TE RAWHITI COMMUNITY MENTAL HEALTH CENTRE

A ONE STOP SHOP FOR PEOPLE WITH CO-EXISTING MENTAL HEALTH AND ADDICTION ISSUES

AT A GLANCE

What: The community mental health clinics in Counties Manukau District Health Board (DHB) attempt to meet the needs of service users with co-existing mental health and addiction problems (CEP or dual diagnosis) under one roof.

Why: To provide a service that meets both mental health and addiction needs in one place, something that service users wanted.

How: All mental health teams were trained in how to screen, assess and treat people experiencing co-existing problems (CEP). After training ended the trainer provided coaching in the workplace for one month. A dual diagnosis specialist based within the team also provided ongoing support.

Target: Adults with both mental health and addiction issues who approach or are referred to mental health services run by Counties Manukau District Health Board (CMDHB).

Where: Te Rawhiti Mental Health Centre in Pakuranga in the Counties Manukau District Health Board (DHB) area.

THE PROFILE

Te Rawhiti, situated in East Auckland, is one of four community mental health centres run by Counties Manukau District Health Board. It offers a wide ranging assessment and treatment service to adults with serious and enduring mental health issues. When people who are simultaneously experiencing mental health and addiction to alcohol or other drug issues approach Te Rawhiti they are shown an open door, not a closed one. Each one gets a face to face assessment, and as many as possible receive both mental health and addiction services in the one place, rather than being referred on to another service. That’s because staff there have been trained to screen, assess and work with these individuals and their family/whanau and networks. Te Rawhiti employs 30 full-time equivalent staff who provide a service to around 650 to 700 service users at any one time.

“Any door is the right door’ was a new approach for us. 
If someone knocks on your door, you should see them, at least for assessment.”
Annamarie Lowndes, Manager Te Rawhiti Mental Health Centre

THE BEGINNINGS

Before this project started in 2007 when a person experiencing both mental health and addiction issues approached a community mental health centre in Counties Manukau they were likely to hear something like ‘come back and see us when you’ve sorted your addiction’. In fact, this was not an uncommon experience for people with co-existing problems throughout the country. So how did this change? It started with a new philosophy that originated in the US...
and Canada. According to this, ‘any door is the right door’. It shouldn’t matter whether a person first approaches a mental service or addiction service – if they have both problems, either service should be able to treat them. The Ministry of Health explored this idea in policy documents like *Te Kokiri*, published in 2006. This action plan made it clear that both addiction and mental health services needed to become more able to meet the needs of people with co-existing mental health and addiction issues. With up to half of mental health clients and an estimated 70% of addiction service clients at that time experiencing co-existing problems there was a growing need for both services to be trained to meet both needs.

In 2007 change was already in the air. Ian McKenzie, then general manager for Mental Health Services for Counties Manukau District Health Board (DHB), had the foresight and enthusiasm to achieve the ideal of ‘any door is the right door’. It was clear that to achieve this Counties Manukau mental health staff needed additional skills and knowledge. After considerable discussion a Memorandum of Understanding (MoU) was signed with Waitemata DHB Dual Diagnosis Services to train all mental health staff employed by the Counties Manukau DHB. These staff included:

- community mental health centre staff
- the Intensive Community Team, and
- staff at Tamaki Oranga Recovery Centre, the region’s inpatient facility.

In addition, managers decided to have three specialist dual diagnosis clinicians work part-time with these teams to provide ongoing support training and mentorship.

Ian’s ideas were supported by local service users. When approached in 2006 by Jenny Wolf (a mental health consultant employed by the DHB) they said they wanted an integrated model of service delivery, where they could access both addiction and mental health services at the same time without being sent to knock at more than one door.

Enthusiastic to get changes underway, managers of mental health teams in Counties Manukau met with staff from Waitemata’s dual diagnosis team to form a steering committee. They wanted training to start before the end of 2007, beginning with the team at Te Rawhiti.

> “All the feedback about training was that she really knew the subject and was a good trainer.”

Jenny Wolf, project manager, Addiction Treatment Services Mental Health & Addiction Programmes Sector Capability and Implementation, Ministry of Health, former consultant to Counties Manukau DHB.

**THE PROCESS**

The first challenge was to find someone who not only had the knowledge but was able to provide inspiring training.

Luckily for the steering committee they found an expert on dual diagnosis with many years of experience. Not only did she really know her subject, but according to staff who attended her training she was also a great teacher. She was employed on a two-year fixed-term contract in a new position, established partly from Counties Manukau funds and partly from the Waitemata dual diagnosis budget.

The new trainer took part in a two-pronged approach to upskilling the staff:

- one: initial training for 10 half-days over 10 weeks for the whole mental health team, and
- two: having the trainer work alongside the team for a month as their in-house coach after training finished.

Before training started, the trainer audited service user files to assess the level of knowledge and practice with dual diagnosis service users.
The training: It was a big ask to get every member of the Te Rawhiti mental health team through the training while keeping the clinic functioning. Goodwill within the organisation led to other teams helping out by taking phone calls and the like while training was on. The dual diagnosis team was also very flexible about the training schedule. Taking only half the team for training at one time also helped.

Training covered the full range of dual diagnosis competencies, as follows.

- Working with Te Tiriti o Waitangi.
- Working with Pacific peoples and people from other cultures.
- Social justice – understanding the social forces that contribute to an individual’s issues and addressing these by advocating for service users, providing choices and seeking expert advice.
- Relating to and communicating with clients, including showing empathy and insight, openness and respect and understanding power imbalances in the therapeutic relationship.
- Engaging with clients to establish trust, improve compliance and build a positive therapeutic relationship.
- Screening and assessment techniques for co-existing problems, including the relationship between mental health and addiction.
- Planning treatment and working with therapeutic groups, families and networks.
- Treatment strategies, including harm reduction, persuasion, the wheel of change.
- Relapse prevention planning and education.

Once the whole team was trained, their teacher changed hats to became their in-house coach. For one month she worked alongside staff at Te Rawhiti, helping them identify and deal with co-existing problems. When she left, to move onto training other teams within CMDHB, her coaching and mentoring role was taken on by the specialist dual diagnosis clinician, who worked part-time at Te Rawhiti and another community mental health centre.

Open doors: These days, everyone who approaches Te Rawhiti for help or is referred there is offered a face to face assessment. Staff use a generic assessment tool that captures information on history, medication and current situation. They now know how to carry out more in-depth assessment of alcohol and other drug issues when this is needed, although evaluation shows that this doesn’t happen as often as it should. The main tools used for assessing substance abuse are Audit, the Leeds Dependency Questionnaire and the Severity Dependency Scale. The Health of the Nation Outcome Scale (HoNOS), a staff-rated measure of the health and social functioning of people with severe mental illness, is also used. In discussion with the service user staff then decide whether Te Rawhiti is the right service for the person they have assessed. If not, they will be referred on to another more appropriate service.

The assessment and treatment pathway: Current work with dual diagnosis service users is based on a model used by alcohol and drug services. This uses broad criteria to place people in one of four groups, as shown in the diagram below illustrates. Each group leads to a different pathway of intervention.

Once staff identify which broad category a person falls into they work from guidelines that give them a pathway for providing treatment. The approach to each group is as follows.

- Quadrant 2 (low mental health and low addiction issues). If people in this group are seen, it is only briefly. They are usually referred back to their GP or to other services. This won’t necessarily be a substance abuse service – it could be budgeting advice or relationship counselling, depending on the person’s needs.
- Quadrant 4 (low mental health and high addiction issues). People in this group are generally referred on to specialist addiction services rather than being seen by Te Rawhiti staff.

![Quadrants of care, Integrated Solutions, MOH 2010, page 13](image-url)
• Quadrant 1 (high mental health and low addiction issues) and green (high mental health and addiction issues). These groups form the main focus for Te Rawhiti staff. Both are assessed and allocated to a key worker and doctor. Those in the blue quadrant are seen mainly by mental health staff, with some support from the dual diagnosis specialist. Those in the green quadrant are usually worked with jointly by mental health and dual diagnosis staff at Te Rawhiti, each addressing the strand they specialise in.

Staff and their roles at the clinics

• Key workers, who carry out assessments and do a lot of the day to day work with service users.
• Psychologists, who provide more in-depth psychological treatment.
• Crisis staff.
• Triage staff.
• Psychiatrists.
• Peer support specialists.

The latter roles are filled by people with personal experience of mental illness. The two part-time peer support specialists at Te Rawhiti provide a range of support and training for service users. For example, they run groups where they support service users to develop a personal Wellness and Recovery Action Plan or WRAP, an approach to recovery developed by Mary Ellen Copeland.

Involvement of other organizations: Five to six years ago Te Rawhiti started hosting a worker from the Community Alcohol and Drug Service (CADS). This person assesses and works with people who fall into the second quadrant (low mental health and low addiction issues) and fourth quadrant (low mental health and high addiction issues). This has proved to be a useful service which helps to make sure that whichever of the four quadrants a service user fits into, they can receive the services they need at Te Rawhiti.

THE UNIQUE APPROACH

When training started in 2007 Te Rawhiti was the one of the first community mental health centres in New Zealand to try to integrate services for individuals with mental health and addiction issues. Before then, a common attitude among mental health staff to service users with co-existing issues was that it was not their job to deal with the problems with alcohol or other drugs. Today four community mental health centres, the Intensive Community Treatment team and the regional in-patient team in Counties Manukau, have been trained in this approach, and a national rollout is underway. But as the first team to be trained, staff at Te Rawhiti were forging a fairly new path.

What made the pilot unique was that instead of sending people with co-existing problems ricocheting from one service to another trying to get all their needs met, Te Rawhiti did their best to meet them under one roof. This meant less stress for many service users who now had to go one less place and tell their story one less time. There are some other things that make this initiative special.

• Staff work with the complex relationship between substance abuse and mental health issues.
• The whole team was trained at one time so they could support each other’s learning, rather than taking one or two staff for training at a time and diluting the impact on attitudes and practice.
• An in-house coach worked with the team after training ended to support staff to develop their practice in the real world.
• A dual diagnosis specialist works in the team for two days a week, during which time she can participate in joint home visits with a key worker, attend an assessment with a doctor, or simply provide advice and support to staff on issues with alcohol and other drugs.
• The dual diagnosis specialist can also teach and train staff, and model how to work with dual diagnosis individuals.

“There was such good will within the organisation that other teams covered while training was going on.”

Jenny Wolf, project manager, Addiction Treatment Services Mental Health & Addiction Programmes Sector Capability and Implementation, Ministry of Health.
THE RESULTS

Anecdotal evidence suggests that being trained in new skills and supported to work in new ways has led to changes in staff practice and in the experiences of the people who attend Te Rawhiiti.

- Clients are more likely to receive treatment for both substance misuse and mental health issues at the one place. So they probably deal with fewer staff and do less running round, and are less likely to be referred onto someone else or seen by two services (although that hasn’t stopped completely).
- Staff have found that the new skills they learned are transferable to other service users. For example, motivational interviewing can be used with people who are experiencing low motivation as a result of depression. The new skills and intention to provide a comprehensive service mean that the work isn’t as fragmented as previously.

The main change has been accepting people with alcohol and other drug issues for an initial assessment. Previously a number would be accepted but more often than not the attitude was that they should go to someone else and sort their alcohol or other drug issues out before mental health treatment could start.

The research and evaluation team at Counties Manukau District Health Board evaluated the impact of the training across the service and published their findings to date in March 2011. This involved:

- surveys of clinicians on the mental health teams before and after training
- an audit of client files before and after training
- an analysis of routinely collected data forms on the patient information system, and
- interviews and focus groups with mental health and dual diagnosis clinicians.

Researcher Liz Stewart found that:

- staff had more understanding and awareness of alcohol and drug issues after the training
- staff now have more tools and options for working with people with co-existing problems
- mental health clinicians are drawing on more brief intervention techniques with dual diagnosis individuals than before training
- team members are also drawing on advice from dual diagnosis specialists or working together with them when someone has co-existing issues
- despite greater knowledge and skills, the use of formal assessment tools is inconsistent even when service users have indicated that their use of substances might be high
- since training, clinicians are more familiar with screening tools for substance use – such as Audit, Leeds and the Severity Dependency Scale – although their use is not always consistent.

The evaluation makes it clear that the Counties Manukau staff greatly value the dual diagnosis specialists in their teams for their coaching, advice and help with complex co-existing issues. The coaching and support provided by these specialists reinforces the message given in training that attending to issues with alcohol and other drugs is now part of a mental health clinician’s job. While dual diagnosis specialists initially found some negative attitudes towards drug and alcohol issues among their mental health colleagues, they found this changed over time. This was because mental health staff saw the positive results that dual diagnosis clinicians were achieving, and saw service users with severe issues with alcohol or other drugs making positive changes. The only downside to this is that staff sometimes refer service users to dual diagnosis specialists instead of providing the interventions themselves. This is because they feel they don’t have enough time, knowledge or skills to do a good job, and that they can better serve service users by supporting the work of their dual diagnosis colleagues.

While regular screening and assessment of alcohol and other drug issues has not changed as much as hoped, training has resulted in positive changes in attitudes, knowledge, practice and multi-disciplinary teamwork. All this adds up to a better deal for individuals with issues with alcohol or other drugs who are referred to Counties Manukau Mental Health Services.
This will get even better in the future as there are plans at Counties Manukau District Health Board to refresh and lift staff practice even further. The plans include:

- talking to mental health teams in Counties Manukau about ‘where to from here?’
- implementing a plan for action, from simple steps like including skills and experience in dual diagnosis in job descriptions, through to more complex actions
- establishing champions for dual diagnosis in each team
- setting targets for each team to achieve
- ensuring all new staff have access to relevant training, and
- making sure existing staff can access regular refresher training.

The district health boards have also identified a need for clarity with staff about the organisation’s expectations – that it should be the norm to ask questions about addiction and provide services for these needs.

THE LESSONS LEARNT

Te Rawhiti has now had several years of using this model – more than most mental health services in the country that have adopted it. As other services go down the same track with the national rollout it is useful to look at Te Rawhiti’s experience and see what worked well – and what could be done for it to work even better.

Training and coaching

- Staff turnover of 50% since the initial training meant that new staff needed to be trained more often than anticipated to keep the skill level of the team up and keep the integrated approach alive.
- It would have been useful to have the in-house coach stay with the team longer than one month after training ended, to support new practice and learning.
- It is critical to get staff on board before training, and make training important in their eyes, as onsite training can be seen as a bit of distraction from ‘real’ work.
- Recruitment needs to be done in a way that ensures staff have the necessary skills to work with people with co-existing mental health and addiction issues.
- The in-house coach and/or dual diagnosis specialist is a particularly important role. This person needs to be a champion of addressing both mental health and addiction issues who works proactively with other staff to identify people with co-existing problems and work out the best plan of action for them.
- Travel time from Waitemata to Counties Manukau made it difficult to recruit staff for the dual diagnosis specialist roles, but more flexible approaches, such as not requiring staff to come to the office before going to the clinic they are working at that day, have eased this situation.
- Adding new specialist tasks to the existing mental health clinicians’ role increased the workload for staff already doing a very demanding job.

Overall, the training and practice Counties Manukau instituted is seen as easily adaptable to other places. Te Rawhiti manager Annamarie Lowndes concludes that “it’s been a worthwhile and valuable experience for staff. The whole team training and ongoing support and coaching from our dual diagnosis clinician has enabled staff to develop the tools and skills to provide a more comprehensive and integrated service for our service users.”

MORE INFORMATION

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Website

- service and contact details for Te Rawhiti, available by visiting http://countiesmanukau.webbhealth.co.nz/provider/service/veiw/2607601

Documents/links

- Pamphlet about Te Rawhiti, available by visiting www.healthpoint.co.nz/download.204666.do
• service and contact details about dual diagnosis service at Waitemata DHB, available by visiting https://waitemata.webhealth.co.nz/provider/service/view/349321/

• Information on co-existing problems, available at the Workforce section of the Te Pou website at www.tepou.co.nz/page/59-co-existing-problems


