

**MENTAL HEALTH AND ALCOHOL AND DRUG CO-EXISTING DISORDERS:
An Integrated Experience for Whaiora?**

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SECTION ONE: Introduction

Mental health clients scare the hell out of me ... I just want to stick with good old [alcohol and other drug clients].

The issue of co-existing mental illness and alcohol and drug addiction has become a focus of mental health and alcohol and other drug services in New Zealand and internationally.

Mental health and alcohol and drug services in New Zealand do not reflect an integrated approach to services for people with experience of both mental illness and alcohol and drug addiction (Matthews 2004b).

Te Kokiri: The Mental Health and Alcohol and Drug Action Plan 2006-2015 has signalled a new direction for mental health and alcohol and drug service delivery in New Zealand (Ministry of Health 2006). Inherent in this action plan is an active decision to strengthen and resource the workforces of these services.

With disparities in access to services by people with both mental health and alcohol and drug problems, there is an urgent need to:

- increase co-existing disorder services
- improve workforce alignment between mental health services and alcohol and drug services
- have an integrated response to this group's needs
- improve the assessment and specialisation skills of the two workforces.

In response to *Te Kokiri*, Matua Raki undertook a project to ask the mental health and addictions sectors for their views on integrated practice and to look to ways we could improve collaborative partnerships between the workforces of mental health services and alcohol and drug services.

Methodology

The project team sent a letter to District Health Board CEOs and mental health managers advising them of the project, explaining the project's aim, approach, time-frames, and asking about the availability of key staff. An interviewer visited all 21 District Health

Boards (DHBs) and interviewed staff in mental health and alcohol and drug services and funding and planning services. One hundred and sixty-five people were involved in the discussions. These staff included general managers of mental health and alcohol and drug services, clinical leaders, DHB funding and planning managers, mental health portfolio managers, team leaders, whaiora (clients or patients) who had presented with co-existing disorders at either service or both services, and other relevant people. Matua Raki also consulted staff in regional and non-government organisation (NGO) services.

Matua Raki has undertaken related work within Maori-specific hui. The first initiative was to bring together Maori designated as 'dual diagnosis' workers or working in 'dual diagnosis' teams within Maori mental health and Maori mental health workers working with coexisting mental health and addiction related issues. The purpose was to discuss how service delivery was occurring, issues around service delivery and examining the difference if any of working with Maori. As well as ascertaining interest in creating a forum or network to be able to discuss issues and models etc the hui was also an opportunity for one Maori mental health service to demonstrate their model of enhancing capability.

Maori Mental Health ADHB (Whatua Kaimarie) have undertaken a project via their regional work force development programme to investigate how they can increase their capacity and capability to address substance misuse amongst their clients. "Piggy-backing" on this project Matua Raki provided opportunities for their project team to meet and discuss their project with a number of 'experts' in the sector. This project was also discussed with the Matua Raki Maori Leadership group and with a group of Maori mental health providers brought together to discuss coexisting disorders or "dual diagnosis". The group came from DHB and NGO services and inpatient and community based services.

As well as a recognised need to work more collaboratively with local AOD services, two main themes came out of the 'networking' day, the first: the issue of competence was raised in terms of raising the capability of mental health services to recognise and work with substance misuse but more particularly what that might mean in a Kaupapa service meeting the needs of Maori whanau. The second the need for greater collaboration and networking between Maori those working with coexisting disorder, including training and discussion of issues.

The initial funding was to support the project to a point of piloting. the funding was only a 'year' and due to uncertainty around budgets, the project has stalled awaiting decisions as to its continued inclusion in the Maori programmes or as a dedicated stream within the

wider mental Health and Addiction project. Piloting and development of the network would seem to be the next steps

This project does not include a literature review, a gap analysis, or determining the level of demand for people with co-existing disorders. These are well covered elsewhere (for example, Todd et al 1999, TIP-42; Adamson et al 2001).

Project aim

The aim of the project was to determine a national strategy for the mental health and alcohol and drug workforces to enable them to work collaboratively for better outcomes for people with both alcohol and drug and mental health issues.

Project objectives

The broad objectives of the project were to:

- understand current service provision, including both integrated and non-integrated models of practice
- make recommendations on how to improve workforce capability in the treatment of people with co-existing disorders.

Prevalence Data

Internationally, the prevalence rates for co-existing mental health and alcohol and drug addiction are well established, with 30-50% of all people diagnosed with a serious mental disorder reported to also have experience of problematic alcohol and drug use (Siegfried, 1998). Dr Fraser Todd 1999 confirms the relevance of this figure in the New Zealand setting (Todd: Personal Communication).

There is less research about people with experience of alcohol and drug addiction and mental illness, although the combined experiences may be seen as the 'norm rather than the exception', with 70% of people in community alcohol and drug services in New Zealand suffering a co-existing Axis I mental health disorder in addition to their substance use disorder. (Adamson et al 2006; Pulford 2002).

Whilst there are differences between the populations accessing services primarily for mental illness or alcohol and drug addiction, both share negative outcomes that include

hospitalisation, overdose, violence, legal problems, homelessness, victimisation, HIV infection and hepatitis (SAMHSA 2003). It is well reported that people receiving services for either mental illness or alcohol and drug addiction separately do not receive the service they need to address both problems (Sciacca 1991).

Contemporary expert opinion and best practice calls for an integrated approach for people with experience of mental illness and alcohol and drug addiction (Drake et al 1998; SAMSHA 2003). It should be noted, however, research to date on the effectiveness of integrated treatment is equivocal, and if it does improve treatment outcomes has at best a modest effect. (In some conditions such as social phobia complicated by alcohol and drug problems, people may actually do worse with integrated treatment approaches (Tiet Q.Q., Mausbach B. 2007).

The barriers to achieving an integrated approach need to be addressed. In New Zealand, these have been shown to include a range of systems issues including a failure to plan regionally for integrated services and contracts for services which do not include dealing with co-existing problems, clinical skills deficits and unhelpful attitudes in both alcohol and drug and mental health services. (Todd et al 2002).

In the United Kingdom, the mental health service has the primary responsibility for providing comprehensive care for people with serious mental illnesses such as schizophrenia and co-morbid substance use problems. The rationale for this is that the mental health service is better placed to offer services such as assertive outreach, crisis management and long-term care than are the substance misuse services. In addition, it is expected that substance use services will support mental health services in this endeavour.

SECTION TWO: Commentary from Interviews

2.1 Common themes from mental health managers and clinical directors

Six common themes and issues arose from the visits:

- Management generally agrees it is important to provide an expert service for people presenting with co-existing disorders.
- There is no standard pathway or approach towards people presenting with co-existing disorders. Each DHB has a unique variation.
- Within DHBs there were markedly different views about what happens for people presenting with co-existing disorders, for example, between managers and clinical team leaders.
- Management is interested in partnership projects with funding support
- Management would like to see co-existing disorder competencies developed as part of the Drug and Alcohol Practitioners' Association of Aotearoa-New Zealand's competencies.
- Identified barriers to change included professional boundaries, patch protection and clinical accountability being kept within professional groupings as barriers to change.

The principle of an integrated service is popular among most mental health managers though often in support of bringing alcohol and drug services 'into line'.

[The] alcohol and drugs workforce should be trained and supervised by [the] mental health [services], especially in risk and crisis management, [cognitive-behavioural therapy] and [dialectical behavioural therapy].

Mental health clinical director, DHB.

[The] problem with [the alcohol and drug] team is that they do not have a great understanding of mental health.

Mental health manager, DHB

The alcohol and drug counsellors in the local [NGO] wouldn't recognise a mental health problem if it slapped them in the face. Waste of time and money. Any real work is done by my nurses.

Mental health manager, DHB.

Alcohol and drug workers can't work with mental health issues. They are not trained to. They are quite good with drug stuff.

Mental health manager, DHB

Historically, [alcohol and drug services have] always felt like the 'poor cousins', recovery based and with a background in counselling. Now, there has been a gradual improvement seen with more nurses and social workers.

Mental health general manager

Alcohol and drug is talking therapy. They are untrained. Real medicine is by mental health.

Mental health, including alcohol and drugs, manager

We have a good alcohol and drug team. Don't ask me what they do.

Mental health manager

Eighty percent of my patients have alcohol and drug problems. No, we don't address these problems.

Mental health clinical director, DHB

Only Odyssey House deals with alcohol and drug really. [The Community Alcohol and Drug Service] is getting into primary prevention. Great. No, I mean it. But bloody little use to us.

Mental health clinical director

Some alcohol and drug managers, however, were equally critical of mental health skills and knowledge:

Comprehensive [alcohol and drug] assessment will pick up mental health issues but not vice versa, therefore mental health trained staff need to do postgraduate [alcohol and drug] studies.

Alcohol and drug manager

There is still a split between mental health and [alcohol and drug services]. For example, patients coming in with alcohol and drug issues are seen by mental health staff as 'belonging' to [alcohol and drug services] - need to change the mindset of mental health workers.

Mental health general manager

2.2 Common themes from Alcohol and drug treatment managers and practitioners

Matthews (2004a) found that Auckland community alcohol and drug staff saw it as their role to work with people with co-existing disorders, and that the majority of their whaiora presented in this way. They felt frustrated by mental health staff believing in a sequential treatment process that first dealt with the alcohol and drug problems, then dealt with the mental health problems. They wanted mental health involved with the more serious, especially acute, mental health issues.

Alcohol and drug services are overall more cautious about integration with advocates across the whole spectrum from full integration to full separation.

Many alcohol and drug practitioners believe mental health practitioners hold negative attitudes about alcohol and drug whaiora and that this inevitably extends to their services and practices.

We refer [clients] to the mental health psychiatrist. But he despises us and our clients. He won't prescribe if clients are using drugs.

Alcohol and drug post-graduate qualified practitioner

I don't think of psychiatric medication for my clients. Trying to access that is impossible.

Alcohol and drug graduate practitioner, urban NGO

Mental health simply stabilises situations. We have to do the change work. Mental health [services] wouldn't know where to start.

Alcohol and drug team leader

Mental health nurses are so medication-focused. There is a hell of a lot more about people than giving them a pill.

Alcohol and drug practitioner

Mental health only wants to contain crises and they are so risk-focused. Wellbeing for people? - forget it!

Alcohol and drug team leader

Psychiatrists are not keen to deal with whaiora with alcohol and drug issues, particularly those on methadone.

Alcohol and drug regional co-ordinator

Mental health [services] will never work with families. They are terrified of them.

Alcohol and drug team leader

Two to three years ago we reviewed and recommended that [alcohol and drug] and mental health [services] have a single care plan for each client with a dual diagnosis. Mental

health has a high staff turnover so this is a difficulty. There was an idea to transfer staff between the services for a month - not happening yet but I think there is still an intention to do so. Dual diagnosis cases need to have one lead case co-ordinator - currently they have two [from mental health and alcohol and drug services] each believing they're the lead person.

Alcohol and drug manager

Other issues common to alcohol and drug team leaders included:

- getting people to up-skill was thought to be 'scary' because of the challenge to change patterns of behaviour, putting it down on paper means a lot more work and some workers have poor writing and/or study skills
- accessing funding for ongoing education, training and development, including the difficulty releasing Clinical Training Authority funding from Post-Entry Clinical Training to allow alcohol and drug counsellors to train and up-skill to degree level.

2.3 Common themes from Mental health practitioners

Mental health practitioners' comments reinforced the notion that the two sectors had different skill-sets and ways of working.

[The alcohol and drug] sector [is] based on 'you come and see me' whereas mental health goes out and visits. [Alcohol and drug services need] to make some philosophical changes.
Mental health team leader

Alcohol and drug [services] won't include the family. They will only work 1: 1 with their whaiora. Home visits? That's a joke right?
Mental health manager, DHB

Alcohol and drug reports are all touchy-feely. You don't have an understanding of a patient's mental health problems from one of their reports.
Nurse, community mental health team

Engagement, and fitness for treatment, were identified as issues. A common problem occurs when people with alcohol and drug issues present acutely after hours, but mental health staff will not think it appropriate to treat them, particularly if they are intoxicated. Also, alcohol and drug clients were seen as a group where engagement was problematic.

About 50% of [alcohol and drug] patients are DNA [did not attend treatment]. All that is done is a letter is sent out but little else in follow-up is done - i.e., the [alcohol and drug] workers won't get out of their office.
Mental health manager, DHB

Separate 'core business' was a recurring theme.

I am here to treat her depression. If she uses cannabis, what am I supposed to do? Depression is my business.

Mental health nurse, talking about a whaiora

Alcohol and drug is not an issue for us. It is an adult problem.

Child and family psychiatrist, DHB

Go to mental health [services] for medication when you're not well. Go to alcohol and drug [services] to get housing sorted or get [Work and Income New Zealand] off your back. Long-term whaiora of both services

[You should] focus on clinical directors' risk aversion to dealing with adult alcohol and drug dependence. Having a senior alcohol and drug specialist working in mental health could deal with this and be more responsive to needs of patients.

Mental health service manager, DHB

People should be able to access service from any point of entry.

Mental health team leader

2.4 Common themes from Funders and Planners

Funders and planners generally feel that sufficient and enabling policy is in place, but people with leadership skills who know and understand policy and can put it into practice are needed. There was also a feeling that progress in this area requires a clearer lead from the national level.

Some mental health funders and planners think they should meet more regularly to gain a greater degree of consistency and allow for better alignment at the strategic level.

Our alcohol and drug service is at 50% Blueprint [funded]. I think that is pretty average.

Mental health manager, DHB

Dual diagnosis patients are the worst attenders at services, therefore you wouldn't want to put more resource into this group.

Funder and planner

We need a more active outreach alcohol and drug service. There is a huge gap between alcohol and drug and tertiary-level care. People disappear in this gap. Alcohol and drug [services] don't have the skills to reach toward tertiary level need. Alcohol and drug services need to appreciate the growing complexity of both clinical and social need.

Funder and planner

2.5 Access as a theme

Several of the DHB mental health service staff spoken to believe people with alcohol and drug issues presenting at mental health services should firstly be referred to alcohol and drug services to be assessed and treated even though they may have moderate to severe mental health concerns. Alcohol and drug practitioners speak often of whaiora not making the transfer across services and there often being no follow-up from the referrer.

Many spoke of the difficulties in getting access to detoxification beds in medical wards as well as the discrimination that prevails by clinicians within those wards. Some are addressing this by providing a consult-liaison nurse who works across services to develop and manage the relationship between the services, and inform and up-skill staff.

Need for staff and services to be flexible to meet needs of people presenting with co-occurring disorders. They just aren't, in my experience.
Whaiora

An identified need to develop more residential services, not just for individuals but also for families, was often raised.

A development three older practitioners and two consumer advisors (all in different districts) noted were young people being referred into services and not wanting to deal with any health issues at all. This leads to considerable staff frustration and is a disincentive to cross-refer.

Seeing an increasing number of women with personality disorders and major alcohol and drug problems - a real gap in service for these women
Alcohol and drug manager, NGO

There is an issue with people presenting acutely on 'P' [methamphetamine].
Funder and planner, DHB, commenting on challenges facing mental health services

Detoxification: We are always having difficulty getting access to a medical bed with usual discriminatory attitudes.
Alcohol and drug manager, NGO

Within Maori mental health services, most of the whaiora have a dual diagnosis. Maori mental health, with a whaiora with alcohol and drug problems, works closely together with alcohol and drugs service. However, whaiora could be seen by Maori services, alcohol and drugs services and mental health services and none of the three would know the other was involved - especially a methadone whaiora. A national methadone database would help address this issue.
Maori alcohol and drug service manager

Many alcohol and drug practitioners seem to prefer to provide detoxification in mental health inpatient units (where home detoxification is not indicated), but detoxification is not seen as a mental health service and mental health staff are resistant to any change in this. Detoxification in medical wards finds little support from medical staff.

Staff in NGOs say they are seeing people with dual diagnoses - mainly alcohol and drug addiction and anxiety and depression. DHB funders and planners expressed concern that they cannot keep funding this group out of Blueprint money as the whaiora group is not part of the 3 percent most acutely affected for which the funding is directed. It seems that in most districts, even if whaiora in this 'group' (primarily young men with alcohol and drug problems, often coming out of prison with moderate to severe alcohol and drug and mild to moderate mental health problems) become very distressed or experience a psychotic episode, they are still seen as alcohol and drug-related problems.

2.6 Perceptions of Barriers to Integration

Professional boundaries, patch protection, and clinical accountability kept within professional groupings are seen as barriers to change. The Health Practitioners Competence Assurance Act 2003 (HPCA) creates an immediate barrier between the two sectors.

No clinical director in our service - just another name for a psychiatrist who cannot be accountable for nursing and other allied staff's practice, especially under the HPCA. [Alcohol and drug] staff [do] not have a regulating body overseeing them and are therefore professionally unaccountable. Therefore, they must work under regulated staff. Most [alcohol and drug] staff are nurses anyway or social workers. We don't employ counsellors.

Mental health manager, DHB

Some services reported difficulties in co-ordinating whaiora care. Disputes over who has a duty of care and case management responsibilities often arise in mental health services. Alcohol and drug services commonly complain about the difficulties they have liaising with mental health services. Both services complain about each other's inability to exchange whaiora information, develop shared treatment plans, conduct joint case conferences and offer consultation support.

Lack of knowledge of each other's services is another factor:

Dual diagnosis services [are] in place although not impressive because no one [knows] what they [do].

Professional nurse advisor

We had a regional strategic document on managing co-existing disorders about two years ago but it didn't involve [alcohol and drug services].

Clinical director, DHB

Differences in compulsion were also raised. Patients being forced (through legislation or crisis) to receive treatment is a critical cultural difference between the two services. Mental health services need to deal with the reality of a severe mental disorder, even though the patient may deny having an alcohol or drug problem or a mental health problem. These patients are often unmotivated to engage with treatment and may be unable to change. Alcohol and drug services work to motivate patients to make changes toward recovery.

Whaiora perceptions of stigma were a recurrent theme:

Our clients don't want the mental health and the [alcohol and drug] issues to be dealt with together.

Alcohol and drug practitioner who has been trying to work in an integrated model

I would be very resistant to having the same counsellor deal with both my mental health and my [alcohol and drug problems]. I don't want them talking to each other.

Whaiora with an alcohol and drug practitioner and a mental health caseworker

Chalk and cheese. Don't mix them. I would zip if I thought they were talking to each other about me.

Whaiora of both services

An integrated team approach/model is the best way to go. However, [alcohol and drug] whaiora want to be separate because of the stigma associated with mental health.

Funder and planner

Link between mental health and alcohol and drugs reasonably good - better here than in adjoining DHBs, but room for improvement. There is a lack of training for mental health staff in alcohol and drugs therefore mental health have tendency to refer to alcohol and drugs service. [Alcohol and drug] service has improved over the last 6-7 years to deal with many mental health issues (for example, anxiety, mild depression). Lots of joint training sessions and manager attends the weekly mental health [MDT] meetings. Psychiatrists are the worst, saying treating alcohol and drugs is not their job. Therefore we don't refer to mental health often. Very good [memorandum of understanding] between mental health and alcohol and drugs - for example, notes exchanged but done manually with its risks of miscommunication. No plans to change to electronic system.

Alcohol and drug manager

Managing dual diagnosis has been very dysfunctional for the last 15-20 years with no direction from national level. Don't see that alcohol and drug and mental health should be separate. Patients fall through the gaps. Training is the big issue. Historically, communication has not been good although this is improving on the ground, especially between CADS [Community Alcohol and Drug Service] and mental health with a slowly

growing ability to deal with dual diagnosis. CADS [has] moved more towards mental health especially over the last 2-3 years. More now about mental health [and] alcohol and drugs rather than seeing them as separate. But still separate with NGOs.

Mental health clinical director

Alcohol and drug work around a harm reduction model - lots of debate and confusion for mental health with different philosophies, cultures and history. We are looking at co-location because of patients with dual issues. All staff [are] undertaking training in motivational interviewing. Some problems with access to mental health information and vice versa although this will improve with new electronic information system, therefore on the verge of getting better integration.

Mental health general manager

Several people at all levels in both sectors commented that current organisational structures and leadership get in the way of integrating services. However, several DHB management teams have prioritised training for support workers, infrastructure development and capacity building.

2.7 Examples of Integrated experience

Central to the integrated treatment model is the principle that co-existing disorder treatments are provided simultaneously, not sequentially, by the same practitioner, team or service. Advocates of an integrated approach champion the similarities in good practice in the mental health and the alcohol and drug services; doubters point to the equivocation of outcome research about its effectiveness.

Some services have moved towards or achieved an integrated experience for whaiora.

Maori mental health starts at a more practical end - for example, we identify the issues and do not worry about who treats which diagnosis. We have funded a project to look at how to develop an integrated service, training staff about what alcohol and drugs is about, care planning etc.

Māori mental health manager

We have worked out a good system and meet regularly to make it work. We stabilise and medicate, if required, alcohol and drug [services] do the hard yards on changing behaviour. Thank God.

Mental health senior nurse

We work so well together. We know each other. Trust each other. Meet weekly to work together on our clients.

Alcohol and drug team leader

Excellent referral and joint casework. We need each other.

Alcohol and drug general practitioner

We are undertaking a new initiative to look at inter-sectoral collaboration for people with significant [alcohol and drug] and mental health problems.
Mental health, clinical director

Alcohol and drug and mental health are parts of one family and not been 'split'. Services are structured to provide an integrated approach. This will be improved again by the building programme currently under way in this DHB that will result in alcohol and drug services and mental health services sharing the same building. Two years ago we implemented a one-file system with a resulting improved patient pathway. Alcohol and drug profile has been raised amongst psychiatrists with the reappointment of a [Medical Officer of Special Scale] who 'specialises' in alcohol and drug [treatment]. We also have a co-existing liaison nurse working in the acute inpatient unit who screens all whaiora coming into the unit. Plus, alcohol and drug counsellors attend inpatient meetings and co-manage whaiora.

Mental health manager, DHB

Our DHB has the vision of both workforces competent in dual diagnosis - that is, working together as a way of learning leading to a shared service, an integrated service. The barrier to this is the mindset of workers, plus the two cultures which are reinforced by contracting arrangements.

Funder and planner, DHB

Whaiora get treatment concurrently through the key worker system. Mental health and [alcohol and drug services] want to keep their integrity but are committed to working together.

Mental health manager, DHB

Relationship between mental health and [alcohol and drug services] organisationally sit close. Excellent clinical leadership with high level of collegial regard.

Mental health manager, DHB

2.8 Discussion of Themes

Some key impressions:

- mental health practitioners are not motivated to think about alcohol and drug problems
- alcohol and drug practitioners are not skilled enough to assess for mental health problems
- the common practice is for mental health and alcohol and drug practitioners to do their own assessments and repeat them when cross-referring
- good integrated practice appears to happen only when individuals know each other well
- most, though not all, practitioners share a vision of an integrated service for people with co-existing disorders.

Many DHB mental health and alcohol and drug services are configured quite differently from each other and have different practices and models for determining whether mental health and alcohol and drug services are offered as an integrated service. Some services

have alcohol and drug staff working within community mental health services; some are stand-alone alcohol and drug services. Several DHBs commented on the 'uniqueness' of their service provision. Other DHBs noted that although it was assumed people's needs were met in an integrated way, they acknowledged that their current structures actually got in the way of fully integrated services.

Models of service delivery differ between the sectors and services attract and maintain the workforce that matches the service culture, thus maintaining the barriers. This affects the ability of services to deliver an integrated mental health and alcohol and drug service competently.

Treating whaiora with co-existing mental health disorders and alcohol and drug problems poses a major challenge for clinicians. Whaiora with co-existing disorders have a greater tendency toward violence, medication non-compliance, and a failure to respond to treatment than do whaiora with just alcohol and drug problems or just mental health disorders. Successful treatment requires an integrated approach that deals with both problems simultaneously.

There was a common view that integration depends upon on the clinician's motivation. Practitioners in both sectors talk of finding whaiora with 'other-sector' issues as scary and unpredictable. Alcohol and drug practitioners confide that they have a taught knowledge of mental health disorders, but do not have the mentored experience of working with these disorders. Mental health workers talk about having a lack of knowledge about illicit drugs and drug behaviours. Both sectors retreat into their areas of expertise and either refer people with the other disorder or ignore the other disorder.

The two sectors speak different languages. Alcohol and drug practitioners speak from a therapeutic lexicon; mental health practitioners draw on their training in nursing and medicine. The differences in these languages seem to encourage an intolerance that leads to feelings of belittlement and lack of confidence in cross-sector communication. Both services need dual competencies training. Language and assessment tools should be common to both services. It is hoped the introduction, promotion and teaching of general competencies ('Real Skills') will help to achieve more confidence in the two sectors.

Where there is strong leadership within alcohol and drug services, there appears to be a more collaborative relationship between mental health services and alcohol and drug services. This is especially so where the alcohol and drug team leader has been in place for

some time, is respected for their knowledge and expertise, and communicates and meets regularly with mental health staff.

Regional workforce development plans include developing alcohol and drug service capacity and capability and encouraging both workforces to work better together. Provider forums, sector forums and interest groups where DHB and NGOs attend are seen as helpful in developing mutual respect and collaboration, building positive relationships and developing more integrated strategies. However, comments were made that too many alcohol and drug interest groups exist at the national level, and decisions are made with little regard to the regions or the DHBs, and do not help to make local mechanisms work as they should.

Inter-sectoral collaboration and co-operation is hindered by mistrust, attitudes of management and leadership, high staff turnover, strong vertical management systems that see individual services more responsive to internal lines of authority rather than to local partners, differences between different professional groupings, and differences between the perspectives of the mental health and the alcohol and drug services.

Many relationships are now based on contractual agreements between purchasers and providers; the manner in which these contracts can be inter-sectoral could have an important bearing on levels of trust and co-operation. In many places, the two sectors distrust each other to a damaging degree, especially around perceived levels of expertise and flexibility of service provision. Suspicion continues that mental health services are too symptom-focused and subservient to DSM-IV diagnostic criteria; that alcohol and drug services are too counselling-focused and bound by standard office hours and settings.

While it seems universally agreed that there is a huge overlap between mental illness and alcohol and drug problems, our services still seem poorly equipped to deal with these co-existing disorders. Debate continues about whether treatments for people with co-existing disorders should be provided by specialist teams or rely on liaison and joint working between existing services.

Conceptualisation of services on a continuum may help services to identify how they can maintain their focus whilst providing better access and quality responses for whaiora (see Figure 1).

Figure 1: Continuum of mental health and alcohol and drug services

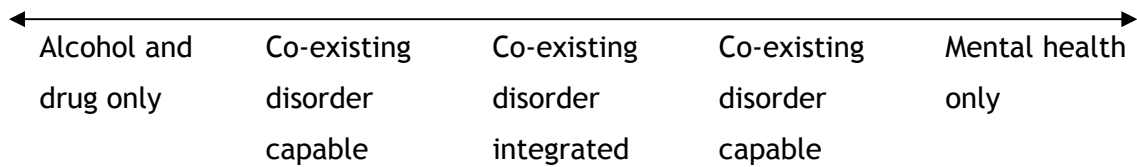


Table 1 outlines the six key strategies for developing a workforce able to provide services for people with co-existing disorders.

Table 1: Strategies for working toward a workforce able to provide for people with co-existing disorders

Strategy		Requirement
Improving clinical capacity	requires	resourcing an interested infrastructure
Improving evaluation and monitoring		better information sharing
Improving evidence and consensus-based practices		competency certification
Implementing workforce development and training		dedicated funding
Screening, assessment and treatment planning		changes to systems
Definitions, terminology and classification		improved services collaboration

(TIP-42).

Todd et al (1999) recommend an integrated approach, but with an early emphasis on improving the capability of all treatment staff in both sectors to recognise and manage issues of co-existing disorders. Todd et al also recommended:

- whaiora should be able to access all alcohol and drug and mental health care through a single point, ideally through a case manager
- alcohol and drug and mental health disorders should be considered primary, and the order of onset of each disorder is irrelevant
- using a harm minimisation model in both alcohol and drug and mental health services

- whaiora should receive as much of their treatment as possible in the same setting
- close liaison between all therapists and treatment agencies involved, including whanau, family and significant others.

SECTION THREE: Workforce Development Issues

3.1 Competencies and Training

There were comments from managers that they would like to see the development of dual diagnosis competencies as part of the Drug and Alcohol Practitioners' Association of Aotearoa-New Zealand's competencies.

Some alcohol and drug managers think there is a need to look again at training: are we training people long enough? Why do we not have a national approach? It was suggested, for example, perhaps training providers could sit down with employers and align training with required skills. However, there is reluctance, at times full resistance, to combined sector training. The orientation of the trainer will often determine the sector that will attend.

Matua Raki short courses seemed popular, with several requests for more of them. Bringing these courses to the regions was appreciated. Several teams spoke of often having difficulty meeting travel costs. HPCA-registered staff get their training costs, travel and accommodation paid, but in some areas, non-HPCA staff get no financial assistance for out-of-district training.

Training has helped mental health staff to move towards changing their culture. However, there is still evidence of stigma against alcohol and drug whaiora especially from mental health, NGOs and [accident and emergency] staff.
Funder and planner

Workforce development is a big issue for most of the DHBs, particularly in terms of the skills people should have to address the needs of people with co-existing disorders. Accessing adequate travel and accommodation funding for staff to undertake study off-site, and backfilling those staff positions are also common concerns. Some DHBs spoke of the lack of motivation among some staff for up-skilling, particularly older workers.

There is a growing call at all levels, whaiora included, for training in alcohol and drug treatment for mental health staff and in mental health treatment for alcohol and drug staff, particularly in the development of dual diagnosis competencies. However, whaiora may not want a more integrated approach to their care.

Most of the DHBs visited were very keen to have Matua Raki assist them in undertaking training and up-skilling, particularly for mental health staff, in motivational interviewing,

brief intervention and cognitive behaviour therapy. NGOs want help to up-skill their workers in dual diagnosis competencies.

There is a very poor motivation of our workers to up-skill. They are an ageing group (approx average age late 40s to 50s and over). Not keen to undertake post-grad study, travel or add to their workload. Whilst money is not too much of an issue, we would like to have additional funding to cover travel expenses and backfill. Funding from Matua Raki has been very helpful and of course we would appreciate funding for alcohol and drug training to be continued. We are doing some on-site training and would value Matua Raki doing training for mental health staff in alcohol and drug assessment, motivational interviewing and brief intervention. Major difficulty getting [alcohol and drug] workers to undertake post-grad qualifications when they need undergrad [qualifications] first, in order to be accepted into post-grad courses. Nursing and medical staff are all at post-grad level - but dual diagnosis competency is very patchy.
Mental health workforce development co-ordinator

It appears skill-based training is lacking, Up until a few years ago there were 2-3 day short courses provided on co-existing disorders both in mainstream and Maori settings; They were aimed at changing attitudes and improving clinical approaches (very hard to teach comprehensive skills in 2-3 days). . But they were not attended as well as they might.

There is also a real need to develop skills in mental health for the [alcohol and drug] service. And mental health tends to pass-the-parcel.
Mental health manager, DHB

Training? Alcohol and drug courses don't fit the national framework. Is anybody monitoring this? What's DAPAANZ [Drug and Alcohol Practitioners' Association of Aotearoa-New Zealand]? Never heard of it.
Mental health clinical director, DHB

The difficulty we have at the moment is training our [alcohol and drug] staff in mental health. They resist what they insist on calling a medical model approach.
Mental health manager, DHB

Still some training issues especially for those staff that have come from counselling services and are not confident in clinical mental health aspects and need up-skilling in mental health assessment etc.
Alcohol and drug manager, NGO

Recently completed a survey of staff training needs and most of those in mental health requested training in [[alcohol and drugs].
Mental health manager, DHB

Several mental health NGOs have asked for alcohol and drug training and feel their staff are often lacking in this area.

There are no alcohol and drug trainers that we can contract in to provide this training.
Mental health manager, NGO

I actually don't know if there is funding available for up-skilling in [alcohol and drugs].
Mental health manager, DHB

3.2 Recruitment

With an ageing workforce, there is concern about how to encourage more people into working in the alcohol and drug area. Some DHBs are looking at this issue, particularly at working in schools to address stigma and discrimination and encourage school leavers into mental health and alcohol and drug services as a career choice. However, many DHBs are relying on recruiting from overseas or new immigrants. There is a noticeable increase in new workers from Britain, Australia and South Africa.

Mental health managers worried about the future workforce and believe that more work in schools is needed to promote mental health as a career. However, an ageing workforce and the increasing complexity of work, rising competency standards and the requirement for greater accountability are seen to make it more difficult to attract youthful practitioners who may have the right skill set. There is still a huge amount of stigma, especially with media, around mental health and alcohol and drug, despite the Like Minds, Like Mine campaign.

Human resources are not well informed of the workforce needs and are still discriminatory around alcohol and drug and mental health [services]. Not much forward planning or thinking.

Regional workforce co-ordinator

There is an anomaly in alcohol and drug [services] with registered nurses working in alcohol and drug services where their registration isn't recognised and is not seen as part of a career pathway.

Mental health professional nurse advisor

Workforce recruitment deficits: including primary care/accident and emergency and all points of entry. Counsellor recruitment not a problem with [alcohol and drug services] but it is a problem attracting doctors, social workers and occupational therapists into this work.

Alcohol and drug team leader

Suggestions to recruit from job centres and provide on-site skills training were met with opposition, especially by whaiora. A repeated anxiety is that people will not have the skills

or attitudes to work in mental health and their primary incentive will be to get off the unemployment benefit.

3.3 Organisational Development

The core issues may be as much systemic as clinical and be about the quality of management and leadership. These can be influenced by training designed for those who are responsible and for advocacy around the partnerships that should be reflected in contracts.

The skills required to plan, commission, co-ordinate, manage and lead services for people with co-existing disorders are considerable. The capacity of managers and leaders varies significantly. Many people involved in these tasks have had little in the way of structured learning about the problems of mental illness and alcohol and drug behaviours. Many contribute on the basis of the occasional workshop, knowledge gained informally or from occasionally reading reports. There is no structured programme of learning and no formal induction processes for people employed to undertake these tasks.

Managing service change - need to help mental health clinicians support choices and opening up people's thinking - around development of clinical pathways and developing competencies in alcohol and drugs. Thinking about what's in common for example, motivational interviewing is highly transferable but people may not have got their head around it especially with someone who has severe mental illness.

Mental health team leader, DHB

SECTION FOUR: Summary and Recommendations

This study has found that alcohol and drug service key workers are not good at identifying psychiatric problems and community mental health team key workers are not good at identifying alcohol problems, although are better at identifying illicit drug problems. In terms of the treatment provided, it finds some improvement in level of provision for patients with dual diagnosis, but also a large degree of unmet need. One draws a picture of mental health and alcohol and drug teams working in parallel rather than collaboratively, and more thinking about wrap-around services would be helpful in bridging unmet need.

Recommended Principles

Principle 1: Rather than seeing people with co-existing disorders as having two separate problems and treated by two separate systems, it may be more useful to think of people with multiple and complex needs.

Principle 2: Any door is the right door. People with complex needs should be able to access a comprehensive, respectful, competent service and the support needed to reach wellbeing.

Principle 3: An integrated service requires an integrated work team. Each sector workforce - mental health and addictions - require expertise within their teams to undertake the assessment and treatment which dual diagnosis conditions require. This should also include the physical health needs of whaiora and how to better provide for those needs, which are as important as other needs but often neglected.

Principle 4: Some whaiora require the specialist assessment and intervention of a dual diagnosis service.

Principle 5: There is no single training programme that can support integration. Co-existing disorder training should be matched to the level of training already undertaken.

Recommended Actions

Recommendation 1: Train the future workforce by ensuring that all post-graduate tertiary training courses include comprehensive dual diagnosis training.

Recommendation 2: Train the current post-graduate workforce by ensuring that clinicians at registered competent practitioner level have access to either the three available postgraduate programmes in co-existing disorders or provide them with focused skills-based training in the treatment and management of co-existing disorders.

Recommendation 3: Train the current un-trained workforce/support workforce by ensuring that clinicians below the registered competent practitioner level receive training in their mental health or alcohol and drug specialism, preferably to graduate level. (These clinicians should not be undertaking assessment and case management with people with co-existing disorders without undergraduate studies).

Recommendation 4: Include consumer educators in all levels of training to support de-stigmatisation in the sector workforces.

Recommendation 5: Identify supervisory and mentoring structures in each region and, where possible, each local district, to support transfer of learning.

Recommendation 6: Fund and implement a national training programme in clinical supervision that will develop practitioners' ability to supervise work with people with co-existing disorders. Developmentally, training in clinical supervision won't help unless the supervisors are also trained in co-existing disorders - perhaps a national network of clinical supervisors and mentors.

Recommendation 7: Review the alcohol and drug practitioner competencies to strengthen the requirement for practitioners to work competently with people with co-existing disorders. The review should include new developments in clinical care of co-existing disorders, such as motivational engagement, motivational interviewing, and holistic wellness approaches that are currently being used clinically

Recommendation 8: Matua Raki to work collaboratively with the other workforce programmes to support the above recommendations.

Recommendation 9: Fund a continuum of services (refer to Figure 1) with the goal of ensuring a spectrum of need is responded to by a spectrum of service. i.e. there is no one treatment which fits all.

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APPENDIX

Guiding principles in treating whaiora with co-existing disorders (MacEwan)

The six guiding principles in treating whaiora with co-existing disorders are as follows.

- 1 Use a wellness perspective.
- 2 Adopt a multi-issue viewpoint.
- 3 Develop a phased approach to treatment.
- 4 Address problems foremost in the whaiora mind early in the treatment.
- 5 Adapt talking therapy to whaiora cognitive and functional impairments.
- 6 Think network and family, using or developing support systems at each stage to maintain and extend treatment effectiveness.

Use a wellness perspective

Whereby health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, (WHO 1947). Pathways seek to develop pleasurable experiences, engagement and meaning in order to strengthen character strengths and values.

Adopt a multi-issue viewpoint

Most whaiora with co-existing disorders present with a range of interlinking issues and needs, including those relating to physical health, alcohol, drug, gambling, family and other close relationships, mental health, and social connections. Many of these are under stress and in need of repair. They are critical to wellness and to enhancing engagement.

Develop a phased approach to treatment

The stages of engagement, risk assessment, stabilisation, negotiated treatment, after-care, and long-term check-up can be consistent with a wellness perspective.

Address problems foremost in the whaiora's mind early in the treatment

To try to impose our own well-meaning health-giving agendas onto the whaiora can be fraught with risk if the whaiora is pre-occupied with real personal, family and social concerns. Housing, court appearances, employment, child management, relationships under stress, and debts may be at the forefront of the whaiora's mind and need to be at least acknowledged, at best addressed, before most whaiora can focus on our agenda.

Working on these issues is an important first step toward achieving engagement with the whaiora and continuing treatment. Engagement is arguably the primary step toward treatment generally and treatment of co-existing disorders particularly, especially since remaining in treatment for a length of time enhances positive outcomes.

Adapt talking therapy to whaiora cognitive and functional impairments

Cognitive and functional impairments call for short, highly structured sessions focused as much as possible on practical life problems. Use structured exercises, pen and paper, or white-board delivery, and be confident in being repetitive. Do not discount learning disabilities; they may have a significant impact on treatment outcome. A careful assessment of impairments will help in treatment planning likely to lead to success.

Think network and family, using or developing support systems at each stage to maintain and extend treatment effectiveness

Family inclusive practice (ref. Kina Trust FIP manuals), 12-step groups, and the social behavioural network of concerned others that you might develop or enlist are essential to the wellbeing of most of our whaiora.

Many of our whaiora with co-existing disorders have not been supported consistently. Their families and networks may be tired, disillusioned, disengaged and/or angry, or simply non-existent. Yet, they are critical therapeutic allies. The role of the practitioner is to recruit, nurture, salve, educate, invigorate, support, and inspire the network to provide the recovery role it, and only it can adequately provide - this will give the best chance of a positive outcome.