that clinicians are encouraged to "keep in their own lane", with the siloing of MH and AOD professionals creating a barrier to coordination between these services. From the client perspective, this lack of integration may result in different medical records and/or multiple care plans.

> *From a primary care perspective, usually mental health and AOD are quite siloed. You refer out to different agencies, different services. There's no clear communication between the two agencies. There's no formal pathway of communication between the two different agencies. And even if say a GP tries to coordinate the patient's care, you're getting two sets of reports [...] and sometimes it can, especially in primary care, be a triangle where, as a GP, you're trying to assist with coordinating care.*
> *– Addiction Medicine Trainee, Workshop #2*

I suppose the problem with having siloed mental health and AOD sectors is that people are sort of pushed from one to the other or turned away from one because [they say] 'we don't do AOD here, we do mental health'. So [...] they're turned away from the AOD because their mental health is seen as primary.
– CEO, AOD NGO, Workshop #2

Technology

Participants felt that access to and comfort with using technology can be a limiting factor, with many clinicians still preferring phone calls. Although technology (zoom, telehealth etc.) can assist with the quick and efficient sharing of knowledge, digital literacy remains a significant barrier to adopting such platforms.

Recruitment

Workforce shortages can also have a notable impact on capacity, with staff vacancies resulting in additional responsibilities given to current clinicians until such roles are filled. Not for profit AOD services are particularly impacted by recruitment issues given the small size of their organisations. A lack of resources in these settings can further compound their ability to provide services quickly and efficiently.

A lot of the not for profit AOD services are quite small, like literally I'm the CEO and I'm running out to the reception area to do something. I think that feeds into stresses in services in general, staffing issues. There's so much change, there's so many differences in what people's capacity is in different services, and I know it's worse out in regional rural areas. I know it's a very broad statement, but it impacts so many things. You know, there could be one car that's associated with these services that they've gotta book three weeks in advance to get to April [...] here's just so many things that can be barriers in this space.
– CEO, AOD NGO, Workshop #2

3.3.6 Regional context

Participants highlighted the disparity between metro and regional locations when it comes to resources that enable integrated care. From a clinical perspective, these differences can be observed in relation to workforce capacity and recruitment, funding, as well as access to training opportunities.

You know, Euroa is just outside my patch. So there's a lot of challenges here about the regional issues. I would be totally surprised that any of our local AOD workers or any of our local mental health workers came together around a person with April's needs. All the AOD workers I know have got caseloads of 30, 35 plus. So they're really, really busy. Most of the mental health workers I know are absolutely flat out with their caseloads when they come together to provide integrated treatment. At the moment, it is nearly always only around when everybody is really, really concerned because there's a really bad outcome in the offering, where you know somebody's going to die or majorly bad things are going to happen.
– Dual Diagnosis Clinician, Workshop #2

Clients also face barriers to care in this context, with peer support options less accessible in regional locations. In addition, the limited availability of facilities such as rehabilitation services and emergency departments may pose barriers to access while also requiring additional travel costs (ambulances are limited) and a significant investment in time from clients. Long wait lists and services that choose not to bulk bill further compound the difficulties individuals face in these settings.

Furthermore, coordination between MH and AOD workers may be limited in these locations, with entrenched differences between rural and metro understandings of care impacting collaboration across services.

3.3.7 Behaviours, attitudes and mindsets

This research further unpacked the issues of stigma, which is thoroughly documented in other reports and publications concerned with co-occurring mental illness and addiction. Participants highlighted that stigma concerning both mental health and addiction exist at the individual, clinical, community and societal levels.

> *One of the major reasons why stigma and discrimination exist is because people don't feel confident about interventions. So concentrating on that, the how to do things like suicide prevention, how to do basic assessments or mental health issues, substance use the interaction, processes, tools and resources are more important in the long term for building confidence than just telling people you need to do this work.*
> *– Mental Health Nurse, Workshop #1*

At the individual level, participants provided examples of a mental health provider being scared of someone with an addiction, or viewing the addiction of clients as a 'moral failing'. Conversely, an AOD provider might be afraid that individuals with psychotic symptoms could be 'violent or aggressive', or not be fully aware of the long-term nature of mental health recovery. Participants suggested that this can be overcome through learning, education and training - but also exposing these providers to perspectives beyond their core responsibilities. For example, creating opportunities for providers to hear from individuals with addiction, suicidality, or those who have experienced profound trauma as well as hearing their recovery journey can prove beneficial to the workforce. This point is discussed further in section 3.5 of this report.

3.4 Enablers to integrated care

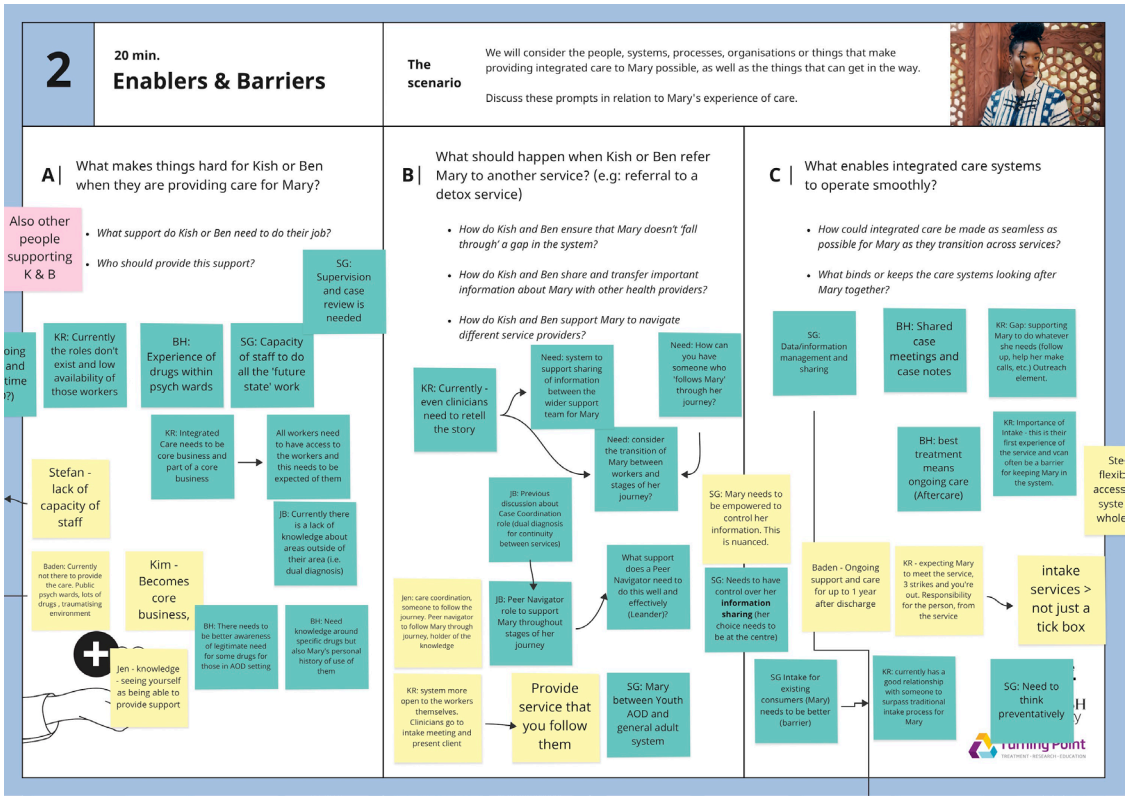

Figure 12 A screenshot of Activity #2 from Workshop #2, focussed on the experience of the Mary persona.

Themes that enable integrated care include creating opportunities for MH and AOD workforces to build relationships, share knowledge and expertise, and co-design a client's care plan. To enable integrated care and collaboration across and between sectors, significant long-term funding, workforce recruitment and training needs to be implemented. There is also a need to consider iteration as central to the model of integrated care, where mechanisms to continually capture learnings are established, so that the model of integrated care can be evolved in response to what is and isn't working.

A central enabler to integrated care, as identified through this research, is workforce training and this will be discussed in detail in section 3.5 of this report.

3.4.1 Organisational and system needs

Funding

Dedicated funding from "Commonwealth funded to state funded" is required to support change management projects at all levels. This includes investment towards developmental education and training as well as ongoing funding towards the AOD sector.

> *We talked quite a bit about how the training could be delivered and fundamentally there's a real need for the organisations to receive adequate funding to do this work so that staff actually have time to be freed up to engage in professional development during work time and that it's valued and supported. So people have capacity within the system to actually do the training. And it can be a combination of sort of education, formal, non-accredited, all the informal opportunities to connect and talk to people as well as some real immersive experiences, whether that be through rotations or or time spent in other services where you actually experience things rather than just learning about them.*
> *– Psychologist, Workshop #2*

Funding for transition clinicians was also considered, with the suggestion that design career transitions for staff could be purposefully designed. As articulated by a lived experience advocate during workshop two:

> *There is funding for transition clinicians at the moment, so people who've been working in areas other than mental health then moving into mental health. And I'm wondering if there's some way that you could encourage people with particular skills to be taking up those places. Like if you say 'X' number of places need to be from AOD … [and] I wonder if it can go the other way as well that there are transition clinicians going from mental health to AOD.*
> *– Lived Experience Advocate, Workshop #2*

Performance metrics

Participants noted the importance of receiving feedback from clients and their family as to how their treatment plan is progressing. Questions should be raised in reference to the service's ability to provide patients with what they need and/or want when it comes to their treatment plan. Interfacing with the client's GP was another recommendation when seeking to evaluate specific and measurable performance metrics. These metrics should also be integrated within an organisation's core business, with participants emphasising the importance of publicising success.

> *What tends to happen is that we focus as human beings on what isn't working and we don't give much support to people [...] but I think the stories of success need to be highlighted and articulated. [...] The issue of feeling hopeful about complex clients or even just any clients needs to be brought to these agendas. Because otherwise what happens, people start to go, as soon as you've got a forensic history, you've got this, you've got the other, and the heads go down.*
> *– Dual Diagnosis Practitioner, Workshop #2*

3.4.2 Workforce

A client's care journey must be considered holistically, with the right people present at different stages of their treatment. For example, if an individual is withdrawing from heroin within a detox facility without a doctor present, then this presents a significant challenge. Participants highlighted the importance of recruiting people who are passionate about change, and are also willing to push through barriers, no matter the length of time this might take.

Multidisciplinary care teams

Participants emphasised the benefit of multidisciplinary teams, where clinicians work collaboratively to build a unified treatment plan for clients. This team might include occupational therapists, psychiatrists, as well as a case manager who can provide clients with different choices surrounding pain relief, career pathways, and peer support. However, some participants argued that instead of relying on multidisciplinary teams, new multidisciplinary roles should be created for Dual Diagnosis workers. The importance of "being dual diagnosis capable", was summarised by a Turning Point staff member:

> *In terms of the core principles of that [dual diagnosis] capability, there was a really interesting discussion there around the sort of silos that exist across the two [sectors], and how to actually sort of bridge that in a way that's achievable and realistic. And part of that was around the capability in screening and assessment as a core component of that dual diagnosis capability with the perspective that we still have specialists and specialised knowledge in skills.*
> *– Turning Point staff member, summarising discussion from their group. Workshop #2*

3.4.3 Coordination and collaboration across Mental Health and Addiction workforces

Given the risk of different interpretations of integrated care and expectations between the MH and AOD sector, it is essential for clinicians to work collaboratively. Professional relationships between clinicians, fostered by in-person interaction, can have a significant and positive impact on overall care delivery for the client. It is also important that both workers have a basic understanding of mental health and addiction practices.

Communication and relationship building

Shared planning, joint reviews, and shared information (i.e. picking up the phone and talking to those in other sectors) will improve communication between MH and AOD professionals. At present, there is limited dialogue between the two systems, with no clear understanding of what the other offers. The consequences of this are that the consumer often has to navigate and interpret dual streams of information. Two sets of reports can also sometimes result in a triangle occurring, with general practitioners trying to coordinate care. Multiple people might be doing the same tasks, resulting in wasted resources. Open communication, including with the client, with the allocation of tasks dependent on areas of speciality, will minimise duplication of services while adding value for clients.

Facilitating real collaboration comes down to the relationships between clinicians, where they can see and communicate with each other. A positive rapport between clinicians will also engender confidence in the client. Participants emphasised that open communication does not simply mean an email referral, but instead a warm and collegial connection between service providers. Although the siloing of these services is prevalent, participants discussed a range of ways that they might connect, ultimately helping both sectors to understand and respect what the other does. One such example provided includes practitioners attending networking meeting and conferences, with an NGO AOD

Practitioner summarising some of the benefits of attending these events:

> *In South Australia they have their comorbidity networking meeting that is held every six weeks and it's all of the integrated supports, like the AOD system, mental health, and they all meet and give updates and stuff like that. Then they have the big conference every six months [that includes] updates in the sector and what they're working towards and any changes in legislation that's coming or things that they're working on with the government, then, you know, changes in services and vacancies and all of these different things. So I think those sorts of things can be really beneficial.*
> *– NGO AOD Practitioner, Workshop #2*

A formal connection between sectors can also help to build connections and relationships across all levels of organisations but it is important that this structure is supported by management. As explained by participants, organisations can often be hesitant, from a funding and resource perspective, if two people are working together. Addressing these organisational challenges will be discussed further in section 3.6, 'Change Management and Culture'.

Co-location

Building relationships and improving communication can be better facilitated by the co-location of MH and AOD clinicians. When under the same roof, interactions are more prevalent, with "learning facilitated on a different level." Considering where clinicians are physically situated can facilitate broader access to each other through open plan discussions, incidental learning, and secondary consultation. Although case conferences do occur between clinicians, participants also discussed the advantages of having AOD workers on MH wards to build these relationships in person while further facilitating a mutual understanding between sectors.

Shared care plan

Participants noted that an 'integrated' or 'shared' care plan can help MH and AOD come together and collaborate. In co-designing a client's care plan, clinicians must question what integrated care actually looks like, with the clear allocation of roles and responsibilities mapped out. Meeting with the clients at the same time during this process and allowing the client to have more input over their care plan will contribute to mutually understood and supported strategies for intervention. As explained by a participant when discussing Jarrah's care plan:

> *Clients need to have more autonomy over their treatment plans. Communications can be short and simple but means that everyone is on the same page and Jarrah knows what everyone's role is. Clinicians aren't doubling up. [This] can be good for people with borderline personality traits - i.e. making it clear what clinician has what role. There will be an element of accountability for Jarrah and the clinicians if this is done. Consumers and their loved ones don't have expertise as clinical team but need to be offered all the choices available.*
> *– AOD Manager, Workshop #2*

It is also beneficial if family or other support persons are involved in the creation of the care plan so that they can have clear goals around things such as housing, employment, and other psychosocial needs that the client might have. As the client may be affected by

substances, having a support person in the room during this process can provide further clarity to the client around their treatment plan.

> *Ultimately Jarrah can be in attendance for those shared care meetings and potentially even a family member because Jarrah may not understand what's happening for him if he's distressed or if he is substance affected. So it might also be good to have a family member attend those shared care plan meetings so that there is a clear understanding of what the treatment plan is.*
> *– AOD Manager, Workshop #2*

Information sharing

As previously mentioned, a shared system around reporting and documentation (i.e. shared case meetings and case notes) will improve coordination between service providers while also providing the client with greater clarity when it comes to their treatment plan. In the interests of client well-being, participants felt that if the documentation is to be transferred into a different format, then this needs to happen behind the scenes rather than the onus being placed on that of the client. Creating a single database to access this information, similar to MyHealth Record, was suggested by participants.

If transferring confidential and private information to an allied system, there needs to be "follow through" from clinicians, with adequate systems in place to support the sharing of information between the wider support team for clients. Participants also discussed the sometimes challenging bureaucracies of different services, with difficulties often faced when attempting to share information in a timely manner (i.e. discharge notification).

> *I think a lot of these agencies and groups like say hospitals or even non-hospital providers, can be pretty clunky bureaucracies with their own paperwork, with their own information requirements. And I work in a clunky bureaucracy now, the public health system. So it's pretty hard to give information out in a timely manner or to give information out that's relevant. Say for example, even getting discharge summaries out to GPs, sometimes the GP gets them somewhere between three to four weeks after the patient's being discharged from hospital and that kind of delay in communication has real impact for patients' care and follow up. So I think the system is not catered towards sharing information promptly and efficiently.*
> *– Addiction Medicine Trainee, Workshop 2*

As referenced previously, improving digital literacy will also facilitate the quick and efficient sharing of knowledge through platforms such as Zoom.

Immediate versus long-term

Although many participants agreed that fully integrating every clinician involved with a patient's journey is ideal, it may be an aspirational goal in the short term. As it is difficult to expect "everyone to be an expert in everything", it was suggested that different people may need to take on different facets of care while working towards the future-state of integrated care.

As articulated by an addiction psychiatrist:

> *In the ideal world we'd love for every clinician to be fully integrated in their care, you know, so for every clinician to have expert mental health, expert drug and alcohol and expert integrated care. But what we realised is that in the short term or the medium term, or even in the longer term, that might be an aspirational goal. That's just impossible to achieve. It's hard to be an expert in everything. But I guess the working synopsis which we've kind of come to is the idea that we might have to have different people that are providing different facets of care that is more sub-specialized and we might have different processes that we as a service have to do in the background to work together and coordinate and supervise. But hopefully the consumer's experience [has been that of] integrated care in that they don't have to know that Ben and Kish are doing different things or that they're doing background paperwork. But their experience of care is that of seamless integration. [...] They don't feel like they're repeating the story or having to go to a different building, or that Ben's not reading the GPs notes, but that they're all in sync.*
> *– Addiction Psychiatrist, Workshop #2*

3.4.4 Transfering to another service

Continuity of care was seen as an important aspect of integrated care. Should clients need to be referred to another service, continuity must continue between service providers, with the client and provider ideally receiving feedback after the referral has been supplied. Participants also felt that having a process in place that allows people to transition from acute settings to community settings will aid greater continuity of care across sectors.

Importantly, clinicians need to be aware of exactly what these services provide so that their client can be provided with all the necessary information when making an informed decision. Any limitations to accessing services also need to be understood. For example, participants explained that MH practitioners may sometimes insist that a client attends a detox facility the next day, but capacity constraints can make this difficult - if not impossible.

Warm Transfer

Participants felt that success increases when you commence an exit plan before the client is discharged. As explained by participants, if clinicians are aware who their clients are being sent to, and there is a relationship between these services (or individuals within these services), then this leads to a better outcome and is the difference between a warm and cold transfer. As captured by participants discussing Jarrah:

> *I think the measures of success are increased when you commence your exit planning at the point of entry and gradually work towards a successful discharge [...] you know who you're sending them to and there's some form of engagement and relationship and some follow up that the person's got there.*
> *– AOD Executive, Workshop #2*

Having the capacity to support Jarrah, to go and have a look at a different service. So whether that be a detox, that can make all of the difference. I think for some people, if they can actually see the facility or meet the other clinician, I guess it's that warm handover or warm transfer, but if they've got a sense of where they're going or who they might be working with next, I think there's a higher rate of success in that. Because quite often, their understanding or their knowledge of what a detox might be is very different to the reality. So anything that we can do or Kish and Ben can do to support Jarrah in understanding, meeting, seeing, any sort of referrals or resources would be beneficial for him.
– AOD Manager, Workshop #2

Clinicians must also understand any history that their clients have had with particular services, such as bad experiences that might impact their willingness to engage.

3.4.5 Mentoring, supervision and leadership

Supervision provides opportunities for more senior staff to guide junior staff's personal growth, goals, and development, while also contributing to their own professional development goals. For postgraduate students, participants described a one meeting per month schedule as being a good rhythm for both provider and learner.

Participants called out that peer workers with lived experience often needed more direct supervision and regular debriefs than most clinical staff, but emphasised that spaces need to be created to support all staff. Participants highlighted time barriers in regards to supervision, where as many as thirty providers might report to just one or two team leads, which can result in the team leader being stretched thin and unable to properly support their staff. Participants suggested that best practice includes independent supervision that is preferably external (e.g. not completed by their line manager).

Although informal conversations on the ward are important and can make a real difference in care provision, participants discussed the advantages of formalising supervision:

We're more in the supervision mentoring space here, you know, the reality for a lot of services is that we just don't have the time. [...] I have 28 practitioners under me that I supervise on a monthly basis, which is hard to fill that in just to do that, but that's mainly line management. I have an open door policy where people come and go when those, non-formal, you know, conversations that make all the world of difference. But there needs to be a space and especially with the peer support workers and lived experience workers, that they need to be heavily supervised and they need to have that opportunity where they can learn and get that feedback and things like that.

[...] I'm a big believer in external supervision. You've got that person who's not actually working within your service, who totally gets what's going on and there's that bit of a space between, you know, the team leader and the practitioner where they can go and have these debriefing sessions and learn from there.
– AOD Team Leader, Workshop #2

Participants also considered the advantages associated with cross sectoral supervision, noting it often works successfully in practice. However, this requires clinicians to have a 'world view' across both systems, as an AOD practitioner articulated in reference to 'cross-sector reflective practice':

> *I also think there's value in cross-sector reflective practice like all group supervision. So looking at case studies and identifying how the two sectors can work together and the benefits of that. So actually, you know, if they're not seeing it in practice, maybe they're seeing it in reflective practice sessions or case studies so that you [understand] how that might work in real life.*
> *– AOD Manager, Workshop #2*

Mentoring was recognised as an important facet of the learning process. However, at present, mentoring often happens "by happenstance" and may need to be embedded and supported within a structured program. The Victorian Healthcare Association's "mentoring program for healthcare leaders" was recommended by some workshop participants, with formal training and support for mentoring relationships a key component for the MH and AOD workforce.

More generally, participants felt that a mentor of any kind can be beneficial to both career development and improving individual capacity.

> *Have a mentor. Have a supervisor. I personally have a mentor. A lot of mental health clinicians and other people do not. I would highly recommend it to everybody because it keeps me open and interested and wanting to learn. So I can talk from the mental health clinician's perspective that those things have helped me.*
> *– Psychiatrist, Workshop #2*

'Flipped mentoring' was also suggested by some participants, where, for example, CEOs are mentored by a harm reduction specialist.

> *I think that traditionally we look at mentoring as like, you know, a senior person will mentor a junior person, but actually in some respects [...], we want to flip that and actually have, you know at least have the openness to have a CEO being mentored by a harm reduction worker on the ground about what it is that they actually do day to day and why it's difficult to integrate that and X, Y, or Z at, or ideas to integrate it.*
> *– Harm Reduction Practitioner, Workshop #2*

Communities of practice

Further to facilitating mentorship opportunities, participants discussed some of the potential benefits that communities of practice (CoPs) can provide:

> *It's really important that our workforces have that inbuilt time where they can work with each other and feel supported by each other. A number of our member organisations have described informal communities of practice that they engage in. And they're at least really, really good for moral support of the workforce. That can also be a really effective way of supervising under these quite challenging circumstances for the workforces where there's so many vacancies. So they*

provide a really nice way for people to support each other and to be supervised when they might not have that ability elsewhere.
– Lived Experience Advocate, Workshop #2

It was also suggested that CoPs could be used to unpack specific topics, themes, and challenges that people are currently facing.

I wonder within those communities of practice if you could have topics that you speak to. So if it is a mental health practitioner, [...] that you have alcohol and other drugs being a topic that they discuss and vice versa. Or you talk about working with non-English speaking communities or working with families and you could actually use those communities of practice to really unpack and talk about the challenges that people are facing on those particular topics.
– Lived Experience Advocate, Workshop #2

3.4.6 Resources, support and advocacy

Participants remarked about the current lack of resources to support integrated care and highlighted that no one service, training or education program will matter if the resources to support integration at the level of service provision are not available. For healthcare staff, integrated care requires communication and agreement about roles and responsibilities of different supports so that resources and people can be allocated appropriately. Having a better understanding of each service's capacity and limitations will help support collaboration between teams.

Although support was described in a variety of different ways by participants, its inclusion in a client's care journey was a consistent theme throughout the research. Ongoing support and care for up to one year after discharge was often recommended, with participants explaining that the "best treatment means ongoing care".

Care Coordinator

Including an integrated care coordinator or peer navigator was suggested by participants to help the patient navigate multiple service providers. This role might involve organising appointments, ensuring they attend - including the provision of transport where possible - collecting medication, and providing an overview of the patient's journey. This can help overcome the barrier that some clients feel when they require care from multiple providers and need to 'navigate' the system. In reference to a regional Victorian Hospital, an addiction medicine trainee explained the role of a care coordinator in further detail:

We had an integrated care coordinator and that was for chronic diseases and that was helping a patient navigate multiple health services and multiple providers. It wasn't quite case management because the load was quite significant, but you had one person kind of almost file reviewing the patient, making sure they were getting funding or transport to attend appointments, making sure appointments and services were being attended and if not, why not, or how the patient would be supported to attend an appointment. So almost having an integrated care team or an integrated care coordinator that's at least having that overarching view of the patient and making sure things are progressing and things are being done was quite useful. For some of our

> *patients, it certainly helped a lot of patients attend appointments and improve outcomes in terms of making sure people were collecting medication and that packs were being done. So that was something that was useful.*
> *– Addiction Medicine Trainee, Workshop #2*

And, as a GP and Health professional articulated:

> *I sometimes think everyone needs a patient advocate for almost anything in health [...] I'm completely biased. I'd say case management or GP care, depending on who's actually engaging. Sometimes it's a family member, you know, like pragmatically, I've seen this work in all of those perspectives, but, generally someone will pick one person as their healthcare person who helps them negotiate the system through this thing.*
> *– GP, Workshop #1*

> *And you used the word navigation, and that is a particular issue for most of our clients is they have, I hate the word complex needs, but they have multiple needs. And which means they have to intersect with multiple systems and for the best of us, we find it obscure and frustrating. So to actually have somebody there that can walk alongside and assist to coordinate or navigate the systems is probably as important as what you might consider as a treatment.*
> *– Health Professional, Workshop #1*

Participants discussed the need to grow and establish a lived experience workforce so that it can be incorporated into 'business as usual'. While it's well established that peer workers with lived experience provide benefits to both care delivery and the overall recovery of clients, creating spaces where providers can learn about these benefits is not well executed. As explained by a peer worker:

> *That can sometimes be hard to sell to the higher doctors cause they don't want to hear it. And as there's certain people, we don't want to hear our stories, but our stories do make change and because we've been where your clients are or your patients are, we help you understand some things or help you learn something. We love talking about all our trauma. It's what we do best and like we turn it into a journey of hope and understanding and it helps you guys see the hope of recovery and the people that you are dealing with who might be quite difficult at that point in time. [...] It's just, unfortunately, it's not done at the moment.*
> *– Peer Worker, Workshop #2*

Participants also highlighted the importance of these advocates having the necessary MH and AOD experience while clinicians should also receive training regarding the specific roles of lived experience advocates. Although an important asset, participants noted the difficulty of recruiting this workforce in regional and rural areas where issues of visibility, stigma, and discrimination may be more severe than in metro areas.

Psychosocial support

Medical and psychosocial models work in different ways, with inherent complexities around individual needs. Participants highlighted the high recidivism rate if you treat clients and then "send them out the door." However, if the treatment approach also includes other aspects such as housing and employment then this could increase satisfaction and purpose for the client, thus, resulting in a more successful care plan.

Although additional resources are required, some participants see allied support to be as critical as medical intervention. In the immediate time frame, considering psychosocial factors improve the quality of medical care, but, ultimately, these factors were deemed most important when looking towards long-term care outcomes.

> *The diagnosis treatment model, the medical model and the psychosocial model work in different ways. The situation and the complexity around an individual's needs, if you just apply a purely technical diagnosis or treatment out the door, within a very short period of time, you will get a return rate. So you get a high recidivism rate because you haven't actually fundamentally changed anything else about the person's life. But if you then intervene with a whole range of other psychosocial supports, you might be able to assist with housing, employment, and increase their level of satisfaction with life and [create a] sense of purpose, then the results are much better. And that's much better done under one sort of model than the other. It doesn't mean that it can't be done here, it's just that they need to devote the resources to do it.*
> *– AOD Executive, Workshop #2*

Clinician support

Although support is often discussed in the context of the client, it is also important to consider providing adequate support for clinicians. 'Caseload stress', carer's fatigue or indirect trauma from workplace client interactions - including assaults - can have significant impacts on staff wellbeing. This is an important component when developing a resilient model for integrated care.

> *We can't give people huge caseloads and expect them to just drive things through and then expect them to be able to do good quality [work] if we don't give them the time for supervision and all the other good things that they need.*
> *– Addiction Psychiatrist, Workshop #2*

3.4.7 Future considerations

Participants questioned how client care might unfold long-term, stating that 'intensive' and potentially short term interventions need to include plans for the client's future. This includes identifying what ongoing support clients might need as well as clear re-contact agreements. As explained by a Dual Diagnosis practitioner when discussing April during workshop two:

> *There needs to be an agreed threshold for recontact from both the brother and April if things start to unwind at a certain stage. And some services are getting better at doing that, but often a large trigger event [is required] for services to go, okay, we will [re-engage]. And that's a problem. Which again, it's a deficit model that brings people into services rather than a supportive one that actually builds people into improving their quality of life. So there's an issue there in terms of how much energy is put into that issue of support when people are doing well rather than dropping support because people are doing well.*
> *– Dual Diagnosis Practitioner, Workshop #2*

Given that services often only re-engage after a larger 'trigger' event has occurred, participants speculated that a system to identify "early warning signs" might be beneficial.

3.4.8 Actionable insights: Enablers of integrated care in Victoria

This research identified the following strategies to address some of the enablers to implementing integrated care in Victoria.

- Work to establish integrated governance across MH and AOD sectors that clarify leadership structures, roles, responsibilities, procedures for who is responsible for making decisions during different stages of care, and procedures for escalation and deescalation of clients.
- Advocate and provide education in reference to co-occurring substance use and mental illness being "the norm rather than the exception". It is important to assess for this co-occurrence at the first point of entry to the system - whether that's at AOD Intake, a hospital or ED, an out-patient setting like a GP clinic or through an allied health service.
- Encourage the use of shared information systems, collaborative decision making and the coming together of providers. Delays in referrals and appointments can have a profound impact on overall recovery and healing.
- Ensure continuity of care when/if clients are referred to another service. This includes commencing an exit plan before the client is discharged, making clinicians aware of who their clients are being sent to and what these services provide, as well as establishing a relationship between these services to ensure a 'warm transfer'.
- Consider introducing further formalised, independent, and cross-sectoral supervision, embedding mentoring within a structured program, and creating CoPs to unpack specific topics, themes, and integrated care challenges that people are currently facing.
- Resource and fund integrated care appropriately, with structured time to support multidisciplinary decision making and meetings to discuss individual clients. Consider the role of human resources to help support workforce load planning, help address workforce shortages, and to support routine staff management. Acknowledge and seek to address disparity between regional and metro contexts.
- Implement strategies to address stigmatised and stigmatising perspectives, attitudes and behaviours. This could include communication and promotional materials, education and training opportunities, and opportunities for providers to hear from lived experience advocates and peer mentors.

3.5 Training and education requirements

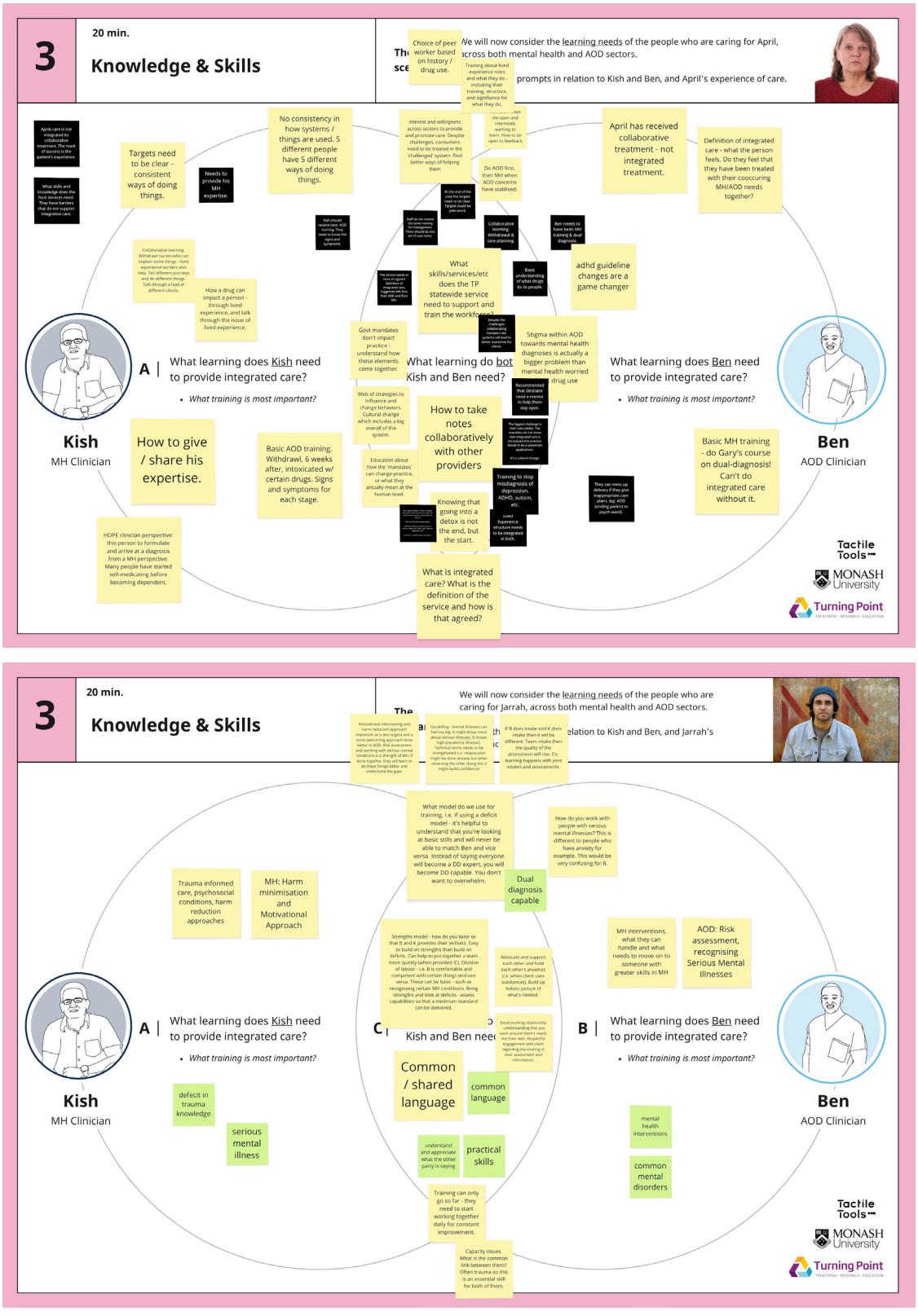

Figure 13 A screenshot of Activity #3 from Workshop #2, focussed on the experience of the April and Jarrah persona.

To enable meaningful training and education of the workforces, participants suggested creating a 'web of iterative strategies' and resources to build role clarity across the workforces before training about integrated care is attempted. As participants articulated: "when job roles are clear it can help build respect and can be empowering." This can be made challenging when the need to create clarity about what each part of the system does and does not do is not well articulated. As a Dual Diagnosis clinician underscored: "that around everybody understanding what everyone else does". In recognition of the many people with specialised skills in the system, other participants suggested a need for people to have 'generalist' training of what other providers to do, so that they were aware of their own 'specialist' training. As a harm reduction practitioner suggested, "we have specialised training, which is really super important, but also some generalist training and communication across the specialties, I suppose you'd say [...] We're not gonna teach everybody about how to do acute alcohol withdrawal, for example. Even though understanding the principles, risks and benefits of that would be useful across [workforces]."

Across the workshops, participants foreshadowed the need for all service providers to work through the many stigmas that surround addiction and mental health. This includes both education and training to address any stigmas held by the providers themselves, but also skills to support providers in challenging stigmatising perspectives they might encounter from other providers, family members or clients themselves. Participants highlighted the need to address stigma at each of these levels as a key change to enable genuine integrated care delivery.

Participants also highlighted a need to provide training about the whole system, and all the services - beyond just AOD and MH - that might be relevant to that person's overall holistic healing. Participants called out training needs around available legal services, housing, general health literacy and other commodities. While individual service providers do not need deep knowledge in these areas, they should have learning to help their clients access the supports they need. As an AOD clinician articulates, this can be a challenge because the 'system' itself is so 'convoluted'.

> *The navigational support for the systems is one of the hardest things to teach and for people to gain knowledge in [...] one of the core problems is that you actually, the system is so convoluted and de-structured that you actually have to have that skill in the first place. And then it's not even just once you learn how to navigate, you actually then for the individual services themselves, you have to know how to navigate that service as well. And that can be very tricky.*
> *– AOD clinician, Workshop 2.*

The challenge of helping clients navigate the system is a challenge for providers itself, suggesting that training about the 'system' would be beneficial for providers.

Participants underscored an overwhelming preference for face-to-face training and learning opportunities. While participants recognised the value of Zoom and online platforms to bridge geographical barriers and time constraints, it does not provide the chance to build genuine interpersonal relationships that can lead to more formal collaboration and integration of service providers in the future. Some participants also suggested that they found in-person talks more 'rich' than the online equivalents.

As a psychiatrist articulated:

> *Well, I think it would be good if AOD workers and people who work with people with substance addictions actually gave talks to the other disciplines. And I also think it's good if the various disciplines like the psychiatrist or social worker is able to give talks to the various members of the team and open up a space for discussion after these talks.*
>
> *[...] when people are doing it from their own experience and they've put all the work into their talks, I think that has a really big impact on people who are listening and I must be honest with COVID, I find face to face discussions so much richer and so much better. I find the online really difficult compared to what, you know, the nuances and things that you pick up when you're actually sitting face to face. [...]*
>
> *I think face to face teaching and, you know, workshops where people sit around a table, eight people and have these discussions [...] I would say [...] not a lecture, but more talks from each person from their experience and what they want to discuss with us face to face.*
> *– Psychiatrist, Workshop #2*
>
> *I can't say strongly enough how much more preferable face to face is. [...] I know Zoom is efficient and it saves people travelling and so on. But you know, with online training, you know, that 10 minute break that we just had, if that had been in person you know, we would've stood around talking to each other and actually doing like continuing the work. [...] So bringing people together again, it's about developing relationships.*
> *– Mental Health Team Leader, Workshop #2*

Participants also highlighted that while identifying training for individual providers was important, it was also important to identify what attitudes and skills the organisations themselves need to enable integrated care. As participants articulated, often the organisations themselves do not support or scaffold integrated care because of the resources they provide to clients. As a Dual Diagnosis provider articulated:

> *What knowledge and skills do the workers need? A much bigger question, and to my mind, a much more pertinent question is what skills, knowledge, attitudes does their service need? You know? Services, structural handrails support the workers in providing better treatment. We've done decades of training workers about integrated treatment. They go back to their host service and they find that the host services, beliefs, attitudes and actual handrails like, you know, assessment proformas, all that sort of stuff do not support integrated treatment. That it's not actually valued by the service. You know?*
> *– Dual Diagnosis Provider, Workshop #2*

3.5.1 Training for AOD workforce

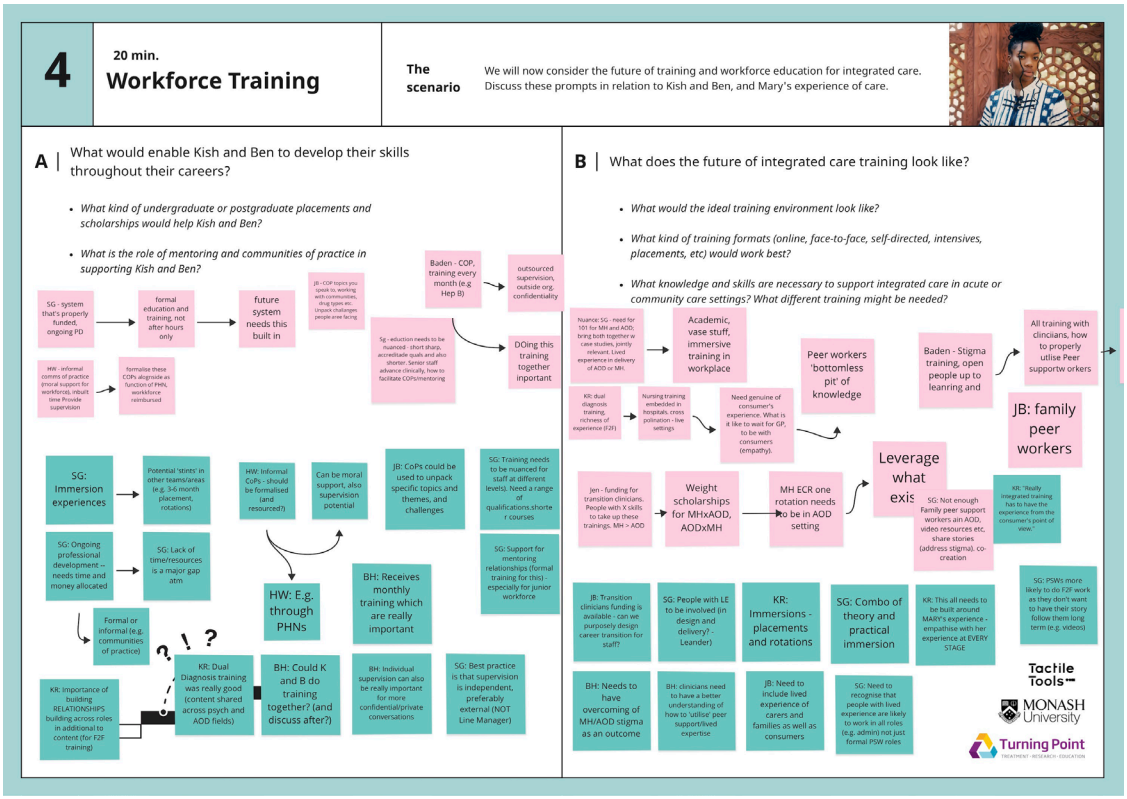

Figure 14 A screenshot of Activity #4 from Workshop #2, focussed on the experience of the Mary persona.

This research confirmed that for the AOD workforce, a generalist and basic understanding of the mental health system is necessary to support the clients they care for. As a Harm Reduction Practitioner suggested:

> *So like knowing the basic you know, parameters for, mental health conditions the system and probably suicide risk comes up all the time. So that's, you know, those basic foundational things. But also then things like from a system's perspective, the mental health act and understanding how the mental health system, the public facing mental health system is, you know, bound by the Mental health Act and, and the limitations or opportunities that that provides.*
> *– Harm Reduction Practitioner, Workshop #2*

3.5.2 Training for MH workforce

Participants articulated that existing mental health providers need training in basic AOD terminology and an understanding of what AOD care can and does involve, such as withdrawal, detox and harm reduction. Participants suggested that many mental health providers do not understand these elements of clinical care, while AOD professionals tend to be more comfortable with this part of client recovery.

3.5.3 Training involving lived experience and peer support workers

Training is required to support AOD and MH workforces to work alongside peer support workers, as well as for peer support workers themselves. As a peer support worker articulated:

> *About needing the organisational training to support work with peer support workers, I think, so that they can really understand the values of peer work and do any of this training that they're receiving [...] could be designed and delivered by peer workers as well.*
> *– Lived Experience Advocate, Workshop #2*

Participants also highlighted the need for training for clinical providers in reference to working with peer support workers:

> *If they did get education then, or that they got peer support workers into this scenario, it'd be good if they had organisational training on how to work alongside a peer support worker.*
> *– Peer Support Worker, Workshop #2*

3.5.4 Training beyond frontline service providers

Beyond staff who are at the frontlines providing care for clients, participants underscored the value in bringing together senior leaders to build professional relationships, develop collaborative partnerships that enable integrated care, and also create a space where leaders who can be disconnected from frontline service provision can listen to 'real challenges' that are emerging 'on the ground'. As participants explained:

> *Try to get your system leaders, your management and your clinical leaders on board with it and develop their unified vision around integrated care. Very, very challenging to do. And there's a truism in capacity building that the more qualifications somebody's got, the harder it is to influence their practice [...]*
>
> *It's relatively easy to influence a new worker's practice. It's almost impossible to influence the practice of somebody who's got a lot of advanced qualifications. So yes, I advocate having central workshops for the leaders of the system, you know, all the management, all the clinical leads and having a reflective type workshop where you try and draw from them their views, their concerns, where you have actual meaningful discussion.*
> *– Dual Diagnosis Clinician, Workshop #2*

The potential of weighted scholarships was also discussed by participants:

> *There's a scholarship program at the moment and I'm wondering if you could [create] weighted scholarship so that those scholarships that are for mental health workers doing AOD or AOD doing mental health would get extra points to get that scholarship. And the other thing is with the early career positions going into mental health services. They do rotations throughout the services and whether there was the opportunity to say that one of those rotations needs to be in an AOD setting,*

and that could be outside the actual clinical service, but in a community service or, you know, something else like that. I'm just wondering if there's creative ways of leveraging the things that are already going on to be able to achieve this.
– Lived Experience Advocate, Workshop #2

3.5.5 Actionable insights for training and education

Is it important to note that integrated care does not require everyone to be an 'expert in everything'. Instead, it requires providers across the system to have deep specialist knowledge in one area, be willing to collaborate with other providers, and bring with them general knowledge about the support services that overlap with their speciality. This research didn't confirm that providers across AOD or MH necessarily need 'formal' education or training - like a degree or Certificate IV - but instead need to be introduced to concepts beyond their speciality and instructed on how it fits into a model of integrated care.

Remaining insights for training and education to enabled integrated care include:

- Preference face-to-face training and learning opportunities. While participants recognised the value of zoom and online platforms to bridge geographical barriers and time constraints, it does not provide the chance to build genuine interpersonal relationships which can lead to more formal collaboration and integration of service providers.
- The AOD workforce needs basic training in regards to mental illness and commonly occuring behaviours and presentations that can emerge in clients with multiple needs that include addiction. This can include information on mental health literacy, suicidal behaviours, safety plans, psychosis, and information about the mental health system, the mental health act and the 'limitations and opportunities this provides'.
- The MH workforce needs training in regards to AOD care, and what it does and does not involve. Specific focusses should be on withdrawal, detox and harm reduction, including the physiological impacts that can surround AOD care (i.e withdrawal and detox).
- Training should be provided for lived experience and peer support workers about the 'system' and organisations they are working with, as well as a basic understanding of clinical terminology that they themselves may not be familiar with. Training is also required for clinical staff who are working with peer support workers to ensure that the value of peer support workers is understood as this will further enable collaborative working relationships.
- Training is required for all providers to address the many stigmas that surround mental illness and addiction, while also addressing how care should be provided in a culturally safe and inclusive manner.
- Beyond frontline service providers, participants also highlighted that training for senior managers, CEO's and executives would also be beneficial to support 'top-down' change in favour of integrated care. Rather than a formal lecture or session, participants suggested that this could be framed as a 'reflective practice' workshop to encourage the sharing of experiences and ideas as well as encouraging collaboration between service providers.

3.6 Change management and culture

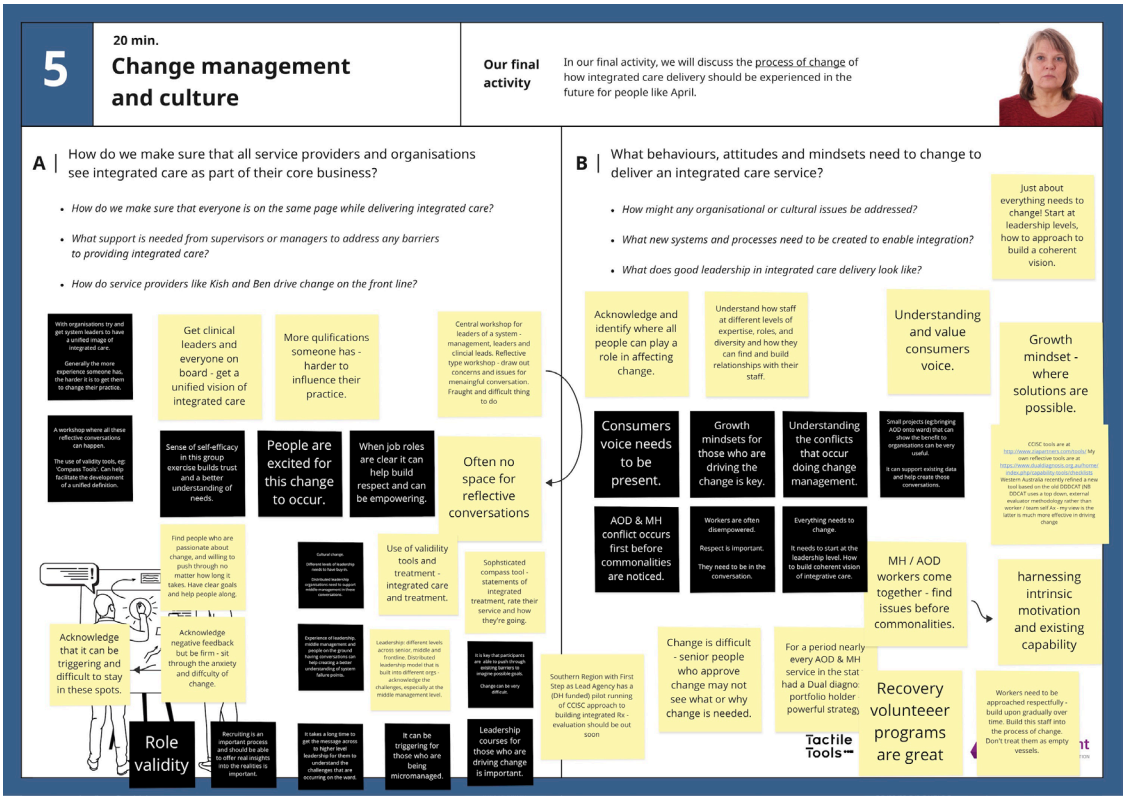

Figure 15 A screenshot of Activity #5 from Workshop #2, focussed on the experience of the April persona.

Participants confirmed that transitioning towards integrated care requires broad transformation of existing systems and services. As a significant change management challenge, this section provides insights to support organisational cultural change at individual, service, institutional and systemic levels. Participants felt that effective change management involved avoiding the fight/flight reaction, selling the vision, explaining the rationale and providing a safe environment to practise the change required. This process also includes harnessing intrinsic motivation and existing capability while making sure that organisations and staff are adequately supported.

Participants emphasised that an appropriate amount of risk needs to be taken by all those involved, rather than relying on the sole expertise of one individual (e.g. a psychiatrist). Clinicians also need to be able to “sit with difficult risk” and be comfortable with change.

3.6.1 Behaviours, attitudes and mindsets

Participants speculated that many of the experienced staff, especially within the AOD sector, experience frustration and disillusionment with this process and emphasised that the more qualifications an individual might have, the more difficult it can be to influence their practice. It can take a long time for the message to reach higher level leadership and for them to understand the challenges that are occurring on the ward. Professionals

may also be performing beyond their standard roles and responsibilities due to current system limitations. When the system doesn't change, clinicians can feel "punished" for knowing more which can be a significant barrier to delivering integrated care. As explained by a Psychiatrist:

> *Why professionals end up giving up is because the system doesn't change and they get punished for doing [more]. The more competent you are, the more you get overloaded with things [...] there's no return coming for that. So if this was a private organisation and my performance was linked with my bonus of pay, I would be motivated to go an extra step and do more. Not in the public system.*
> *– Consultant Psychiatrist, Workshop #2*

Participants also discussed the consequences of 'potential outliers' or those who may think that they are exempt from change. For cultural change to happen, everyone needs to be "brought along on the journey" and be supported by a unified vision of integrated care.

The importance of needing "small wins early" was emphasised by participants as this will help clinicians see how integration can make their job easier. This approach can also highlight the better quality outcomes that their patients are receiving. This will, in turn, build confidence in larger change. When discussing Johan, a Addiction Psychiatrist articulated:

> *If you can help the clinicians [that are] working with Johan, actually see how integration actually makes their job easier [...] people innately want to be able to do the easiest thing. But if they can actually see how it makes their job easier and how Johan has better outcomes, then maybe they're more likely to put it in action.*
> *– Addiction Psychiatrist, Workshop #2*

Beyond communicating small wins, participants felt that continual feedback involving stories of when integrated care has worked well - and hasn't worked well - is also needed.

Lastly, participants discussed the benefits of creating a sense of 'permission' for change toward integrated care delivery as this does not currently exist. As explained by an AOD clinician: "there needs to be a sense of permission. And having worked in the area mental health service system, that is definitely not a current state".

3.6.2 Policy

Before discussing the role of organisational leadership below, it is important to note the need for government policy to first be in place. As outlined by an Addiction Psychiatrist:

> *Management will need directives from a policy level because short of that, management is too busy to really give a damn about any new idea unless it is put on the head that this is government policy, this has to be core business [...] Unless it is policy driven, management has been in that role for decades, they're not going to be able to even think about it in a new way. The thinking is too set in its manner. But when something comes through policy, then you have the whole organisation, top executives, everybody behind that, that drives change.*
> *– Addiction Psychiatrist, Workshop #2*

After the introduction of policy, KPIs and other output metrics - to provide objective tracking of how integration is working - can help ensure that the system keeps running efficiently.

3.6.3 Organisational leadership

Participants articulated the important, but perhaps understated, role that leadership plays in facilitating change to enable integrated care. This can be made complex when senior leaders don't spend time 'on the ground' and actually understand the problems faced across the two sectors. Those in positions of leadership, middle management, and people on the front-line having conversations can help create a better understanding of system failure points.

Participants highlighted that the change required is significant, and requires a 'growth mindset' for leaders across the workforce. As participants articulated:

> *Change is difficult and it's very difficult for everybody, but top management people who are not sitting on the ground dealing with consumers every day … it's difficult for them to really understand what we're trying to drive.*
> *– Psychiatrist, Workshop #2*

> *I think there needs to be a growth mindset and a mindset where solutions are possible and to really try and get into a more positive space for the people who are driving this change. And just coming to work with a positive energy if one can't manage or struggling to have their own private space to manage that. So we don't bring that into the workplace. We can facilitate, you know, really positive motivated change.*
> *– Psychiatrist, Workshop #2*

> *Just about everything needs to change though. At the same time, you know, we need a huge amount of change. That's really, really gotta start at the leadership levels, you know, and how we approach the leadership, how we build their coherent vision of integrated treatment. You know it's massive work.*
> *– Dual Diagnosis Practitioner, Workshop #2*

Participants expressed that change can be difficult and 'scary', especially for individuals with entrenched ways of doing things. Staff across the healthcare system should be approached 'respectfully', and build upon the positive things they already do in their respective roles; rather than change how they are expected to act and perform radically. As a Dual Diagnosis practitioner described:

> *The workers and the systems need to be approached respectfully. You know, that recognises the great things they do already. And let's try and build on those. Here's a few more things that we can try and build on those gradually. They need to be in the conversation. It's a dynamic process. It's a two way process. It is not, you know, inserting knowledge or skills into empty vessels.*
> *– Dual Diagnosis Practitioner, Workshop #2*

This requires staff across workforces to be 'flexible' and 'adaptable' to change, which necessitates the 'right' kind of people to champion change across the sectors. These

individuals need to be identified and supported on the front-line. Participants suggested leadership courses to empower team leaders and organisational leaders alike to support and lead their staff through the process of change. Reflective workshops were also recommended by participants, which can assist in drawing out concerns and issues for meaningful conversation. As a Psychiatrist articulated:

> *I think people are scared of change. They rather sitting with what they're comfortable with, even though they know it doesn't really work the way they want it to work. But change requires adjustment and people have to be flexible and adaptable, and that's difficult when people are stressed and tired.*
>
> *Some people are more adaptable than others and other people are not. So it's also dependent on different personalities. So you need the right people to be driving these type of things who are more flexible and can withstand the difficulties that go with it and are able to stay put and to move forward and focus on what they want to achieve and who are talking about it and are passionate about it, interested, happy, you know, don't see all the negatives, but see the possible solutions.*
>
> *So I think leadership courses are really important,[...] leadership skills for people who are driving this type of change, wherever you sit in the hierarchy. And also to acknowledge that some people don't understand why you want to drive this change and they're not in the same circumstances as you, and you have to explain it to them in a way that makes them want to do it <laugh>. So it's, considering all of those different things, it takes a long time.*
> *– Psychiatrist, Workshop #2*

An important part of successful change management is establishing 'buy-in' at different hierarchies within the system, to champion change toward integrated care and support others in shifting their current approaches to treatment and care. Beyond just senior leaders like CEO's, it's important that specific strategies are created to support middle managers. As a Clinical Nurse Consultant explained:

> *That sort of distributed leadership model that is built into huge organisations, and smaller ones in terms of providing healthcare, acknowledging the challenges, particularly at that middle management level. They're often the people that are forgotten in terms of organisational change pieces and supporting their own capability to affect change, including by being supported through the provision of time as well as what they're talking about.*
> *– Clinical Nurse Consultant, Workshop #2*

3.6.4 Resources

Participants discussed specific 'tools' and resources that they had used in their own practice to enable integrated care. Participants gave examples such as; a 'compass tool' to ensure that all providers were aligned and pointing care in the 'right' direction for their client, shared statements of what integrated treatment means to that provider, tools for use at intake to ensure inpatient services are across 'all connections', and a survey tool for both clients and providers to rate their experience of care and how 'integrated' their

service was. The use of such validity tools can help facilitate the development of a unified definition of integrated care.

As highlighted by a Dual Diagnosis clinician:

> *One of the approaches that I really like, is making sure everyone is on the same page when delivering integrated care is the use of validity tools. You know, you've got a model of integrated treatment, an emerging model of integrated treatment in your service, [...] they've got a really sophisticated use of their compass tool. And basically that's a process where everybody sits down with a whole lot of sort of statements about integrated treatment, what it is, and then they rate their service or how they're going with achieving integrated treatment. It's beautiful, and, there's been other tools, you know, I've invented, I've done some of those tools myself, and I believe some more tools may be in the pipeline from the Vic gov.*
> *– Dual Diagnosis Clinician, Workshop #2*

3.6.5 Actionable insights for organisational change to enable integrated care

- The Statewide Centre should consider developing a 'web of iterative strategies and resources' to support integrated care across Victoria.
- Government policy needs to be in place to help organisations make integrated care "core business". After the introduction of policy, KPIs and other output metrics should be developed to track how integration is working on the ground.
- Consider 'co-designing change' by encouraging collaboration and consultation during the planning process, elevating people's expertise and knowledge within these discussions, and encouraging 'buy in' from multiple levels of the organisation.
- Management should communicate "small wins" early while also providing continual feedback regarding when integrated care has - or hasn't - worked well.
- Good leadership should be in place to support those who might themselves be barriers to change. This includes spending time 'on the ground' to understand the problems faced across both sectors, approaching workers about change gradually and respectfully - building upon the positive things they already do in their respective roles, and creating a supportive environment so that staff can implement change without fear of reprisal.
- Consider the use of 'validity tools' to support services in starting integrated care delivery in their own organisations, but also tools to enable team leaders to work with their staff to address potential challenges.

4 Persona users

Part of this research involved a focussed interrogation on the personas used in this research. These personas built upon vignettes previously developed by Turning Point, which were iterated upon through collaboration between Turning Point and Monash researchers. These personas aim to represent just a small section of the kind of people who might experience co-occurring mental illness and addiction across Victoria, and ultimately the people who stand to benefit from integrated care delivery in the future.

The summaries that are presented in this section highlight findings about how to improve each persona to better reflect actual clients in the Victorian community. These findings are validated through a synthesis process that triangulates findings through ethnographic research methods. These findings then led to improved personas which were printed as A2 posters and posted to participants in Workshop #2.

4.1 Engaging with the persona stories

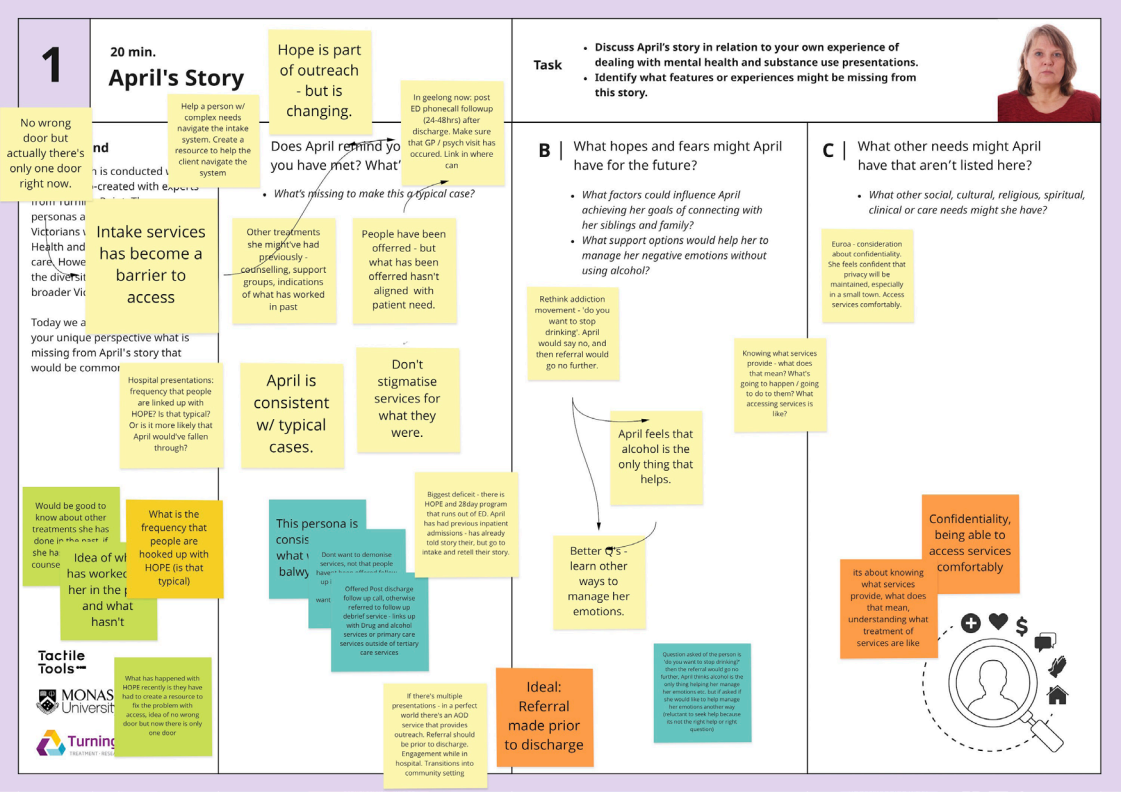

Figure 16 A screenshot of Activity #1 from Workshop #1, focussed on the experience of the April persona.

In Workshop #1 participants interrogated the established persona users provided to each group in relation to their own experiences, and reflected upon how they represented real-life cases and individuals from the Victorian community. A prominent gap that emerged across all four personas was an overview of their life before they presented at a service seeking help. In overview, all personas lacked detail into their life story, social context and cultural background. They provided only minimal insight into their motivations for substance use, and hopes for the future. These factors are important as they shape and inform overall healing and recovery, and the approach taken by care providers.

4.1.1 Insights to improve all personas

- Provide additional background information, context and detail to present the individual person as a whole, complex and 3-Dimensional person complete with strengths, weaknesses, hopes and fears.
- Reframe persona stories to be 'strength' based; highlight positive aspects of the persona's lives and not just a list of deficiencies, weaknesses, or things that have gone wrong. Persona stories should highlight moments or periods in their lives where they have experienced success and were in good health.

A summary of the focussed discussion on each persona, as well as the improved persona provided to participants in Miro in workshop #2, is presented in the following section. Reproductions of physical posters of the personas, printed and posted to participants to provide additional narrative information, are presented in Appendix C.

4.2 Mary's persona

Figure 17 A screenshot of the Mary persona that was provided to participants in Miro in Workshop #2.

Participants suggested that further detail and context regarding Mary's life would be pertinent to providing better quality care. Participants questioned how she ended up as an inpatient, including whether she was detained under the Mental Health act or whether she sought help on her own. Mary's motivations for substance use - including GHB, methamphetamine and alcohol - is not made clear in the existing story. Participants speculated that because she left school in Year 10, it's possible that Mary could have undiagnosed ADHD and is self-medicating with other drugs. Other participants suggested that Mary could be experiencing drug induced psychosis or is self-medicating to deal with PTSD symptoms arising from childhood trauma, suicidal ideation or other trauma not described in the story.

Understanding Mary's motivations is important as it informs the treatment and care plan that both mental health and AOD workers provide. This additional context is

not just clinical, but covers a range of factors from the psychosocial to the physical. Understanding her cognitive capacity, proficiency with English, history of depression and/or anxiety, migration experience, and any other underlying neurological or physical issues or diagnoses is important. Understanding Mary's other interactions with the primary care system - ranging from a visit to her GP or elsewhere in the healthcare system - helps elucidate other risks for Mary which might range from suicide risk, self harm, sexual risk such as blood-born viruses and neglect within her own family.

Participants also suggested that Mary's hopes for the future are not about the service or system, but more likely deeply personal. For Mary, this might be as simple as a 'good night's sleep' - given the challenges of sleep deprivation - improving her own hygiene, improving her diet, or to find ways of managing her emotions without relying on substances. Other longer term goals might include learning through vocational or higher education, improving relationships with her family and friends, or looking to move out of home.

Other participants highlighted the important cultural and spiritual needs of Mary that will need to be fulfilled in order to provide holistic care and healing. While an exact denomination is not listed in the persona at present, it is possible that as a Sudanese woman Mary might identify as any number of diverse religions. Understanding Mary's cultural and religious needs, and any associated shame around substance use, should be addressed as part of Mary's recovery.

4.2.1 Actionable insights to improve Mary's persona

- Provide additional details and context about Mary's prior history and experiences before the start of the Persona story, including why she left school at Year 10.
- Add detail about Mary's motivations for substance use. Some participants speculated that this could be self-medicating for ADHD and to deal with feelings arising from her PTSD symptoms.
- Add detail relating to Mary's cultural and spiritual needs.

4.3 Johan's persona

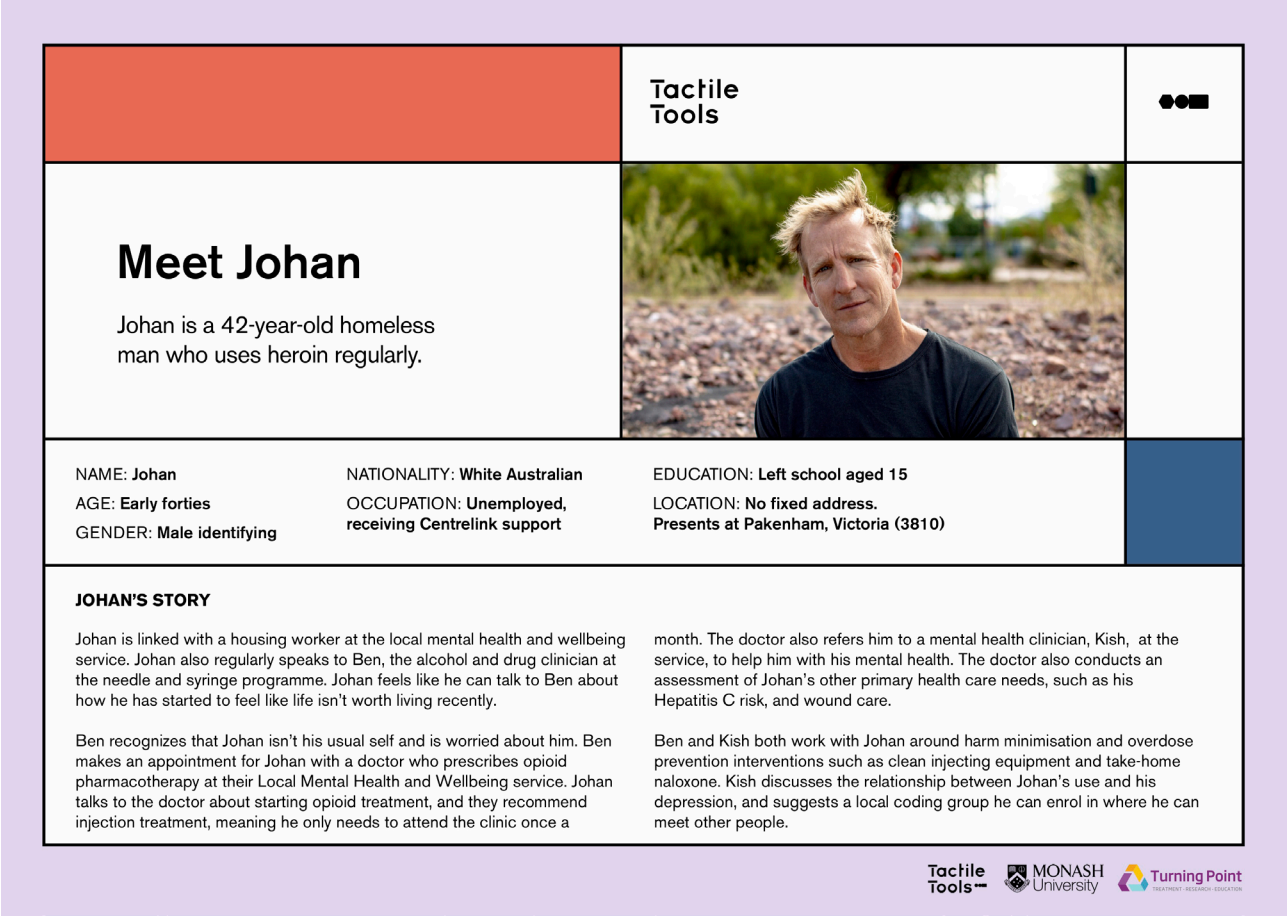

Figure 18 A screenshot of the Johan persona that was provided to participants in Miro in Workshop #2.

Participants believed that Johan represented a very credible client of the existing AOD system, but pointed out some missing details in the existing narrative that would be pertinent for providers to know when providing care.

Participants expressed that a full history of Johan's life - as well as any periods or times of success in his life - would be important to understand how to develop a treatment plan for him. Important details such as his relationship to heroin, how he first started using it and how he is funding his heroin use is not made clear in the current story. His heritage, sexuality, past relationships, children, friendships or other social supports are also not made clear in the persona. Participants expressed that it was likely that Johan would have had contact with the police and other authorities, with these external factors making his life more complex as a result. Participants underscored that understanding Johan's life story more fully is important to being able to suggest the best treatment pathways and other appropriate services.

It is also likely Johan has a number of other needs that are not well articulated in his existing story. These range from the psychological to the physical and social. It is likely Johan has unaddressed physical health needs - such as chronic disease management,

sexual health, dental care, pain management, wound care and risk of Hepatitis C. Johan may require financial support to secure housing, and then social support to secure an income. Longer term, Johan will likely need help securing meaningful and long term employment. If Johan had experienced the criminal justice system previously he may also have co-occurring legal needs.

4.3.1 Actionable insights to improve Johan's persona

- Provide more detail and context about Johan's life prior to his presentation to health services in the existing Persona story.
- Provide a brief overview of how Johan started using heroin and how he is funding his ongoing use.
- Provide an outline of additional needs that Johan has beyond just housing, addiction and mental health. This should include an outline of his legal needs, other physical health needs and information about his previous relationships and children.
- The narrative should also highlight and list things that Johan likes to do. Some participants suggested that this might include computer programming he learned at libraries, painting or drawing, or reading about history.

4.4 April's persona

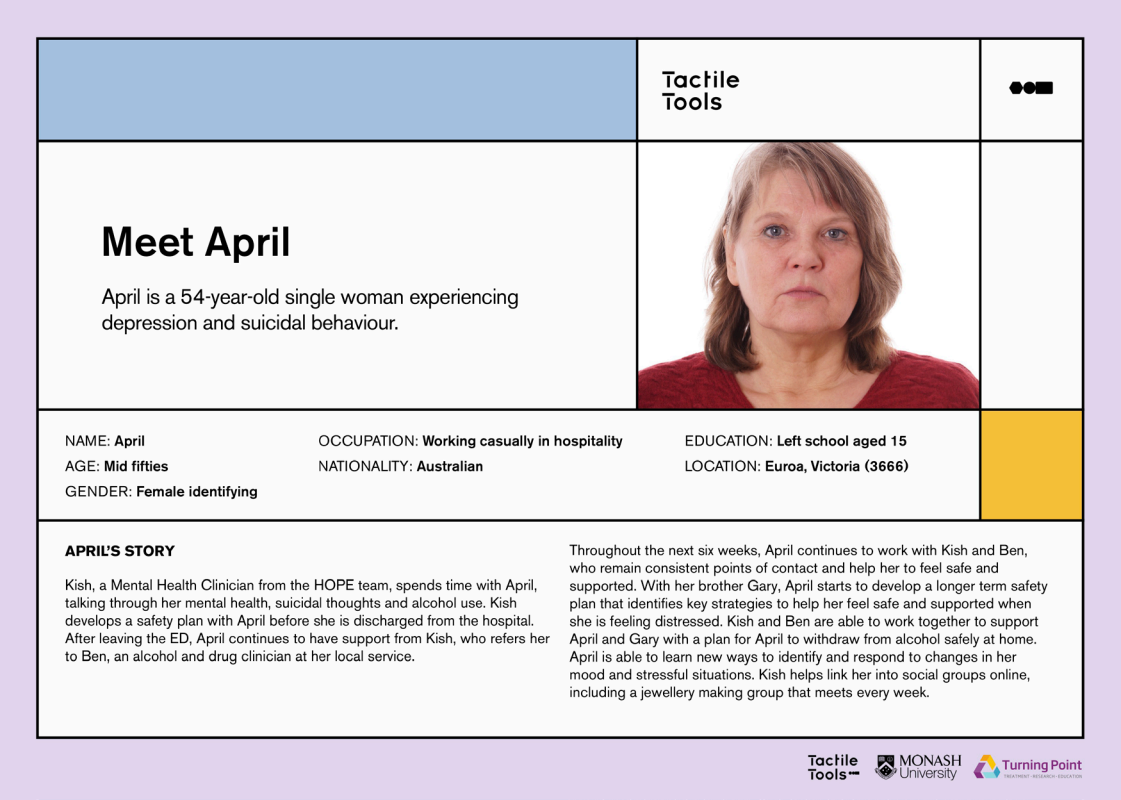

Figure 19 A screenshot of the April persona that was provided to participants in Miro in Workshop #2.

Multiple participants confirmed that April is consistent with typical cases that present to health services in rural, regional and urban locations. However, some participants underscored that the care provided to April through the HOPE program was not representative of what would likely happen currently in a regional context.

Participants felt that given April would be seeking help in a regional location, it's likely that she may not have been referred to the HOPE program at all, or have fallen "through a gap in the system" due to her geographic location and having no ED or hospital nearby. Participants highlighted that the HOPE program did not operate out of every hospital, and not every ED across the state would necessarily refer April to the HOPE program. Even if they did, the scope of the HOPE program means that the service provision provided here can only address her immediate mental health, as well as suicidal and safety needs rather than her addiction, alcohol use, or other needs that would be part of integrated, holistic or 'whole-of-person' care. Participants confirmed that the HOPE program would not address her alcohol use for example, with some other participants suggesting that it may even be downplayed by providers in light of the suicide attempt.

Participants highlighted that there is pertinent background information that is missing from the existing narrative that would be required by health providers to provide integrated and holistic care to April. Information and detail relating to April's previous romantic relationships, relationships with family, housing, and financial contexts are important for providing care. Additionally, clinical information such as previous diagnosis(es), relevant co-morbidities, previous suicide attempts, previous in-patient stays or other engagement with psychiatric services and family histories provide important and relevant context to further validate the persona. In terms of April's journey to recovery, it would be important to understand what had worked for April previously in managing her emotions.

4.4.1 Actionable insights to improve April’s persona

- Provide and expand detail relating to April's previous romantic relationships, her sexuality, relationships with family, housing, and financial contexts. All of these elements of April’s life are important for providing care.
- Provide and outline clinical information such as family histories with mental illness or addiction, previous diagnosis(es), relevant co-morbidities, previous suicide attempts, previous in-patient stays or other engagement with psychiatric services to provide further context about the moments prior to April’s suicide attempt.
- Provide information about what had worked for April previously in managing her emotions and alcohol use.

4.5 Jarrah's persona

Figure 20 A screenshot of the Jarrah persona that was provided to participants in Miro in Workshop #2.

Participants highlighted that Jarrah's story only provided a 'cursory' summary of his life and insight into a single point of time in his life. Participants suggested that it would be important to understand Jarrah as a "whole, complex, and 3-Dimensional person" to provide holistic care. Specifically, participants called out the need to understand his prior engagement and access with healthcare services - such as GP, mental health assessment or AOD services - which may have been made complex due to his location in regional Victoria. Participants also suggested that the personas needed more context to support Jarrah's diagnosis in relation to mood or anxiety. Understanding Jarrah's whole life and how it led to this moment: from his childhood, schooling, any relevant social circles and friendships, and other risk factors such as a family histories of mental illness, suicide and/or other substance-use issues - is important to more accurately understand how to provide appropriate and holistic care.

Participants speculated that it was likely that Jarrah would meet the definition of Cannabis-Abuse disorder and anxiety. Participants highlighted that the two are interrelated, where some anxiety would likely be induced by cannabis use while some is pre-existing, but it was possible that the initial trigger for Jarrah's anxiety may not have been related to his substance use and instead had emerged in response to something else in his life.

Some participants speculated that Jarrah started self-medicating to manage his feelings and emotions. To provide integrated care, it would be important to determine how his cannabis use actually started. Participants expressed that it was likely that a number of psychosocial factors were contributing to both how he started - and why he has continued - using cannabis.

Given that Jarrah identifies as a First Nations Australian man, it would be important to identify any relevant cultural, generational or associated trauma and the impact it has had on Jarrah and his mother in his life so far. Participants highlighted that it was very likely that the process of seeking help would be scary for both Jarrah and his mother - especially if it's the first time he is seeking professional help. Participants noted an important cultural dimension where a 'white system' was providing care for Jarrah, and it was likely that he would be fearful of this. Participants suggested that linking with Aboriginal health services would be beneficial, and that the social and emotional wellbeing (SEWB) model of care would be important for Jarrah, but acknowledged that this model is not done well currently.

4.5.1 Actionable insights to improve Jarrah's persona

- Provide details about Jarrah's engagement and access with other healthcare services previously in his life, as well as other risk factors such as a family histories of mental illness, suicide and/or other substance-use issues.
- Provide details about Jarrah's diagnosis in relation to mood, general anxiety and its intersection with his cannabis use. Participants suggested that Jarrah would likely meet the definition of Cannabis-Abuse disorder and anxiety.
- Provide details about how Jarrah first started using cannabis. Some participants suggested that he may have been introduced to it recreationally, but continued using it as a way of self-medicating to manage his feelings and emotions.
- Provide detail about Jarrah's concerns as a First Nations Australian seeking help in a 'white system', and concerns that he and his mum may have based on their previous experiences with the health system.

5 Next steps

The findings from this study will be used in collaboration by Monash Design Health Collab and Turning Point to support the ongoing work of the Statewide Centre. Monash Design Health Collab would like to thank all those who participated in the workshop and contributed to this research.

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7 Appendices

A Appendix A: List of workshop facilitators

A1 Workshop #1 facilitators

Leah Heiss
Nicole Kenny
Shalini Arunogiri
Gretchen Coombs
Olivia Hamilton
Annie Williams
Troy McGee
India Macpherson
Annette Peart
Dallas Wingrove
Myra Thiessen
Amy Killen
Jon Tyler
Rosie Kalogeropoulous

A2 Workshop #2 facilitators

Leah Heiss
Leander Kreltszheim
Margret Petrie
Shalini Arunogiri
Gretchen Coombs
Olivia Hamilton
Rosie Kalogeropoulous
Troy McGee
Maryke Laubscher
Annie Williams
Myra Thiessen
Amy Killen
Daniel Pham
Jon Tyler
Dallas Wingrove
Michelle Sharkey

B Appendix B: Blank Miro boards

B1 Workshop #1

Mary

Tactile Tools

Reading • 5 min.

Meet Mary

Mary is a young Sudanese woman who has a history of using multiple substances. She is being treated for her psychotic symptoms and post-traumatic stress disorder.

NAME: **Mary**
AGE: **Early twenties**
GENDER: **Female identifying**
NATIONALITY: **South Sudanese**
OCCUPATION: **Part-time Student**
EDUCATION: **Left school in Year 10 (in Australia)**
LOCATION: **Public Housing. Flemington, Victoria (3031)**

MARY'S STORY

Mary is linked with Jen, an alcohol and drug peer support worker, who sees her in the inpatient mental health unit. Jen talks to Mary about safer ways to use, and how to reduce her risk of a GHB overdose.

Mary is also seen by an addiction specialist, who supports her mental health team to manage her alcohol withdrawal, to prescribe medication to support alcohol reduction, and to prescribe medications to reduce and cease her benzodiazepines. The mental health and addiction specialist teams meet with Mary to understand what is driving her recent increase in substance use, and identify that she is suffering from post-traumatic stress disorder. They discuss antidepressant and antipsychotic medication for the short-term that can help her manage her current difficulties, and will support her linking into appropriate psychotherapy to work on trauma.

Mary's mother Achol is also supported to meet with a carer consultant, with an interpreter. Achol is distressed about Mary's admission, and feels that Mary's behaviour has brought shame on her family.

Mary is supported to return home with weekly follow-up appointments with a case manager, who works with her in a trauma-informed manner, supporting her to link into counselling at her TAFE. She is also linked with suicide prevention mental health supports, which include home visits and outreach in her community. They help her start to venture out of her home more often, and also help her link into a basketball team in her local community.

The carer consultant continues to work with Achol following Mary's discharge, and links her into transcultural mental health and community supports.

Tactile Tools | MONASH University | Turning Point

1

20 min.

Mary's Story

Task

- **Discuss Mary's story in relation to your own experience of dealing with mental health and substance use presentations.**
- **Identify what features or experiences might be missing from this story.**

Background

This research is conducted with 4 personas, co-created with experts from Turning Point. These personas aim to tell stories about Victorians who may access Mental Health and Wellbeing services for care. However, they can't cover all the diversity and nuance of the broader Victorian community.

Today we are keen to hear from your unique perspective what is missing from Mary's story that would be common to this case.

A | Does Mary remind you of someone you have met? What's missing?

- *What's missing to make this a typical case?*

B | What hopes and fears might Mary have for the future?

- *What factors could influence Mary's goals of managing to sleep without nightmares and staying in her hospitality course?*
- *How do these relate to her goal to support herself out of home?*

C | What other needs might Mary have that aren't listed here?

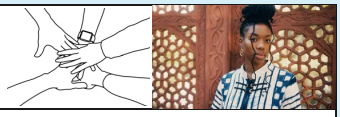
- *What other social, cultural, religious, spiritual, clinical or care needs might she have?*

Tactile Tools | MONASH University | Turning Point

2 20 min.

Integrated Care
Inclusion

Inclusion All mental health and wellbeing and AOD services welcome people with co-occurring needs, and their families and supporters.



A | How are people with co-occurring substance use and mental health problems welcomed into integrated care?

- *How is integrated care provided with respect, dignity and equity?*
- *What would make Mary feel welcome?*

B | How are families and supporters included in integrated care?

- *How does Mary's mother become part of her journey to recovery and overall healing?*

C | What does high quality 'integrated care' look like for Mary?

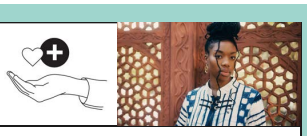
- *How do we ensure that all healthcare providers are on the 'same page' in providing inclusive, accessible integrated care?*
- *What role might Jen play in Mary's integrated care experience?*

Tactile Tools | MONASH University | Turning Point

3 20 min.

Integrated Care
Access

Access People with co-occurring needs, and their families and supporters, have equitable access to treatment, care and support.



A | How might we ensure that Mary and family and/or supporters have access to integrated care, no matter which point of entry to the system they have taken?

- *How do we enable continuity of care for Mary?*
- *How is integrated care made as seamless as possible for Mary, particularly at transition points?*

B | What could be done to maximise the accessibility to integrated care for Mary?

- *With her experience as a child refugee, compounded by her experiences of trauma, what could be done to ensure that integrated care is as accessible as possible for Mary?*

C | What considerations need to be made for cultural safety, to ensure that all people of all backgrounds can access the care they need?

- *Is there anything else that could be done to address access inequities or barriers that currently exist?*
- *How does integrated care meet Mary's cultural needs, and that of her mother Achol?*
- *How can care be adapted to ensure access and safety for people of culturally and linguistically diverse backgrounds?*

Tactile Tools | MONASH University | Turning Point

Johan

Tactile Tools

Reading • 5 min.

Meet Johan

Johan is a 42-year-old man who uses heroin regularly. He is homeless, unemployed, and receiving Centrelink support.

NAME: **Johan**
AGE: **Early forties**
GENDER: **Male identifying**

NATIONALITY: **Australian**
OCCUPATION: **Unemployed, receiving Centrelink support**
EDUCATION: **Left school aged 15**

LOCATION: **No fixed address. Presents at Pakenham, Victoria (3810)**

JOHAN'S STORY

Johan is linked with a housing worker at the local mental health and wellbeing service. Johan speaks to a harm reduction practitioner Jen at the needle and syringe programme. Johan feels like he can talk to Jen about how he has started to feel like life isn't worth living recently. He has had multiple heroin overdoses in the past.

Jen recognizes that Johan isn't his usual self and is worried about him.

Jen accompanies Johan to an appointment with a general practitioner who prescribed opioid pharmacotherapy, co-located at their Local service. Johan talks to the doctor about starting opioid treatment, and they recommend injection treatment, meaning he only needs to attend the clinic once a month. The doctor also refers him to a psychologist at the service, to help him with both his mental health and substance use.

Jen continues to work with Johan around harm minimization interventions such as clean injecting equipment and take-home naloxone.

Tactile Tools | MONASH University | Turning Point

1 20 min.

Johan's Story

Task

- **Discuss Johan's story in relation to your own experience of dealing with mental health and substance use presentations.**
- **Identify what features or experiences might be missing from this story.**

Background

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Today we are keen to hear from your unique perspective what is missing from Johan's story that would be common to this case.

A | Does Johan remind you of someone you have met? What's missing?

- *What's missing to make this a typical case?*

B | What hopes and fears might Johan have for the future?

- *What factors could influence Johan learning to manage his emotions without needing to resort to heroin, alcohol or any other drugs?*
- *What support options would help him finding secure housing?*
- *How do these relate to his other hopes of completing a trade certification and finding employment in his community?*

C | What other needs might Johan have that aren't listed here?

- *What other social, cultural, religious, spiritual, clinical or care needs might he have?*

Tactile Tools | MONASH University | Turning Point

2 **20 min.**

Integrated Care
Inclusion

Inclusion All mental health and wellbeing and AOD services welcome people with co-occurring needs, and their families and supporters.

A | How are people with co-occurring substance use and mental health problems welcomed into integrated care?

- *How is integrated care provided with respect, dignity and equity?*
- *What would make Johan feel welcome?*

B | How are families and supporters included in integrated care?

- *How is integrated care delivered with hope, respect and non-judgement?*
- *How does Johan reconnect with his mother so that she can be part of his journey to recovery and overall healing?*

C | What does high quality 'integrated care' look like for Johan?

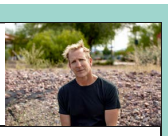
- *How do we ensure that all healthcare providers are on the 'same page' in providing inclusive, accessible integrated care?*
- *What role might Jen play in Johan's integrated care experience?*

Tactile Tools | MONASH University | Turning Point

3 **20 min.**

Integrated Care
Access

Access People with co-occurring needs, and their families and supporters, have equitable access to treatment, care and support.



A | How might we ensure that Johan and family and/or supporters have access to integrated care, no matter which point of entry to the system they have taken?

- *How do we enable continuity of care for Johan?*
- *How is integrated care made as seamless as possible for Johan, particularly at transition points?*

B | What could be done to maximise the accessibility to integrated care for Jarrah?

- *As someone who has experienced long term homelessness and childhood trauma, what could be done to ensure that integrated care is as accessible as possible for Johan?*

C | What considerations need to be made for cultural safety, to ensure that all people of all backgrounds can access the care they need?

- *Is there anything else that could be done to address access inequities or barriers that currently exist?*
- *How does integrated care meet Johan's cultural needs?*

Tactile Tools | MONASH University | Turning Point

April

Tactile Tools

Reading • 5 min.

Meet April

April is a 54-year-old woman experiencing mental health challenges related to ongoing alcohol use.

NAME: **April**
AGE: **Mid fifties**
GENDER: **Female identifying**

OCCUPATION: **Working casually in hospitality**
NATIONALITY: **Australian**

EDUCATION: **Left school aged 15**
LOCATION: **Euroa, Victoria (3666)**

APRIL'S STORY

After leaving the emergency department, April is contacted 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.

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.

Tactile Tools | MONASH University | Turning Point

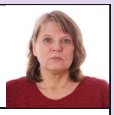
1

20 min.

April's Story

Task

- **Discuss April's story in relation to your own experience of dealing with mental health and substance use presentations.**
- **Identify what features or experiences might be missing from this story.**



Background

This research is conducted with 4 personas, co-created with experts from Turning Point. These personas aim to tell stories about Victorians who may access Mental Health and Wellbeing services for care. However, they can't cover all the diversity and nuance of the broader Victorian community.

Today we are keen to hear from your unique perspective what is missing from April's story that would be common to this case.

A | Does April remind you of someone you have met? What's missing?

- *What's missing to make this a typical case?*

B | What hopes and fears might April have for the future?

- *What factors could influence April achieving her goals of connecting with her siblings and family?*
- *What support options would help her to manage her negative emotions without using alcohol?*

C | What other needs might April have that aren't listed here?

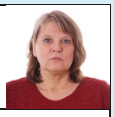
- *What other social, cultural, religious, spiritual, clinical or care needs might she have?*

Tactile Tools | MONASH University | Turning Point

2 20 min.

Integrated Care
Inclusion

Inclusion All mental health and wellbeing and AOD services welcome people with co-occurring needs, and their families and supporters.



A | How are people with co-occurring substance use and mental health problems welcomed into integrated care?

- *How is integrated care provided with respect, dignity and equity?*
- *What would make April feel welcome?*

B | How are families and supporters included in integrated care?

- *How is integrated care delivered with hope, respect and non-judgement?*
- *How does Gary, April's brother, become part of April's journey to recovery and overall healing?*

C | What does high quality 'integrated care' look like for April?

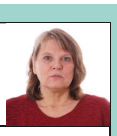
- *How do we ensure that all healthcare providers are on the 'same page' in providing inclusive, accessible integrated care?*
- *What role might the HOPE program, and Zoe play in April's integrated care experience?*

Tactile Tools | MONASH University | Turning Point

3 20 min.

Integrated Care
Access

Access People with co-occurring needs, and their families and supporters, have equitable access to treatment, care and support.



A | How might we ensure that April and family and/or supporters have access to integrated care, no matter which point of entry to the system they have taken?

- *How do we enable continuity of care for April?*
- *How is integrated care made as seamless as possible for April, particularly at transition points?*

B | What could be done to maximise the accessibility to integrated care for April?

- *As someone who lives in regional Victoria, what could be done to ensure that integrated care is as accessible as possible for April?*

C | What considerations need to be made for cultural safety, to ensure that all people of all backgrounds can access the care they need?

- *Is there anything else that could be done to address access inequities or barriers that currently exist?*
- *How does integrated care meet April's cultural needs?*
- *How can care be adapted to ensure safety for people from an LGBTQI background?*

Tactile Tools | MONASH University | Turning Point

Jarrah

Tactile Tools

Reading • 5 min.

Meet Jarrah

Jarrah is a single, 29-year-old who is currently unemployed and experiencing anxiety. Jarrah has never sought professional mental health services.

NAME: **Jarrah**
AGE: **Late twenties**
GENDER: **Male identifying**

OCCUPATION: **Unemployed**
NATIONALITY: **Aboriginal and Torres Strait Islander**

EDUCATION: **Secondary School**
LOCATION: **Morwell, Victoria (3840)**

JARRAH'S STORY

Recently Jarrah has been experiencing more anxiety as a result of not being able to find employment and has increased the frequency and quantity of cannabis he smokes. He feels strung out and easily panicked, and is having thoughts that disturb him, including thoughts about harming himself. He has withdrawn from friends and family, can't sleep without smoking cannabis, and is exhausting his saved finances from past labouring work. He feels ashamed that his drug use has increased so much and that he can't find a job.

After visiting his GP with his mother Keira, Jarrah and Keira are connected with a case worker named Nadine, who meets with them separately to discuss their situation and how they want to be supported.

Based on this discussion and initial needs assessment, Nadine suggests that Jarrah may additionally benefit from some support available from the local alcohol and other drugs service. Nadine offers a supported referral option to Jarrah, which he accepts as he wishes to manage his cannabis use. Nadine helps Jarrah to organise an appointment and accompanies Jarrah and Keira to their first appointment at the Area Service.

Tactile Tools | MONASH University | Turning Point

1 20 min.

Jarrah's Story

Task

- **Discuss Jarrah's story in relation to your own experience of dealing with mental health and substance use presentations.**
- **Identify what features or experiences might be missing from this story.**

Background

This research is conducted with 4 personas, co-created with experts from Turning Point. These personas aim to tell stories about Victorians who may access Mental Health and Wellbeing services for care. However, they can't cover all the diversity and nuance of the broader Victorian community.

Today we are keen to hear from your unique perspective what is missing from Jarrah's story that would be common to this case.

A | Does Jarrah remind you of someone you have met? What's missing?

- *What's missing to make this a typical case?*

B | What hopes and fears might Jarrah have for the future?

- *What factors could influence Jarrah achieving his goals of long term employment?*
- *What support options would help him stop using cannabis and have better mental health?*

C | What other needs might Jarrah have that aren't listed here?

- *What other social, cultural, religious, spiritual, clinical or care needs might he have?*

Tactile Tools | MONASH University | Turning Point

2 20 min.

Integrated Care
Inclusion

Inclusion All mental health and wellbeing and AOD services welcome people with co-occurring needs, and their families and supporters.

A | How are people with co-occurring substance use and mental health problems welcomed into integrated care?

- *How is integrated care provided with respect, dignity and equity?*
- *What would make Jarrah feel welcome?*

B | How are families and supporters included in integrated care?

- *How is integrated care delivered with hope, respect and non-judgement?*
- *How does Keira, Jarrah's mother, become part of Jarrah's journey to recovery and overall healing?*

C | What does high quality 'integrated care' look like for Jarrah?

- *How do we ensure that all healthcare providers are on the 'same page' in providing inclusive, accessible integrated care?*
- *What might Nadine's role be in helping Jarrah to access integrated care?*

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3 20 min.

Integrated Care
Access

Access People with co-occurring needs, and their families and supporters, have equitable access to treatment, care and support.

A | How might we ensure that Jarrah and family and/or supporters have access to integrated care, no matter which point of entry to the system they have taken?

- *How do we enable continuity of care for Jarrah?*
- *How is integrated care made as seamless as possible for Jarrah, particularly at transition points?*

B | What could be done to maximise the accessibility to integrated care for Jarrah?

- *As an Aboriginal and Torres Strait Islander, what could be done to ensure that integrated care is as accessible as possible for Jarrah?*
- *How can services maximise accessibility for his mother, Keira?*

C | What considerations need to be made for cultural safety, to ensure that all people of all backgrounds can access the care they need?

- *Is there anything else that could be done to address access inequities or barriers that currently exist?*
- *How does integrated care ensure Aboriginal cultural safety and self-determination for Jarrah and his family?*
- *How does this enable his right to make decisions on matters that affect his life and those around him?*

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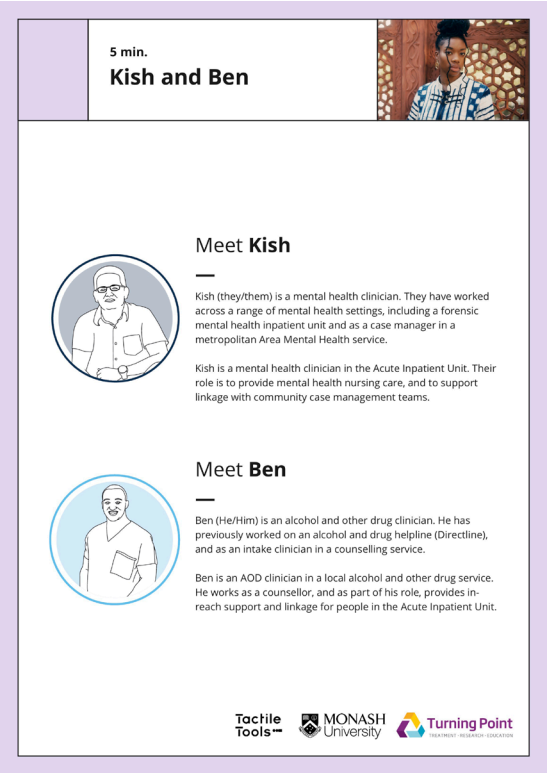
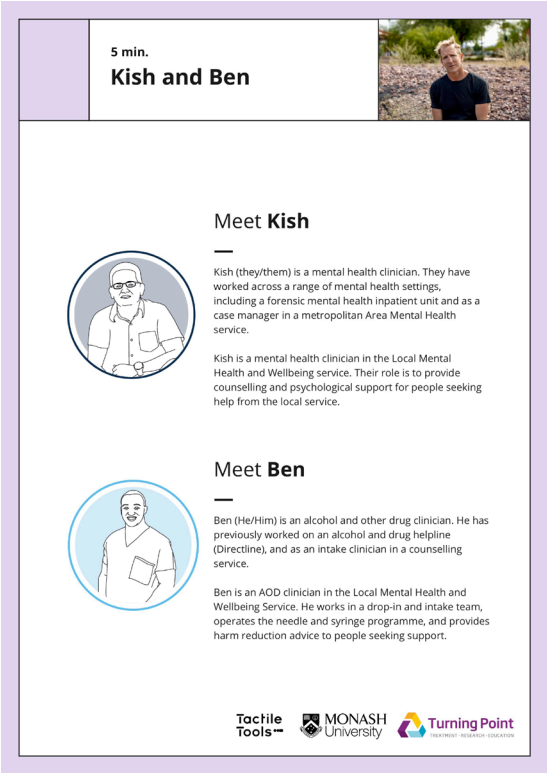
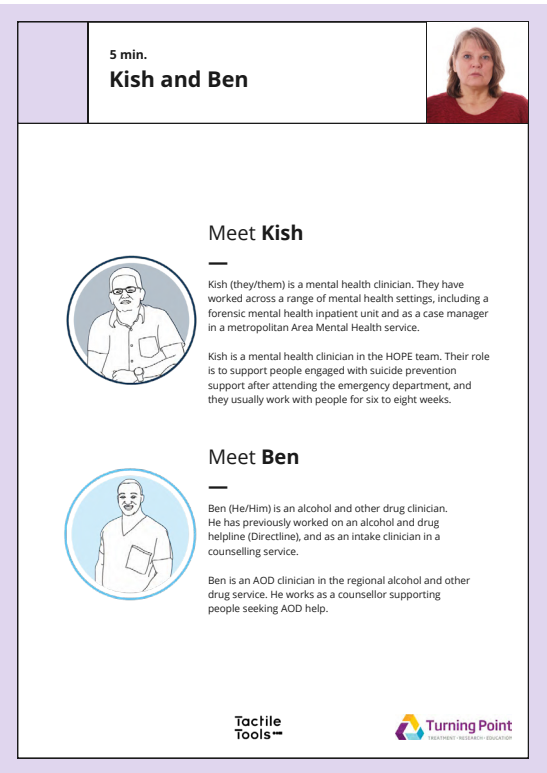
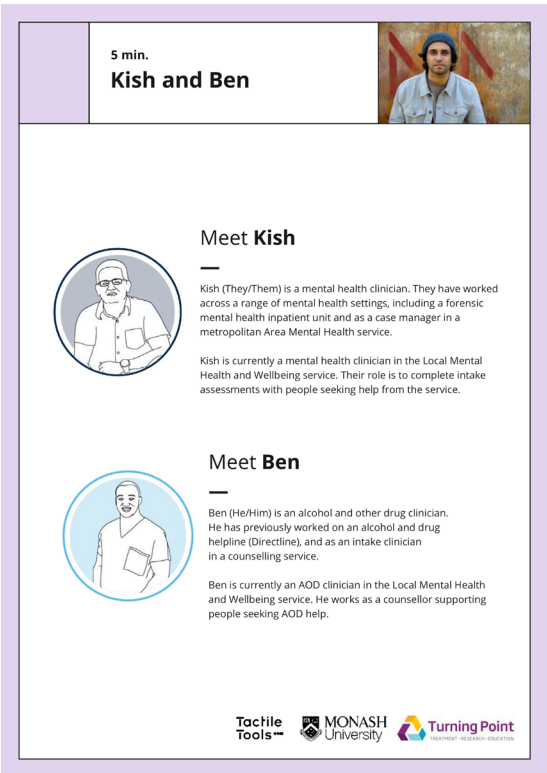
B2 Workshop #2

Screenshots of the stories provided to participants in to give context to the Kish and Ben characters.









Mary

Tactile Tools

Meet Mary

Mary is a 23-year old Sudanese woman who has a history of trauma and substance use.

NAME: **Mary**
AGE: **Early twenties**
GENDER: **Female identifying**
NATIONALITY: **South Sudanese**
OCCUPATION: **Part-time Student**
EDUCATION: **Left school in Year 10 (in Australia)**
LOCATION: **Public Housing. Flemington, Victoria (3031)**

MARY'S STORY

Mary is seen by mental health clinician Kish, who identifies that she is withdrawing from multiple substances, and that this is contributing to her presentation. Kish refers Mary to their addiction specialist team, who support Kish and Mary's mental health team to manage her alcohol withdrawal, and to help her reduce and her GHB use. Kish, Mary's treating psychiatrist and the addiction specialist team meet with Mary together, to understand what is driving her recent increase in substance use, and identify that she is suffering from post-traumatic stress disorder. They discuss medication options for the short-term that can help her manage her current difficulties, and will support her in accessing appropriate psychotherapy to work on trauma.

Mary is linked with Ben, an alcohol and drug clinician, who sees her in the inpatient mental health unit. Ben has a handover from Kish to understand Mary's current treatment plan and supports. Ben talks to Mary about safer ways to use, and how to reduce her risk of a GHB overdose.

Ben also discusses the option of continuing to support Mary with AOD counselling when she leaves the unit.

Mary's mother, Achol, is also supported to meet with a carer consultant, with the aid of an interpreter. Achol relates she is distressed about Mary's admission, and feels that Mary's behaviour has brought shame on her family.

Mary is supported to return home with weekly follow-up appointments with a case manager, who works with her in a trauma-informed manner, supporting her to link into counselling at her TAFE. She is also linked with suicide prevention mental health supports, which include home visits and outreach in her community. These supports help Mary to start to venture out of her home more often, and support her to join a basketball team in her local community.

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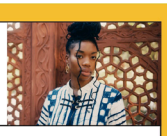
1 20 min.

Integrated Care Principle 3 (Capability)

Capability means...

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 supports.

Discuss what capability means from the perspectives of Kish and Ben.



A | Do we think Kish and Ben have the same understanding of what integrated care means?

- *Why / Why not?*
- *What helps to get everyone on the same page?*

B | What do we imagine Kish and Ben will be delivering in providing integrated care for Mary?

- *How do we imagine Kish and Ben respond to Mary's co-occurring mental health and addiction needs?*
- *What type of interventions or activities would Kish or Ben likely deliver?*
- *How do Kish and Ben ensure that care is led by Mary and her family?*

C | How do Kish and Ben collaborate together to provide care to Mary?

- *What helps Kish and Ben work together? (e.g: Joint meetings, shared information systems, shared working environments)*
- *What makes collaboration challenging for Kish and Ben?*

Tactile Tools | MONASH University | Turning Point

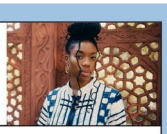
2 Enablers & Barriers

20 min.

The scenario

We will consider the people, systems, processes, organisations or things that make providing integrated care to Mary possible, as well as the things that can get in the way.

Discuss these prompts in relation to Mary's experience of care.



A | What makes things hard for Kish or Ben when they are providing care for Mary?

- *What support do Kish or Ben need to do their job?*
- *Who should provide this support?*

B | What should happen when Kish or Ben refer Mary to another service? (e.g: referral to a detox service)

- *How do Kish and Ben ensure that Mary doesn't 'fall through' a gap in the system?*
- *How do Kish and Ben share and transfer important information about Mary with other health providers?*
- *How do Kish and Ben support Mary to navigate different service providers?*

C | What enables integrated care systems to operate smoothly?

- *How could integrated care be made as seamless as possible for Mary as they transition across services?*
- *What binds or keeps the care systems looking after Mary together?*

Tactile Tools — MONASH University — Turning Point

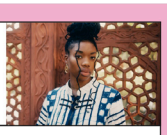
3 Knowledge & Skills

20 min.

The scenario

We will now consider the learning needs of the people who are caring for Mary across both mental health and AOD sectors.

Discuss these prompts in relation to Kish and Ben, and Mary's experience of care.



Kish

A | What learning or training does Kish need to provide integrated care?

- *What training is most important?*

C | What training do both Kish and Ben need?

B | What learning or training does Ben need to provide integrated care?

- *What training is most important?*

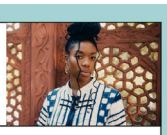
Ben

Tactile Tools — MONASH University — Turning Point

4 20 min.

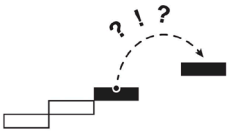
Workforce Training

The scenario We will now consider the future of training and workforce education for integrated care. Discuss these prompts in relation to Kish and Ben, and Mary's experience of care.



A | What would enable Kish and Ben to develop their skills throughout their careers?

- *What kind of undergraduate or postgraduate placements and scholarships would help Kish and Ben?*
- *What is the role of mentoring and communities of practice in supporting Kish and Ben?*



B | What does the future of integrated care training look like?

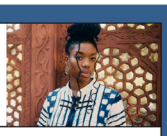
- *What would the ideal training environment look like?*
- *What kind of training formats (online, face-to-face, self-directed, intensives, placements, etc) would work best?*
- *What knowledge and skills are necessary to support integrated care in acute or community care settings? What different training might be needed?*

Tactile Tools — MONASH University — Turning Point

5 20 min.

Change management and culture

Our final activity In our final activity, we will discuss the process of change of how integrated care delivery should be experienced in the future for people like Mary.



A | How do we make sure that all service providers and organisations see integrated care as part of their core business?

- *How do we make sure that everyone is on the same page while delivering integrated care?*
- *What support is needed from supervisors or managers to address any barriers to providing integrated care?*
- *How do service providers like Kish and Ben drive change on the front line?*

B | What behaviours, attitudes and mindsets need to change to deliver an integrated care service?

- *How might any organisational or cultural issues be addressed?*
- *What new systems and processes need to be created to enable integration?*
- *What does good leadership in integrated care delivery look like?*

Tactile Tools — MONASH University — Turning Point

Johan

Tactile Tools

Meet Johan

Johan is a 42-year-old homeless man who uses heroin regularly.

NAME: **Johan**
AGE: **Early forties**
GENDER: **Male identifying**

NATIONALITY: **White Australian**
OCCUPATION: **Unemployed, receiving Centrelink support**

EDUCATION: **Left school aged 15**
LOCATION: **No fixed address. Presents at Pakenham, Victoria (3810)**

JOHAN'S STORY

Johan is linked with a housing worker at the local mental health and wellbeing service. Johan also regularly speaks to Ben, the alcohol and drug clinician at the needle and syringe programme. Johan feels like he can talk to Ben about how he has started to feel like life isn't worth living recently.

Ben recognizes that Johan isn't his usual self and is worried about him. Ben makes an appointment for Johan with a doctor who prescribes opioid pharmacotherapy at their Local Mental Health and Wellbeing service. Johan talks to the doctor about starting opioid treatment, and they recommend injection treatment, meaning he only needs to attend the clinic once a month. The doctor also refers him to a mental health clinician, Kish, at the service, to help him with his mental health. The doctor also conducts an assessment of Johan's other primary health care needs, such as his Hepatitis C risk, and wound care.

Ben and Kish both work with Johan around harm minimisation and overdose prevention interventions such as clean injecting equipment and take-home naloxone. Kish discusses the relationship between Johan's use and his depression, and suggests a local coding group he can enrol in where he can meet other people.

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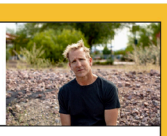
1 **20 min.**

Integrated Care Principle 3 (Capability)

Capability means...

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 supports.

Discuss what capability means from the perspectives of Kish and Ben.



A | Do we think Kish and Ben have the same understanding of what integrated care means?

- *Why / Why not?*
- *What helps to get everyone on the same page?*

B | What do we imagine Kish and Ben will be delivering in providing integrated care for Johan?

- *How do we imagine Kish and Ben respond to Johan's co-occurring mental health and addiction needs?*
- *What type of interventions or activities would Kish or Ben likely deliver?*
- *How do Kish and Ben ensure that care is led by Johan and any family or other chosen supports?*

C | How do Kish and Ben collaborate together to provide care to Johan?

- *What helps Kish and Ben work together? (e.g: Joint meetings, shared information systems, shared working environments)*
- *What makes collaboration challenging for Kish and Ben?*

Tactile Tools | MONASH University | Turning Point

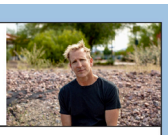
2 Enablers & Barriers

20 min.

The scenario

We will consider the people, systems, processes, organisations or things that make providing integrated care to Johan possible, as well as the things that can get in the way.

Discuss these prompts in relation to Johan's experience of care.



A | What makes things hard for Kish or Ben when they are providing care for Johan?

- *What support do Kish or Ben need to do their job?*
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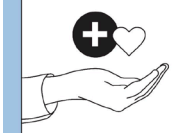


B | What should happen when Kish or Ben refer Johan to another service? (e.g: referral to a detox service)

- *How do Kish and Ben ensure that Johan doesn't 'fall through' a gap in the system?*
- *How do Kish and Ben share and transfer important information about Johan with other health providers?*
- *How do Kish and Ben support Johan to navigate different service providers?*

C | What enables integrated care systems to operate smoothly?

- *How could integrated care be made as seamless as possible for Johan as they transition across services?*
- *What binds or keeps the care systems looking after Johan together?*

Tactile Tools — MONASH University — Turning Point

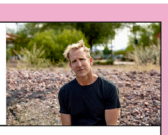
3 Knowledge & Skills

20 min.

The scenario

We will now consider the learning needs of the people who are caring for Johan across both mental health and AOD sectors.

Discuss these prompts in relation to Kish and Ben, and Johan's experience of care.



Kish
MH Clinician

A | What learning does Kish need to provide integrated care?

- *What training is most important?*

C | What learning do both Kish and Ben need?

B | What learning does Ben need to provide integrated care?

- *What training is most important?*

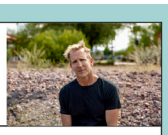
Ben
AOD Clinician

Tactile Tools — MONASH University — Turning Point

4 20 min.

Workforce Training

The scenario We will now consider the future of training and workforce education for integrated care. Discuss these prompts in relation to Kish and Ben, and Johan's experience of care.



A | What would enable Kish and Ben to develop their skills throughout their careers?

- *What kind of undergraduate or postgraduate placements and scholarships would help Kish and Ben?*
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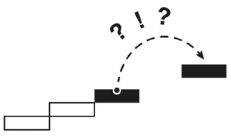

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- *What would the ideal training environment look like?*
- *What kind of training formats (online, face-to-face, self-directed, intensives, placements, etc) would work best?*
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Tactile Tools — MONASH University — Turning Point

5 20 min.

Change management and culture

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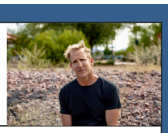

A | How do we make sure that all service providers and organisations see integrated care as part of their core business?

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B | What behaviours, attitudes and mindsets need to change to deliver an integrated care service?

- *How might any organisational or cultural issues be addressed?*
- *What new systems and processes need to be created to enable integration?*
- *What does good leadership in integrated care delivery look like?*

Tactile Tools — MONASH University — Turning Point

April

Tactile Tools

Meet April

April is a 54-year-old single woman experiencing depression and suicidal behaviour.

NAME: **April**
AGE: **Mid fifties**
GENDER: **Female identifying**

OCCUPATION: **Working casually in hospitality**
NATIONALITY: **Australian**

EDUCATION: **Left school aged 15**
LOCATION: **Euroa, Victoria (3666)**

APRIL'S STORY

Kish, a Mental Health Clinician from the HOPE team, spends time with April, talking through her mental health, suicidal thoughts and alcohol use. Kish develops a safety plan with April before she is discharged from the hospital. After leaving the ED, April continues to have support from Kish, who refers her to Ben, an alcohol and drug clinician at her local service.

Throughout the next six weeks, April continues to work with Kish and Ben, who remain consistent points of contact and help her to feel safe and supported. With her brother Gary, April starts to develop a longer term safety plan that identifies key strategies to help her feel safe and supported when she is feeling distressed. Kish and Ben are able to work together to support April and Gary with a plan for April to withdraw from alcohol safely at home. April is able to learn new ways to identify and respond to changes in her mood and stressful situations. Kish helps link her into social groups online, including a jewellery making group that meets every week.

Tactile Tools | MONASH University | Turning Point

1 20 min.

Integrated Care Principle 3 (Capability)

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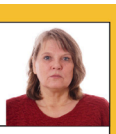


A | Do we think Kish and Ben have the same understanding of what integrated care means?

- *Why / Why not?*
- *What helps to get everyone on the same page?*

B | What do we imagine Kish and Ben will be delivering in providing integrated care for April?

- *How do we imagine Kish and Ben respond to April's co-occurring mental health and addiction needs?*
- *What type of interventions or activities would Kish or Ben likely deliver?*
- *How do Kish and Ben ensure that care is led by April and her family?*

C | How do Kish and Ben collaborate together to provide care to April?

- *What helps Kish and Ben work together? (e.g: joint meetings, shared information systems, shared working environments)*
- *What makes collaboration challenging for Kish and Ben?*

Tactile Tools | MONASH University | Turning Point

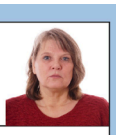
2 Enablers & Barriers

20 min.

The scenario

We will consider the people, systems, processes, organisations or things that make providing integrated care to April possible, as well as the things that can get in the way.

Discuss these prompts in relation to April's experience of care.



A | What makes things hard for Kish or Ben when they are providing care for April?

- *What support do Kish or Ben need to do their job?*
- *Who should provide this support?*

B | What should happen when Kish or Ben refer April to another service?

- *How do Kish and Ben ensure that April doesn't 'fall through' a gap in the system?*
- *How do Kish and Ben share and transfer important information about April with other health providers?*
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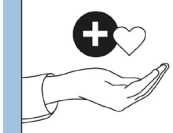


Tactile Tools — MONASH University — Turning Point

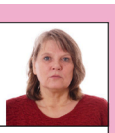
3 Knowledge & Skills

20 min.

The scenario

We will now consider the learning needs of the people who are caring for April, across both mental health and AOD sectors.

Discuss these prompts in relation to Kish and Ben, and April's experience of care.



Kish
MH Clinician

A | What learning does Kish need to provide integrated care?

- *What training is most important?*

C | What learning do both Kish and Ben need?

B | What learning does Ben need to provide integrated care?

- *What training is most important?*

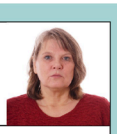
Ben
AOD Clinician

Tactile Tools — MONASH University — Turning Point

4 20 min.

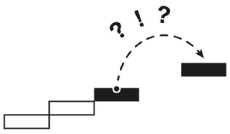
Workforce Training

The scenario We will now consider the future of training and workforce education for integrated care. Discuss these prompts in relation to Kish and Ben, and April's experience of care.



A | What would enable Kish and Ben to develop their skills throughout their careers?

- *What kind of undergraduate or postgraduate placements and scholarships would help Kish and Ben?*
- *What is the role of mentoring and communities of practice in supporting Kish and Ben?*



B | What does the future of integrated care training look like?

- *What would the ideal training environment look like?*
- *What kind of training formats (online, face-to-face, self-directed, intensives, placements, etc) would work best?*
- *What knowledge and skills are necessary to support integrated care in acute or community care settings? What different training might be needed?*

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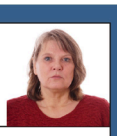
5 20 min.

Change management and culture

Our final activity In our final activity, we will discuss the process of change of how integrated care delivery should be experienced in the future for people like April.



A | How do we make sure that all service providers and organisations see integrated care as part of their core business?

- *How do we make sure that everyone is on the same page while delivering integrated care?*
- *What support is needed from supervisors or managers to address any barriers to providing integrated care?*
- *How do service providers like Kish and Ben drive change on the front line?*

B | What behaviours, attitudes and mindsets need to change to deliver an integrated care service?

- *How might any organisational or cultural issues be addressed?*
- *What new systems and processes need to be created to enable integration?*
- *What does good leadership in integrated care delivery look like?*

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Jarrah

Tactile Tools

Meet Jarrah

Jarrah is a single, 29-year-old who is currently unemployed and experiencing anxiety.

NAME: **Jarrah**
AGE: **Late twenties**
GENDER: **Male identifying**

OCCUPATION: **Unemployed**
NATIONALITY: **Aboriginal and Torres Strait Islander**

EDUCATION: **Left school in year 10**
LOCATION: **Morwell, Victoria (3840)**

JARRAH'S STORY

Recently, Jarrah has been experiencing more anxiety as a result of not being able to find employment and has increased the frequency and quantity of cannabis he smokes. He feels strung out and easily panicked, and is having thoughts that disturb him, including thoughts about harming himself. He has withdrawn from friends and family, can't sleep without smoking cannabis, and is exhausting his savings from past labouring work. He worries that the lack of income might impact his family's financial stability and create more stress for his mum. He feels ashamed that his drug use has increased so much and that he can't find a job.

After his mother suggests he visits his GP, Jarrah and Keira are connected with mental health clinician Kish from the Local Mental Health and Wellbeing team, who meets with them separately to discuss their situation and how they want to be supported.

Based on this discussion and initial needs assessment, Kish suggests that Jarrah may additionally benefit from some support from alcohol and drug clinician Ben, who also works at the Local Mental Health and Wellbeing Team. Kish offers a supported referral option to Jarrah, which he accepts as he wishes to reduce his cannabis use.

Things initially get better for Jarrah, and Ben helps him to get placed on a waitlist for a detox service so he can quit smoking cannabis. The waitlist is long, and Jarrah decides to try and quit on his own. He finds his anxiety gets worse, and the thoughts of hurting himself become more intense. He mentions this to Ben at his weekly AOD counselling appointment, and Ben makes a referral to the crisis team at their Area Mental Health Service.

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1

20 min.

Integrated Care Principle 3 (Capability)

Capability means...

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 supports.

Discuss what capability means from the perspectives of Kish and Ben.

A | Do we think Kish and Ben have the same understanding of what integrated care means?

- *Why / Why not?*
- *What helps to get everyone on the same page?*

B | What do we imagine Kish and Ben will be delivering in providing integrated care for Jarrah?

- *How do we imagine Kish and Ben respond to Jarrah's co-occurring mental health and addiction needs?*
- *What type of interventions or activities would Kish or Ben likely deliver?*
- *How do Kish and Ben ensure that care is led by Jarrah and his family?*

C | How do Kish and Ben collaborate together to provide care to Jarrah?

- *What helps Kish and Ben work together? (e.g: Joint meetings, shared information systems, shared working environments)*
- *What makes collaboration challenging for Kish and Ben?*

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2 Enablers & Barriers

20 min.

The scenario

We will consider the people, systems, processes, organisations or things that make providing integrated care to Jarrah possible, as well as the things that can get in the way.

Discuss these prompts in relation to Jarrah's experience of care.

A | What makes things hard for Kish or Ben when they are providing care for Jarrah?

- *What support do Kish or Ben need to do their job?*
- *Who should provide this support?*

B | What should happen when Kish or Ben refer Jarrah to another service? (e.g: referral to a detox service)

- *How do Kish and Ben ensure that Jarrah doesn't 'fall through' a gap in the system?*
- *How do Kish and Ben share and transfer important information about Jarrah with other health providers?*
- *How do Kish and Ben support Jarrah to navigate different service providers?*

C | What enables integrated care systems to operate smoothly?

- *How could integrated care be made as seamless as possible for Jarrah as they transition across services?*
- *What binds or keeps the care systems looking after Jarrah together?*

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3 Knowledge & Skills

20 min.

The scenario

We will now consider the learning needs of the people who are caring for Jarrah, across both mental health and AOD sectors.

Discuss these prompts in relation to Kish and Ben, and Jarrah's experience of care.

Kish
MH Clinician

A | What learning does Kish need to provide integrated care?

- *What training is most important?*

C | What learning do both Kish and Ben need?

B | What learning does Ben need to provide integrated care?

- *What training is most important?*

Ben
AOD Clinician

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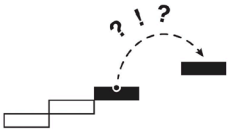
4 Workforce Training

20 min.

The scenario We will now consider the future of training and workforce education for integrated care. Discuss these prompts in relation to Kish and Ben, and Jarrah's experience of care.

A | What would enable Kish and Ben to develop their skills throughout their careers?

- *What kind of undergraduate or postgraduate placements and scholarships would help Kish and Ben?*
- *What is the role of mentoring and communities of practice in supporting Kish and Ben?*



B | What does the future of integrated care training look like?

- *What would the ideal training environment look like?*
- *What kind of training formats (online, face-to-face, self-directed, intensives, placements, etc) would work best?*
- *What knowledge and skills are necessary to support integrated care in acute or community care settings? What different training might be needed?*

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5 Change management and culture

20 min.

Our final activity In our final activity, we will discuss the process of change of how integrated care delivery should be experienced in the future for people like Jarrah.

A | How do we make sure that all service providers and organisations see integrated care as part of their core business?

- *How do we make sure that everyone is on the same page while delivering integrated care?*
- *What support is needed from supervisors or managers to address any barriers to providing integrated care?*
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B | What behaviours, attitudes and mindsets need to change to deliver an integrated care service?

- *How might any organisational or cultural issues be addressed?*
- *What new systems and processes need to be created to enable integration?*
- *What does good leadership in integrated care delivery look like?*

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C Appendix C: A2 persona posters that were provided to participants

Mary

Image of the persona poster for the Mary persona that was printed on A2 paper and posted to participants.

Tactile Tools

Meet Mary

Mary is a 23-year old Sudanese woman who has a history of trauma and substance use.

NAME: **Mary**
AGE: **Early twenties**
GENDER: **Female identifying**

NATIONALITY: **South Sudanese**
EDUCATION: **Left school in Year 10 (in Australia)**

OCCUPATION: **Part-time Student**
LOCATION: **Public Housing. Flemington, Victoria (3031)**

BACKGROUND AND LIFE STORY

Mary was born in what is now South Sudan and left the country with her family as refugees when she was 6 years old. Just before she left Sudan, her father was killed in a street riot while she, her mother and brothers watched nearby. Mary and her family struggle to talk about the violence they experienced as refugees.

Mary and her family lived in a number of different refugee camps across Africa before coming to Australia when she was 9. She experienced trauma living in these camps, but struggles to talk about this openly with anyone.

In Australia she attended school in the Northern Suburbs of Melbourne. Mary spoke little English before she moved. She learnt to speak English well at school though still struggles to read and write in English. Mary's favourite subjects at school were art and music.

Mary liked attending school at first, but was bullied by other students when she started high school. She fell behind academically and struggled with her studies. Mary had difficulty focussing in class, and often spent time drawing instead of doing her school work. By the time she was in Year 10, she struggled to 'fit in' and couldn't keep up with her studies. Eventually, Mary stopped attending classes altogether.

SOCIAL CONTEXT

Mary has been sexually assaulted a number of times whilst intoxicated. Most recently, this was perpetrated by a friend she trusted. She has been reliving this trauma through nightmares lately.

To help her sleep and deal with her anxiety around the assault, Mary started using alcohol and GHB to manage her feelings. Mary uses some savings she has from casual work to fund this drug use.

Mary used to have a close relationship with her mother, but this became more strained in the past few years when Mary started to use substances.

HOPES AND FEARS

Mary has struggled to sleep well for a long time. She doesn't feel like her life is worth living at the moment, and is worried that nothing will ever get better. She is hopeful for a simple 'good night's sleep', without nightmares or restlessness.

Mary feels intense shame around her drug use and mental illness. She struggles to talk about her use with other people and has withdrawn from many of her friends and family. Mary has only limited social contact with others. Mary senses her mother is disapproving of her friends and her lifestyle; she feels her mother no longer understands her. Mary is worried she will have to drop out of her TAFE course in hospitality. She was hoping to be able to complete this to get a job in a cafe, and to support herself to move out of home.

REFERRAL PATHWAY

Mary has previously had a number of overdoses on GHB, some of which were intentional.

Mary has been seeing the same GP as the rest of her family since she moved to Melbourne when her mother had made the appointments. Because of the strained relationship with her mother, Mary has not had an appointment with her GP or a regular checkup in some time.

A stranger called Victoria Police with concerns for Mary after they found her wandering the streets of Flemington with psychotic symptoms. Victoria Police believed that Mary was at risk of suicide, so detained Mary under the Mental Health Act for her own safety. Mary was admitted to a psychiatric ward where she received care and follow up out-patient care.

WHAT DOES SUCCESS LOOK LIKE FOR MARY?

Mary wants to have a good night's sleep and be able to fall asleep without thinking about the past. She wants to improve her relationship with her mother and the rest of her family.

Mary's Story

Mary is seen by mental health clinician Kish, who identifies that she is withdrawing from multiple substances, and that this is contributing to her presentation. Kish refers Mary to their addiction specialist team, who support Kish and Mary's mental health team to manage her alcohol withdrawal, and suggest medications to support alcohol reduction, and to reduce and cease her GHB use. Kish, Mary's treating psychiatrist and the addiction specialist team meet with Mary together, to understand what is driving her recent increase in substance use, and identify that she is suffering from post-traumatic stress disorder. They discuss medication options for the short-term that can help her manage her current difficulties, and will support her linking into appropriate psychotherapy to work on trauma.

Mary is linked with Ben, an alcohol and drug clinician, who sees her in the inpatient mental health unit. Ben has a handover from Kish to understand Mary's current treatment plan and supports. Ben talks to Mary about safer ways to use, and how to reduce her risk of a GHB overdose. Ben also discusses the option of continuing to support Mary with AOD counselling when she leaves the unit.

Mary's mother, Achol, is also supported to meet with a carer consultant, with the aid of an interpreter. Achol relates she is distressed about Mary's admission, and feels that Mary's behaviour has brought shame on her family.

Mary is supported to return home with weekly follow-up appointments with a case manager, who works with her in a trauma-informed manner, supporting her to link into counselling at her TAFE. She continues to see Ben for AOD counselling. She is also linked with suicide prevention mental health supports, which include home visits and outreach in her community. They help her start to venture out of her home more often, and also help her link into a basketball team in her local community.

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Johan

Image of the persona poster for the Johan persona that was printed on A2 paper and posted to participants.

Tactile Tools

Meet Johan

Johan is a 42-year-old homeless man who uses heroin regularly.

NAME: **Johan**
AGE: **Early forties**
GENDER: **Male identifying**

NATIONALITY: **White Australian**
OCCUPATION: **Unemployed, receiving Centrelink support**

EDUCATION: **Left school aged 15**
LOCATION: **No fixed address. Presents at Pakenham, Victoria (3810)**

BACKGROUND AND LIFE STORY

Johan was born and lived in the Mornington Peninsula for most of his adult life. Johan has no siblings. His father drank heavily and was violent and abusive. His father passed away more than twenty years ago and Johan has a strained relationship with his mother, who divorced from Johan's father when Johan was 5. Johan hasn't spoken with his mother in ten years.

Johan ran away from home at 13 and left school aged 15 for a job at the local butcher shop. Johan has always been interested in computers and programming and taught himself python and C# at local libraries in his spare time.

In his late teens and early 20s, Johan lived in crisis accommodation. He left his job in the butcher shop when it closed and started work as a labourer. He moved from crisis accommodation into a rental with friends from work. He managed to remain in housing, employed and enjoyed life.

Johan was involved in a car crash in his late 20s that left him with chronic back pain. He has self-medicated his back pain since. In his mid-to-late thirties, Johan started using heroin regularly to manage the pain. In recent times, Johan lost his job, became unable to pay rent, and then became homeless.

SOCIAL CONTEXT

Johan started smoking cannabis in his early teens. Later, Johan was prescribed Oxycodone as a result of a car accident. At some point, a friend introduced Johan to heroin and he continued injecting multiple times per day.

Johan became homeless again about 18 months ago when he lost his labouring job. He funds his heroin use through a combination of his Centrelink payments and savings.

HOPES AND FEARS

Johan is homeless, unemployed and receiving Centrelink support. He is afraid that nothing will ever change, and that he will always be a 'failure', never have a partner again, or establish meaningful relationships with others. Johan has had a couple of overdoses in the past, and has been thinking about this again because he feels so hopeless about his current situation and that nothing will change.

Johan hopes to manage his back pain without needing to spend almost all his income on heroin, and learn to manage his pain, isolation and low mood without needing to resort to drug use.

REFERRAL PATHWAY

Johan has no consistent GP and has not had a regular checkup in more than 10 years.

Johan previously received opioid pharmacotherapy (methadone), and has recently considered trying again because he has run out of funds to support his heroin use. He hopes that methadone will help with the back pain. Johan hears from a friend that a Local Mental Health and Wellbeing service in Pakenham can help with secure housing. Johan presents at the service to seek help.

WHAT DOES SUCCESS LOOK LIKE FOR JOHAN?

Johan would like secure housing, and to find employment in his community. Johan would like a job that is not dependent on his physical fitness, such as a desk job or working with computers. Johan hopes to improve his relationships with other people, feel more connected with others around him, and establish a relationship with his mother.

Johan's Story

Johan is linked with a housing worker at the local mental health and wellbeing service. Johan also regularly speaks to Ben, the alcohol and drug clinician at the needle and syringe programme. Johan feels like he can talk to Ben about how he has started to feel like life isn't worth living recently.

Ben recognizes that Johan isn't his usual self and is worried about him. Ben makes an appointment for Johan with a doctor who prescribes opioid pharmacotherapy at their Local Mental Health and Wellbeing service. Johan talks to the doctor about starting opioid treatment, and they recommend injection treatment, meaning he only needs to attend the clinic once a month. The doctor also refers him to a mental health clinician, Kish, at the service, to help him with his mental health. The doctor also conducts an early assessment of Johan's other primary health care needs, such as his Hepatitis C risk, and wound care.

Ben and Kish both work with Johan around harm minimization and overdose prevention interventions such as clean injecting equipment and take-home naloxone. Kish discusses the relationship between Johan's use and his depression, and suggests a local coding group he can enroll in where he meets other people.

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April Image of the persona poster for the April persona that was printed on A2 paper and posted to participants.

Tactile Tools

Meet April

April is a 54-year-old single woman experiencing depression and suicidal behaviour.

NAME: **April**

AGE: **Mid fifties**

GENDER: **Female identifying**

OCCUPATION: **Working casually in hospitality**

NATIONALITY: **Australian**

EDUCATION: **Left school aged 15**

LOCATION: **Euroa, Victoria (3666)**

BACKGROUND AND LIFE STORY

April was born in Sydney and lived with her parents, two brothers and a sister – Gary, Jim and Rachel – until moving out of home when she was 17. Both of April's parents have since passed away.

April came out as a lesbian when she met her partner Jane at 20. Because of their religious beliefs, April's parents and brother Jim were not supportive; April maintained contact with Gary and Rachel after moving out.

April and Jane lived in Sydney and travelled often. April managed her own jewellery making business. Their relationship deteriorated 10 years ago, and Jane left April 5 years ago. April's parents passed away in the same year. April decided to move to Euroa to be nearer her brother Gary, who worked as a teacher at a local school. She rents her own apartment and has a casual job in a local café.

HOPES AND FEARS

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.

Because of the discrimination April has faced as a queer woman earlier in her life, April is distrustful of many healthcare services. She feels that previous experiences with adult psychiatric services have not been helpful, so is reluctant to engage with existing services in her area.

April doesn't see the point in seeing her GP. The last time April saw her GP, she felt that her GP 'rushed' through her appointment and just wanted to get her out the door. She is also worried about her privacy and confidentiality about seeking help in a small town, where people may see and 'judge' her seeking help.

April hopes that she can find something to live for, such as developing her arts and crafts skills, and perhaps meeting a life partner.

SOCIAL CONTEXT

Gary visits April regularly and her sister Rachel - who she is very close with - moved to live in Western Australia 5 years ago. April and Rachel talk on the phone once a week.

April has lost a lot of weight. She isn't sleeping well at night, which she puts down to her daytime napping on the couch. She has started drinking alcohol on the days she doesn't work at the café, to get to sleep and to manage her negative thoughts.

She has stopped making jewellery and has withdrawn from the few friends she has made in local arts and crafts groups. Outside of her cafe work, April has little social contact with others.

REFERRAL PATHWAY

April has a long history of depression, with input from adult psychiatric services starting from when she first came out to her family. This has included inpatient admissions to manage suicidal behaviours. April had made several attempts on her life when she lived in Sydney. Her last suicide attempt was just after her separation from Jane and when her parents passed away, five years ago.

April is currently being supported by her GP but hasn't kept an appointment in some time. April's brother Gary is concerned about April when he hasn't heard from her in a few days. When he visits, he finds that April has attempted to take her own life. April is treated at her local emergency department (ED). While she has attended ED several times before, she has not been offered follow up support and so has been reluctant to seek help.

After leaving ED, 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.

WHAT DOES SUCCESS LOOK LIKE FOR APRIL?

April would like to be better connected with other people and manage her emotions and depression without using alcohol to dull her feelings. She would like to make contact with her brother Jim and make jewellery to sell at the local market.

April's Story

Kish, a Mental Health Clinician from the HOPE team, spends time with April, talking through her mental health, suicidal thoughts and alcohol use. Kish develops a safety plan with April before she is discharged from the hospital.

After leaving the ED, April continues to have support from Kish, who refers her to Ben, an alcohol and drug clinician at her local service.

Throughout the next six weeks, April continues to work with Kish and Ben, who remain consistent points of contact and help her to feel safe and supported. With her brother Gary, April starts to develop a longer term safety plan that identifies key strategies to help her feel safe and supported when she is feeling distressed. Kish and Ben are able to work together to support April and Gary with a plan for April to withdraw from alcohol safely at home. April is able to learn new ways to identify and respond to changes in her mood and stressful situations. Kish helps link her into social groups online, including a jewellery making group that meets every week.

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Jarrah

Image of the persona poster for the Jarrah persona that was printed on A2 paper and posted to participants.

Tactile Tools

Meet Jarrah

Jarrah is a single, 29-year-old who is currently unemployed and experiencing anxiety.

NAME: **Jarrah**

AGE: **Late twenties**

GENDER: **Male identifying**

OCCUPATION: **Unemployed**

NATIONALITY: **Aboriginal and Torres Strait Islander**

EDUCATION: **Left school in year 10**

LOCATION: **Morwell, Victoria (3840)**

BACKGROUND AND LIFE STORY

Jarrah was born in Morwell and has lived in the Latrobe Valley in South Eastern Victoria his whole life. Jarrah's father struggled with alcohol use problems for most of his adult life. Jarrah's father completed suicide when Jarrah was ten, leaving Jarrah and Keira alone. Jarrah left school in year 10 to work, and has since been working as a labourer so that he could help his mum with the family finances.

SOCIAL CONTEXT

In high school, Jarrah started smoking cannabis socially, initially a few days a month with friends. He continued into his 20s as a way of managing feelings of loneliness or worry, or when he is having trouble sleeping. In the past Jarrah has experienced frequent and prolonged periods of anxiety, but he has never sought help from mental health services, due to feeling ashamed of his feelings and mood.

WHAT DOES SUCCESS LOOK LIKE FOR JARRAH?

Finding secure employment for the long term and moving out of home. He'd like to find ways to manage his anxiety and sleep other than using cannabis. Longer term, Jarrah hopes that he can seek treatments and support options to help him stop using cannabis altogether and improve his mental health.

REFERRAL PATHWAY

Jarrah has been seeing the same family GP for many years, but has usually been resistant to the idea of going to the doctor. He has never sought professional mental health or drug and alcohol services before.

Keira is very concerned about her son and worried he will harm himself. Her own wellbeing is also being impacted as she feels that she is constantly on guard watching him. A few years ago, Keira was diagnosed with anxiety by her local GP and was provided with medication and a treatment plan.

At Keira's insistence, Jarrah goes to see their family GP, who refers Jarrah to the Local Mental Health and Wellbeing service for support with his mental health.

HOPES AND FEARS

Jarrah worries that he is "going down the same path as his dad", but is fearful of seeking professional help. He fears the 'system built by white people' won't help or work for him.

One of his favourite hobbies is to travel interstate to music festivals and gigs. In the future, Jarrah hopes to secure longer term employment and form a band like he had in high school.

Jarrah's Story

Recently, Jarrah has been experiencing more anxiety as a result of not being able to find employment and has increased the frequency and quantity of cannabis he smokes. He feels strung out and easily panicked, and is having thoughts that disturb him, including thoughts about harming himself. He has withdrawn from friends and family, can't sleep without smoking cannabis, and is exhausting his saved finances from past labouring work. He worries that the lack of income might impact his family's financial stability and create more stress for his mum. He feels ashamed that his drug use has increased so much and that he can't find a job.

After his mother suggests he visits his GP, Jarrah and Keira are connected with mental health clinician Kish from the Local Mental Health and Wellbeing team, who meets with them separately to discuss their situation and how they want to be supported.

Based on this discussion and initial needs assessment, Kish suggests that Jarrah may additionally benefit from some support from an alcohol and drug clinician Ben, who also works at the Local Mental Health and Wellbeing Team. Kish offers a supported referral option to Jarrah, which he accepts as he wishes to manage his cannabis use.

Things initially get better for Jarrah, and Ben helps to get him on to a waitlist for a detox service so he can quit smoking cannabis. The waitlist is long, and Jarrah decides to try and quit on his own. He finds his anxiety gets worse, and the thoughts of hurting himself become more intense. He mentions this to Ben at his weekly AOD counselling appointment, and Ben makes a referral to the crisis team at their Area Mental Health Service.

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D Appendix D: Example of Miro synthesis board from Workshop #2

Statewide Centre for Addiction and Mental Health
Consultation: Synthesis and Insights Report, 2023

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