A CO-EXISTING PROBLEMS TRAINING FRAMEWORK FOR THE ADDICTION AND MENTAL HEALTH WORKFORCE
Citation: Matua Raki, 2009. A co-existing problems training framework for the addiction and mental health workforce. Wellington: Matua Raki.

October 2009

MATUA RAKI
National Addiction Workforce Development Centre

www.matuaraki.org.nz
PO Box 25056
Panama Street
Wellington 6146
TABLE OF CONTENTS

1 EXECUTIVE SUMMARY ........................................................................................................................................4
2 RECOMMENDATIONS ........................................................................................................................................5
3 INTRODUCTION ..................................................................................................................................................6
   PURPOSE .........................................................................................................................................................6
   METHODOLOGY .............................................................................................................................................7
4 CURRENT SITUATION .........................................................................................................................................7
   INTRODUCTION ............................................................................................................................................7
   PREVALENCE OF CEP IN NEW ZEALAND .................................................................................................8
   THE ADDICTION AND MENTAL HEALTH WORKFORCES ........................................................................10
   Current Workforce Situation ..........................................................................................................................11
   INITIATIVES FOR CEP CAPABILITY ...........................................................................................................13
      Service Initiatives for CEP Capability .........................................................................................................13
      Education/Training Initiatives for CEP Capability .......................................................................................15
   Dissemination of Information Initiatives .......................................................................................................16
   Workforce Development Related Documents and Initiatives ......................................................................17
   BARRIERS TO TREATMENT AND TRAINING .............................................................................................18
5 CO-EXISTING PROBLEMS (CEP) INTEGRATED TRAINING FRAMEWORK ...........................................21
   INTRODUCTION ...........................................................................................................................................21
   A THREE PHASED CEP INITIATIVE ...........................................................................................................21
      Phase One: Strategic Leadership ..................................................................................................................21
      Phase Two: Leadership Training ................................................................................................................21
      Phase Three: Practitioner Training ...........................................................................................................24
   ROLES AND TASKS WITHIN THIS TRAINING FRAMEWORK ..................................................................25
   PRACTITIONER CAPABILITY LEVELS ........................................................................................................28
   CEP CAPABILITIES - TRAINING CONTENT ..............................................................................................29
6 TRAINING DESIGN OPTIONS AND CONSIDERATIONS .......................................................................31
   PRINCIPLES OF TRAINING ...........................................................................................................................31
   TRAINING CONCEPTS .................................................................................................................................32
   TRAINING APPROACHES ............................................................................................................................33
   SUPERVISION .............................................................................................................................................35
   USE OF TECHNOLOGY IN TRAINING ..........................................................................................................35
7 GLOSSARY .....................................................................................................................................................37
8 APPENDICES ...............................................................................................................................................38
   APPENDIX 1: A SELECTION OF NEW ZEALAND CEP CAPABLE SERVICE INITIATIVES (MINISTRY OF
      HEALTH, 2009) .........................................................................................................................................38
   APPENDIX 2: SUMMARY OF BARRIERS TO OPTIMAL CARE (TODD, ET AL., 2002) ............................42
   APPENDIX 3: POTENTIAL CEP TRAINING PROVIDERS .............................................................................44
   APPENDIX 4: SUMMARY OF CEP TRAINING FRAMEWORK ..................................................................46
9 ACKNOWLEDGEMENTS .................................................................................................................................47
10 REFERENCES ...............................................................................................................................................48
1 Executive Summary

This document outlines an integrated framework for the addiction and mental health sectors which will support the dissemination and implementation of the updated clinical practice guidelines *Te Ariari o te Oranga: The Assessment and Management of People with Co-existing Mental Health and Substance Use Problems* (Todd, 2009), and the *Service Delivery for People with Co-existing Mental Health and Addiction Problems - Integrated Solutions* service guidance document (Ministry of Health, 2009b).

People with co-existing problems (CEP) can fall between the gaps of addiction and mental health services, with the outcome being ineffective treatment, or no treatment at all, and increasing miscommunication between agencies. There is an urgent need for better communication and the development of shared understandings between addiction and mental health services – to recognise and respect their differing expertise, develop coordinated assessment and treatment plans and convey this information to the wider helping services sector. Cross-training is essential (Howard, Stubbs and Arcuri, 2007).

A method of enhancing CEP capability, using a national training framework, is proposed in this document. The context and rationale for this proposition are described, as are barriers that may hinder the development of a CEP capable workforce which is able to contribute to the reduction of addiction and mental health related harms to tangata whaiora, families and whānau. The suggested training framework has been developed through reference to the addiction and mental health sector, past and current local and national initiatives as well as international literature.

The framework designed to enhance services’ CEP capability is a national, three phased approach of sustainable initiatives. This approach targets the wider systems and decision making structures of addiction and mental health services, individual practitioner and service sector needs. Roles identified within this framework will be described, competency levels and training content identified and peer supervision initiatives explained. Individual practitioners will have access to current CEP information, resources and learning opportunities – commensurate with their role and career development.
2 Recommendations

It is recommended that:

1. The Ministry of Health undertake a national CEP training project to support the addiction and mental health workforce sectors to increase CEP capability.

2. Matua Rakī develop and coordinate the delivery of a national CEP training programme to the addiction and mental health workforce sectors.

3. The CEP training programme, under the guidance of a National Project Manager based in Matua Rakī, support a regionally focussed approach.

4. Two phases of training and education be delivered. The first phase will target funders and planners, managers, clinical leaders and NGO board/trust leaders; the second clinicians/practitioners.

5. Workshops for funders and planners, managers, clinical leaders, and NGO board/trust leaders will focus on: promoting decision maker and leadership acceptance of a CEP imperative; collaborative and intersectoral approaches for mental health and addiction services; staff support to participate in CEP training and in-service delivery.

6. Practitioner CEP capability training centre on the principles of optimal CEP treatment from the updated clinical guidelines (Todd, 2009).

7. Regional pools of enhanced practitioners are established to assist in training and supervision.

8. Local peer supervision groups are formed during the CEP training to practitioners.

9. An online reservoir of CEP information, initiatives, screening and training tools be developed by the National Project Manager and hosted by Matua Rakī. This information will be disseminated through regional and national newsletters, conferences, workforce development centres, sector websites, electronic fora and service networks.

10. The Ministry of Health commission a formative evaluation of the implementation of this integrated framework.
3 Introduction

Purpose

The Government has set a priority to build health service capacity and capability to address CEP through the addiction and mental health sectors. *Te Kokiri: The Mental Health and Addiction Plan 2006-2015* (Ministry of Health, 2006, p.58) clearly states a requirement that the Ministry of Health and District Health Boards (DHBs) "develop a coherent national approach to co-existing mental health and substance use/abuse disorders". This government mandate requires services to be responsive to tangata whaiora and the Ministry of Health has initiated a three-pronged action to improve the quality and alignment of addiction and mental health services:

1. Clinical Practice Guidelines - *Te Ariari o te Oranga: The Assessment and Management of People with Co-existing Mental Health and Substance Use Problems* (Todd, 2009);

2. A service guidance document - *Service Delivery for People with Co-existing Mental Health and Addiction Problems – Integrated Solutions* (Ministry of Health, 2009b);

3. A national training framework to support the dissemination and implementation of the guidelines (Matua Raki, 2009).

These initiatives will guide the coordinated development of the addiction and mental health workforce and bring about sustainable improvements in CEP related skills, knowledge and attitudes. To ensure that change will occur within the systems that supply and support addiction and mental health services it is imperative that sector leaders are supportive of the Ministry of Health's three-pronged approach.

The outcome of effective implementation of this training plan will be better, sooner and more convenient treatment for tangata whaiora with CEP, wherever they present, with reduced costs to families and whānau, communities and the health system.

Throughout this document, the clinical guidelines *Te Ariari o te Oranga: The Assessment and Management of People with Co-existing Mental Health and Substance Use Problems* (Todd, 2009) will be referred to as Te Ariari o te Oranga, and the *Service Delivery for People with Co-existing Mental Health and Addiction Problems – Integrated Solutions* (Ministry of Health, 2009b) document will be referred to as Service Delivery-Integrated Solutions.
Methodology

The development of this framework has involved:

1. Review and analysis of policy, discussion and strategy documents.
2. Review and analysis of CEP best practice guidelines and research.
3. Review of CEP training initiatives within New Zealand, Australia, United Kingdom, United States of America and Canada.
4. Interviewing service providers, clinical leaders, clinicians/practitioners, consumers and workforce development professionals about the following:
   • The current situation
   • Past initiatives and lessons learnt
   • Training needs to build CEP capability
   • Development and implementation of CEP capability initiatives
   • The readiness of the sector for CEP capability building

This document is divided into two sections. The first places the current situation into context, reviewing the prevalence of CEP, the current workforce and service development strategies, as well as recognising barriers to change. The second section describes the training framework and its implementation. This is framed as a three phased approach. Phase one involves Ministry of Health guidance and initiatives – including the development of the three documents mentioned above. The second phase involves the funders and planners, managers, clinical leaders, and NGO board/trust leaders, who advise and provide support for the training framework, giving an impetus for successful and sustainable implementation. Phase three builds on the CEP competence of addiction and mental health sector practitioners and workers, through training initiatives and the development of regional training pools and local peer supervision groups.

4 Current Situation

Introduction

The accepted understanding is that CEP is the expectation and not the exception in terms of presentation at addiction and mental health services. Encouraging the recognition of CEP in the provision of addiction and mental health services has been highlighted by Minkoff's (2000) four quadrant model which encouraged the development or adaptation of services to better meet the needs of tangata whaiora with varying addiction and mental health issues in a number of countries and settings.

While recognising the quadrant model as a good starting point, tangata whaiora do not always fit neatly into quadrants and there have been various assumptions that go with severity, treatment needs and practitioner capability requirements which have been challenged by the sector. Flewett (personal communication, 2009) adapted Minkoff's model, suggesting that there be an assumption of CEP capability within all services and training needs for all. This model, which is more integrative, would ultimately require a wider systems strategy, including a review of funding and service structures, and a focus on initial undergraduate training in co-existing disorders across all sectors.
Prevalence of CEP in New Zealand

Co-existing addiction and mental health problems are common. *Te Rau Hinengaro* (Oakley-Browne, Wells and Scot, 2006), a national population survey, showed 21 percent of the study population experienced a mental health disorder. Of this group, 45 percent experienced a drug-use disorder and 31 percent met the criteria for alcohol dependence. Those with a mental health disorder were twice as likely to undertake hazardous alcohol use when compared with those without any mental health disorder.

Māori and Pacific peoples were found to have a higher than average prevalence of CEP. Twelve month prevalence figures for any mental health and substance use disorder were 29.5 percent for Māori, 24 percent in Pacific people, and 19.3 percent for other population groups. For Māori who experienced an anxiety disorder, 17.5 percent also experienced a substance use disorder. In the same 12 month period, 20.5 percent of those with a mood disorder were also found to have a substance use disorder. Among Pacific people with an identified mood disorder, 16.8 percent also had a substance use disorder (Oakley-Browne et al, 2006). Substance use (Wells, Baxter and Schaaf, 2007) and gambling (Bellinger, Abbot, Williams and Gao, 2008) have a high occurrence rate in Pacific populations, significantly impacting their families. Pacific peoples were less likely to access treatment than the total New Zealand population (Oakley-Browne et al, 2006) and presentations were frequently through the Justice system.
New Zealand prevalence rates of substance use disorders among tangata whaiaora accessing mental health services is scarce, although a national survey of psychiatric inpatients reported 48 percent concurrent substance use issues (Ministry of Health, 1997). Among tangata whaiaora presenting at two large DHB outpatient substance use services, prevalence rates of another DSM-IV (American Psychiatric Association, 2000) Axis I disorder were found to be 74 percent and only 10 percent of this sample were engaged in mental health services (Adamson et al, 2006). The prevalence of CEP among tangata whaiaora in prisons, attending community probation services and within forensic mental health services has also been found to be significant (Brinded et al, 1995; Brinded et al, 2001).

Gambling:
Past research focusing on the co-occurrence of disordered gambling and other mental health disorders has left no doubt that significant overlap exists between disordered gambling and substance use, mood, and anxiety disorders (Crockford and et al, 1998; Kessler et al, 2008; Petry, Stinson, and Grant, 2005). The results of the 2006/07 New Zealand Health Survey indicated that problem gambling was significantly associated with current smoking and hazardous alcohol consumption. Compared to people with no gambling problems, problem gamblers were found to be (after accounting for possible confounding factors) 3.7 times more likely to be a current smoker and 5.2 times more likely to have hazardous drinking behaviour. Problem and moderate-risk gamblers were also more likely to have a high or very high risk of an anxiety or depressive disorder (according to the K10 screen), compared to people with no gambling problems (Ministry of Health, 2009a).

Other studies have also shown that problem gamblers have a high prevalence of depression (Johansson, Grant, Kim, Odlaug and Götestam, 2008) and suicidality (Penfold, Hatcher, Sullivan and Collins, 2006). Despite this, Penfold and colleagues (2006) found however that problem gambling is only infrequently screened for when tangata whaiaora present to primary care with depression or suicidality.

Young People:
There is a notable correlation between substance use severity and CEP. For example, Horwood and Fergusson (1998) found 40 percent of the Christchurch Health and Development Study cohort aged 16-18 years met criteria for any psychiatric disorder. This comprised 26 percent with a substance use disorder only, 30 percent with a substance use disorder and mood, anxiety or conduct disorder, and 44 percent with a mood, anxiety or conduct disorder in the absence of substance use disorder. Furthermore, they found important ethnic patterns; for example, young Māori females were at a higher risk of being diagnosed with multiple disorders (anxiety or mood disorders and substance use disorders) than non-Māori, and Māori males appeared to be the group with the highest rate of multiple disorders.

Young people who present to AOD treatment in New Zealand bring with them a range of complex needs, particularly substance use and mental health issues, educational issues, and criminality (Schroder, et al, 2008).
The Addiction and Mental Health Workforces

The Mental Health and Addiction Workforce Stocktake (Ministry of Health, 2008b) identify 12,432 full time equivalent (FTE) addiction and mental health workers over the 2006-2007 period. This must be viewed as an estimate only, as differences in definitions, measurements, identified personnel and collection techniques provide variances, and significant portions of the workforce are part time, and thus any figures under-represent total actual personnel. Furthermore, although the Ministry of Health indicates that at least 40 percent of the total workforce FTEs is in the NGO sector, specific NGO workforce data is not highly reliable.

A national AOD workforce stocktake (Matua Rakiri, 2009) indicates that this sector is significantly smaller than the mental health services workforce by a ratio of approximately 1:10. Workforce numbers are highly concentrated in the DHBs identified as metropolitan (i.e. populations greater than 90,000 include the DHBs of the Auckland region, Waikato, Greater Wellington, Canterbury and Otago areas). They contain nearly three quarters of the addiction and mental health workforce, the characteristics of which, when compared to those in regional areas, are quite diverse. The metropolitan areas, due to their larger size, tend to have greater client capacity and trend toward ‘silo thinking’. Regional workforces which face lower economies of scale trend towards greater collaboration and cohesion across services allow for flexibility of role identity and display a greater degree of integration. These differences have implications for workforce development, particularly training. To date metropolitan areas have been able to offer a wider variety of training fora, whole team training, greater access to existing training providers and specialist discipline courses delivered within services which the regional areas may have struggled to provide or access.

The existing workforce in the addiction and mental health sector is diverse, both on a sector and an individual basis. The origins of interest in a chosen field, life experiences, structures of existing training and qualifications, pay incentives and the range of roles among addiction and mental health sectors are very different. This diversity is to be both expected and encouraged in order to assist and relate to the differences of tangata whaiora but requires recognition of the sector cultures, conflicts and individual capability needs.

Workforce development must be designed to match these diversified groups and geographical areas, consolidating the existing knowledge and skills. There must be commitment to expanding and developing improved attitudes and skills and working towards more integrated service provision.
Current Workforce Situation

The Addiction Workforce
The term addiction worker most commonly refers to those with AOD knowledge and experience. Sections of the addiction workforce have mental health training to an undergraduate level, and a smaller number have postgraduate level mental health qualifications. Twenty-seven percent of the addiction workforce have postgraduate AOD qualifications (Adamson, S., et al, 2008), and the content of this training usually includes a CEP component. Many practitioners work with tangata whaiora with CEP but without a clear knowledge or skills base and without ready access to advanced practitioners, psychologists or psychiatrists, or easy access to mental health services. Basic training for much of the addiction workforce will be required in understanding mental health, engagement, screening and assessment, well-being, commonly prescribed medications, accessing acute services and engaging in appropriate treatment strategies for tangata whaiora with co-existing mental health problems.

The Mental Health Workforce
The mental health workforce generally does not receive training in addiction unless very specific postgraduate training has been pursued. Traditionally, the focus of training has been from a medical perspective with addiction sometimes being perceived as ‘self medication’, or a behaviour that must be challenged or ceased before other issues can be managed. Thus, a basic understanding is required of the process of ‘addiction’, gambling and AOD use indicators, engagement, alleviation of dysphoria hypotheses, harm minimisation, screening, assessment, motivational approaches to engagement, well-being, and relapse prevention. In addition, training regarding the interaction between addiction and mental health problems, including assessment and treatment (including interactions of licit and illicit substances and medications) are essential.

The Māori Workforce/Kaupapa Māori Services
The development of Kaupapa Māori or Māori Mental Health Services was primarily a response to concerns about the increasing number of Māori being admitted to psychiatric facilities (Durie, 1994). During this same period, Māori AOD service development was driven more by a concern that a significant number were not staying in treatment and/or relapsing (Cave et al, 2009). Concerns arose that Māori tangata whaiora (in particular) were being misdiagnosed, that cultural behaviours were sometimes misread, and treatment plans were accordingly incomplete (Baker, 1988; Kingi, 2002). By developing services and a workforce able to incorporate Māori perspectives and methods it was felt that a more informed approach to assessment, treatment and care, would result – as would better outcomes (Rankin, 1986; Pumanawa Hauora, 1995). A “Kaupapa Māori” philosophy does not exclude non-Māori from those services nor does it mean that such services reject Western models of practice. What often occurs in such services is a complementary and integrated approach whereby both cultural and clinical elements are designed and used to best meet the needs of tangata whaiora and their whānau.

As well as generic CEP training, Māori workers will need to develop suitable resources to complement such models as whānau ora, the Rangi Matrix, competency sets such as the Takarangi Competency Framework, Mauri Ora Framework or Huarahi Whanake.
There is a shortage of Māori involved in the addiction and mental health workforces and many of those working in the sector are in support roles rather than in clinical decision making or management roles.

*Te Ariari o te Oranga* emphasises the need for consideration of ethno-cultural variables, solid engagement and an understanding of well-being from the tangata whaiora’s perspective. Given the prevalence of CEP among Māori who present at services, there is an imperative to recruit and train more Māori workers as well as develop a Māori responsive workforce.

**The Pacific Workforce**
The Pacific workforce, in comparison to its population, is very small. All regions have experienced rapid Pacific population growth, and there is a priority to recruit and develop workers to the sector to match this growth. The majority of the Pacific population are in the Waitemata, Auckland, Counties Manukau, Waikato, Capital & Coast, Hutt Valley and Canterbury DHB areas, with the most concentrated population in the Northern region. This demographic reflects the current location of the Pacific workforce. Although Pacific focused resources are being developed, there is still a requirement for further consideration of the availability of current resources, improved access to tertiary qualifications and training, considerations of learning through the concept of collective knowledge, communication barriers, and the need to acknowledge the diverse range of languages and cultures within the broad term of Pacific people.

**Youth and Young Persons Workforce**
Working with young people requires a workforce with unique training, skills and practice. Treatment for young people needs to be cognisant of developmental cycles and environments that precipitate and perpetuate CEP and a recognition that problems may persist or recur throughout life if early intervention is inadequate. Specialist child and youth mental health and addiction services are delivered both by DHB provider services and NGO services. The Werry Centre is the leading workforce centre for child and adolescent mental health and is able to contribute to any development of training initiatives for working with youth and young people.

**Consumer and Peer Workforce**
The consumer and peer workforce is becoming an integral part of the service users’ journey to well-being and thus CEP capability is considered essential for them. Consumer advisors require training that supports their role, including an awareness of systemic issues and barriers, and promoting and supporting CEP capability across the mental health and addiction sectors. As the peer support workforce is focused on the service users’ journey of well-being their CEP training needs reflect many of the identified training needs of the mental health and addiction workforce. Consumer and peer leaders as participants in shared training initiatives will provide a greater focus on the service user perspective as well as creating greater opportunities for collaboration.
Support Worker Workforce
In mental health, support workers are frequently both the initial and the regular interface of support and contact for many tangata whaiora in the community and residential facilities.

“Community support workers are the professionals that some tangata whaiora see most often” (workforce development coordinator)

“They [support workers] will know the person better than the clinician. The person will often tell a support worker things they won’t tell their clinician, so they will be more likely to pick up if there is a co-occurring problem” (consumer advisor)

Support workers form a significant and specific target workforce for CEP training, with particularly large numbers working in mental health. It will be beneficial for tangata whaiora that support workers have an awareness of the indicators of CEP and some basic intervention techniques.

Service Managers, Clinical Leaders and NGO Trust/Board Leaders
Differences in attitudes and approaches to CEP capability between teams and services can be strongly influenced by leadership, both the formal management roles as well as the clinical and professional leadership arrangements within and between services. To support the workforce to expand CEP capability requires direction and support from leadership as much as service delivery and training opportunities. Experience has shown that strong and supportive leadership has a significant effect in shaping a service's response to building CEP capability. Gaining leadership acceptance and supporting leaders to sustain progress are crucial steps in ensuring that service development and training initiatives will lead to a successful CEP capability training initiative.

Funders and Planners
DHBs employ funders and planners who influence service configurations and undertake contractual relationships with all service providers. Funders and planners have considerable influence regarding distribution of funding to services and projects. The CEP training strategy will rely on funders and planners to sufficiently resource internal training systems and structures.

Initiatives for CEP Capability
In New Zealand there have been a range of national, regional and local initiatives to address CEP. These have included service developments and training initiatives, as well as the development of discussion and strategic documents. These initiatives have helped to develop some CEP capability and competency, but have not resulted in a national consistency and quality service for tangata whaiora with CEP.

Service Initiatives for CEP Capability
Specific Service Initiatives - A number of services have made efforts to address CEP for tangata whaiora, their families and whānau. Many of the initiatives have been
effective, but have been delivered in an ad hoc manner, have been localised and generally have not addressed the broader issue of integration. These initiatives have relied on the impetus of specific staff members, a supportive team and minimal funding. For a selection of initiatives addressing CEP refer to appendix 1.

**Dual Diagnosis Services** - These services have been developed in some regions to produce an expert resource in treating CEP. Their primary functions are to provide a consultation service to other services and support training initiatives. Limited resources and a lack of infrastructural support however have limited the effectiveness of these services in reaching a wide audience.

**Staff Crossover** - When professionals move from one service arm to another, skills and knowledge evident in the new workplace are learnt and prior experience carried over. The extent of staff crossover and the degree to which this assists developing co-existing capability is difficult to quantify. Mental health workers are more easily able to cross over into the addiction sector, with the existing employment structures and training resources, than addiction workers into the mental health field. By the very nature of their interest in crossing over, these staff might not have the attitudinal barriers that can be evident among some of the workforce.

**Train the Trainers** - Building a network of trainers to deliver training packages to the mental health workforce nationally has been trialled (for example, risk assessment and MH-Smart), and training fora and support have been set up and some efficacy reported. However, the quality of the delivery has been variable, with trainer recruitment and retention inconsistent and trainers frequently being taken from the existing workforce with little or no compensation for existing work and caseloads.

“*When sustainable, it’s a good method to ensure repeated training opportunities in essential skills across a workforce that has constant turnover. Especially if these skills become part of a mandatory base line requirement for in-service training*” (workforce development professional)

“*Be wary of ‘train the trainer’ because –you need to be sure that the trainers – are doing the training – or are still in post*” [and that] “*Supervision of trainers is important to ensure quality control*” (clinician)

**Training Coordinator Roles** - A number of the larger DHB services have employed training coordinators. These roles include the identification of training needs within the service, provision of in-house training as appropriate and the delivery of training to other sectors as requested. As a concept and when fully supported this strategy has been shown to be very effective, however, training coordinator positions are frequently part time, inadequately resourced, cover a range of topic areas and do not reach the full potential they could offer.

**Primary Health Care Integration** - There is an expanding role for Primary Health Organisations (PHO) in the provision of more convenient care for addiction and mental health-related problems. Communication between primary care services and those of the addiction and mental health sector is not always effective, due in part to misunderstandings about information sharing, variances in practice and stigma attached to people with addiction or mental health related problems. Informants stated
the importance of including primary health care in future training strategies to enhance collaboration and coordination for the seamless care of tangata whaiora across the spectrum of services.

Education/Training Initiatives for CEP Capability

Initial/Undergraduate Training - Several tertiary institutions offer addiction-focused courses which include CEP components, and mental health training is variably based in curricula from nursing, counselling, medical, social work and occupational therapy courses. There is a need to ensure that all undergraduate training that involves addiction and mental health curricula include a comprehensive CEP element.

Clinical Training Agency (CTA) - In 2003 the CTA supported allied health professionals (nurses, social workers, occupational therapists) to participate in accredited postgraduate courses. Te Pou, building on this existing programme, is currently piloting a new service specification for a CEP programme. Auckland and Massey Universities have previously used these funds for postgraduate courses. In 2010 co-existing substance use and mental health programme trainee course fees will be funded through a scholarship/grants process through Skills Matter, a funding and planning organisation which is part of Te Pou.

Post Graduate Training - A number of practitioners have undertaken postgraduate training to complement their existing roles, providing a small pool of practitioners with co-existing expertise across the sector. However, the number and spread of these practitioners is insufficient to create a critical mass of sustainable co-existing capability and implementation of new skills is not always facilitated with existing service structures.

Working with Justice Clients Workshops - Previously known as Mobile Training, these packages were developed and delivered in 2008 by Matua Rakiri and Te Rau Matatini. They supported accelerated workforce development for the addiction sector to meet the alcohol and other drug related health needs of people who have been in or are involved in the Justice system. Feedback suggested that the training was positively received by the organisations and its impact is, at the time of writing, being evaluated by Matua Rakiri.

The potential exists for mobile training packages to deliver short training to the workforce, such as awareness raising workshops. However, increasing the skill level of the workforce in CEP capabilities requires a more intensive range of training packages. The potential for trainer fatigue, given the small pool of recognised experts and the size of the workforce, is a possible limitation to this model.

“There has been lots of training over the past decade - a lot of two-three day workshops -consciousness raising - that sort of thing. There has been some movement but barriers - attitudes of staff, lack of broader support from management systems - means there hasn’t been huge change” (clinician)
**Ongoing Training** - The DHBs and larger NGOs offer ongoing training and workshops for the professional development of staff. However, it is fragmented, localised and not linked to any national training strategy. Content is frequently addiction or mental health focussed and tends not to generate CEP capability or service integration. It is difficult to quantify the exact form and amount of this CEP training as little data is available.

**Career Pathways** - Informants noted how career pathways and associated training needs are lacking for addiction workers in particular. Many practitioners, particularly those working within mental health, enter the field from a nursing, social work or occupational therapy background, with career pathways and incentives that do not match those of the addiction or mental health worker. Currently Matua Rakī is developing a career pathways framework for addiction nurses, which will be linked to the development of addiction nurses standards and competencies. Te Pou is developing national supervision guidelines and an associated training structure for addiction and mental health nurses.

**Review of Addiction Sector Competencies** - Matua Rakī has contracted DAPAANZ (Drug & Alcohol Practitioners Association of Aotearoa New Zealand) to review existing practitioner competencies. It aims to align with problem gambling, smoking cessation, Effective Intervention initiatives, Let’s Get Real, Māori based competencies frameworks such as the Takarangi Competency Framework and Pacific frameworks such as the Seitapu Framework.

**Dissemination of Information Initiatives**

Information and knowledge about CEP initiatives and best practice are widely available to the addiction and mental health sectors. The challenge however is disseminating it and making the information accessible to practitioners busy with day to day contacts with tangata whaiora, their families or whānau.

A range of opportunities currently exists for the dissemination of information coordinated through the DHBs and four regions for consumer, clinical, portfolio and managerial networking of addiction and mental health workers, and includes a range of collaborative initiatives. These networking occasions provide a platform for discussion and the seeking of solutions to CEP related issues across a range of skills and knowledge bases. Training and further dissemination of information could be combined across these sectors encouraging further collaboration, networking and liaison links.

Currently national conferences tend to be either addiction or mental health focused. These events provide an information dissemination opportunity for showcasing local and national CEP initiatives, exemplar services and current evidence based knowledge.

The internet is fast becoming a source of information sharing. Matua Rakī is developing a storehouse of addiction resources and will be able to provide a web-based reservoir of CEP materials. Te Pou hosts a primary mental health care website, *Te Pae Kaiāwhā*, to provide information for the promotion, prevention, early intervention, assessment, treatment and ongoing management of people with mental
health and/or addiction issues in primary health care settings. Te Rau Matatini, Te Pou, the New Zealand Drug Foundation, the Mental Health Foundation and the Ministry of Health websites also have significant resources, disseminate web-based material and publish regular newsletters aimed at the addiction and mental health sectors.

**Workforce Development Related Documents and Initiatives**

The mental health and addiction workforce is not static and efforts have been made to address workforce development, although not necessarily with a CEP capability focus. There are a number of strategic and discussion documents related to the addiction and mental health workforces that make recommendations and provide guidelines for the development of workforce capacity and capability.

**A Guide to Talking Therapies in New Zealand** (Te Pou, 2009) – This guide for service users and family members was developed by Te Pou and the Royal Australian and New Zealand College of Psychiatrists. The guide concisely explains common therapies, mental health issues covered by each therapy, how to access the therapies that are currently in use, and the enhancement of basic engagement and counselling skills. This initiative promotes a skill set that can be used across addiction and mental health.

**Huarahi Whanake** – Established from the project Te Rau Ararau, the aim of Huarahi Whanake is to enhance the development and retention of Māori expertise in Māori health through the identification of Māori health core competencies and career pathways. Huarahi Whanake is a career pathway for Māori mental health community support workers, developed by Te Rau Matatini.

**Identification of Common Mental Disorders and Management of Depression in Primary Care** (New Zealand Guidelines Group, 2008) – This guideline is aimed at improving the assessment of common mental disorders and the management of depression in primary care. It acknowledges that both antidepressants and psychological therapies are equally effective in the management of moderate depression, that psychological therapies are important in community settings, and endorses initiatives that make “talking therapies” available.

**Let’s get real: Real Skills for people working in mental health and addiction services** (Ministry of Health, 2008a) – *Let’s get real* provides a framework describing essential knowledge, skills and attitudes required for the delivery of effective addiction and mental health services. It is not designed as a replacement for professional or service addiction frameworks but complements the essential knowledge, skills and attitudes required of all people working in the services. There are seven identified skills sets: working with service users; working with Māori; working with families/whānau; working within communities; challenging stigma; and discrimination; law, policy and practice; and professional and personal development. Each ‘Real Skill’ is defined and has performance indicators at the levels of essential, practitioner and leader. *Let’s get real* will soon become part of the nationwide service framework. It is anticipated that this framework can link in with CEP capability training, in particular in relation to the ‘well-being’ module and/or at an introductory level.
Real Skills Plus CAHMS (Werry Centre, 2008) – The Werry Centre for child and adolescent mental health has built on Real Skills to develop Real Skills Plus CAHMS. This document describes and identifies performance indicators for the additional core competencies that practitioners require when working with infants, children and young people. There are six skills defined at two practitioner levels (core and specialist) for working effectively with children and young people who have moderate to severe mental health and addiction problems. CEP capabilities for practitioners working with children and young people must incorporate the specific aspects of working with these groups.

Real Skills plus Seitapu (Le Va, 2009) – This extends the Let’s get real framework. It describes the essential and desirable knowledge, skills and attitude attributes for any person in the addiction and mental health workforce who is working with a Pacific person, people or their families. It is intended to infuse Pacific knowledge, skills and attitudes by empowering services and people to become more responsive and accessible to Pacific service users.

Seitapu (Le Va, 2007) – Seitapu was developed as a clinical and cultural competency framework for addiction and mental health workers, educators, regulators and funders. It defines a competent worker working with Pacific people as someone who can integrate cultural and clinical theory and practice and apply this knowledge to their work. The framework focuses on a range of interactions with people, including working with families, language, tapu considerations and organisations. It clearly stipulates that this work is supported by the competency of the organisation in which they work. The combination of practising as a competent worker, supported by competent organisations, demonstrating knowledge of, and practice in, cultural competencies will result in effective service delivery.

The Takarangi Competency Framework (Huriwai et al, 2009) – Matua Rakii has supported the development of the Takarangi Competency Framework against which practitioners working in addiction and mental health can measure their capability and competency to utilise Māori congruent practices in their work. The Framework provides a basis for creating workforce and service development pathways as well as a potential quality assurance framework for practitioners, teams and services.

Barriers to Treatment and Training

There are a number of recognised barriers to optimal treatment (Todd, 2002). They can broadly be categorised as those that stem from the wider system and service provision, those with a clinical focus which tend to point to skills, knowledge and practice guidelines, and those which are attitudinal. (These are tabled as a summary in Appendix 2.) While these barriers are directly related to treatment, they clearly have implications for both the planning and the delivery of training.

The ongoing resistance or barriers that exist to training initiatives need to be addressed in order to make the framework for CEP capability training effective. Barriers identified by practitioners that directly relate to training and the adoption of
new skills include a lack of support from management and colleagues, negative attitudes as funding and output restrictions do not support newly learnt initiatives, feeling overwhelmed by extra work (to train or to practise and implement new skills and knowledge) on top of busy caseloads, role legitimacy (the extent to which a practitioner perceives it is their responsibility to intervene, or take on that role), and a lack of understanding of the prevalence and impact of CEP on tangata whaiora.

Strategies to support training attendance, from a service priority perspective, have included the suggestion of mandatory training. While this may increase the physical presence of a resistant and over-committed workforce, it is unlikely to produce positive changes. Rather, resistance is best met with leadership support, awareness raising activities and good supervision.

"[Practitioners] need to see this as enhancing their role with tangata whaiora – not an extra administrative burden” (workforce development professional)

“They need [colleagues] to understand that it is their role and they will be supported to provide co-existing interventions - not rebuked for working out of role as may have happened in the past” (clinician)

“Confidence and competence are key – [practitioners] are unlikely to look for a problem if they don’t feel confident that they can address it effectively” (clinician)

Further boundaries exist around the implementation and maintenance of skills once they have been gained. There are practitioners within the workforce who have the desired skill capabilities through prior training and experience; however their enhanced capabilities are often under-utilised due to factors such as professional isolation, unsupportive leadership and lack of confidence, application and supervision. Issues of rigid infrastructures and service boundaries and the lack of opportunities to practise and refine skills also increase the risk of these capabilities being lost. Those interviewed for this report expressed concern that the amount of resources made available for an effective CEP training initiative would be inadequate for the start-up of any national training programme.

Teams and practitioners reported that they do not feel supported by management and clinical leaders to undertake training. Training the workforce must include the provision of CEP knowledge to management to ensure that the complexities and impact of CEP on tangata whaiora and their families or whānau are recognised. Management and clinical leaders must also have a role in motivating and encouraging their staff in their newly acquired skills and providing opportunities for skills reinforcement, coaching and case supervision. Furthermore they must foster liaisons and collaborative relationships, and develop service level agreements across the addiction and mental health sectors if there are to be enduring changes in attitudes, sustainable systems and service developments.

From a service delivery perspective, there are also a number of identified barriers, including the requirement for outputs related to contractual obligations, limited service specifications, scope of practice and poor attitudes about the capabilities of other services (MacEwan, 2007). With recognition that CEP is core business of both addiction and mental health services, many of these service barriers will need to be
overcome. The Service Delivery - Integrated Solutions document and its recommendations may go some way to resolving this.

“In terms of improving cross service collaboration, training may be an opportunity to break down barriers, but the overarching infrastructure and mechanisms will still need to be in place to share knowledge, support access to training and ensure that the learning is sustainable” (workforce development coordinator)

“Institutional attitudes - this is what we deal with – rigid service criteria and thresholds for service can be quite high” (practitioner)

“Different services have approached the problem in different ways with an emphasis seemingly on mental health staff acquiring addiction skills. Attempts have been rather piecemeal and rather uncoordinated” (practitioner)

“Key barriers to implementing or sustaining change are lack of supportive structure in system design and leadership” (practitioner)

“Ultimately you need to drive a culture change that shifts clinicians and services away from paperwork and service specification to be driven by the needs of the tangata whaiora and to see the tangata whaiora in the context of their lives” (clinician)
5 Co-existing Problems (CEP) Integrated Training Framework

Introduction

Te Tāhuhu (Ministry of Health, 2005) provides the vision for improving addiction and mental health services based on whānau ora, recovery, and wellness. In line with this vision the Ministry of Health will coordinate activities and strategies to improve access to, and the availability of, quality CEP capable addiction and mental health services. This CEP response will involve Ministry of Health led activities occurring in conjunction with the five national workforce development centres (Matua Raki, Te Pou, Te Rau Matatini, Le Va and The Werry Centre).

A lack of coordination between addiction and mental health services and poor outcomes for tangata whaiora who experience CEP related issues, have motivated the Ministry of Health to develop a three-pronged approach to build and strengthen capacity and capability across addiction and mental health services. Increasing the alignment between these services will require systemic level changes across DHB and NGO services, and the development of a coherent national strategy for CEP training.

A Three Phased CEP initiative

Phase one involves the strategic development of clinical and service guidelines for the addiction and mental health sectors, and the scoping of a CEP training framework. Phase two involves CEP training for funders and planners, managers, clinical leaders and NGO board/trust leaders. Phase three addresses the specific training needs of practitioners.

Phase One: Strategic Leadership

Ministry of Health's development of clinical and service guidelines for the addiction and mental health sectors will be complemented by an implementation strategy founded on a national CEP training framework. The training initiative will require the Ministry of Health to coordinate activities with Matua Raki, Te Pou, Te Rau Matatini, Le Va and The Werry Centre.

Phase Two: Leadership Training

Matua Raki will appoint a National Project Manager to oversee the national training of leaders and practitioners in the addiction and mental health sectors. The National Project Manager will liaise closely with Te Pou, Te Rau Matatini, Le Va, The Werry Centre and the four regional workforce coordinators to synchronise activities and utilise leadership networks.
Training for funders and planners, clinical leaders and service managers

Leaders in the addiction and mental health sector require a thorough understanding of the complexities of CEP and the importance of integrated service provision. Leaders must be supportive of building capability in CEP care and ensuring CEP focused training is an integral part of their service development. Their role will include liaison with the National Project Manager, assessment of CEP capability and shortfalls within services, supporting the regional pool of CEP enhanced practitioners and motivating staff to become engaged in CEP training initiatives and ongoing skills enhancement.

Funders and planners, service managers, clinical leaders and NGO board/trust leaders will attend a one day regional workshop. The workshop will provide CEP information (prevalence, current workforce situation, barriers to treatment and training, trialled initiatives, best practice research, and the tools for implementing systems changes). This training will involve the addiction, mental health, NGO and DHB sectors in a concerted effort to create collaborative relationships and integrative treatment provision, with a recognition change occurs as a result of personal relationships before a broader cultural shift takes place. The workshop will explain the training framework and how it can be implemented utilising existing initiatives and training facilities. It will also explore the motivating influence that managers/leaders can provide to their practitioners. As an adjunct to the workshops, clinical leaders, service managers and NGO board/trust leaders will be offered Tools ‘N’ Techniques training. This training will be adapted from a project begun by Te Pou in 2003 to promote service improvement and transformation using different tools and techniques for leaders to initiate positive and measurable change.

The National Project Manager, service managers and clinical leaders will identify potential CEP enhanced practitioners who are committed to working towards a cultural shift in service delivery. They will support these practitioners to increase their skill level as necessary and then participate in the delivery of training workshops as appropriate and facilitate the development of intersectoral peer supervision groups. Service managers and clinical leaders will also support their practitioners to attend CEP capability training courses and workshops by actively encouraging professional development, and by providing study leave and funding assistance.

Training providers and training coordinators

Training providers have been identified as a pool of existing resources that will be used to train the addiction and mental health workforces. The providers will be consulted and advised on the CEP framework and its implications by the National Project Manager. Providers include the tertiary institutes that provide courses and papers with CEP content, independent training organisations which can develop and deliver training packages and workshops, and training coordinators from DHBs and NGOs who are able to coordinate the provision of training forums and workshops.
Dissemination of information
The National Project Manager will take responsibility to develop and facilitate the dissemination of CEP information in conjunction with the workforce development centres. A key part of this work is to highlight existing CEP initiatives, current best practice models, CEP success stories and CEP proficient teams. This activity will increase awareness of prevalence and the needs of tangata whaiora and encourage relevancy to clinical practice. The Matua Rakī website will be used as a storehouse for this information, in addition to promoting other networks for CEP resources and materials, such as Te Pou's website, Addiction Treatment Research News, Mental Health Commission, New Zealand Drug Foundation, Mental Health Foundation, Ministry of Health newsletters, national and regional fora and conferences. Matua Rakī will also act as a broker for requests for clinical information, referring inquiries to appropriate practitioner specialists.

Phase Three: Practitioner Training

Developing a regional pool of enhanced practitioners
Regional pools of enhanced practitioners are groups of practitioners with enhanced CEP capability and training skills. Selection, co-ordination and support of the regional pool of enhanced practitioners will be carried out by the National Project Manager in consultation with service managers, clinical leaders and NGO board/trust leaders. Those selected will be willing to enhance their own skill and knowledge base; have the capabilities, potential and commitment to become trainers, coaches and champions for CEP capability; be supported by their managers and colleagues for release of training delivery and be open to inter-agency liaisons.

The regional pool of enhanced practitioners will support the delivery of CEP training to addiction and mental health practitioners in their region. In conjunction with service managers, clinical leaders and NGO board/trust leaders, they will also role model and encourage the implementation of new skills and practices in their workplaces and have a pivotal role in the development and maintenance of peer supervision groups across the addiction, mental health, NGO and DHB services.

Any identified training required to develop a regional pool of enhanced practitioners will be facilitated by the National Project Manager using contractors and CEP enhanced practitioners, using assistance from the regional workforce coordinators. This package will consist of both didactic and experiential teaching approaches guided by the principles of optimum treatment set out in Te Ariari o te Oranga. The pool may require support regarding the practice of teaching and a short 'train the trainers' course may be useful. Individual practitioner and service nuances and needs may require flexibility and training needs analysis will be required to establish customised training.

Addiction and mental health practitioner training
CEP training will be based on the seven key principles of optimal treatment set out in Te Ariari o te Oranga. Many of these modules of CEP capability are already available through existing tertiary training institutes. Access and resources that facilitate attendance (funding and study leave) must be promoted by clinical leaders, service managers and NGO board/trust leaders. Independent training providers will be contracted to develop and deliver workshops, primarily to the NGO sector as needs are identified. Training coordinators within addiction and mental health services will be resourced to expand existing initiatives, utilise cross training and explore collaborative relationships. Training will be available and repeated on a regular basis, providing services and practitioners with the opportunity to build capability at a pace suitable to their ability and commensurate with their role and career pathways.
Skills development will be supported through interagency collaboration. A number of creative initiatives already exist within services, but it is anticipated that the combined impact of managerial and clinical leader support and networks, a regional pool of enhanced practitioners working across the sectors, and improved attitudinal shifts, will encourage a culture of collaboration and sharing of resources and initiatives. In addition to the peer supervision structures noted below, this may also include intersectoral observations, participation in multidisciplinary teams, live coaching, mentoring, modelling, job shadowing, and shared cross-trainings.

**Local peer supervision groups**

Supervision is commonly used across the sector to enhance workplace performance. The models for supervision vary and include elements of education, support and administration. The recommendations made in the framework are not intended to supersede, but to complement, current supervision practices.

For the purpose of this framework there is an emphasis placed on peer supervision as a process that enhances the transfer of skills to practice in order to build confidence and competence. An important component of the training to both NGO and DHB practitioners is the development of local peer supervision groups comprised of addiction and mental health practitioners. These groups will be supported and resourced by the National Project Manager and guided by the regional pool of enhanced practitioners. Practitioners will attend monthly intersectoral peer supervision meetings at the directive of service managers, clinical leaders and NGO board/trust leaders. An emphasis will be placed on practitioners sharing case information that clarifies or enhances CEP knowledge and skills, while also developing interagency links.

**Roles and Tasks within this Training Framework**

**National Project Manager**

The National Project Manager role, based with Matua Raki, will be established to facilitate:

- A nationally consistent training approach to CEP across addiction and mental health sectors.
- Coordination and support among the addiction and mental health sectors.
- Liaison with the Ministry of Health, workforce development centres, regional workforce coordinators, DHBs and NGO leaders and managers regarding training and implementation.
- Development and facilitation of one day regional CEP workshops to funders and planners, managers and clinical leaders.
- Consultation and support to service managers, clinical leaders, NGO board/trust leaders and the regional pool of enhanced practitioners as required.
- Identification and targeting of sections of the workforce for particular training, and raising awareness in services that are not CEP capable.
- Identification of existing and potential training providers. Promotion and marketing of these courses and workshops across the country.
- Coordination of training coordinators and training events. Identification and facilitation of shared opportunities for training.
- Identification of practitioners with CEP enhanced capability skills to form the basis of regional pools of enhanced practitioners.
- Coordination of the training and mentoring of regional pools of enhanced practitioners.
- Promotion and support of practitioner attendance at training courses and workshops.
• Encouragement of peer support, peer supervision and experiential opportunities across the sectors.
• Collation and dissemination of relevant CEP information and literature to the workforces, including the development of a brokerage system for clinical information requests.
• Identification of local post-training activities involving case reviews based on local learning initiatives.

Funders and planners
To support the planned training framework funders and planners will:
• Show a commitment to understanding the complexities of CEP and the potential for significantly improved treatment experience for tangata whaiora.
• Support integrated treatment and service provision for CEP.
• Support a culture change of service provision.

Service managers, clinical leaders and NGO board/trust leaders
Service managers, clinical leaders and NGO board/trust leaders play an important role in determining the culture of their services and will:
• Show a commitment to understanding the complexities of CEP and the potential for significantly improved treatment experience for tangata whaiora.
• Actively promote and participate in leadership/management CEP capable training initiatives.
• Actively foster collaborative relationships across the sectors.
• Develop memorandums of understanding and shared care paperwork with other services.
• Identify services’ needs and develop strategies to becoming CEP capable.
• Identify practitioners with the potential to become part of the regional pool of enhanced practitioners. Support these practitioners in this role.
• Facilitate enrolment in, and completion of, courses and workshops (including funding and time resourcing).
• Support the workforce to participate in training and implement new skills.
• Encourage and facilitate peer supervision networks and attendance.

NGO and DHB training coordinators
Training coordinators from the NGO and DHB sectors have a role to:
• Liaise with the National Project Manager and regional pool of enhanced practitioners.
• Identify needs within services.
• Respond to the needs across the sectors.
• Develop and/or facilitate presentations and workshops on CEP training capabilities.
• Engage the various sectors in collaborative training initiatives, i.e. addiction, mental health, DHB and NGOs.

Training providers
The National Project Manager will consult with training providers to:
• Inform training providers about the requirements of the CEP training framework in relation to their development of courses, papers and modules.
• Encourage the awarding of certificates for the completion of papers that complement the requirements of the CEP training framework.
The workforce
The addiction and mental health workforce will:

- Undertake CEP training.
- Support the breakdown of attitudinal and clinical barriers.
- Support systemic changes to breaking down barriers and enhancing practice.
- Actively engage in and implement newly gained CEP strategies, skills and knowledge.
- Actively participate in peer supervision groups.

The regional pools of enhanced practitioners
Practitioners who already have enhanced CEP skills will be the foundation for regional pools. They will:

- Develop and enhance their practice to become CEP capable.
- Undertake training in adult education skills.
- Liaise and support training providers and coordinators. Be available to facilitate the delivery of training as appropriate with these groups.
- Provide supervision and mentoring support.
- Develop and foster intersectoral collaborative relationships.
- Role model appropriate responses and practices to colleagues and tangata whaiora with CEP.
- Actively participate in and support intersectoral peer supervision strategies.
- Contribute to the dissemination of information strategies.

Local peer supervision groups
Local peer supervision groups formed during the practitioner training process will:

- Liaise with the National Project Manager and regional pools of enhanced practitioners.
- Meet monthly to provide intersectoral peer support and supervision.
- Promote, discuss and constructively critique CEP initiatives.
- Contribute to dissemination of information strategies.
- Undertake educational activities including the discussing of journal articles, practice casework and CEP initiatives.

Implementation of this framework will begin with the appointment of a National Project Manager who will organise workshops targeted at funders and planners, clinical leaders and service managers in the Central region. A key component of these workshops will teaching based on Tools ‘N’ Techniques training (Te Pou, 2004). The workshops will be followed by training to practitioners. This cycle will be repeated in the three other regions on a two to four month cycle, allowing some time for adaptation as necessary.
Practitioner Capability Levels

The addiction and mental health workforce is diverse and there are different levels of CEP capability required or expected within that workforce. The integrated training framework takes these levels of expected knowledge and skills into account in its proposed implementation plan.

<table>
<thead>
<tr>
<th>CAPABILITY</th>
<th>Support workers</th>
<th>INTRODUCTORY</th>
<th>INTERMEDIATE: CEP capable addiction and mental health</th>
<th>ADVANCED: CEP enhanced addiction and mental health</th>
<th>Trainer/skills coach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural capability</td>
<td>/</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>///</td>
</tr>
<tr>
<td>Well-being</td>
<td>/</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>///</td>
</tr>
<tr>
<td>Engagement</td>
<td>/</td>
<td>/</td>
<td>///</td>
<td>///</td>
<td>///</td>
</tr>
<tr>
<td>Motivation</td>
<td>/</td>
<td>/</td>
<td>///</td>
<td>///</td>
<td>///</td>
</tr>
<tr>
<td>Assessment</td>
<td>Screening</td>
<td>/</td>
<td>/</td>
<td>///</td>
<td>///</td>
</tr>
<tr>
<td></td>
<td>Brief assessment</td>
<td>#</td>
<td>/</td>
<td>///</td>
<td>///</td>
</tr>
<tr>
<td></td>
<td>Comprehensive assessment – including diagnosis, aetiological formulation &amp; treatment plan</td>
<td>#</td>
<td>/</td>
<td>///</td>
<td>///</td>
</tr>
<tr>
<td>Clinical case management</td>
<td>#</td>
<td>/</td>
<td>///</td>
<td>///</td>
<td>///</td>
</tr>
<tr>
<td>Integrated care</td>
<td>/</td>
<td>/</td>
<td>///</td>
<td>///</td>
<td>///</td>
</tr>
<tr>
<td>Additional</td>
<td>Adult teaching skills</td>
<td></td>
<td></td>
<td></td>
<td>///</td>
</tr>
</tbody>
</table>

* Core
# Introductory level knowledge
/ Introductory level knowledge and application required
// Intermediate level knowledge and application required
/// Advanced level knowledge and application required

People working in support worker roles are expected to have introductory level capabilities which enhance their ability to advocate and collaborate effectively with practitioners over shared care of tangata whaiora. They should have an overarching understanding of cultural competence and well-being and a basic understanding of CEP prevalence and associated problems. Support staff will be able to engage and motivate clients, screen for problems and coordinate care with the appropriate service.
Intermediate level capabilities should be evident for practitioners working in mental health or addiction specific services where CEP integration is expected (e.g. residential and inpatient services, addiction practitioners, mental health care managers). While the core business of intermediate level staff may continue to be addiction or mental health specific, their skills will develop to become commensurate to a CEP capable team. Skills will be clearly developed in screening, brief and comprehensive assessment, engagement (including use of motivational approaches), case management and intervention skills. Practitioners will share skills across the sector, linking in with practitioners from other services to build on current knowledge e.g. problem gambling services, Kaupapa Māori services, mental health teams.

Advanced level capabilities are expected of all other practitioners working in tertiary level services including community mental health teams, AOD and problem gambling services. Skills and knowledge will be attained through level 7 and above qualifications and extensively supported supervision and skills coaching. Practitioners will become CEP enhanced and have a role in disseminating their knowledge and skills to introductory and intermediate level practitioners.

**CEP Capabilities - Training Content**

Todd (2009) has identified seven principles of optimal treatment for the assessment and management of CEP. For the effective care and treatment of tangata whaiora these principles must be incorporated into training capabilities and integrated into practice. The following capabilities expected of practitioners in the addiction and mental health fields respond to those of optimal treatment as outlined by Todd:

1. **Cultural Considerations:** Consider the cultural needs and values of all tangata whaiora throughout the treatment process.

2. **Well-being:** Take a well-being perspective by considering problems as barriers to well-being and seeing a state of positive well-being as the key outcome variable rather than the absence of dysfunction.

3. **Engagement:** Actively incorporate strategies to increase and maintain engagement with the clinical case manager, the management plan and the service.

4. **Motivation:** Actively incorporate strategies to enhance motivation, including but not limited to CEP adapted motivational interviewing techniques.

5. **Assessment:** Screen all tangata whaiora presenting in mental health and alcohol and drug services for CEP. When they screen positive, undertake a comprehensive assessment that gives equal weight to diagnoses, individualised problems and an integrated aetiological or causal formulation.

6. **Management:** Use clinical case management to deliver and coordinate multiple interventions appropriate to the phase of treatment.

7. **Integrated Care:** Integrate care by placing the needs of tangata whaiora first and deliver care, driven by the integrated formulation, in a single setting wherever possible, and ensuring close linkages between all services and workers involved.
Adult Teaching Skills

Clinicians cannot be expected to walk in to a role of trainer without some knowledge and skills in adult education. There are a number of existing ‘train the trainer’ courses that are linked to the Certificate in Adult Education. This would address topics such as facilitating adult learning in New Zealand’s cultural environment, creating and maintaining a positive learning environment for adult learner groups, delivering learning presentations, on-job training and group training sessions to adults.
6 Training Design Options and Considerations

This section explores known approaches to CEP training and provides an overview of training concepts and key strategies considered in the design of the training framework outlined. It draws upon a literary review exploring the local and international experience of training initiatives and their impact on workplace practice. It also considers the collective knowledge and experience of informants as to perceived best practice and strategies to training the addiction and mental health workforce in New Zealand. These design considerations highlight the need to gain the support of planners, funders and decision-makers, as well as the clinical leaders who offer the support to practitioners and facilitate the clinical and attitudinal culture within which practitioners work.

Principles of Training

The principles of training are recommendations made to guide the design and development of CEP training to a consistent and standardised level (Roche et al, 2008).

**Tangata whaiora-centred**
Training is to be based around the concept of delivery to tangata whaiora-centred service in accordance with Todd’s (2009) principles for optimum CEP treatment.

**Experiential**
Training makes use of on the job experiential learning where possible. Programmes and materials are aligned to the experiences and processes of the target group.

**Recognises workforce diversity**
Training will be designed to match trainees’ needs and their work environments by using a training needs analysis.

**Progressive and flexible**
Training involves an incremental approach to learning for individuals by building on existing knowledge and previous training. Practitioners are supported and encouraged to continually enhance CEP skills and knowledge in workplace.

**Emphasis on skills transfer to practice**
Practitioners are supported to consolidate learning through a longitudinal process of acquiring skills and knowledge, followed by opportunities and encouragement to use the learnt skills, giving feedback and further opportunities for refinement.

**Integration**
Shared training opportunities between addiction and mental health services are to be undertaken wherever possible. This enhances wider understanding and increases collaboration across both sectors.

**Coordinated**
National coordination ensures optimum utility of training resources and training opportunities.

**Recognition of training**
The training will provide credits and points towards professional development, and will lead to accredited achievement certificates. This will allow practitioners to enhance their career opportunities.
Training Concepts

Effective training transfer

The challenge of bringing about improvements in workplace practice through the application of newly acquired knowledge, skills or attitudes is widely acknowledged. This has been referred to as the “transfer of training problem” (Salas, 2001).

Key areas for effective training transfer have been defined by Goldstein and Ford (2002) and include trainee factors and instructional design.

Trainee factors refer to the trainee characteristics that can be enhanced to support training initiatives in the workplace. Goldstein and Ford (2002) identify the following:

- **Role Adequacy** - Practitioners must feel that the training enhances their current practice and that they are able to implement their new skills and effective interventions. For example, informants noted that training in the application of screening tools will be ineffective if the practitioner is unable to use these in practice.

  “Confidence and competence - that’s what it comes down to” (trainer)

- **Role legitimacy** - Practitioners must understand that working with CEP is within the scope of their role and within the capability of their service.

  “They must feel that it’s part of their job to do it [work in a CEP manner]” (clinician)

- **Individual motivation and reward** - Formal recognition of learning enhances participant motivation. Therefore it is recommended that any training framework is recognised through certification, accreditation or contribution to any continuing education points framework.

- **Personal views** - Poor attitudes towards the training or the trainer have the potential to negatively impact on training outcomes. Leaders have a role in motivating and encouraging openness to training opportunities and trainers are expected to have the capability to engage students and disseminate information across a range of learning styles, and to be relevant.

- **Career motivation** - Training is to link with learners’ career pathways and professional development structures so as to enhance professional practice and competence (For example, DAPAANZ points system, nursing competency frameworks, continuing medical education points).

Instructional design refers to the practice of maximising the effectiveness, efficiency and appeal of instruction and other learning experiences. The process involves determining the current state and needs of the learner, defining the end goal and creating some "intervention" to assist in the learning experience. Training should be customised to suit the group being trained. Addiction and mental health services have both common and diverse training needs, different skill levels are required for practitioners in different service settings and individual practitioners have different levels of capability.
“It is necessary to understand the level of capability required for different workforce groups - be clear about what level of skill you are training for - you don’t want to make an expert out of everybody” (workforce development professional)

In order to make training practical and relevant to workforce needs and experiences across sectors, teams, services, demographics and professional groups, a training needs analysis will help to develop training solutions for each training group.

A variation on this is a lesson learnt in the development of Māori-centric AOD training in New Zealand. Location, the deliverer of training, and processes used in training are all important to attracting and motivating Māori (Cave et al, 2009). To be useful to Māori presenting at services all training design will need to be Māori responsive. There will be a similar need for the Pacific workforce.

**Targeted Training**

Training must be practical and relate directly to the trainees’ working experience. This enhances engagement and helps the trainee transfer the training into their practice. A range of training scenarios will need to be developed for the New Zealand context for trainers to share nationally, based on vignettes and case scenarios reflecting the needs of tangata whaiora.

“People need to know what to do when the person walks through the door - so training should include demonstration practice and feedback” (trainer)

**Support of Training**

Training that involves leaders and their staff increases motivation to learn and enables leaders to identify both training content and the means of supporting trainees on their return to the workplace (Shoobridge, 2008).

**Training Approaches**

**Cross training**

Cross training is the placement of experts from different agencies in teams. These initiatives include activities such as co-location, job shadowing, and reciprocal rotation.

Co-location is the locating of experienced practitioners into teams that require training in either addiction or mental health skills. Success depends on a number of factors such as a supportive environment, leadership that supports the placement team and the individual practitioner, collegial support from the base team, a clear role definition and practitioner characteristics.

“Around the country initiatives have often involved co-locating addiction workers with community mental health teams. Whether the aim is to introduce new skills and awareness for the MH clinicians or to take up addiction clinical work — these initiatives have often failed due to MH teams’ expectations that the addiction worker will carry the addiction-centred caseload. The burden of this workload has lead to clinician isolation, disenchantment and burn-out” (workforce development coordinator)

Conversely, other informants identified that the placing of ‘dual diagnosis’ clinicians into community mental health teams has been effective. These clinicians were carefully selected for their experience working with tangata whaiora with CEP, having mental health and addiction qualifications and coaching training skills, having an ability to build collaborative relationships with other clinicians,
and an ability to withstand the pressure to take on a caseload. Sellars, et al, (2008), for example, undertook a reciprocal rotations project involving addiction and mental health workers engaged in a work placement in their opposite sectors and found that all workers reported increased skills, knowledge and confidence in the opposite domain.

Shared Training
Teams from different sectors can learn together to develop shared understandings, integration skills and collaboration techniques as a valuable format to increase knowledge and skills. Combined groups of addiction and mental health workers are seen as a means to change attitudes, build collaborative relationships, break down barriers and develop shared approaches. However, actual variations in baseline skills have created complexities in training design.

Calderwood and Christie (2003) describe a service development initiative to increase service linkages between AOD and MH services. One of “the most successful components of the models [developed] were training for front-line workers”. Two counties developed their own service improvement packages based on a training needs assessment and group consensus. The training differed in timeframe, style and processes, although workshop style training was utilised by both groups. Positive feedback and high participation rates were reported. The authors note this change initiative addressed each county’s “unique” needs and implemented change when there was a built-in commitment from the agency.

Sciacca and Thompson (1996) describe a systems integration programme to provide a comprehensive CEP service. They provided theoretical training to five AOD and twelve mental health clinicians one day a month for ten months, plus supportive supervision to implement a CEP programme at their site. As a result all participants actively conducted one or more treatment groups, and service statistics demonstrated a sustained participation in CEP treatment and enhanced care closely attuned to actual tangata whaiora needs.

Training MH Clinicians in AOD and AOD Practitioners in MH

“The emphasis [and funding] in recent years seems to have been on the community mental health teams. I am not aware of a large amount of training on mental health going into the addiction sector …. it might exist but I am not aware” (clinician)

The majority of literature available describes training mental health workers in AOD. While studies appear ambivalent about the extent to which training produces sustained practice change the trend is positive with an increased intensity of training, post training support and leadership support (Hughes et al, 2008).

The sustainability of newly learnt skills when practitioners return to the workplace can be challenging. These are often due to clinical/professional isolation and heavy workloads. The solutions discussed to ameliorate this problem are:

- Regular follow up support using skills coaching and supervision.
- Using strong leadership and management skills to support CEP practice and culture change in the team.
- Using whole team training to gain CEP skills.

Two studies that explored the impact of training staff at a youth AOD service, one on mental health screening tools and the other on a two day cognitive behavioural skills training programme for
addressing CEP, found improvements in mental health knowledge, skills and confidence at 12 months and six months respectively (Hides et al, 2007a; Hides et al, 2007b).

**Whole Team Training**

Training whole teams of workers appears to have positive and lasting implications on CEP capability. The COMPASS project in Birmingham UK (Graham, 2003) trained whole teams of mental health outreach workers. The project involved a six day programme, post-training and a specialist co-morbidity clinician to provide advice, supervision and support. Significant improvements in skills and knowledge of practitioners were reported 18 months after the training, and client engagement improved over the course of study.

In 2006, the Waitemata DHB Community Alcohol and Drug Service (CADS) utilised the Birmingham COMPASS model of training for its Early Intervention Psychosis team. This training was designed to enhance knowledge and skills when working with dual diagnosis tangata whaiora. A key component of the programme was ongoing supervision and coaching for staff in their clinical environment. Evaluation after six months demonstrated improvements in clinicians’ abilities to work with co-existing substance use. Furthermore, the extent to which clinicians gained proficiency could be correlated to the amount of time they had spent in supervision and skills coaching.

**Supervision**

Informants stated that support for practitioners to apply their newly gained skills and knowledge to their work environment is important. This is confirmed by literature which states skill retention and improvement in competence is significantly enhanced by post training supports such as skills coaching and supervision (e.g. Steenhuisen et al, 2006; Sciacca, 1996; Miller, 2001).

There are differences of opinion about existing supervisory arrangements and post-training support due to the variability of supervisors’ knowledge of CEP. Furthermore there are different definitions and modalities of supervision provision, including one on one supervision, peer supervision, modelling, job shadowing, observation etc. However, there is unequivocal consensus regarding the necessity for providing workplace support for transferring skills into practice.

**Use of Technology in Training**

Technology is regarded as having an important role in the current work environment for the addiction and mental health workforces.

**Online training**

Web based training tools provide opportunity to further incrementally disseminate CEP information and knowledge. They are recommended as a supplement to traditional training modalities with a view to increasing online content over time and are a cost effective method of providing access and resources to a wide group of learners.

Flexibility in terms of locality (e.g. regional areas) and training in a self-paced manner are clear advantages. However, not all learners find computer technology intuitive and struggle using this medium. In addition, the reduced social and cultural interaction can be limiting as some people find the group dynamics of learning activities to be a reinforcing factor in the learning process.
Furthermore, internet based systems of learning are expensive to set up and the ongoing technical support and knowledge required to maintain and manage system can require specialist resourcing.

Initial options could consist of an inexpensive web hosting system used as a repository of CEP resources. It is useful to have an experienced administrative person to help the National Project Manager and trainers to add content and maintain the site. Later a dedicated server can be developed as demand increases.

A number of independent training providers currently offer courses with online teaching.

“Online asynchronous self directed training is really useful for busy people” (clinician)

“A limitation of online training is that the quality of therapeutic relationship training online is harder to gauge and harder to train” (trainer)

“Useful adjunct to class teaching” (workforce development coordinator)

“Possibly useful for some online skill training but efficacy largely unknown” (clinician)

“Make sure that the delivery mode is selected to complement the training content not the other way around” (trainer)

**Email groups**

Email groups have been shown to be effective in sharing and disseminating information and reinforce learning and skills acquisition. Email groups and discussion forums can be instigated as part of an existing training course or as an interest group.

“Useful for keeping contact and providing support between training days - be mindful that some areas have poor online provision and may be excluded from participation” (trainer)

“Collaboration – can be learnt through group projects communicated at a distance through alternative media” (trainer)

**Audio and video conferencing**

This may be especially useful for maintaining links with geographically remote trainees and as an adjunct to e-learning modalities when developed.

“Useful to be providing follow-up training and support post block courses” (trainer)

“Potentially useful especially if one trainer is training multiple teams at a time, a lot of communications could be audio online. However, not useful when interpersonal skills are being developed as congruence and incongruence is harder to gauge -you still need some face to face” (trainer)
7 Glossary

Key terms used in this document are defined below. These terms are consistent with those used in Te Ariari o te Oranga, the Service Delivery - Integrated Solutions document and other recognised literature.

**Co-existing Problems (CEP)**
This is an abbreviation for co-existing addiction and mental health-related problems. The phrase “co-existing” implies an interaction. The word “problems” is preferred over “disorders” in that one or the other of substance use and mental health symptoms may occur at levels that do not meet the criteria for disorders alone and yet still may be interacting with the other disorder. Other terms used synonymously include: dual diagnosis/ concurrent disorders/ co-morbidity or co-occurring disorders.

**CEP Capable**
Addiction and mental health practitioners who are able to work with both mental health and addiction-related issues where the needs of the service-users are of a low to medium level.

**CEP Enhanced**
Addiction and mental health practitioners who are able to work with both addiction-related issues and mental health where the needs of the service-users are of a medium to high level.

**CEP Specialist Trainers**
Trainers who possess a mastery of both addiction and mental health knowledge and skills, who are able to work with CEP.

**Integrated Services**
Integrated service approaches combine elements of both addiction and mental health systems into a unified programme. They involve cross-trained clinicians and unified case management. Each system of care within the integrated model must include programme elements to meet the needs of tangata whaiora at every phase of rehabilitation.

Integrated services are those in which the relationships and contributions of mental health and addiction providers are merged into a single treatment setting or unified treatment regimen involving more than one setting (adapted from SAMHSA, Report to Congress, 2002).

**Integrated Treatment**
Integrated treatment is "any mechanism by which treatment interventions for co-occurring disorders is combined within the context of a primary treatment relationship or service setting" (SAMHSA, Report to Congress, 2002). Integrated treatment refers to any mechanism by which treatments for each ‘disorder’ are combined into a person-centred coherent whole at the level of the service user and each treatment can be modified to accommodate issues related to the other ‘disorder’ (Minkoff, 2000).

**Integrated System**
The organisational structure for supporting an array of programmes for people with different needs, including individuals with CEP. The system is responsible for ensuring appropriate funding mechanisms to support the continuum of services needs, addressing credentialing/licensing issues, establishing data collection/reporting systems, needs assessment, planning and other related functions (SAMHSA, Report to Congress, 2002).
Appendix 1: A Selection of New Zealand CEP Capable Service Initiatives (Ministry of Health, 2009b).

- **Adventure Development** (South Island): based in Christchurch, Dunedin, Invercargill, and Timaru. It runs outdoor courses for young people aged 13-19; the programmes address alcohol and other drug (AOD) use and mental health problems through outdoor wilderness and adventure therapy. The programmes, which can include counselling, last up to six months and form an interactive service for youth and their families. The services work on young people’s goals for change and the life that they would like to have in the future. The focus is on using the young person's strengths and the support from family and community to achieve change. The young person is referred to other agencies if the service does not meet their needs.

- **CADS Altered High Youth Service** (Waitemata DHB): a mobile, tertiary young people’s alcohol and drug specialist service within Auckland CADS. It features a multidisciplinary team that includes a psychiatrist, dual diagnosis clinicians, referral co-ordinator, same sex attraction clinician and AOD youth clinicians. Family inclusive practice is integral to service provision. Altered High promotes routine screening for substance use problems. The adult Dual Diagnosis Service also works with clients 18 years of age upward, if they are accessing adult mental health services. Altered High offers training, liaison and sharing of skills to other DHB CAMHS services with the aim of enabling mental health services to eventually deliver the treatments required for dually diagnosed clients from within their own teams.

- **CADS and Mental Health Acute Services** (Canterbury DHB): all clients receive a comprehensive mental health and AOD assessment. When a mental health client is referred to CADS, their case manager sits in on the assessment and is involved throughout their treatment. Clinical nurse specialists have been trained to screen for substance use problems. There is consultation/liaison between mental health and psychiatrists who specialise in addiction. Previously, dual diagnosis specialist roles were swamped with mental health work and addiction was neglected. All forensic clients receive an AOD assessment, but staff changes and lack of resources have been problematic. The current approach is to obtain funding to place addiction staff into forensics teams.

- **Child Protection Service** (Otago DHB): co-ordinates and facilitates access to services for out-of-control and out-of-care young people with substance use, pregnancy and safe parenting issues. It has two staff, undertakes 500 consultations a year, offers support to clinicians, links into youth teams and has a family focus.

- **Dialectical behavioural therapy** (Auckland DHB): Auckland DHB has expanded access across its mental health services, and developed a dialectical behavioural therapy programme for tangata whaiora with personality disorders - noting a lot of these clients have substance use issues also.

- **Dual Diagnosis Service** (Lakes DHB): has a strategy of working with the whole person, and not only their mental health and addiction issues. Memoranda of Understanding exist between clinical and non-clinical agencies in the district.
- **Dual Diagnosis Service** (Waitemata DHB): has a team of 12 (six cover the region) and provides clinical work and training. Training (either five day or whole team) begins with examining attitudes and beliefs around addiction, facts and effects, motivational interviewing skills, pharmacology, assessments, screening tools, relapse prevention, and the wheel of change. The whole team training approach (based on a model from Birmingham) was developed to respond to the lack of support experienced by people who had attended individual training on return to their workplace and the unmanageable number of referrals to the Dual Diagnosis Service. The Dual Diagnosis Service was supported to implement a project for the Waitemata Early Psychosis Intervention team, involving the development of a tailored programme. Pre- and post-audit of clinical files demonstrated the project was successful. Counties Manukau Mental Health has since purchased this same project. The training provides a focus on changing attitudes at both an individual and organisational level.

- **Evolve: Youth Service** (Wellington): a ‘one-stop-shop’ for young people aged 10 to 24 which offers primary health care, sexual health, social support, counselling, peer support and activity-based projects. Evolve is youth-owned and youth-led, governed by a trust and funded by the DHB via a local PHO. The activities and programmes provide opportunities for young people to form supportive relationships with their peers, and foster positive youth participation, by engaging young people with issues affecting their health and well-being. Evolve accepts youth with mental health and AOD problems. For details, visit [www.evolveyouth.org.nz](http://www.evolveyouth.org.nz).

- **Māori Mental Health Services** (Auckland DHB): have developed an integrated model of service delivery. The model uses a Māori paradigm based on Nga patu e wha, the four internal walls of the wharenui (meeting house), and utilises that metaphor to represent clinical intervention, the kaupapa of the ADHB Māori Mental Health Service, mental health and addiction document infrastructure and quality components that support, integrate, guide and enhance service delivery for CEP. The current ADHB Maori Mental Health comprehensive assessment tool *Tupurea Aromatawai* has been further developed to integrate AOD information within the dimensions of wairua, whānau, tinana, and hinengaro. This model has been used to train staff, including a dedicated AOD worker, enhance reporting requirements and provide a platform for working with dedicated AOD services.

- **MASH Trust** (Palmerston North): a child and youth crisis respite house with six beds and two staff, providing informal individually targeted attention for young people aged 5-19 years (average is 13) with addiction, mental health and conduct disorder problems. The programme includes activities and one-on-one interventions in a family home and country setting. The maximum stay is seven days (although extensions are possible), and the average length of stay is three days. [http://www.mashtrust.org.nz/](http://www.mashtrust.org.nz/)


- **Mental Health and Addiction Service** (Northland DHB): works towards integrating care for people with CEP. The addiction service does not need to refer to mental health as it is capable of addressing mental health problems and an addiction person works within the mental health team. The services are on a pathway to integration.
• **Mirror Counselling** (Dunedin): a community service providing assessment, counselling (including motivational interviewing/enhancement techniques) and mentoring for children and young people up to 20 years of age who require assistance for a wide range of reasons including drug and alcohol use, mental health issues, personal, relationship and family challenges, abuse and violence.

• **Multi Systemic Therapy** (Central Region): The MST service involves a 10 week programme for young people aged 10-17 with many issues including CEP. There is no clinic and teams are highly mobile. They carry very small case-loads and are available 24/7 to families. They focus on rural areas, work flexible hours and visit homes and communities thus removing many access barriers.

• **Non-clinical support/regional collective** (Midland DHB): has funded non-clinical support services for people with CEP over a number of years. The service operates through identifying support needs and linking clients to services. It has also developed a “Regional Dual Diagnosis Collective” and developed practice guidelines. This group has been running for a number of years.

• **Odyssey House** (Auckland): a residential service for individuals with a psychiatric disorder who also experience problems related to substance abuse or gambling. Odyssey House provides psychiatric services for these clients while maintaining close liaison with mental health services. Family members are encouraged to be involved with the treatment process via community dinners, weekend visits, and a forum for family members. The service is for people over the age of 18 years and available at three locations: Auckland City, Counties Manakau, and Whangarei.

• **Pegasus PHO** (Christchurch): has a project called “Services to Improve Access” (SIA) to engage people in primary care. It is a physical health improvement programme for people who have an enduring mental illness, unmet physical health needs, and are not accessing general practice regularly and includes those with CEP. There are two referral pathways, the first is via an NGO, secondary care services or other mental health provider in which case Pegasus will find a GP for them, and the second is referral by the GP where Pegasus provides $500 one-off funding to address the client’s immediate, outstanding health needs.

• **Service Responsiveness** (MidCentral DHB): A project initiated in 2008 to improve service responsiveness to CEP. This includes NGO and provider arm services. Activities include gap analysis, planning, service structures, evidence based best practice models, staff survey, development of consumer pathways, assessment of training needs, development of assessment and screening tools, and an implementation plan. Mental health clinicians assess alcohol and other drug use history.

• **Sharing the Kete Family Inclusive Practice Project, Youth and Cannabis** (Kina Trust and Hawke’s Bay DHB): recognises the capacities of families to be viewed as ‘agents of change’ in responding to young people’s cannabis abuse. Cannabis abuse is a concern in Hawke’s Bay, impacting significantly on the health and well-being of youth presenting to mental health and addiction services. Involving families is seen as valuable, but requiring intervention frameworks to support this in practice. For details, visit [www.kinatrust.org.nz](http://www.kinatrust.org.nz).

• **Single Client Pathway** (Nelson/Marlborough DHB): has developed a single client pathway for mental health and addiction, and overcome many obstacles to do so. In Marlborough the addiction and mental health services have co-located in the one building. In 2008 all mental
health and addiction staff received motivational interviewing training. Each mental health team has a representative who attends addiction team meetings. There are designated specialist dual diagnosis staff working and screening for CEP in the acute mental health unit.

- **Staff Training Initiative** (Counties Manukau DHB and Waitemata DHB): Counties Manukau DHB has embarked on a project in collaboration with Waitemata Dual Diagnosis Service to train all DHB mental health staff to be dual diagnosis capable. Some of the Dual Diagnosis Service positions are embedded within Counties Manukau DHB mental health teams but managed by Waitemata DHB. Additionally, NGOs working with mental health clients have been trained to respond to substance use problems by ABACUS.

- **Central Health Ltd** (formerly Te Whatuiapiti Trust, Hawke’s Bay): an AOD residential service for rangatahi/youth including those with CEP between 14 and 19 years of age. It offers a voluntary kaupapa Māori alcohol and other drug residential service for rangatahi/youth referred from the Central Region.

- **Traditional and Complementary Therapies** (Tairawhiti DHB): is using traditional healing and complementary therapies, acknowledging CEP relating to physical health. As a DHB serving a very high Māori population, Tairawhiti offers a cultural assessment at the first point of engagement. This has helped with gaining the confidence of Māori communities.

- **TuPU Pacific Team** (Waitemata DHB): has dedicated dual diagnosis clinicians. TuPU operates a satellite clinic one day per week at Counties Manukau Faleola Mental Health Services.
Appendix 2: Summary of barriers to optimal care (Todd, et al, 2002)

Summary of barriers to optimal care for people with co-existing substance use and mental health problems

**Systems**

1. **Lack of regional planning**
   Individual services established without a vision for how they might be integrated. Gaps between services plugged with new services in ‘piecemeal’ fashion, creating more gaps. Insufficient involvement of clinicians, consumers and families in service development.

2. **Fragmentation of services and inconsistency of care**
   A lack of strategic planning for integrating services leading to fragmentation of mental health services. Patients referred from service to service making integrated treatment difficult to achieve. Patients receive several assessments before they receive any significant treatment.

3. **Contracts encourage a narrow focus**
   Services often funded for a limited number of sessions (to undertake specific tasks). Limited sessions restrict the interventions that may be offered to people with complex conditions.

4. **Lack of resources**
   Heavy patient loads, lack of access to training, waiting lists for treatment. Little time to undertake effective interventions of proven efficacy e.g. family interventions.

5. **Problems in rural areas**
   Large distances between services and lack of access to tertiary specialist services place more pressure on families and whānau, police and general health care workers. Health workers required to have a broad range of skills but often lack necessary specialised skills.

**Clinical**

1. **Lack of clinical skills**
   A minority of clinicians able to plan effective interventions for people with co-existing disorders. Very few clinicians with the broad range of skills necessary to carry out effective interventions. Clinicians often expected to work in generic fashion without formal training in key skills such as assessment and case management.

2. **Lack of knowledge**
   A general lack of knowledge about the nature and interactions of co-existing disorders, especially the nature of addiction among mental health workers.

3. **Inadequate family involvement**
   Failure to include families in assessment and treatment planning processes and their concerns often overlooked. Issues of confidentiality misused, often restricting family involvement.
4. Cultural issues
Specific skills and knowledge needed to work effectively with Māori lacking in many clinicians.
Professional training seldom deals with specific needs of Māori. Clinicians fail to recognise limits of
their expertise when dealing with cultural issues.

5. Lack of assertive follow-up
Patients too easily allowed to discontinue and drop out of treatment.

Attitudes

1. Judgemental attitudes
Implicit beliefs that substance use problems were a matter of choice and therefore of personal or
moral deficit.

2. Rejection of a disease model
Antipathy towards the use of a disease or medical model from certain professional groups that may
lead clinicians to reject biologically based interventions. Rejection of a disease model often due more
to professional rivalry and a lack of knowledge of its uses, strengths and weaknesses than the
limitations of the model.

3. Territoriality
Rivalry between professional groups and regions makes the interface between services less
permeable.

4. Insistence on abstinence and confrontation
Patients often under pressure to stop using alcohol and drugs completely with little serious
consideration given to the health benefits that could be obtained from reduced levels of use.

5. “Addiction is not the business of mental health services”
Patients often turned away from mental health services regardless of the other mental health
problems they may suffer.
Appendix 3: Potential CEP Training Providers

There are a small number of training providers which have the knowledge and experience to deliver CEP-related training. The following providers potentially could be involved in the design, development and delivery of CEP-related training, and have indicated an interest in being involved in any CEP initiatives in the future. At the implementation phase of this framework there may be others to be considered.

ABACUS Counselling, Training & Supervision Ltd

Established in 2002, ABACUS has experience in delivering addiction and problem gambling training to the NGO and DHB sectors. Currently ABACUS is involved in training and the development of competencies for the problem gambling workforce, brief intervention training for community and addiction specialists, and workshops for working with those in the Criminal Justice system. Utilising a pool of 50 trainers, ABACUS has the ability and knowledge base to be involved in any planned CEP training workshop based initiatives in New Zealand.

Adult Education Training

A number of institutes provide ‘train the trainers’ programmes. These are frequently unit standard based and allow learners to gain credits toward the National Certificate in Adult Education and Training – Level 4. These include WelTec, Te Wānanga o Aotearoa, New Zealand Institute of Management, QED Associates Ltd, Open Polytechnic, Otago Polytechnic, Aoraki Polytechnic.

Auckland University

Auckland University is currently delivering a Post Graduate Certificate in Health Sciences which involves two courses: 1) CEP theory and principles, and 2) CEP interventions. Auckland University has been involved in addiction training for some time and has the capacity and capability to be involved in any future CEP training.

Blueprint for Learning

Blueprint was established in 1999 and is experienced at delivering mental health training to a variety of mental health, addiction and social service agencies. Blueprint currently delivers leadership and management programmes, the National Certificate in Mental Health, workshops and tailor designed programmes to suit individual workforce needs. Presently, Blueprint is also involved in developing learning modules that connect to the Let’s get real competency framework. Blueprint has the knowledge base, ability and skills to help develop and deliver future CEP training and has indicated a willingness to be involved.

Careerforce: Community Support Service Industry Training Organisation

Currently Careerforce is reviewing the National Certificate in Mental Health Support Work (level 4). This certificate has become the benchmark for support workers entering and working within mental health services. The review of this certificate will integrate basic addiction knowledge into the core compulsory section of the certificate, including an elective specialist addiction section.

Hall McMaster & Associates Limited (HMA)

Formed in the mid 1990s HMA has been involved in the delivery of training and social services connected with the addiction and justice sectors in both New Zealand and Australia. HMA has experience and expertise developing and delivering nation-wide training, which includes: group
facilitation skills training, social services supervision, and training in motivational interviewing. HMA has the resources and knowledge base to be involved in any future CEP training initiatives.

**Joel Porter - Motivational interviewing**

Joel Porter, BA, MA, PsyD is the Director of the Pacific Centre for Motivational Change in Hamilton. With over 15 years of dedicated clinical experience in the addiction field, Joel has worked in a wide range of community and residential addiction and mental health services in the United States, Germany and New Zealand. Trained by Dr William Miller, Dr Theresa Moyers and Denise Ernst, Joel is a member of the Motivational Interviewing Network of Trainers. He has provided MI training throughout New Zealand and Australia, as well as Myanmar, Singapore, China and Canada. He has been one of the driving forces behind the biannual School of Addiction.

**Massey University**

Massey University is currently delivering a Post Graduate Certificate in Health Science (Dual Diagnosis) and has been involved in addiction training for more than 10 years. The College of Humanities and Social Sciences has strong links with Rehabilitation, Mental Health/Nursing, Māori Studies, Social Work and Psychology, with capacity and capability to be involved in any future CEP training.

**Moana House Training Institute**

Moana House Training Institute developed and delivered a series of mobile training packages nationally from 1998 to 2005. Their initiative began with a mainstream contract in the Midlands region from 1998, which was open to all practitioners working with co-existing disorders. This led to two national contracts undertaken between 2001 and 2005, which included a wānanga delivered into regional areas - three day training and two day follow-up assessment. Moana House has capacity to contribute to the development and implementation of co-existing training - with a Māori cultural component. The Institute has linkages with TuPu (Waitamata CADS Pacific Counselling Service) and Future Skills South Auckland to deliver Pacific Island competencies via Moana House.

**National Addiction Centre**

The National Addiction Centre (NAC) has been involved in addiction research and training since 1996. Currently the NAC is delivering national post-graduate CEP courses at a certificate and diploma category. It pioneered and has been actively involved in the delivery of short courses on Co-existing Disorders throughout New Zealand. Dr Fraser Todd, Deputy Director of NAC, is the principal author of *Te Ariari o te Oranga: The assessment and management of people with coexisting mental health and substance use problems*. NAC is available to be part of any CEP training planning, development, delivery and evaluation.

**Wellington Institute of Technology (WelTec)**

WelTec delivers certificate, diploma, degree and graduate level qualifications in Alcohol and Drug Studies at its three campuses in Wellington, Auckland and Christchurch. The qualifications are modular based, including those in motivational interviewing, assessment and treatment planning, mental health, addiction and cultures, whakaruruhau, Te Kotahitanga Hauora Māori, gambling and other impulse control disorders and co-existing mental health and substance use disorders. These papers can be delivered as part of a full qualification or independently as certificates of proficiency. New courses that are under development include addiction and domestic violence, and addiction and forensics. All WelTec courses qualify for DAPAANZ Continuing Education Programme (CEP) points.
Appendix 4: Summary of CEP Training Framework

Phase One
- Te Tāhuhu (Ministry of Health, 2005) provides the vision for improving addiction and mental health services based on improving whānau ora, recovery, and wellness. In line with this vision the Ministry of Health has developed clinical and service guidelines for the addiction and mental health sectors, and will facilitate a national CEP training framework. The training initiative will require coordination between Matua Raki, Te Pou, Te Rau Matatini, Le Va and The Werry Centre, and the four regional workforce coordinators, to promote the framework and identify training needs.

Phase Two
- A National Project Manager with extensive clinical and education experience and comprehensive addiction and mental health networks will be appointed to oversee systems change training to facilitate competent and capable CEP practice, in conjunction with the Ministry of Health.
- Combined regional one-day workshops on CEP inspired systems changes will be held. Clinical leaders, service managers and NGO board/trust leaders will be offered Tools ‘N’ Techniques training (Te Pou, 2004).
- Training providers and service training coordinators will be consulted and advised on CEP developments and implications for training and education.
- A reservoir of information will be developed to feed the sector with CEP knowledge, tools, ideas, and information, and provide linkages to appropriate services for clinical inquiries.

Phase Three
- Practitioners to be trained through existing training systems (DHBs) and contracted workshops (NGOs) across the addiction and mental health sectors, using Te Ariari o te Oranga as a foundation. An important component of the workshops will be the development of local peer supervision groups.
- Local peer supervision groups of addiction and mental health practitioners will be developed to provide peer support, training and coaching, and to encourage the cross-fertilisation of ideas and knowledge.
- Regional pools of CEP enhanced practitioners (to be used as role models, trainers and coaches) will be identified by the National Project Manager, leaders and managers. The pools will be resourced by the National Project Manager through training and the information reservoir.
- Training will start in the Central region based on training to leaders and managers, and two months later training will be delivered to practitioners. This will be repeated in the regions on a two to four month cycle.
9 Acknowledgements

This document has been produced with the support of the Matua Rak'i staff. Numerous people have informed the content and the report is a synthesis of the combined wisdom, experience and passion of those involved. Many thanks to:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Simon Adamson</td>
<td>Deputy Director – Research, National Addiction Centre</td>
</tr>
<tr>
<td>Raine Berry</td>
<td>Director, Matua Rak'i</td>
</tr>
<tr>
<td>Hinerangi Bidois</td>
<td>Programme Manager, Matua Rak'i</td>
</tr>
<tr>
<td>Marion Blake</td>
<td>CEO, Platform</td>
</tr>
<tr>
<td>David Bradley</td>
<td>Project Lead NGO Workforce Development, Te Pou</td>
</tr>
<tr>
<td>Klare Braye</td>
<td>Lecturer, WelTec</td>
</tr>
<tr>
<td>Clarissa Broderick</td>
<td>Team Leader, Community Alcohol and Drugs Service, Capital and Coast DHB</td>
</tr>
<tr>
<td>Guy Burns</td>
<td>Training and Development Project Leader, Matua Rak'i</td>
</tr>
<tr>
<td>Shona Clarke</td>
<td>Youth Consumer Advisor/Project Leader, The Werry Centre for Child and Adolescent Mental Health</td>
</tr>
<tr>
<td>Dr Daryle Deering</td>
<td>Deputy Director – Liaison, National Addiction Centre</td>
</tr>
<tr>
<td>Dr Bronwyn Dunnachie</td>
<td>Senior Advisor, The Werry Centre for Child and Adolescent Mental Health</td>
</tr>
<tr>
<td>Janet Edmond</td>
<td>Central Region Workforce Coordinator, Te Pou</td>
</tr>
<tr>
<td>Dr Monique Faleafa</td>
<td>National Manager, Le Va</td>
</tr>
<tr>
<td>Dr Tom Flewett</td>
<td>Consultant Psychiatrist, Dual Diagnosis Service, Capital and Coast DHB</td>
</tr>
<tr>
<td>Trish Gledhill</td>
<td>Director, Kina Families and Addiction Trust</td>
</tr>
<tr>
<td>Stuart Gray</td>
<td>Southern Regional Workforce Coordinator, Te Pou</td>
</tr>
<tr>
<td>Pauline Hinds</td>
<td>Consumer Advisor, Mental Health Commission</td>
</tr>
<tr>
<td>Terry Huriwai</td>
<td>Senior Advisor, Matua Rak'i</td>
</tr>
<tr>
<td>Catherine Inder</td>
<td>Senior Policy Analyst, Addiction Treatment Services, Ministry of Health</td>
</tr>
<tr>
<td>Ian MacEwan</td>
<td>Acting Director, Matua Rak'i (at the time of writing)</td>
</tr>
<tr>
<td>Kirsty Maxwell-Crawford</td>
<td>CEO, Te Rau Matatini</td>
</tr>
<tr>
<td>Chas McCarthy</td>
<td>Senior Contracts Manager, Māori Population Health Group, Ministry of Health</td>
</tr>
<tr>
<td>Shani Naylor</td>
<td>Senior Communications Advisor, Matua Rak'i</td>
</tr>
<tr>
<td>Angela Norman</td>
<td>Northern Regional Workforce Development Coordinator, Northern DHB Support Agency</td>
</tr>
<tr>
<td>Paula Parsonage</td>
<td>Director, Health &amp; Safety Developments</td>
</tr>
<tr>
<td>Haechatu Phillips</td>
<td>Midland Regional Workforce Development Coordinator, Midland DHB</td>
</tr>
<tr>
<td>Tracey Potiki</td>
<td>Project Leader, Te Rau Matatini</td>
</tr>
<tr>
<td>Susan Rawlins</td>
<td>Contractor, Agon Limited</td>
</tr>
<tr>
<td>Paul Robertson</td>
<td>Senior Lecturer, Otago University</td>
</tr>
<tr>
<td>Rhonda Robertson</td>
<td>Consumer Project Leader, Matua Rak'i</td>
</tr>
<tr>
<td>Susan Schofield</td>
<td>Training Coordinator Dual Diagnosis Team, Waitemata DHB</td>
</tr>
<tr>
<td>Lealofi Siö</td>
<td>Project Leader Pasifika, Matua Rak'i</td>
</tr>
<tr>
<td>Dr Sean Sullivan</td>
<td>Director, ABACUS Counselling, Training and Supervision Ltd</td>
</tr>
<tr>
<td>Carolyn Swanson</td>
<td>Service User Workforce Development Manager, Te Pou</td>
</tr>
<tr>
<td>Dr Fraser Todd</td>
<td>Deputy Director -- Teaching, National Addiction Centre</td>
</tr>
<tr>
<td>Sue Treanor</td>
<td>Director, Workforce Development, The Werry Centre for Child and Adolescent Mental Health</td>
</tr>
<tr>
<td>Pauline Tucker</td>
<td>Team Leader Community Alcohol and Drugs Service, Waitemata DHB</td>
</tr>
<tr>
<td>Dr Jane Vanderpyp</td>
<td>National Research Manager, Te Pou</td>
</tr>
<tr>
<td>Denise Whitfield</td>
<td>Primary Mental Health Project Coordinator, Te Pou</td>
</tr>
<tr>
<td>Rick Williment</td>
<td>Rick Williment &amp; Associates</td>
</tr>
<tr>
<td>Te Puea Winiata</td>
<td>Service Manager, Māori Mental Health Services, Auckland DHB</td>
</tr>
<tr>
<td>Jenny Wolf</td>
<td>Project Manager, Addiction Treatment Services, Ministry of Health</td>
</tr>
<tr>
<td>Emma Wood</td>
<td>National Workforce Manager, Te Pou</td>
</tr>
</tbody>
</table>
10 References


