SEAMLESS SUPPORT

TOWARD AN INTEGRATED TREATMENT EXPERIENCE FOR YOUNG PEOPLE WITH CO-OCCURRING ALCOHOL AND OTHER DRUG USE AND MENTAL ILL-HEALTH

Turning Point
TREATMENT · RESEARCH · EDUCATION

orygen

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CONTENTS

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The final report reflects Orygen's analysis and independent conclusions. It may not necessarily reflect all the opinions or conclusions of project partners, key contributors or stakeholders.

STAKEHOLDER CONSULTATION

Consultation with service funders, providers and practitioners was undertaken to inform this policy project. A stakeholder survey was conducted in November 2020 and an online consultation event was held in June 2021.

STAKEHOLDER SURVEY

This policy project was informed by a survey of professionals working with young people, service managers, and staff from Primary Health Networks (n=231). Of survey respondents who reported that their role involved direct care of individuals with mental illness or alcohol and other drug (AOD) issues (n=147), almost all (98.6%) had experience working with young people. Most reported that their primary role was providing mental health support (40.1%) or a combination of mental health and AOD support (34.5%). Psychologists and social workers accounted for the largest proportion of respondents who reported working directly with individuals, followed by nurses/mental health nurses, counsellors and drug and alcohol workers.

Of survey respondents in service management roles (n=68), just over half (55.2%) worked in mental health and/or AOD services and a majority (85.1%) worked in a youth-specific service. 16 survey respondents were from Primary Health Networks.

ONLINE CONSULTATION EVENT

Stakeholders (n=33) from government departments, national organisations, services and universities, as well as individual practitioners involved in youth mental health and AOD service provision, participated in an online consultation. The consultation examined key barriers and solutions to providing integrated service and treatment experiences for young people. It was widely recognised that the sectors had been through this process previously, yet many of the same barriers persisted. The passion and expertise present in the consultation group, if harnessed and supported, could help to advance the development and implementation of integrated service and treatment opportunities for young people.

GLOSSARY

AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and other drugs
CBT	Cognitive behavioural therapy
DBT	Dialectical behaviour therapy
FTE	Full-time equivalent
MBS	Medicare Benefits Schedule
MI	Motivational interviewing
LHN	Local Health Network or District
PHN	Primary Health Network

EXECUTIVE SUMMARY

The challenge of delivering integrated treatment experiences for young people with both alcohol and other drug (AOD) use problems and mental ill-health is a recurrent policy issue in Australia. Progress has been slow and people working to support young people are frustrated by the lack of improvement in this area. Despite this frustration, there is widespread commitment to advancing integrated treatment experiences for young people.

A substantial proportion of lifetime mental ill-health starts between the ages of 12 and 25 years. Similarly, the onset of problematic AOD use increases from adolescence into early adulthood. The potential for the two health issues to overlap, contributing to or exacerbating each other, makes this a key health issue for young people. Mental illness and AOD use disorders co-occur at high rates in young people. Variation in illness complexity, as well as the range of psychosocial challenges faced by young people with co-occurring AOD use and mental ill-health, necessitate service models and professional skill sets that can respond effectively to a range of needs.

A developmental perspective recognises that adolescence into emerging adulthood comprises a critical period of brain development and life transitions in which young people navigate entry into the workforce, independent living, and the development of key adult relationships. Negative impacts of mental ill-health and problematic AOD use during this time can influence outcomes well into later adulthood. Conversely, effective, developmentally-informed and timely early intervention, support and treatment can reduce or even prevent many of these negative impacts.

Emerging mental illness in young people is marked by nonspecific patterns of symptoms, with fluid, evolving presentations common before more differentiated diagnoses emerge. Problematic AOD use and related problems commonly contribute to the complex clinical picture during this stage. It may be difficult for young people and their clinicians to disentangle the impacts of AOD use from symptoms of emerging mental illness. Integrated treatment is therefore particularly critical at this developmental juncture.

INTEGRATED TREATMENT

This policy paper is focused on integrated treatment to coordinate the provision of services focusing on AOD use problems and mental ill-health, with both problems addressed at the same time.

Integrated treatment can be delivered by an individual provider or multidisciplinary team approaches within a single service, co-location of two or more services providing collaborative care, or well-structured collaborative arrangements between services that are not co-located. More broadly, integrated services can also provide access or connection to social services.

This policy paper focuses on recognising where progress toward integrated treatment experiences have been made and identifying the opportunities for further improvement. While full integration of the two service systems may ultimately best serve the developmentally-specific needs of young people, this paper recognises that next steps and pathways to treatment integration will differ between states and territories due to differences in public funding models of services. A pragmatic approach has therefore been taken, aiming to present a range of possible policy solutions to maximise the degree of integrated treatment provision that can be achieved nationally, recognising differences in funding and services structures between jurisdictions. Policy solutions to scale up best practice examples and trial new initiatives require a workforce that is capable of, and supported to, work with young people with co-occurring issues. Therefore, policy solutions for workforce education and training, and expanding practice guidelines have also been prioritised.

Engagement with stakeholders informed the development of these policy solutions. A stakeholder survey in November 2020 identified

where progress toward integration had been made and the preferred options for delivering integrated care. An online consultation in June 2021 identified barriers to delivering integrated treatment experiences and opportunities to address these barriers.

Four principles have underpinned the development of these policy solutions aimed at enhancing access and improving outcomes for young people. These principles are harm reduction, early intervention, de-stigmatisation and developmentally-informed care. Harm reduction approaches aim to minimise the negative health, social and legal impacts of drug use, drug policies and drug laws. Intervening at the earliest possible point to reduce the impact of health issues is the basis for early intervention approaches. Young people often seek help for their mental ill-health more readily than they do for problematic AOD use. This presents an important opportunity for early identification and support for co-occurring AOD issues. Delays in accessing AOD use support, in part, result from continuing stigma linked to problematic AOD use. The stigma associated with mental illness has received significant attention in recent years. Further work to de-stigmatise problematic AOD use and mental ill-health could help young people seek treatment for these problems. Developmentally-informed care recognises the unique needs of young people in terms of their psychosocial and neurobiological developmental stages. It also recognises key features of developing/early-stage mental ill-health and co-occurring AOD use that necessitate youth-specific treatment responses. Finally, maximising the integration of treatment for young people, to enhance access and improve outcomes, is the key overarching principle of this policy document.

POLICY SOLUTIONS

Solutions presented in this policy paper focus on opportunities to (1) improve the capacity of services to deliver integrated treatment, (2) support collaboration and prepare the workforce to deliver integrated approaches, and (3) monitor outcomes to inform future improvement.

SERVICES

An imbalance in funding and differences in funding models between the AOD and mental health sectors comprise key structural barriers to the implementation of integrated treatment. As part of a mapping process, identifying and reviewing existing integrated service models both within Australia and internationally is needed to identify best practice examples. Improved mapping of services, and the funding models supporting them, would enable future prioritisation of coordinated funding to maximise integrated treatment delivery and support the establishment of structured referral pathways. Where service gaps exist, increasing service collaboration would support the delivery of integrated treatment and facilitate referral so each young person's treatment needs are met. At the lower end of illness severity, the necessary workforce development, treatment options and partnerships needed to deliver AOD services at a primary care level need to be in place. For young people with complex co-occurring needs, there is a gap in service provision that requires a trial service model informed by the available evidence.

WORKFORCE

A clearer understanding of the existing workforce is needed to inform workforce development policy, planning and funding. Annual health workforce data should be extended to include AOD counsellors alongside psychiatrists, mental health nurses and psychologists. Guidelines can support the existing workforce to deliver evidence-based treatments. Guidelines for integrated treatment in AOD service settings should be expanded to include resources for youth-specific care and application in mental health settings. A key opportunity for developing future workforce capacity is via formal education programs. A nationally consistent curriculum, including training in assessing AOD use, AOD use disorders and integrated treatment, is required across undergraduate and postgraduate medical, nursing and allied health courses.

Connecting workforce development and service delivery to provide integrated treatment requires formalised structures and resourcing across the range of available services and jurisdictional intersections. To facilitate treatment planning, Medicare Benefits Schedule (MBS) items for multidisciplinary case conferencing need to be expanded. Implementing case management roles within services, and resourcing formalised networks, would provide staffing resources and operational structures to establish and maintain referral pathways.

MEASURING OUTCOMES

The evidence-base for integrated treatment would be strengthened by the coordinated collection of outcome data for young people. While AOD issues are often captured at intake, the collection of outcome data is more limited. For example, the Health of the Nation Outcome Scales instrument has a single AOD item. The AOD item does not include the type of substance, whereas the mental or behavioural problems item includes the disorder type.(1)

Progress in standardised outcome measures in mental health would be enhanced by including problematic AOD use and related risky behaviours as a core outcome domain. Adapting existing measures in use, such as, the MyLife Tracker outcome tool used in headspace centres or those under development would increase the value of these measures and minimise the investment needed to enable the collection of outcomes data for integrated treatment and services. An audit of current projects would support the identification of an outcome measure suited to this expanded application.

TABLE 1. POLICY SOLUTIONS FOR SERVICES, WORKFORCE AND MEASURING OUTCOMES

SERVICES	WORKFORCE	OUTCOMES
Identify opportunities to trial new initiatives for expanded service integration. Map existing services to identify best practice in integration models and service gaps. Review integrated service models to inform best practice guidelines. Improve assessment of AOD use and integrated treatment capacity in headspace. Trial a single site multidisciplinary service model for young people with complex comorbidity.	Support collaboration and develop workforce capacity to implement integrated treatment. Resource participation in treatment planning. Coordinate care pathways. Formalise local networks to enable collaboration. Expand workforce reporting. Review and update university curricula, including work placements in both settings. Expand integrated treatment guidelines.	Drive improvement in service design, treatment delivery and workforce practice. Identify an outcome measurement tool for integrated treatment outcomes and resource development if required.

INTRODUCTION

Services for young people with co-occurring AOD use problems and mental ill-health are funded or provided by both federal and state and territory governments. While numerous policy attempts have been made to better integrate treatment, many current policies and funding arrangements continue to reinforce a divide in service provision. The Productivity Commission's Mental Health report concluded that, although there is widespread recognition of the need to cohesively address co-occurring AOD use and mental ill-health, overall progress has been 'frustratingly slow in some areas and outcomes remain poor.'(2)

Recognition of the importance of integrated treatment for co-occurring AOD use problems and mental ill-health is not new, yet this issue continues to present substantial policy challenges. Addressing treatment needs for young people has the added complexity of developmentally-specific needs, including the dynamic and largely undifferentiated nature of emerging illnesses. There is also limited evidence about integrated treatment models specific to this cohort.

Longstanding failures to integrate care provision have produced a range of barriers to treatment access.(3) Referral to different services and changes in health professionals providing care often require a young person having to repeat information and redevelop therapeutic relationships, presenting barriers to young people's engagement with services and adherence to treatment.(4, 5)

The benefits of integrated treatment experiences include reduced barriers to access care once help-seeking has been initiated, and coordinated, complementary treatment approaches.(3) There is evidence that integrated and coordinated care models work for a range of issues in young people.(6, 7)

The rationale for developing and implementing policy solutions to integrate treatment experiences for young people is informed by several underlying principles. These principles reflect the existing evidence-base and best practices in supporting young people experiencing mental ill-health, problematic AOD use and a combination of the two. The principles are harm reduction, early intervention, reducing stigma and developmentally-informed care.

UNDERLYING PRINCIPLES

HARM REDUCTION

For young people experiencing significant mental ill-health, abstinence from AOD use is likely to be optimal, particularly when mental health symptoms are exacerbated by AOD use. Young people taking psychiatric medication may find they become intoxicated at lower levels of AOD use. Even low levels of use can interact with psychiatric medications, negatively impacting treatment outcomes.

While abstinence is likely optimal, young people may not perceive their AOD use to be problematic nor acknowledge a need to address this as part of their mental health care. In some cases, they may see AOD use as the solution rather than a part of the problem. A requirement that young people abstain from drug use can therefore present a substantial barrier to accessing care, especially when alcohol or drug use is common within their peer group or social networks.

While abstinence is a goal of many AOD and mental ill-health interventions, harm reduction approaches are designed to help young people to receive the care, support, and treatment they need, recognising that many young people do not wish to stop using alcohol or other drugs. Harm reduction aims to reduce the negative health, social, and legal impacts associated with AOD use. Harm reduction is a particularly important principle in the case of young people, given that AOD use is quite normative in some groups of young Australians. It is common for young people experiencing mental ill-health to have ongoing AOD use and associated problems during treatment. To enable help-seeking and treatment access, a harm reduction approach with associated treatment goals is best practice.(8)

EARLY INTERVENTION

The earlier support can be provided for emerging mental ill-health and AOD use problems, the more likely the impact on a young person's health and wellbeing can be minimised. Successful early intervention for co-occurring problems requires addressing both issues in a coordinated way and at the same time, irrespective of the level of illness. Delivering integrated treatment experiences is fundamental for early intervention models of treating co-occurring AOD use problems and mental ill-health.(9, 10)

Opportunities to provide early interventions differ depending on the service access pathway a young person takes. Young people are more likely to seek help for their mental health, whereas many young people accessing AOD services will have been referred, for example the justice system, welfare agencies. This influences the level of symptom severity a young person may present with, being comparatively lower in mental health services compared with AOD services. Because young people may identify problems with their mental health more readily than with problematic AOD use (11), presentation at mental health services represents a key opportunity for early intervention to reduce the development of problematic AOD use.

DE-STIGMATISATION

Stigma is experienced at three levels: structural, public and internalised. Structural stigma manifests in terms of laws, regulations, policy documents, language, funding, and access to evidence-based treatment. Public stigma operates at the healthcare level and relates to prejudice and discrimination in health care settings. Internalised stigma is when a young person identifies with negative messages. These forms of stigma contribute to delays in help-seeking, treatment withdrawal and withholding information for fear of being excluded.(12, 13)

While progress has been made in addressing mental health related stigma, problematic AOD use remains highly stigmatised.(14, 15) Stigmatisation is a major barrier to help-seeking and raising awareness of these health issues and available forms of support.(16) Stigma associated with AOD use is also experienced by staff across the broader health sector. The reduced stigma around mental illness, the result of years of awareness raising, has not included problematic AOD issues.(17) The same level of commitment and resourcing is required to address AOD-related stigma, as well as promoting and facilitating treatment-seeking for problematic AOD use in young people.

DEVELOPMENTALLY-INFORMED CARE

The period of adolescence and early adulthood (roughly corresponding to age 12 to 25 years) is a period of rapid social and neurobiological development. During this time, young people engage in a range of important developmental tasks, including transition into the workforce or higher education, development of independent living capacities, and forming key relationships outside of their family of origin as they transition into adulthood. Mental ill-health and AOD use problems during this period can have greater – and more persistent – negative impacts than they would if they occurred at a later developmental stage, when adult roles and identities are more established. A key goal of treatment for problematic AOD use and mental ill-health during this period should be to limit damage to the developmental trajectory and support the transition to adulthood.

Emerging mental ill-health in young people has key features that are distinct from mental illness in older adults. It is characterised by nonspecific symptoms, with dynamic and evolving symptoms common before the emergence of more differentiated diagnoses in middle adulthood.(18, 19) Symptoms observed during this period commonly include anxiety, depression, problematic AOD use and disordered eating.(20) The complexity of these experiences are often compounded by marked psychosocial problems. In this context, it may be difficult for young people or their service providers to adequately separate AOD-related issues from mental ill-health. The dynamic and undifferentiated clinical presentation observed in young people with early-stage mental ill-health, often including problematic AOD use, makes integrated care particularly critical in this developmental stage.

CO-OCCURRING AOD USE AND MENTAL ILL-HEALTH IN YOUNG PEOPLE

A majority of lifetime mental ill-health has its onset before the age of 25 years.(21) Similarly, the onset of problematic AOD use increases from adolescence into early adulthood.(22) These experiences potentially overlap during the key transitional period of emergent adulthood. This confers risks for a range of impacts on social and neurobiological development. The wide range of potential impacts can result in multiple layers of disadvantage and increased barriers to service access. Problems arising during the transition to adulthood can have lasting effects that persist throughout adulthood.

Among young Australians overall, AOD use has been decreasing in recent years, with a corresponding increase in the age of initial use.(23) Despite these promising changes, young people experiencing mental ill-health continue to have substantially higher rates of problematic AOD use and disorders than their same-age peers without mental health issues.(24, 25) Poorer physical health is a further comorbidity for young people experiencing co-occurring mental ill-health and problematic AOD use.(26, 27) This includes tobacco smoking, which in Australia is becoming increasingly concentrated in vulnerable groups including those with mental illness and problematic AOD use.(28)

Mental illness and AOD use disorders co-occur at high rates across the lifespan, with the highest rates of comorbidity observed in young people. (29) The presence of one health issue increases the risk of developing the other.(2) Common risk factors and the potential for reciprocal impacts between these domains can lead to comorbidity among young people.(22) The prevalence of AOD use disorders increases with the level of psychological distress, with young people with more serious mental illness using alcohol and other drugs at disproportionately high rates. (25, 30) The specific nature of emerging mental illness in young people, which is often fluid and undifferentiated, can make it difficult to separate the effects of problematic AOD use from symptoms of mental ill-health.

Importantly, not only can these problems co-occur, experiencing both leads to poorer outcomes than experiencing either alone.(2) For example, young people with AOD use disorders and co-occurring high prevalence mental health disorders have increased suicidality and more severe AOD use disorders, as well as poorer social and academic function.(8) Co-occurring AOD use disorders and mental illness appears to be an important marker for poorer functional and relational outcomes in young people.(31)

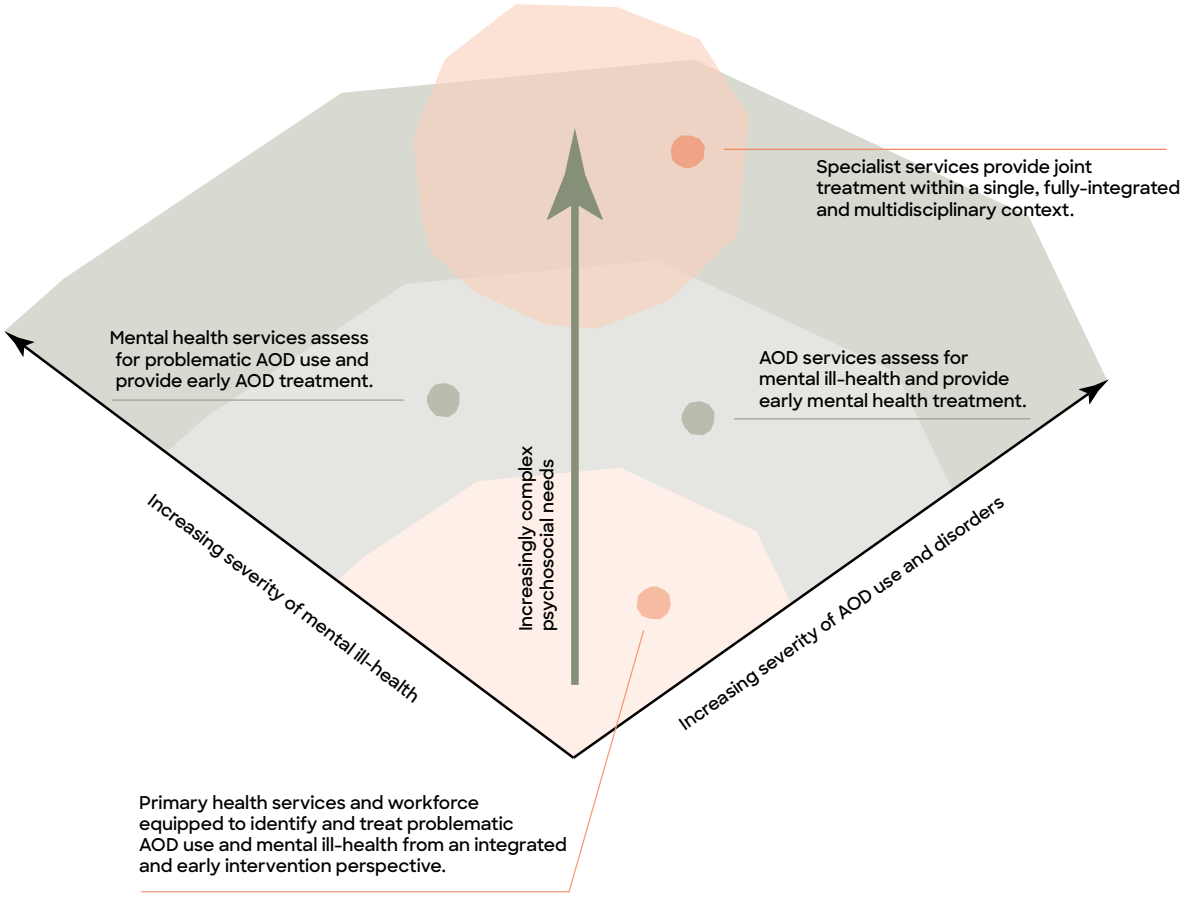
PSYCHOSOCIAL NEEDS

Many young people with co-occurring problematic AOD use and mental ill-health have additional needs for psychosocial support. Psychosocial support can not only address broader welfare and education needs, it can also scaffold continued engagement with health services and treatment adherence. The increasing complexity of psychosocial support needs among young people with more severe AOD use disorders and/or mental ill-health needs to be recognised by both AOD and mental health services. Psychosocial support can play a key role in protecting the developmental trajectory of young people with co-occurring problematic AOD use and mental ill-health to minimise negative effects persisting into later adulthood. Integrated services provide a basis for incorporating psychosocial support.

GRADATIONS OF COMPLEXITY

The severity of problematic AOD use and mental ill-health can vary markedly in young people experiencing both issues. The prevalence of mental ill-health is higher in young people accessing AOD services – reportedly as high as 80 per cent – compared with rates of problematic AOD use in young people seeking mental health care.(32, 33) This may be because the threshold for help-seeking is higher for problematic AOD use than for mental ill-health, which influences the illness severity and services needed to respond once a young person seeks help.(34) Greater stigma associated with problematic AOD use and disorders compared with mental ill-health is also a factor. Service design, workforce composition, and treatment responses will, therefore, need to differ depending on where and when a young person seeks help. A potential, simplified model operating across the severity spectra for AOD and mental health problems is presented in Figure 1.

FIGURE 1. APPROACH TO INTEGRATION BASED ON SEVERITY OF PRESENTING ISSUES



The variation in severity from emerging mental ill-health and problematic AOD use to mental illness and AOD use disorders will influence the most appropriate service and treatment options for a young person. At the primary health service level there is an opportunity to improve workforce capacity to identify emerging health issues, enable help-seeking and provide brief, early interventions. To provide an integrated treatment experience, services need the capacity to screen for co-occurring health issues, provide an appropriate intervention where presenting symptoms are mild to moderate, and have an identified and formalised collaborative framework for providing integrated care for young people requiring more intensive support in addition to treatment for the presenting issue.

For young people experiencing complex mental health and AOD use disorders, new service initiatives are required. A trial of single site multidisciplinary services to support young people experiencing co-occurring complex disorders and provide integrated treatment is outlined in this report.

POLICY CONTEXT

Recognition of the high prevalence and poorer health outcomes associated with co-occurring problematic AOD use and mental ill-health has informed national health policy for more than 20 years. For much of that time, the former Council of Australian Governments pursued a 'dual diagnosis' approach with workforce development centred around building capability within the AOD sector to support this. Unfortunately, the lack of long-term resourcing limited the success of this strategy. More recently, government policies have shifted to a focus on collaboration, with a range of collaborative mechanisms being identified nationally and by states and territories.

There was a perception among survey respondents for this project that state and territory health departments were more focused on mental health services for young people than AOD services. This perception was shared among respondents working with individuals, those managing services and working for Primary Health Networks (PHNs). Further engagement during the online policy consultation heard frustration expressed by AOD stakeholders at the experience of being the 'poor cousin' of mental health.

DUAL DIAGNOSIS

The past focus on dual diagnosis saw the development of screening and assessment tools, staff training resources and service design models. Dual diagnosis toolkits were developed for both AOD and mental health treatment services. The toolkits were designed to identify low or no-cost options to enhance capability where benchmarks were not being met.(35)

Despite the development of dual diagnosis guidelines and some investment in workforce development, successful implementation has often been short-lived. Without ongoing funding and formal structures in place to sustain implementation and inter-sector collaboration, practitioners have regularly reverted to the former practices services were originally designed to support. Where programs have been successful, success has often been dependent upon individuals and local teams working without resources to maintain initiatives after funding has finished.

Developing dual diagnosis workforce capacity remains a policy focus in some jurisdictions. Approaches identified include suicide awareness training for the non-mental health workforce in New South Wales,(36) attracting workers with mental health skills to the AOD sector and supporting career pathways and accredited training in Victoria.(37) In Western Australia, which has an integrated strategy document, developing workforce capacity for treating co-occurring health issues is considered a long-term outcome.(38) Investment in integrated care remains a focus in Victoria, having been identified as a priority in the Royal Commission into Victoria's Mental Health System.(39)

COLLABORATION

More recently, the focus of policy has shifted from system-wide service initiatives to improving integrated service provision by building collaboration between services. Strategy documents, including the *National Drug Strategy 2017-26* (40), outline concepts to support collaboration, including: developing a culture of partnership, referral pathways, linkages with leadership groups and service coordination. Survey respondents for this project also perceived that health departments placed a higher priority on developing inter-agency collaboration than integrated services, which reflects the changing policy emphasis. While there is an overarching theme of collaboration between AOD and mental health sectors in government policy, beyond conceptual terms there is limited detail on how this will be achieved and sustained. Clear policy direction and funding is required to achieve effective collaboration.

COMBINED STRATEGIES

Queensland and Western Australia have both taken the step of publishing combined mental health and AOD strategies. The Queensland strategy sets out an intention to focus on 'strengthening collaboration and effective integration across

our treatment service system'.(41) The Western Australian strategy is focused on the 'optimal mix' of services; that is how many services from each sector are needed rather than how they will be "mixed" together in an integrated service delivery model.(42) While demonstrating leadership in moving to an integrated policy approach, the policy ambition is tentative with details for the two sectors still largely presented separately.

In developing a renewed statewide plan for AOD services, the Queensland Mental Health Commission published 10 consultation papers, including papers for workforce capacity, young people and options for reform.(43) This level of consultation demonstrates the size of the policy reform task required to develop and deliver an integrated treatment experience given existing service systems.

Despite widespread recognition of the need for integrated treatment in current policies from federal and state and territory governments, there is a lack of consistency in how this will be best achieved. This policy paper provides policy solutions for different governments to enable strategic objectives to be implemented to improve integrated treatment delivery for young people across a range of jurisdictions.

PROGRESS

Survey respondents for this project (n=231) reported that there had been some improvement in the delivery of integrated services for young people, but that barriers still exist. Service managers were more likely to agree that PHNs (50.0%) placed a high priority on inter-agency relationships compared with practitioners (41.1%). The perceived priority of inter-agency relationships by local health district/area was closer (42.9% and 40.0%, respectively).

Survey respondents who worked for PHNs also reported that inter-agency relationships in their region had improved in the past five years and anticipated continued improvement in the coming five years. Practitioners and service managers believed there would be a further improvement over the coming five years.

Optimism about the future of inter-agency collaboration on the one hand, and perceived lack of evident prioritising on the other, suggests that a strategic implementation plan and dedicated funding will be required to realise the collaborative objectives identified in government policies.

RECENT POLICY DIRECTION

Recent policy direction has restated a commitment toward integration. Both the Productivity Commission and the Royal Commission in Victoria reports recommended that mental health services should be able to provide some level of integrated treatment. It is important that reforms and associated funding also consider the role of AOD services in realising system reform and provision of integrated treatment.

PRODUCTIVITY COMMISSION

The Productivity Commission's Mental Health inquiry report focused on the role of state and territory governments in supporting integration through commissioning and providing services for AOD use and mental health disorders at a regional level (Actions 14.2, 23.4).(2) The report included detailed reforms to funding arrangements to support this.

The Productivity Commission stated that mental health services should be required to ensure treatment is provided (or referred) for both conditions where they co-occur; and that mental health and AOD services should jointly develop and implement operational guidelines for screening, referral pathways and training, and other guidelines and educational resources. The Productivity Commission has directed governments to plan and commission AOD and mental health services at a regional level to ensure variations in service gaps and demand between regions are met.

VICTORIAN ROYAL COMMISSION

The Royal Commission into Victoria's Mental Health System made two recommendations about co-occurring mental illness and AOD use disorders.(39) The first (Recommendation 35), stated that all mental health services should provide integrated treatment and that people living with substance use or addiction are not excluded from accessing mental health treatment, care, and support (in line with harm reduction principles). The second (Recommendation 36), recommended establishing a new statewide specialist service that would: undertake dedicated research, support education and training, provide primary consultation to people with complex needs and secondary consultation across both sectors. For young people, the proposed new statewide Youth Area Mental Health and Wellbeing Services, as well as local Mental Health and Wellbeing Services (likely to be delivered in headspace centres) will be required to provide integrated care. The recommended service model would be built on the foundations established by the Victorian Dual Diagnosis Initiative reflecting the level of investment in this model in Victoria. The need to increase the number of AOD specialists, including through opportunities for federally-funded AOD specialist trainee positions in Victoria, was recognised.

SERVICES

The AOD and mental health sectors continue to be largely siloed in Australia. This persistent division – despite the evidence supporting integrated health service delivery for young people (44, 45) and government policies intended to improve collaboration and create integrated service models – is sustained through predominantly separate funding mechanisms, activity targets and service delivery structures.

DIFFERENCES IN FUNDING

Funding structures are a key determinant in whether and how service integration can be achieved. Service managers surveyed for this project strongly agreed that how a service is funded is a determining factor in how successfully integrated treatment can be delivered.

Data on publicly funded AOD and mental health services published by the Australian Institute of Health and Welfare (AIHW) are limited to service delivery and do not include expenditure. The level and format of published budget details for mental health and AOD services differ between jurisdictions. For example, the Victorian budget papers provide specific budget line items, but the New South Wales budget papers do not. In Western Australia, a combined headline figure for AOD and mental health services is reported as part of the state's move to an integrated service.

Reform of funding structures needs to be undertaken in the context of existing funding disparities between AOD (comparatively underfunded) and mental health services across the country along with specific jurisdictional contexts. Consultations undertaken for this project heard about experiences of budgets being 'subsumed' into general funding pools when services were integrated. It is important that service levels are maintained when services are funded to deliver integrated care, with measures implemented to track and maintain service delivery.

MENTAL HEALTH SERVICES

Mental health services are delivered through primary care, community mental health services and hospitals. The funding of most mental health services is shared by federal and state and territory governments. The Federal government, through the MBS, funds the delivery of primary care which aims to meet the needs of young people with emerging and mild symptoms. MBS funding is also provided for allied health professionals to provide care for young people with symptoms meeting the criteria for a mental illness. The headspace National Youth Mental Health Foundation is a youth-specific model for this level of support, with both mental ill-health and AOD use treatment recognised as core business for headspace. However, the provision of AOD services as well as integrated care – both of which are locally coordinated – has been mixed. Specialised care is provided by state and territory funded community-based and inpatient services. While a similar child and adolescent mental health service model is used across the country, only some jurisdictions have adopted a youth age range of 12 to 25 years.

Presentation at mental health services may provide an opportunity for early intervention with young people with mental ill-health who do not perceive their AOD use to be problematic. Clinical research testing innovative early interventions will be necessary to inform these kinds of opportunistic approaches. These models likely differ from those required for older populations, highlighting the need to adapt and trial existing evidence-based approaches for the developmentally-specific needs of young people.

ALCOHOL AND OTHER DRUG SERVICES

AOD services offer a broad range of treatment types and service delivery models. While the approach to mental health service funding and delivery is similar across the country, there are differences in the delivery of AOD services. For example, in New South Wales a majority of AOD services are provided through government health services, whereas in Victoria most services are provided by non-government and in some instances non-health organisations. In Queensland and Western Australia, AOD services come under the mental health branch of government, although services may still be provided by non-government organisations.

Publicly funded AOD services are provided directly through public health services or outsourced to non-government organisations. Provision by non-government organisations is highest in Victoria (99%), Western Australia (91%) and the Australian Capital Territory (88%) and lowest in New South Wales (36%).(46) While the AIHW has reported difficulty fully quantifying the scope of AOD services, it reports that there were 1,283 AOD agencies in Australia in 2018-19, of which approximately two-thirds (881) were non-government agencies.(47)

Data on publicly funded treatment services are collected through the Alcohol and Other Drug Treatment Services National Minimum Data Set. Despite collecting data on the number and type of services provided, the AIHW acknowledges that fully quantifying the scope of AOD services in Australia is difficult.(48) Variability in service availability, an issue identified by the Productivity Commission, is a key factor in being able to provide integrated treatment for young people. Geographic variability in service availability can be large, especially outside of urban areas.(49)

A lack of coordinated information on AOD treatment services is a barrier to determining the number of youth-oriented services. For example, on one national website information was limited to nine services for young people in every state and territory except for South Australia,(50) whereas a review of available evidence-based AOD interventions for young people in a community setting for the South Eastern New South Wales PHN reported that there were 14 community-based youth AOD services in New South Wales.(51) Coordinated collection and publishing of data from PHN service activities and state and territory funded services would provide an overview of the availability of youth AOD services (and integrated services).

POLICY SOLUTION	EVIDENCE AND RATIONALE	OUTCOME
MAP SERVICE BALANCE IN MENTAL HEALTH AND AOD SERVICES		
Service mapping of commissioned services and publicly funded state/territory services be used to assess current service availability and balance. PHN/LHN partnerships: • identify gaps in service balance to inform future commissioning; and • coordinate collaboration pathways between commissioned and state/territory funded services. Mapping to include analysis of federal and state/territory funding streams with the aim of identifying overlap and gaps to enable better coordination between jurisdictions. Service maps are used to inform additional service funding through National Partnership Agreements to deliver increased service delivery efficiency and equity of access.	A lack of coordinated information on mental health, AOD and integrated services is a barrier to determining the number of youth-oriented services. A balance of services is required to ensure the right service capacity is available to meet young people's needs. The Productivity Commission recommended that governments plan and commission AOD and mental health services at a regional level to ensure improved equality in service access (Action 14.2).	Funding is coordinated between federal and state and territory governments. Service gaps are identified and commissioned to improve system balance. Primary health services have clear pathways for referring young people to appropriate services.
Mechanism: Department of Health in partnership with state and territory health departments.		

INTEGRATED TREATMENT MODELS OF CARE

An integrated service experience can be beneficial for young people. Integrated models of care have been recommended by Australian and international (52) government bodies, as well as by a range of experts and organisations.(53-55) This is supported by evidence that integrated and coordinated care models work for a range of issues in young people.(6, 7) Benefits include reducing the time and money young people need to spend accessing services, a coordinated, complementary treatment approach, and a reduced burden on young people from having to repeat their stories. Confidentiality remains an important professional practice and permission should still be sought from a young person to share information or case notes in facilitating integration.(44)

Integrated treatment can be provided either by one service – and potentially a single clinician – or via a coordinated care plan delivered by more than one service in an integrated way (see Table 2). This is contrasted with sequential care, where treatment for one health issue is provided initially, followed by treatment for the second. It also differs from parallel care, in which two separate services provide care concurrently, but independently. The current policy emphasis on collaboration may inadvertently work against increased service integration by favouring parallel treatment models. If the inherent connectedness of co-occurring issues is not recognised in the delivery of sequential and parallel models it could lead to young people 'falling through the gaps' between services, and not receiving the care they need.(8, 56)

TABLE 2. SERVICE DELIVERY MODELS

TREATMENT MODEL	DESCRIPTION
Sequential	Young people receive treatment for either a mental health or AOD use disorder. Following discharge from one treatment, they progress to treatment for the other illness. Limitations: This approach can contribute to delayed or even missed treatment and frustration at the swaying between services. Sequential treatment is not well supported by evidence and fails to recognise the interdependence of problematic AOD use and mental health symptoms.
Parallel	Young people receive treatment for both their mental health and AOD use disorders at the same time from different services, largely in isolation from each other, without coordination between clinicians. Limitations: Treatments are typically delivered in isolation and may have differing or conflicting treatment philosophies. Service providers are unsure of how to effectively collaborate and communicate with each other to ensure optimal interventions are delivered. Parallel treatment can also present practical issues such as the need to see two different providers who may not be co-located.
Integrated	A single treatment plan considers both mental illness and AOD use. Integrated treatment approaches include: Single-site, concurrent treatment, where the same provider or a multidisciplinary team offers treatment. Co-located services providing coordinated care for both mental health and AOD use disorders. Multi-site integration, where a client receives intervention for their mental health problem and AOD use at different sites or services, but with a cohesive treatment approach. Limitations: Multi-site integrated treatment approaches require collaboration and communication between services and providers, with well-designed and maintained structures and administrative supports. Given the developmentally-specific needs of young people, it is likely that optimal integrated treatment would be facilitated by single site integrated multidisciplinary treatment.

Despite the apparent benefits of integrated care, there is a lack of high-quality evidence on optimal integrated models of care for young people. A small number of studies suggest that integrated psychological interventions including multidimensional family therapy and cognitive behaviour therapy can reduce both problematic AOD use and symptoms of mental illness in young people.(57, 58) Yet, there is a lack of evidence examining models of integrated care across different types of services and the spectrum of problem severity. This highlights the critical importance of research to guide service system reform, and ongoing evaluation of changes as they are implemented.

PERCEPTIONS OF INTEGRATION MODELS

Consultation with workforce and service stakeholders revealed differences in preferred models of delivering integrated treatment and services.

Among health professionals working with young people, the first preference was for one person to provide an integrated service (37.2%). The options of two services working closely together (21.2%) or two people within the same service (20.4%) were similarly supported, followed by two services operating in the same setting (17.5%).

Among service managers, slightly more favoured two services operating in the same setting (29.0%) followed by the same person in the same service (25.8%) and two services working closely together (24.2%). The lowest support was reported for two people with specific skills within the same service (16.1%).

POLICY SOLUTION	EVIDENCE AND RATIONALE	OUTCOME
REVIEW OF INTEGRATED SERVICE MODELS		
Commission a review of services providing integrated, youth-specific mental health and AOD use support and treatment to identify best practice models. Service model guidelines are developed and used to: • outline available evidence-based treatments and workforce roles; • guide implementation within existing services; and • inform the commissioning of integrated services for young people.	Integrated models of care are recommended for young people, but implementation and best practice evidence is limited. Approaches to treatment for co-occurring problematic AOD use and mental ill-health issues can take many forms. A review of integrated services would provide direction for implementing this approach optimally across jurisdictions.	Funding of integrated service models requires evidence-based practice and service reporting that includes the proportion and type of evidence-based interventions provided.
Mechanism: Department of Health.		

OPPORTUNITIES IN PRIMARY AND HIGHLY COMPLEX SERVICES

There are significant policy opportunities for improving or developing integrated service model responses at either end of the spectrum of illness severity (see Figure 1).

At one end there is the opportunity to identify and treat co-occurring emerging or low level problematic AOD use issues and emerging or mild mental ill-health in primary health. Help-seeking for problematic AOD use in young people is low relative to other mental illnesses.(34) The heightened risk for problematic AOD use and associated problems among young people with mental ill-health means that headspace services provide a key service opportunity for early intervention.

The integration of mental health into primary care has provided evidence for integrated models.(56) Extending this approach to problematic AOD use would broaden the scope of integrated capacity available to young people. This capacity would be further enhanced by establishing or strengthening network connections between primary care and specialist mental health and AOD use services. There is an opportunity for the Royal Australian College of General Practitioners to facilitate these connections through

collaborative initiatives with PHNs, headspace National, state and territory health departments and child and adolescent/youth mental health services.

HEADSPACE

The headspace model is designed to provide support for emerging mental health and problematic AOD use – along with physical health care and vocational services – for young people. Despite the intended service model, mental health support has been the primary reason (72.7%) that young people have accessed headspace services, compared to 3.1 per cent presenting for AOD use.(59) Nationally, headspace recognises the need to increase the provision of AOD treatment.

Steps to improve headspace capacity to deliver integrated AOD services include establishing service partnerships, workforce development and promotion of available AOD services. Most AOD services provided through headspace are provided in-kind from co-located services or a consortium partner.(59) A combined approach is required to attract and increase rates of help-seeking. Increased service demand will be necessary to support ongoing investment in service provision and the development of workforce capacity to provide integrated treatment.

Capped funding and lack of funding streams (beyond the MBS) for AOD treatment within headspace have been identified as a barrier to providing AOD support for more young people.(60) The Department of Health recognises the limitations of the MBS-based funding model and has identified that increased grant funding is required. A lack of funding incentives for collaborative treatment approaches between AOD workers and MBS funded allied health providers is a further barrier. While this is a challenge, it is also an opportunity to provide training to allied health professionals working in headspace centres in identifying co-occurring AOD use problems and delivering integrated treatment responses.

POLICY SOLUTION	EVIDENCE AND RATIONALE	OUTCOME
IMPROVE CAPACITY TO PROVIDE AOD AND INTEGRATED SUPPORT IN HEADSPACE CENTRES		
Develop an action plan to increase AOD treatment capacities, including implementation of a standardised screening approach for problematic AOD use and provide an expanded range of primary care responses. headspace provide targeted training to increase the capacity of headspace staff, including private practitioners and salaried clinical staff, to provide evidence-based integrated treatment for co-occurring AOD use and mental health issues. headspace be required to report on the provision of integrated services for problematic AOD use and mental ill-health.	AOD services were intended to be a central feature of the headspace model, however, levels of service delivery are low. Increased workforce capacity is required to increase integrated treatment experiences for young people.	Young people feel safe accessing support for problematic AOD use through headspace. Services available at headspace centres can identify co-occurring issues and provide appropriate integrated care.
Mechanism: headspace National and headspace centres.		

SINGLE SITE MULTIDISCIPLINARY SERVICES FOR COMPLEX NEEDS

Although better collaboration will improve integrated treatment experiences for young people, increasing the capacity of single sites to provide integrated treatment will likely be needed to provide optimal care for many young people. In particular, for young people with high levels of severity of both AOD use and mental health disorders who are currently not well served by either service sector. Developing services to respond to complex needs requires flexible approaches to coordinating integrated experiences and the need for workforce development to provide treatment for young people with the highest needs.

POLICY SOLUTION	EVIDENCE AND RATIONALE	OUTCOME
TRIAL A SINGLE SITE SERVICE MODEL FOR COMPLEX MENTAL HEALTH AND ALCOHOL AND OTHER DRUG USE ISSUES		
Support a trial of a single site multidisciplinary service model for young people with complex needs. The federal Department of Health provide resource support for a state/territory service trial. The trial is undertaken by a service(s) with experience in treating young people for severe AOD use and mental health disorders and a track record in the implementation of evidence-based interventions. Requirements of the trial: • the model be informed by a review of international best practice models for young people; • that it be a two-year trial; • a rolling outcomes evaluation be undertaken (up to 12-months post discharge); and • guidelines for a best practice model to be developed.	Young people with high levels of severity in both mental health and AOD use disorders are currently not well served by either service sector. Development of single site multidisciplinary services is required to meet complex service needs. This service will also need to address psychosocial complexity, which is high in many young people in this category of illness severity.	A service model for providing treatment to young people with complex needs related to co-occurring AOD use and mental health disorders is developed and evaluated.
Mechanism: Federal Department of Health, selected state/territory health department.		

SUPPORTING AN INTEGRATED EXPERIENCE

Delivering integrated treatment experiences requires coordination.(61) Coordinating an integrated experience requires knowledge of a young person and where the treatment and services they need are available. Care coordination supports a focus on a young person's psychosocial needs in addition to their mental health and AOD use treatment needs. Coordination will be enhanced through greater resourcing for participation in treatment planning, case management roles and mapping and maintaining formalised service networks.

There was a shared view among survey respondents regarding which factors were important in improving service integration. Organisational factors, such as leadership, and having a shared purpose and culture were identified as necessary. Structured processes for integration were also seen as being important. Practitioners also placed importance on the role of professional networks and relationships, as did PHN respondents. Practitioners identified the importance of designing and funding service systems to support collaboration. This included providing time for staff to develop inter-agency/network connections and to use these connections to support young people.

TREATMENT PLANNING

The existing resourcing of treatment planning does not equally provide support for participation. Allied health professionals do not have the same access to MBS items as medical professionals for initiating or participating in treatment planning. This is a barrier to private practitioners and services predicated on an MBS-funded service model participating in treatment planning. Removing this barrier would enable improved coordination to enhance the delivery of integrated treatment experiences for young people.

POLICY SOLUTION	EVIDENCE AND RATIONALE	OUTCOME
RESOURCING PARTICIPATION IN TREATMENT PLANNING		
Treatment planning and shared consultation between health professionals (within and between services) be resourced. Existing (or new) MBS items for multidisciplinary case conferencing be expanded to enable allied health professionals to organise and participate in case conferencing to support planning and delivery of shared care.	Care coordination enables the provision of integrated treatment experiences. Participation in treatment planning and consultation needs to be supported.	Non-salaried health professionals supported to initiate treatment planning and team members reimbursed for participation.
Mechanism: The Federal Department of Health.		

CASE MANAGEMENT

Case management provides care coordination, supports the maintenance of engagement with services, and facilitates referral pathways. Case management is appropriate for young people with more established or complex health issues as they can experience additional barriers to remaining engaged with their treatment and services. Evidence that therapists working with young people spend time each session on case management highlights the importance of resourcing this role alongside counselling or therapy.(62)

Case management enables collaboration and supports practitioner involvement in the delivery of integrated treatment, addressing psychosocial needs and protecting the developmental trajectory. Implementation of case management would provide a role and model for collaboration within a service and with other services. To support an integrated treatment experience, case managers need to engage with both mental health and AOD services. To undertake this role, designated, specific funding is required for case manager positions to ensure the role is not subsumed into other functions and responsibilities.

POLICY SOLUTION	EVIDENCE AND RATIONALE	OUTCOME
COORDINATED CARE PATHWAYS AND INDIVIDUAL SUPPORT NEEDS		
Case management roles are incorporated into commissioned services providing mental health and/or AOD services for young people.	Case management roles enable a young person's service pathways within a service system. De facto case management functions performed by staff reduce the time available for treatment.	Young people experience an integrated treatment experience. Support provided includes needs additional to, and supportive of, mental health and AOD treatment, including addressing psychosocial needs.
Mechanism: The Federal Department of Health.		

OUTREACH

For a range of reasons, not all young people will seek help for AOD use or mental health issues or disorders. In these cases, assertive outreach services provide an opportunity to take services to young people. For example, assertive outreach services for homeless young people with co-occurring mental health and AOD use disorders have been found to reduce hospitalisation time and achieve housing stability sooner.(63) Outreach services are another form of integration in which mental health and/or AOD services collaborate with a welfare support service already engaged with young people. Examples include housing, education, and employment services.

NETWORKS

Existing relationships between PHNs and local health networks/districts (LHNs) provide a ready framework for developing collaboration in service planning and commissioning. The task is to establish and maintain a consistent level of locally functioning network connections across the country. Resourcing for collaborative mechanisms and roles between services within PHNs/LHNs should be identified in service models and performance criteria for commissioned services and corresponding service delivery metrics and data reporting for public services.

Improved collaboration within and between services will deliver an enhanced experience of service integration for young people. Mapping and evaluating existing networks and collaborative mechanisms would provide a model for ensuring all services within a region are positioned to deliver or collaborate in the delivery of an integrated treatment experience. Local input would ensure that existing collaboration mechanisms are incorporated, formalised, and strengthened through this process. For example, the Queensland Mental Health Alcohol and Other Drugs Workforce Development Framework 2016-2021 identified the importance of developing a culture of partnership through inter-disciplinary and team-based practice.(64)

Mapping enables services and service systems to identify gaps in service collaboration and resource allocation to support the implementation of best practice models already operating in a similar context. This process provides the basis for allocating resources for collaborative mechanisms and evaluation. Establishing a service collaboration facilitation network would enable the transfer of knowledge and supported implementation at a service level and a point of contact for service system communication and coordination of learning from implementation across local health districts.

POLICY SOLUTION	EVIDENCE AND RATIONALE	OUTCOME
RESOURCE FORMALISED LOCAL NETWORKS TO ENABLE COLLABORATION		
Coordinate a census of formalised networks between AOD and mental health services. Seed funding for formalised local networks is provided through PHNs. Services identified as having no networks or reliant on informal connections invited to develop a strategy for establishing and maintaining formal service networks and funding proposals. Evaluation of network initiatives is undertaken.	Formalised networks enable the delivery of integrated service experiences. Staff should be supported to build and maintain network connections.	Network connections enable young people to move smoothly between services. Referrals are enabled through established care pathways between services.
Mechanism: Federal Department of Health.		

WORKFORCE

Variability in roles and education and training all contribute to workforce differences between the mental health and AOD sectors. Separate national workforce data reporting for mental health and AOD sectors illustrates this divide. While the AIHW annually reports on workforce data for psychiatrists, mental health nurses and psychologists, workforce data collection for the AOD sector is inconsistent.

ALCOHOL AND OTHER DRUG USE SERVICES

The AOD workforce includes AOD counsellors, nurses, social workers, general practitioners, peer workers, needle and syringe program workers, prevention workers, AOD medical specialists and specialist psychologists and psychiatrists. Workforce data collection is inconsistent across jurisdictions and between government and non-government sectors.(65) The *National Alcohol and other Drug Workforce Development Strategy 2015-2018* suggested that a national census be undertaken using consistent role terminology. To date, this has not been actioned.

A national census would likely reveal differences in workforce investment and development between states and territories. For example, it has been reported that a five-fold increase in the number of addiction medicine specialists would be required in Victoria to reach a proportional level to that of New South Wales.(66) This gap was recognised by the Royal Commission into Victoria's Mental Health System, which recommended prioritising an increase in the number of addiction specialists (Recommendation 36).

In the absence of a national census, the National Centre for Education and Training on Addiction published national workforce survey data in 2020 (the first since 2005).(67) The survey data provided a snapshot of the composition of the AOD workforce. The survey sample was predominantly from non-government services (57%) followed by government agencies (39%). 71 per cent of respondents indicated that service provision was their leading role. AOD counsellors accounted for 23 per cent of direct client service roles, followed by AOD nurses (10%). Counselling was the most common treatment type delivered for young people's own drug use (35.5% for 10 to 19-year-olds; 43.1% for 20 to 29-year-olds).(68) Two-thirds of people employed in direct client service roles reported having an AOD-related vocational qualification, for example Certificate IV in Alcohol and Other Drugs or tertiary qualification.

While survey data provide an indicative workforce picture, more accurate and comprehensive data on the number of people employed in AOD services and their roles are required. Accurate workforce data would enable the mapping of workforce availability to service needs and substantively inform investment in workforce development, particularly in the context of advancing integrated treatment provision.

POLICY SOLUTION	EVIDENCE AND RATIONALE	OUTCOME
EXPANDED WORKFORCE REPORTING		
Annual health workforce data reported by the AIHW be expanded to include AOD workers. AOD counsellors are reported alongside psychiatrists, mental health nurses and psychologists. Workforce data reporting be expanded to include the service sector roles are employed in.	Workforce data collection and reporting for the AOD sector is inconsistent.	Improved workforce data is available to support service planning.
Mechanism: Australian Institute of Health and Welfare.		

MENTAL HEALTH SERVICES

The mental health workforce includes mental health nurses, psychiatrists, nurses, general and other medical practitioners, occupational therapists, social workers, psychologists, Aboriginal mental health workers and peer workers. General practitioners provide a considerable proportion of mental health services, and in terms of the full-time equivalent (FTE) clinical workforce, represent almost half of the mental health workforce.(2) While many health service roles may include providing mental health care, it is the primary role of psychiatrists, mental health nurses and psychologists.

Nationally, there are 11.2 FTE clinically practicing psychiatrists per 100,000 population, 81.1 mental health nurses and 67.9 psychologists.(69) The FTE number of psychiatrists per 100,000 population is fairly even between jurisdictions, but there are differences in the ratio of practicing mental health nurses and psychologists between states and territories.

There are more psychologists by population in New South Wales, Victoria and Western Australia and the Australian Capital Territory (which is an outlier) than there are nationally. South Australia and Tasmania have relatively fewer psychologists, but the number of mental health nurses is approximately in line with the national average, whereas the number of mental health nurses in New South Wales and Queensland is below the national average.

EDUCATION AND TRAINING

The AOD and mental health workforces consist of a mix of roles and vocational and tertiary qualifications. Improving workforce capacity to deliver evidence-based interventions requires inclusion in education of the future workforce and training for the current workforce.

Psychosocial interventions for problematic AOD use and mental ill-health can be delivered by staff working in a variety of roles and with differing qualifications. This capacity enhances options for integrated service delivery for young people, but also raises issues about workforce equality. Pay disparities between vocational and tertiary qualified staff, trained in the same intervention, may present a disincentive to undertaking training or practice. A balance is required in developing workforce capacity to deliver evidence-based treatment that recognises the level of education and training undertaken and practice skills and experience.

EDUCATION

Education qualifications that prepare a professional for their primary roles and specific training in evidence-based interventions can enhance their skills and capacity for delivering integrated treatment. Increased training and qualifications will enhance the workforce's capability to deliver an integrated experience for young people. Workforce development strategies are currently being developed by the Federal Department of Health for both the mental health and AOD sectors.

POLICY SOLUTION	EVIDENCE AND RATIONALE	OUTCOME
REVIEW AND UPDATE UNITS IN UNIVERSITY COURSES		
A nationally consistent curriculum be developed and taught in undergraduate and postgraduate courses. Units for mental health, AOD use and co-occurrence in medical, nursing, allied health and pharmacy courses are reviewed and updated to align with a national curriculum. Curriculum to use a shared language and framework for identification, diagnosis and treatment.	An ability and expectation of providing integrated care needs to be established before health professionals enter the workforce. The Productivity Commission has recommended that educational resources should be developed and implemented (Action 14.2).	The future workforce is prepared for and expected to provide integrated treatment for young people.
Mechanism: Tertiary Education Quality and Standards Agency.		

TRAINING

Training in evidence-based interventions strengthens workforce capacity and individual staff capability to deliver optimal care for a young person. The Productivity Commission has identified that: 'Governments and service providers should ensure that workers in mental health and AOD settings have access to training that covers identifying and treating comorbidities' (Action 14.2).(2)

The level of training a practitioner has will underpin their confidence to deliver an intervention and recognise when collaboration is required. Training requires commitment from organisations and individuals.(61) Services need to commit to workforce learning and resourcing to support the adoption of new practices and individuals need to commit to learning and applying new skills in practice. Among survey respondents for this project, those working with young people reported strong support for participating in training in delivering integrated treatment, and service managers also reported support for increased training opportunities.

The potential of this mutual commitment will be reinforced by demonstrated organisational support for training and professional development, service changes to enable new practices and recognition of improved skills. This will encourage a reciprocal commitment from staff to a service, to practice changes and the implementation of evidence-based interventions. Between service managers and those working with individuals, shared willingness to participate in training and preferences for the format and approach to training indicates that well-designed training policy solutions could be readily implemented.

PLACEMENTS

Greater opportunities for trainee mental health practitioners to work in AOD settings during undergraduate and postgraduate training would increase foundational understanding of young people's treatment needs. Participation would increase the level of understanding about AOD use disorders, development of AOD competencies and awareness of the employment opportunities available for mental health professionals in AOD services. The current absence of such opportunities can be linked to a lack of funding for AOD academics and curricula within university departments and courses.

INTERVENTIONS

Young people experiencing co-occurring AOD use and mental health issues require specific interventions.(9) It is inadequate and inappropriate to simply transfer adult interventions to a youth setting. Approaches to treatment for co-occurring AOD use and mental health issues can take many forms, often reflecting the legacy of historical policies. The opportunity available in mental health services is to ensure that AOD screening is undertaken to identify any co-occurring issues. If present, the stage of AOD use may be an opportunity to integrate early intervention with treatment for the presenting mental health issue.

Evidence-based interventions for co-occurring issues in young people is emerging and best practice approaches exist.(70) Implementation of evidence-based interventions requires commitment from both services and the workforce. Guidelines provide a framework for implementation. Further research, and the trialling of new treatments, adapted adult treatments, and the transfer of interventions between sectors is needed to support further development of the existing evidence-base.

PSYCHOSOCIAL

The available evidence for psychosocial interventions varies based on the diagnostic focus, intervention method and illness severity. The available evidence is largely restricted to individual studies rather than systematic reviews of the evidence. While the existing evidence-base does not support any single psychosocial treatment over standard care,(71) available evidence supports the use of motivational interviewing and cognitive behavioural therapy.(9) A detailed assessment of the available evidence is beyond the scope of this policy paper. Selected examples are provided to illustrate the breadth of available and promising interventions (Table 3).

TABLE 3. EVIDENCE-BASED PSYCHOSOCIAL INTERVENTIONS

INTERVENTION	DESCRIPTION/OVERVIEW
Cognitive behavioural therapy (CBT)	An approach that focuses on the role of a young person's thinking in how they feel and behave. CBT interventions include restructuring patterns of thinking, altering behaviours to change thoughts and feelings, goal setting and problem solving. There is a strong evidence-base for CBT with young people with mental ill-health (72, 73) and emerging evidence for use in young people with co-occurring AOD.(74, 75)
Motivational interviewing (MI)	A young person-centred approach that identifies and explores opportunities to enhance motivation and commitment to change problematic behaviours. The QuikFix program is an example of a brief motivationally oriented two to three session intervention that uses personality targeted coping strategies to treat alcohol/cannabis use and psychological distress or behavioural disorders in young people.(76, 77)
Multisystemic therapy (MST)	A solution focused approach, MST involves a young person and their family. MST is effective in improving individual, family functioning and parenting, improving communications and reducing mental health symptoms for young people and parents/carers.(9, 78)

PHARMACOLOGY

Medications are available to treat more severe mental health and AOD use disorders. These include opioid agonist treatment[A] and specific options for different mental health disorders. Providing opioid agonist treatment would broaden the capacity of headspace to provide integrated treatment for the small cohort of mostly older young people who present to headspace services. This treatment option would be limited to headspace centres with a GP. Guidelines (Canada) advise caution when treating young people and encourage collegiate consultations in making prescribing decisions and collaboration with multi-discipline partners in a young person's care.(79) Australian guidelines highlight that some substitution therapies can improve responses to cognitive interventions by reducing withdrawal symptoms or distraction from cravings.(8)

The benefits of pharmacological treatments can be negatively affected if a young person does not take their medication as prescribed (adherence) or there are interactions with other medications or AOD use. Best practice guidelines recommend that pharmacotherapies are supported by psychosocial interventions, which can also support adherence.(8) Communication and coordinated management of pharmacological treatment are required to support a young person's treatment.

A range of health professionals may be part of a young person's care and their communication will support the delivery of an integrated experience. A psychiatrist or medical practitioner prescribing medication should work with a young person and other AOD or mental health care providers to find the medication best suited to a young person's needs. AOD and mental health staff working with young people need to be aware of how AOD use and prescribed medication can interact. Pharmacotherapy adherence and monitoring can be managed by a nurse, preferably with specialist AOD use and/or mental health training or experience. Communication channels with pharmacists also need to be maintained during treatment.

GUIDELINES

Australian guidelines have been published for managing co-occurring AOD use and mental health issues and disorders within AOD services.(8) The focus and funding of the guidelines for an AOD services and workforce audience have resulted in them having low take-up within the mental health workforce. Federal Department of Health funding for the revision of the current guidelines, *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings* by the Matilda Centre (The University of Sydney), does not include broadening the scope to mental health services. This is a missed opportunity to strengthen guidelines for integrated treatment experiences.

The current guidelines have only one and a half pages specifically addressing young people. This reflects the current lack of evidence of the efficacy of youth-specific integrated interventions for the treatment of co-occurring problems.(56) There is, however, evidence for mental health treatments for young people that could be integrated into broadened guidelines on the management of co-occurring AOD use and mental health conditions. Practice guidance has recently been published that contributes to the available knowledge,(80) however, integrated guidelines would best serve the implementation of integrated treatment experiences for young people.

The Federal Department of Health funding of guideline development and revision needs to be increased to enable integrated guidelines to be published, including expanded information for health professionals to support young people.

International guidelines are also available, alongside those published by some Australian states and professional bodies. These include guidance for improving service integration (Aotearoa/New Zealand),(81) clinical guidelines and a clinician toolkit (Queensland)(82, 83) and clinical guidelines for acute care settings (New South Wales).(84) Best practice guidelines from professional bodies include the importance of assessing the presence of co-occurring problematic AOD use and mental ill-health symptoms when seeing a young person.(85) The use of screening is central to providing an integrated service and treatment experience for young people. It is also recommended in state policy documents, such as the *South Australian Specialist Alcohol and Other Drug Strategy 2017-2021* (86) and the *Western Australian Alcohol and Drug Interagency Strategy 2018-2022*.(87)

The Productivity Commission directed governments to work with professional colleges, associations and education providers to 'ensure that mental health services and professionals have access to comprehensive guidelines and other resources on substance use comorbidities' (Action 14.2).(2)

A Opioid Agonist Treatment is designed for people who are dependent on opioids (e.g. heroin or morphine) and have had difficulty accessing, or staying on, drug treatment programs.

POLICY SOLUTION	EVIDENCE AND RATIONALE	OUTCOME
EXPAND INTEGRATED TREATMENT GUIDELINES		
Commission an extension of the guidelines for integrated treatment in AOD services to include application in mental health services. Shared guidelines would include: • evidence-based integrated mental health and AOD interventions (prevention, early intervention and treatment) for young people; and • common terminology for adoption across AOD and mental health sectors and reference point for the broader health sector, government, education and media. Evidence gaps for young people are identified and communicated to the National Health and Medical Research Council.	Existing service guidelines to support integrated treatment for the AOD sector highlight the absence of equivalent guidelines for the mental health sector. Combined guidelines for both sectors – with an expanded section on evidence-based treatment for young people – would support increased integration in treatment delivery. The Productivity Commission recommended that guidelines should be jointly developed and implemented (Action 14.2).	An up-to-date resource for evidence-based integrated treatments for mental health and AOD services for young people is available to support treatment decision making. Future research priorities are informed by identified evidence gaps.
Mechanism: Federal Department of Health.		

MEASURING OUTCOMES

Collecting outcomes data enables the effectiveness of treatment and service delivery to be measured. The implementation of policy solutions to integrate treatment experiences for young people would be supported by measuring and collecting outcomes data. Data linkage and increased public accessibility will maximise the value of data collection.

While implementation guidelines are available in Australia and internationally, resistance to change and time pressures remain notable barriers to the implementation of outcome measures. Additional data collection requirements can be perceived as burdensome by the workforce and young people if the relevance of the data being collected is not evident.(88) Balance is required between demonstrating clinical benefits to support implementation with a service audit focus to guide improvement in service and treatment delivery.

It is also important that youth-specific outcome measures are implemented in services for young people. Progress is being made in the development of measures for use in youth mental health service settings. Identifying measures under development that are suitable for, or could be adapted for, an AOD service setting would enable measurement of outcomes for young people with co-occurring AOD use and mental health issues and disorders. Adapting existing measures in use or under development would increase the value of these measures and minimise the investment needed to enable the collection of outcome data for evaluating integrated treatment and services. For example, additional questions about AOD use could be readily added to the MyLife Tracker outcome tool used in headspace centres.(89)

POLICY SOLUTION	EVIDENCE AND RATIONALE	OUTCOME
REVIEW CURRENT DEVELOPMENT OF YOUTH OUTCOME MEASURES TO IDENTIFY A CANDIDATE FOR APPLICATION IN CO-OCCURRING CONTEXTS		
Conduct a review of current research and development projects focused on outcome measures for young people in mental health settings. Identify candidates amenable to application in co-occurring AOD use and mental health contexts. Review identified projects for potential inclusion or expansion of additional data. Fund a preferred candidate(s) to support the development of an outcome measurement tool for co-occurring AOD use and mental health contexts.	Outcomes data provide evidence for measuring and improving the effectiveness of treatment and service delivery. Youth-specific measures are required to measure outcomes for young people with co-occurring health issues.	Useful data are available for measuring outcomes for young people to guide treatment decisions and inform improvements in service models and treatment approaches.
Mechanism: Australian Institute of Health and Welfare, Federal Department of Health.		

SUMMARY

Opportunities exist to progress the integration of AOD and mental health service delivery and treatment experiences for young people. Existing examples of best practice provide direction for policy solutions. Alongside an expansion of existing examples of best practice, new initiatives are required to fill service gaps for young people with emerging or complex needs. Implementing best practice models and developing new services will be dependent upon an available, qualified, and capable workforce.

The following key policy solutions for delivering an integrated treatment experience for young people with co-occurring problematic AOD use and mental ill-health across a range of severity levels are recommended:

- using service mapping to inform service commissioning to meet treatment needs;
- reviewing integrated service models and implementation approaches to guide further development and implementation;
- developing integrated service approaches in primary and complex service settings;
- resourcing local networks to enable collaboration;
- updating university courses to equip the future workforce to deliver integrated treatment; and
- expanding the content and audience for integrated treatment guidelines.

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