Report to the Mental Health Commission Board and the Alcohol Advisory Council of New Zealand:

Getting it Right for People with Co-existing Addiction and Mental Health Problems

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Getting it Right for People with Co-existing Addiction and Mental Health Problems

**Background**
The Mental Health Commission (MHC) and the Alcohol Advisory Council of New Zealand (ALAC) have recorded a Memorandum of Understanding 2007-2009 with the aim of working collaboratively to enhance each organisation’s ability to make a positive difference to people with co-existing mental health and addiction problems. This paper is one of the deliverables of the MHC and ALAC mental health and addiction project.

**Introduction**
Working with people with co-existing mental health and addiction problems is one of the biggest challenges facing frontline mental health and addiction services in New Zealand and overseas. The co-occurrence of these problems adds complexity to assessment, case planning, treatment and recovery.

The issue has gained prominence in the past few decades due at least in part to the increasing availability and accessibility of alcohol and other drugs, the move out of institutions and into communities by people with severe mental health problems, and the highlighting of its prevalence through the use of structured diagnostic interviews in large scale population surveys.

In New Zealand there have been a number of national and local initiatives aimed at improving treatment for people with co-existing problems, including the 1998 publication of the guidelines, *The Assessment and Management of People with Co-existing Substance Use and Mental Health Disorders (1998 Guidelines)* (Todd et al 1998). However, evidence suggests that clinical services remain largely separated along mental health and addiction treatment lines, and that many people with co-existing problems do not receive optimal treatment (MacEwan 2007).

The need to improve the treatment of people with co-existing mental health and substance-use problems is already a Government priority, as identified in *Te Tāhuhu, Improving Mental Health 2005-2015 (Te Tāhuhu)* (Ministry of Health 2005) and *Te Kōkiri: The Mental Health and Addiction Action Plan 2006-2015 (Te Kōkiri)* (Ministry of Health 2006). The strategy is to develop a “coherent national approach to co-existing mental health and substance-use/abuse disorders” (Ministry of Health 2006: 58).

**Purpose**
This report has two aims:

1. To inform the Mental Health Commission Board and the Alcohol Advisory Council about co-existing mental health and addiction problems: prevalence, current policy, what constitutes optimal treatment, barriers
preventing delivery of optimal treatment, international responses, and the challenge of service integration.

2. To inform the Mental Health Commission Board and the Alcohol Advisory Council about how they can support and enhance government policy, as set out in Te Kōkiri, the Mental Health and Addiction Action Plan 2006-2015 (Ministry of Health 2006) to develop a coherent national approach to co-existing mental health and substance-use/abuse disorders.

**Terminology**

There are debates about the best way to describe co-existing problems with mental health and addictions. Terms commonly in use include dual diagnosis; dual disorders; concurrent disorders and co-morbidity.

This paper uses the description co-existing mental health and addiction problems or, in short form, co-existing problems. Terms such as dual diagnosis, dual disorders and co-morbidity come from the medical lexicon and do not necessarily reflect the multifaceted needs of the people who experience both mental health and addiction (alcohol, drug or behavioural) problems, one or other or all of which may fall short of the formal threshold for classification as a diagnosis or disorder (Velleman and Baker 2008). In this report, the terms disorder or diagnosis are only used when referring to other publications or sources that have used those descriptions.

The terms co-existing or co-occurring are preferable to the term dual. This is because ‘dual’ suggests that there are just two conditions, very often people experience other co-existing problems (for example, an addiction, an intellectual disability, or an eating disorder). Also, ‘dual’ has a fixed quality whereas most people’s substance-use and mental health problems will vary in nature and over time.

The term addiction is used because it is inclusive of substance-use and behavioural addictions\(^2\) such as gambling. There is clear evidence that people with gambling problems usually also experience co-existing mental health and/or substance-use problems.

This terminology is in keeping with the approach to mental health and addictions demonstrated in kaupapa Māori services where cultural models accept a multiplicity of problems and promote recovery through holistic interventions which integrate cultural processes and mental health and addiction treatment interventions.

**Prevalence**

**Te Rau Hinengaro: The New Zealand Mental Health Survey**

*Te Rau Hinengaro: The New Zealand Mental Health Survey* (Te Rau Hinengaro) (Oakley Browne et al 2006) provides recent, important and not previously available information about the rates of co-existing mental health and substance-use disorders in New Zealand. *Te Rau Hinengaro* describes
the prevalence rates of major mental disorders for the total New Zealand, Māori and Pacific populations living in New Zealand. The four main objectives of Te Rau Hinengaro were, for the total New Zealand, Māori and Pacific populations living in New Zealand, to:

- describe the one-month, 12-month and lifetime prevalence rates of major mental disorders among those aged 16 and over living in private households, overall and by sociodemographic correlates
- describe patterns of, and barriers to, health service use for people with mental disorder
- describe the level of disability associated with mental disorder
- provide baseline data and calibrate brief instruments measuring mental disorder and psychological distress to inform the use of these instruments in future national health surveys.

The presence of a disorder is determined in accordance with The Diagnostic and Statistical Manual of Mental Disorders (DSM), the American Psychiatric Association’s official classification system for defining mental disorders (Oakley Browne et al 2006: 18). Interviewees were asked in a questionnaire about their symptoms, and when these started and ended. This information was used to determine whether the interviewee had experienced a mental disorder in the course of their lifetime (lifetime prevalence) or in the last 12 months (12-month prevalence).

It is important to note that Te Rau Hinengaro does not provide prevalence rates for people with severe low-prevalence disorders such as schizophrenia.

The following is a snapshot of what Te Rau Hinengaro tells us about the distribution, patterns and severity of co-existing mental and substance-use disorders in New Zealand over a 12 month period.³

**Distribution**

- 20.7% of the population will have experienced a mental health or substance-use disorder.
- 3.5% of the population will have a substance-use disorder.
- 4.4% of the population will have experienced two disorders at the same time.
- 3.3% will have experienced three or more disorders at the same time.
- A little over a third of those with any disorder will have more than one disorder.

**Ethnic comparisons**

- The prevalence of disorders for Māori and Pacific peoples is higher than for the Other composite ethnic group (29.5% for Māori and 24.4% for Pacific peoples).
- Substance-use disorders for Māori are 6% higher and 3.2% lower for Pacific people than for the Other composite ethnic group.
- Māori experience much higher rates of co-existing disorders than the Other composite ethnic group (25.7% prevalence of 2 disorders for Māori with a 12-month disorder compared with 7.6% for the Other
composite ethnic group and 18.8% prevalence of three or more disorders compared with 5.5% for the Other composite ethnic group) (Baxter 2008: 22).

- Among Maori with a 12-month substance use disorder, 39.7% also experienced an anxiety disorder and 26.4% also had a mood disorder (Baxter 2008: 41).

**Patterns**

- 29.0% of the population with a substance-use disorder will have a mood disorder and 40.0% will have an anxiety disorder.
- Mood and anxiety orders commonly co-occur (49.6%); by comparison, substance-use disorders occur less frequently with other categories of disorder.
- 45.3% of those with a drug use disorder also meet criteria for alcohol abuse and 30.7% meet criteria for alcohol dependence.

**Severity**

- A clear relationship exists between an increasing number of disorders and case severity with 59.6% of people experiencing multiple disorders classified as serious.
- Conversely a large proportion of those with one disorder are classified as mild cases (43.5%) whereas only 4.6% of participants with three or more disorders can be considered mild.
- Co-existing mental health and addiction problems are associated with suicidal behaviour and increases in service use.
- People with mental disorders have a higher prevalence of severe chronic physical conditions compared with people without mental disorders of the same age.

The findings of *Te Rau Hinengaro* in relation to the prevalence of co-existing problems are similar to findings overseas (Oakley Browne et al 2006: 79).

**Severe low prevalence disorders**

*Te Rau Hinengaro* does not provide prevalence rates for people with severe low prevalence disorders such as schizophrenia and schizoaffective disorder. However, the most widely cited international study, the *National Institution of Mental Health Epidemiological Catchment Area Study*, which examined the prevalence of co-existing alcohol, other drug, and mental disorders in the United States community and institutional population found that participants with a diagnosis of schizophrenia had a 47% lifetime substance-use disorder prevalence rate (Regier et al 1990 quoted in Todd et al 1998: 22).

**Prevalence in treatment settings**

It is important to note that within therapeutic settings, rates of co-existing problems are significantly higher. Three quarters of 105 patients attending one of two outpatient AOD clinics were diagnosed with a current co-existing psychiatric disorder with 90% of the sample meeting the criteria for a lifetime psychiatric diagnosis. The most commonly experienced disorders are anxiety,
mood including major depressive disorders, social phobia, post-traumatic stress and anti-social personality disorders (Adamson et al 2006).

There have been few published studies in New Zealand of prevalence rates of substance-use problems in mental health treatment settings. A survey of 28 acute psychiatric units nationally reported that 48% of current inpatients also had a current substance use issue documented in their clinical file (Ministry of Health 1997). It is estimated that between a third and a half of all patients in addiction or mental health settings in New Zealand are likely to have a co-existing mental health or addiction problem (Todd 2008).

**Problem gambling**

People with gambling related problems are likely to meet criteria for other mental disorders. A survey of 9,282 English speaking adults in the United States found a 0.6% lifetime prevalence of pathological gambling almost all of whom also had another lifetime disorder (96.3%) and 64.3% suffered from three or more disorders (Kessler et al 2008).

**The prison population**

A national study conducted in 1999 involving all female prisoners, all male remand prisoners and an 18% sample of male sentenced prisoners showed markedly elevated prevalence rates for major mental disorders in the prison population, particularly for women. Of particular concern was -

- The increased prevalence rate for schizophrenia (4.2% for women, 3.4% for remanded men and 2.2% for sentenced men compared with current prevalence rates in the community estimated to be 0.1% with a lifetime rate of 0.3%)
- The high level of co-existing mental and substance-use disorders (Brinded 2001:166-173).
- There was a similar prevalence rate of mental disorders among ethnic groups but Maori and Pacific inmates were less likely to have or be in receipt of treatment.

**The forensic mental health population**

A 7.5 year retrospective study of 105 patients discharged from the Auckland Regional Psychiatry Service to the forensic community team looking at outcomes in terms of re-arrest, re-hospitalisation, and re-imprisonment found that 78% of the cohort had a co-existing alcohol and or substance use or dependence disorder (Simpson et al 2006).

**Primary Care**

A study carried out by the MaGPIe Research Group into the prevalence and types of common mental disorders among patients attending New Zealand general practices found that more than one third of people attending their GP had a diagnosable mental disorder during the previous 12 months. The most common disorders identified were anxiety, depression and substance use disorders. The study notes that the levels of co-existing disorders are as common as disorders occurring alone, for example, substance use with either
depression or anxiety disorder was as common as substance use alone (MaGPIe Research Group 2003:11-12).

The study also suggests that rates of mental disorder (anxiety, depressive and substance use disorders) among Māori general practice attendees are higher than for non-Maori (MaGPIe Research Group 2005:404).

**Summary**

- Co-existing problems are common rather than exceptional among people with serious mental health problems.
- Many people with drug and alcohol problems experience a range of mental health problems at higher rates than in the general community, most commonly depression and anxiety.
- Māori and Pacific people carry a higher burden of mental health and substance-use disorders than the general population.
- Alcohol misuse is the most common form of substance misuse.
- Drug misuse often coexists with alcohol misuse.
- Problem gambling often coexists with mental health and/or substance-use problems.
- Prison inmates have a high prevalence of co-existing mental health and substance-use problems.

*Te Rau Hinengaro* and other studies confirm that co-existing mental health and addiction problems are the expectation rather than the exception throughout the New Zealand mental health and addiction treatment system including in primary care. This report will make it clear that this knowledge has not yet fully dawned on those who are responsible for delivering mental health and addiction treatment services.

**Co-existing Addiction and Mental Health Problems**

People with co-existing problems are a large and heterogeneous group and this presents both clinical and organisational challenges for service providers -

> The type, intent and frequency of substance-use, the nature and severity of illness, the age of the user, and the physical and social impact of either or both disorders, all contribute to and expand the scope of problems and complexity of diagnosis. (VDGHS 2007: 4)

The UK Department of Health, *Dual Diagnosis Good Practice Guide* (UKDH 2002) provides a useful summary of the relationship of mutual influence that occurs between mental illness and alcohol and drug use:

- *A primary psychiatric illness precipitates or leads to substance abuse;*
- *Use of substances makes the mental health problems worse or alters their course;*
- *Intoxication and/or substance dependence leads to psychological symptoms;*
- *Substance misuse and/or withdrawal leads to psychiatric symptoms or illnesses.* (UKDH 2002: 7)
Some people have severe problems with both their mental health and addictions, which makes it difficult for them to function day to day. Others have milder mental health and addiction problems but find the impact on their lives hard to manage.

The prevalence of particular combinations of co-existing mental health and addiction problems varies with different treatment settings. For example, people with severe mental health and severe addictions are likely to present in acute and emergency settings; people with mild to moderate mental health and addiction problems are likely to be seen in outpatient and NGO addiction treatment and primary treatment settings.

Young people with co-existing problems are particularly at risk of poor outcomes because their age and stage of development makes them vulnerable. The impact of co-existing problems on older people is also of concern due to aging physiology and, in many cases, reduced social interaction. There are significant differences between men with co-existing mental health and addiction problems and women; for example, women who misuse substances are significantly more likely than other women or men to have experienced childhood sexual abuse (UKDH 2002:19).

People with co-existing problems, especially those with severe mental health problems, come into contact with a wide range of professionals working within mental health services, alcohol and drug services and the social services (both the statutory and the NGO sector). Many people with co-existing problems lose touch with specialist medical, psychiatric and addiction services and go on to present challenges for social service and primary treatment agencies who struggle to cope with their complex needs.

The combination of the failure of services to respond adequately or appropriately to people with co-existing mental health and addiction problems and the severity of the problems themselves means that co-existing problems are associated with underachievement or failure across a number of key life domains including academic, employment, relationship, social and health. People with severe co-existing mental health and addiction problems also experience greater involvement with the criminal justice system, higher rates of institutionalisation, more failed treatment attempts, poverty, homelessness and risk of suicide.

**Optimal Treatment**

The almost limitless combinations of co-existing mental health and addiction problems, varying degrees of severity, and the accompanying multiple forms of disadvantage mean that optimal treatment involves integrating treatment for mental health and addiction problems into a coherent package at the level of the individual client. Not surprisingly, services struggle with how to ensure that people with co-existing problems receive the help they need.
**Integrated treatment**

The SAMHSA Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders concludes that -

*Many approaches to treat co-occurring disorders that do not meet strict standards of evidence are nevertheless commonly accepted and believed to be effective based on the best available research, clinical expertise, individual values, common sense, and a belief in human dignity. It is incumbent on practitioners to use the best available approaches.* (SAMHSA 2002:9)

The *Clinical Guidelines for the Assessment and Management of People with Co-existing Mental Health and Substance Use Problems 2008* (Todd 2008: draft), which are currently in development and will update the 1998 Guidelines, state that there is good evidence that programmes which include more of the following core components do better than programmes that have fewer:

- **Integration of services** – the provision of services for mental health and substance use problems at the same time in the same service by the same clinician.
- **Staged interventions** – conceptualising treatment as a series of stages while understanding that patients may be in different stages for different problems and will cycle backwards and forwards between stages over time.
- **Assertiveness** – the use of assertive interventions such as assertive community outreach to encourage engagement and compliance.
- **Motivational interventions** – as a way of enhancing the desire and capacity for behaviour change.
- **Multiple psychotherapeutic modalities** – offering individual, group, family and social interventions as needed.
- **Long-term perspective** – acknowledges that people with co-existing mental health and addiction problems may take longer to improve than others.
- **Comprehensiveness** – treatment addresses a wide range of problems including housing, finances, coping skills, relationships and employment.
- **Reduction in negative consequences** – the key aim is to reduce the harmful effects of co-existing mental health and addiction problems in a non-judgmental and non-confrontational way.
- **Cultural sensitivity and competence** – is essential to ensure access and engagement in treatment.

However, there are limitations to the approaches outlined above which are upheld by expert opinion despite the limited evidence supporting their effectiveness (Todd 2008: draft). For example, a recent Cochrane Collaboration review and follow-up of the effectiveness of psychosocial interventions for people with both severe mental illness and substance misuse found –

*No compelling evidence to support any one psychosocial treatment to reduce substance-use or to improve mental state by people with severe mental illness… No one can suggest to people entering a service that one form of support should really take precedence over another.* (Cleary et al 2008:19)
Developments in specific treatments and models of service delivery are still taking place and there is a gap between what research shows to be effective and what is practised. There are major methodological issues in the evaluation of integrated treatment, and limited financial resources to carry out evaluations. The good news is that the evidence base is expected to build rapidly (Cleary et al 2008:19).

It is important that co-existing substance-use is detected as early as possible and appropriate, effective treatment is provided (Cleary et al 2008:2). It is clear also that a range of psychosocial interventions are effective in the treatment of addictions in the general population.

The Clinical Guidelines for the Assessment and Management of People with Co-existing Mental Health and Substance Use Problems 2008 (Draft) (Todd 2008), which will be published by the Ministry of Health in 2009, are similar to the 1998 Guidelines but there are some key differences in emphasis and content as follows –

- Increasing recognition that integration of care follows naturally from a holistic understanding of the person in their social context and that many of the problems experienced by people with co-existing mental health and addiction problems exist due to the imposition of service and systems issues on the person with co-existing problems.
- Recent research indicating that treatment integration is associated with at best modest improvements in outcome in people with co-existing mental health and addiction problems.
- Recognition that engagement and motivation are at least as influential on outcomes as specific interventions and systems of care.
- Recent developments in the science of subjective well-being and positive psychology, in motivational interviewing for coexisting disorders and in thinking about underlying personality and character traits. (Todd 2008)

Integrated services
A number of service delivery approaches have been developed to meet the needs of people with co-existing mental health and addiction problems. They can be conceptualised as follows -

**Serial**
This approach involves diagnosing then treating a single primary problem and only proceeding to treat the other problem if it does not remit after treatment of the first. This approach ignores the reality that co-existing problems maintain and exacerbate each other which makes the treatment of one problem in isolation difficult and unlikely to succeed. A serial approach to treatment may mean that many people never receive treatment for one or more of their problems, thereby reducing their opportunity for recovery, or that treatment is delayed while a diagnosis is established.
**Parallel**
The approach involves the concurrent but separate treatment of both the mental health and addiction problems by both mental health and addiction services. This approach can also be problematic especially if it requires people to attend different services resulting in potentially fragmented and contradictory treatment.

**Integrated**
This approach involves a combining and blending of both mental health and addiction services by one individual or clinical team, in one setting at the level of the individual client. This approach can be difficult to achieve due to fact that mental health and addiction treatment services are separated along clinical lines and both services need to improve their capability to treat people with co-existing problems.

**Specialist Dual Diagnosis**
This approach involves establishing a separate service whose responsibility it is to provide care for all people with co-existing mental health or addiction problems, alleviating mental health and addiction services from responding to this group of people. The problem with this approach is that it ignores the reality that co-existing problems are ‘the expectation and not the exception’ in both sectors.

It should be noted that these approaches describe service delivery mechanisms and not the kind of care that is provided to the service user or consumer. For example, integrated mental health and addiction treatment can be provided by separate mental health and addiction services and, for some people with particular combinations of mental health and addiction problems, a serial approach to treatment may be indicated.

Just as there is no one size fits all treatment for people with co-existing mental health and addiction problems, there is no ideal service delivery model. Services offering interventions for people with co-existing problems need to ensure an array of internal capability or linkages to other programmes to ensure that services are provided in an appropriate, accessible setting based on the needs of the population they serve.

**Integrated systems**
The organisational structure at a systems level needs to be in place to enable services to provide optimal treatment for people with co-existing mental health and addiction problems, across the spectrum of need.

**Current Policy**
Up until recently addiction and mental health policies were developed largely in isolation of each other and there was little attempt to develop policy responding to the needs of people with co-existing mental health and addiction problems. Significantly, the Government’s second mental health strategy, *Te Tāhu, and Te Kōkiri*, are titled respectively “The Second New Zealand Mental Health and Addiction Plan” and “The Mental Health and
Addiction Action Plan 2006-2015. Addiction and mental illness are no longer viewed as separate and unrelated, nor is addiction engulfed by mental health.

Addiction
Addiction is one of 10 leading challenges set out in Te Tāhuhu. By 2015, the government aims to:

- Improve the availability of and access to quality addiction services and strengthen the alignment between addiction services and services for people with mental illness – with immediate emphasis on:
  - Broadening the range of services that are funded for substance-use problems;
  - Maintaining and developing responsive and effective problem gambling services;
  - Building the expertise of addiction and mental health providers to conduct complementary assessments and treatment planning.

Co-existing mental health and addiction problems
There are 18 specific actions detailed in Te Kōkiri that sit under the leading challenge of addiction. Many, if not all, of the specific actions will have a positive impact on the treatment of people with co-existing mental health and addiction problems. The most apposite specific actions are:

- 7.8 All providers will ensure that service users and tangata whaiora receive seamless service delivery and are supported to make informed choices.
- 7.13 Continue to develop and support intersectoral initiatives and frameworks to ensure the needs of people in the criminal justice and youth justice system are met.
- 7.16 Implement Matua Raki, the addiction treatment sector workforce development programme.

One of the measures for action 7.16 is that within one to five years, training initiatives are in place that enable addiction and mental health providers to conduct complementary assessments and carry out treatment planning that addresses co-existing disorders, including nicotine addiction.

The action most relevant to co-existing mental health and addiction problems is 7.17 -

- 7.17 Develop a coherent national approach to co-existing mental health and substance-use/abuse disorders.

The specific measures include that within one to five years a national approach is developed and implemented, and DHBs demonstrate how service delivery is aligned for people with co-existing disorders.

Additionally, another of the leading challenges in Te Tāhuhu is “Working Together”. The associated action point in Te Kōkiri, action 10.2, has direct...
bearing on improving services for people with co-existing mental health and addiction problems.

10.2 Strengthen the partnership relationships between DHB mental health and addiction services through, for example:
- Sharing best practice
- Peer review and supervision
- Information sharing

Summary

Action 7.17 directs the Ministry of Health and DHBs to jointly lead the development of a coherent national approach to co-existing mental health and addiction problems. The project, at this stage, is largely reliant on DHBs for implementation. It remains to be seen how successful this approach will be in bringing about systems change. This paper describes the responses of some other comparable jurisdictions that have developed high level policy frameworks to drive and support the “joined up thinking” necessary to deliver integrated treatment and treatment to people with co-existing mental health and addiction problems.

\textit{Te Hononga}

A discussion of the policy framework is not complete without mentioning the Mental Health Commission’s single unifying picture of the mental health and addiction sector in 2015, \textit{Te Hononga 2015: Connecting for Greater Well-being (Te Hononga)}. \textit{Te Hononga} complements and builds on \textit{Te Tāhuhu} and \textit{Te Kökiri}. \textit{Te Hononga} means to -

\textit{Connect physically, socially and spiritually – achieving connectedness and synergies whenever people come together, whether as families/whanau and communities, or as part of services, systems and sectors.} (MHC 2007: XI)

The overarching key principles are –

- To promote mental health and wellbeing for all New Zealanders.
- In 2015 there will be connectedness between systems, services, service users, families/whanau, NGOs, the wider Government sector and the community.
- In 2015 responses for people with experience of mental illness and/or addiction will match their needs.
- In 2015, the recovery values of self-determination, social inclusion, hope and choice will be the foundation of services.

\textit{Te Hononga} recognises that by 2015, the mental health and addiction sectors will be integrated and that a full range of addiction services will be available and accessible.

Getting it right for people with co-existing mental health and addiction problems means that people with addiction issues will be able to receive
comprehensive and connected interventions to meet their needs, including where addiction and mental illness present together.

Getting it right for people with co-existing mental health and addiction problems will help embed ways of working that will enhance the ability of the mental health and addiction sectors to get it right for all service users, in accordance with the vision in *Te Hononga*.

**Barriers to the Delivery of Optimal Treatment**

**Introduction**

The mental health and addiction sectors have long struggled for recognition and resources within the larger health treatment system but, of the two, mental health has received the lion’s share of funding. In the past decade the mental health sector has made great progress, largely due to substantial injections of funding but the fortunes of the addiction sector have not improved in anything like the same way (ALAC and MHC 2007).

The inadequate resourcing of the addiction sector is acknowledged in *Te Tāhuhu* and *Te Kōkiri*, and people with co-existing problems will directly benefit from improved availability of and access to, quality addiction services. As a result, the focus of this section is on barriers to the delivery of optimal treatment that directly affect people with co-existing problems rather than the current under-resourcing in the addiction treatment sector.

This summary is also a high level one. There have already been two comprehensive investigations in New Zealand in the past decade, the most recent in 2007, by the National Centre for Addiction Treatment, (Department of Psychological Medicine, Christchurch School of Medicine) (Todd et al 20020 and Matua Raki, (National Addiction Treatment Workforce Development Programme) (MacEwan 2007) into the barriers to providing optimal treatment for people with co-existing mental health and addiction problems.

These studies show that despite increased awareness about high rates of prevalence of coexisting problems and the need for mental health and addiction services to work together, that mental health and addiction services largely remain “divided bureaucracies across discrete disorders” (Sciacca 1996). It should be noted that the barriers are not unique to New Zealand. Addiction and mental health services in the USA, the UK, Australia, Canada and elsewhere also grapple with how to respond adequately and appropriately to people with co-existing mental health and addiction problems.

A brief summary of the two studies is set out below followed by a description of barriers to the delivery of optimal treatment to people with co-existing problems. The barriers have been categorised at the level in which they manifest: service user or consumer level, practitioner or clinical level and the mental health and addiction system level.
The National Centre for Treatment Development (Alcohol, Drugs and Addiction), Department of Psychological Medicine, Christchurch School of Medicine study (NCTD study)

This research, published in 2002 but carried out in 1997, was a part of the project to draw up the guidelines, *The Assessment and Management of People with Co-existing Substance use and Mental Health Disorders* (Todd et al 1998). Eight clinical scenarios were presented at 12 focus groups around New Zealand. The 261 participants of the focus groups were asked to comment on what was optimal management for each of the scenarios and to identify barriers to optimal treatment in their region.

The NCTD study found that while there was marked regional variation in treatment approaches and service structures, many of the barriers to optimal treatment were common to all regions. The study identified a wide variety of barriers ranging from the attitudes of individual clinicians to the structure of the systems in which they work.

The Matua Raki study (Matua Raki study)

In 2007, Matua Raki, the National Addiction Treatment Workforce Development Programme, undertook a project to develop a national strategy for the mental health and addiction workforces to enable them to work for better outcomes for people with coexisting problems. The project aimed to:

- Understand current service provision, including both integrated and non-integrated models of practice
- Make recommendations to improve workforce capability in the treatment of people with co-existing disorders (MacEwan 2007)

A researcher visited all 21 DHBs and interviewed staff in mental health, alcohol and drug services, and Funding and Planning Directorates. A total of 165 people were involved in discussions, including general managers of mental health and alcohol and drug services, clinical leaders, DHB funding and planning managers, mental health portfolio managers, team leaders, clients or patients who had presented with co-existing disorders at either or both services, staff in regional and NGO services and other stakeholders.

The study found that alcohol and drug workers are not good at identifying psychiatric problems and community mental health team key workers are not good at identifying alcohol problems, although they are better at identifying illicit drug problems. In terms of treatment, the project found that there has been some improvements in the level of provision for patients with co-existing mental health and addiction problems, but there remains a large degree of unmet need.

Service user or consumer level barriers to the delivery of optimal treatment

Barriers at the service user or consumer level are intrinsic to people with co-existing problems and prevent them getting the treatment they require. Many of the problems experienced by people with co-existing mental health or
addiction problems are the consequence of or have been exacerbated by the imposition of service or system issues.

People with co-existing problems, especially those with severe mental health problems, live with mental, emotional and psychiatric difficulties as well as with problematic substance-use whether of alcohol, other psychoactive drugs, or medication. Often they are dealing with chronic physical illnesses and have legal, relationship, family, housing and financial problems. They may be involved with statutory agencies such as those in the criminal justice and the child protection sectors. For all these reasons, they are an extremely vulnerable population and effective interventions are usually well beyond the capacity of any one agency.

This group can also be a very challenging group to help for reasons such as lack of insight into the scale and scope of problems, denial about alcohol and/or drug dependence, lack of motivation, poor treatment compliance, high rates of relapse, reduced cognitive and social functioning, and lack of personal and economic resources and hope. People with co-existing problems often display higher levels of verbal hostility, disruptive behaviour and aggression.

People with co-existing problems are also doubly stigmatised for both their mental health problems and for their addictions. While there have been concerted efforts in the past decade to destigmatisate mental illness there has been little or no corresponding work to inform and influence society’s understanding of the causes of addictive behaviours and the journey to recovery. Society tends to ascribe character defects to people with addictions such as moral failure and weakness of will. Addiction is often linked in people’s minds with criminality. There is a tacit belief that “addicts” invite and deserve discrimination. This is despite the increasingly clear evidence that addictive behaviours have a neurobiological basis, the effect of which is a serious erosion of free will. In short, they have chronic health conditions for which there are proven, successful interventions. The double stigma makes it more difficult for people with co-existing problems to get help and engage with treatment.

**Practitioner or clinician level barriers to the delivery of optimal treatment**

These barriers operate to prevent mental health and addiction practitioners from being able to offer optimal treatment to people with co-existing problems. The systemic issues discussed in the next section also have a bearing on the ability of practitioners to offer optimal treatment and this section is more narrowly focussed on education, training and workforce issues.

The NCTD study categorises the practitioner or clinical level barriers as follows:

1. Lack of clinical skills – general inability among clinicians to plan and implement effective interventions, lack of formal training in key skills such as assessment and case management.
2. Lack of knowledge among mental health workers – about the nature and interactions of co-existing disorders, the nature of addiction and the principles of harm minimisation.
3. Inadequate family involvement – family not included in assessment and treatment planning and their concerns not listened to.
4. Cultural issues – lack of specific skills and knowledge for working with Maori in mainstream services.
5. Lack of assertive follow-up – more can be done to engage and retain clients in treatment.

The Matua Raki study found that –
- Alcohol and drug practitioners may receive some training in mental health disorders but are not skilled enough to assess for mental health problems because they lack ongoing, on-the-job, supervised training.
- Alcohol and drug team leaders found a challenge both in getting people to up-skill and accessing funding for ongoing education, training and development.
- Mental health practitioners are not good at identifying alcohol problems, although are better at identifying illicit drug problems and are not motivated to think about alcohol and drug problems.
- Both mental health and alcohol and drug practitioners experience difficulties liaising with each other over shared cases.

The lack of education, training and support in how to help this particularly challenging and vulnerable population creates a negative cycle. Both mental health and alcohol and drug practitioners lack confidence and feel powerless treating people with multiple problems who are beyond their capacity to help. Interventions fail or appear to fail; staff burn out and/or leave and people with co-existing problems drop out of treatment or fall between the gaps in services.

This situation should be of utmost concern given the high prevalence of people with severe mental health problems who are also problematic substance-users and the already over-stretched mental health and alcohol and drug work force.

The Matua Raki study concludes with five recommended principles for responding to and treating people with coexisting mental health and addiction problems and nine recommended actions on how to improve workforce capability in the treatment of people with co-existing mental health and addiction problems (see Appendix).

**Mental health and addiction system barriers to the delivery of optimal treatment**

In many ways the barriers at the system level to the delivery of optimal treatment for people with co-existing problems can be distilled into two fundamentals –
- the need for leadership to drive complex organisational changes; and
• the need to challenge attitudes to ameliorate the fragmentation that exists between the mental health and addiction sectors.

Strong leadership is required to ensure that mental health and addiction services meet the needs of people with co-existing problems. Real and lasting change is dependent on a fundamental shift in attitudes across the mental health and addiction sectors.

The NCTD and Matua Raki studies provide clear evidence of the need for leadership and attitudinal changes at the system level and their findings are discussed under these headings.

The need for leadership
The huge clinical challenges in providing optimal treatment for people with co-existing mental health and substance-use problems are mirrored at an organisational level. People with co-existing problems are a large and heterogeneous population who require both mental health and addiction interventions delivered in a coherent package and tailored to their individual needs. The clinicians tasked with doing this operate out of silos which have proven very difficult to break down.

The NCTD study described the systems level barriers as follows:
• Lack of regional planning – individual services established without a vision of how they might be integrated; gaps between services plugged in piecemeal fashion creating more gaps, insufficient involvement of clinicians, consumers and families in the development of services.
• Fragmentation of services and inconsistency of treatment – a lack of strategic planning for integrating services resulting in fragmentation of mental health services; patients referred from service to service making integrated treatment difficult to achieve; patients receiving several assessments before they receive any significant treatment.
• Contracts encourage a narrow focus – services often funded for a limited number of sessions which restrict the interventions that can be offered to patients with complex conditions who may require more than standard treatment.
• Lack of resources – heavy patient loads; lack of access to training; waiting lists; little time to undertake many effective interventions of proven efficacy, for example family interventions.
• Problems in rural areas – large distances between services; lack of access to specialist tertiary services.

Ten years on the Matua Raki study shows that while there have been some improvements, overall not much has changed:
• Management generally agrees it is important to provide an expert service for people with co-existing problems.
• There is no standard pathway or approach towards people presenting with co-existing problems. Each DHB has a unique variation.
• Within DHBs there are markedly different views about what happens for people with co-existing problems, for example between managers and clinical team leaders.
• The common practice is for mental health and alcohol and drug practitioners to do their own assessments and repeat them when cross-referring.
• 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.
• Good integrated practice appears to happen only when individuals know each other well.

Up until the advent of Te Tāhuhu and Te Kōkiri, there was no national leadership around co-existing mental health and addiction problems and the responsibility for improving services was left up to individual service providers and DHBs that recognised the need for change. Te Tāhuhu and Te Kōkiri task the Ministry of Health, in conjunction with DHBS, with developing a “coherent national approach” to co-existing problems. This much needed leadership should improve responsiveness to co-existing problems.

The need for attitudinal change
The NCTD study considered the attitudes of individual clinicians a major barrier to providing optimal treatment for people with co-existing problems. The study sets out five different ways in which unhelpful attitudes are apparent in this area:

1. Judgmental attitudes – implicit beliefs that substance-use problems are a matter of choice, and therefore a personal or moral deficit, remains evident, especially within mental health services.
2. Rejection of a disease model – antipathy towards any use of a disease or medical model from certain professional groups that often led clinicians to reject biologically-based interventions.
3. Territoriality – rivalry between professional groups and regions seemed common and appeared to make the interfaces between services less permeable. Maori services were not immune to difficulties in this area.
4. Insistence on abstinence and confrontation – patients were often under pressure to stop using alcohol and drugs, with little serious consideration given to the health benefits possible from a reduction in drug use.
5. Addiction is not considered the business of mental health services – patients with alcohol and drug problems were often turned away from mental health services regardless of the other mental health problems they suffered.

The Matua Raki study, much of which consists of comments by practitioners from both the mental health and alcohol and drug treatment sectors, makes it abundantly clear that the attitudes described above remain alive and well. It is salient to reproduce a sample of the comments below –

_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._
Manager, mental health, DHB
Alcohol and drug is talking therapy. They are untrained. Real medicine is by mental health.
Manager, mental health, including alcohol and drugs

Eighty percent of my patients have alcohol and drug problems. No, we don’t address these problems.
Clinical Director, mental health, DHB

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

Mental health nurses are so medication focussed. There is a hell of a lot more about people than giving them a pill.
Alcohol and drug practitioner

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

I am here to treat her depression. If she uses cannabis, what am I supposed to do? Depression is my business.
Nurse, mental health, talking about a service user

Alcohol and drug is not an issue for us. It is an adult problem.
Psychiatrist, child and family, 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.
Manager, mental health, DHB

Also of relevance is a recent New Zealand study entitled Mad or Bad? The Role of Staff Attributions in Dual Diagnosis (Gregory J 2007) which found important and interesting differences in the way that mental health clinicians responded to mental health disorder, dual diagnosis, and substance-use disorder vignettes. Clinicians attributed more responsibility, felt increased anger and experienced less treatment optimism in respect of the dual diagnosis vignette.

Such attitudes permeate the mental health and addiction system and have many flow-on effects. For example, people with mental health problems are often judgmental about people with addiction problems and vice versa. Also, the mental health service user workforce far outnumbers the alcohol and drug consumer workforce with consequent implications for service quality and development.

This report has purposely avoided cataloguing these impacts, not because they are unimportant, but because some of them are in the process of being addressed under the auspices of Te Tāhuhu and Te Kōkiri and others will ameliorate as attitudes change and the mental health and addiction system begins to comprehensively address the needs of people with co-existing mental health and addiction problems.
International Perspectives

United Kingdom
The United Kingdom has devoted substantial resources to improving outcomes for people with co-existing mental health and addiction problems. The publication by the Department of Health of the Dual Diagnosis Good Practice Guide (the Guide) sets out current policy and good practice in the provision of mental health services to people with severe mental health problems and addictions.

The Guide establishes a policy framework it refers to as “mainstreaming”. It places responsibility for the delivery of “high quality, patient focused and integrated treatment” (UKDH 2002:4) for people with severe mental health problems who also misuse substances on mental health services, as a way of ensuring that people are not shunted between services and put at risk of dropping out of treatment. The Guide states that the role of alcohol and other drug treatment services is to continue to treat the majority of people with addiction problems and to advise on addiction issues. It summarises good practice in relation to assessment and treatment and states that well organised parallel treatment can be used as a stepping stone to integration.

The Guide sets out a number of preconditions for mainstreaming to work including local services developing focussed agreed definitions of dual diagnosis which reflect local patterns of need and specialist teams of dual diagnosis workers providing support to mainstream mental health services. The Guide is aimed at all those who commission and provide mental health and addiction services.

Australia

Federal
Over the last three to five years, Australian governments have sought to improve treatment responses to co-occurring mental health and addiction problems. Two commonwealth initiatives – the National Co-morbidity Initiative and the Improved Services for People with Drug and Alcohol Problems and Mental Illness Initiative (improved Services Initiative) represent the most significant injection of new money to date.

Approximately AUS$3.5 million per annum is provided to 2010-11 for the National Co-morbidity Project Initiative which aims to improve service coordination and treatment outcomes for people with co-existing mental health and substance-use disorders. It focuses on the following priority areas:

- raising awareness of co-morbidity among health workers and promoting examples of good practice;
- providing support to general practitioners and other health workers to improve treatment outcomes;
- facilitating and improving access to resources and information for consumers; and
- improving data systems and collection methods within the mental health and alcohol and other drugs sectors to manage co-morbidity more effectively.
Two projects that sit under the National Co-morbidity Project are the development of national co-morbidity guidelines and funding for the clinical supervision of psychologist and social worker placements in alcohol and other drug NGO treatment settings. Another initiative is the National Alcohol and Mental Health Co-morbidity Project, “Managing the Mix”. which is a collaboration involving the Alcohol Education and Rehabilitation Foundation, the Mental Health Council of Australia, the Departments of Health and Aging, and Veterans Affairs and the Australian Divisions of General Practice. The project recognises the links between alcohol and common mental health problems and is focussed on the potential of general practitioners to identify and treat co-existing mental health and addiction problems.

The Improved Services Initiative with its emphasis on capacity building within the alcohol and drug NGO sector began in January 2008 and projects are funded for 3 years at a cost of AUS$73.9 million.

A range of co-morbidity projects also operate outside these initiatives and continue to be supported by other government funding and research or educational grants (M Butler 2008:14).

Victoria
Initiatives that respond to people with co-existing problems are underway in most Australian states. The largest scale initiative is the Victorian Dual Diagnosis Initiative funded by the Victorian Mental Health Branch and the Drugs Policy and Service Branch (which have recently been brought together as the Mental Health and Drugs Division of the Department of Human Services).

The Dual Diagnosis Subcommittee, which reports to the Ministerial Advisory Committee on Mental Health, has published *Dual Diagnosis - Key Directions and Priorities for Service Development* (VDHGS 2007). This provides guidance for service leaders and managers responsible for ensuring that dual diagnosis becomes core business within their services, and sets out actions to implement the directions and the key priorities for the period 2007-10.

The paper establishes a policy framework described as a three-level schema to ensure a more systematic approach to the treatment and treatment of people with co-existing problems. It is similar to the mainstreaming approach in the United Kingdom in that it places responsibility for the delivery of integrated treatment“ on mental health services.
The Victorian government has established an AUS$8 million programme to deliver:

- Four dual diagnosis teams (38 staff) to provide direct treatment to the most complex cases and to support staff in mental health and drug treatment services across the state with eight staff specifically to target young people;
- Youth dual diagnosis positions to support young people in residential rehabilitation services;
- 21 professionals to work in the state’s mental health mobile support and treatment teams focusing on dual diagnosis needs.
- Innovative training positions (156 staff trained over three years) supported by a state-wide education and training unit, enabling staff to rotate between services and sectors to gain broader experience;
- Funding for dual diagnosis specialist psychiatrists to provide expert clinical input and leadership.

**United States of America (USA)**
The USA has been in the vanguard in terms of both its recognition of the prevalence of co-existing mental health and addiction problems and the need to prioritise and resource improvements in treatment. Significant developments include –

- The federal United States Department of Health and Human Services, Substance and Mental Services Administration (SAMHSA) has identified improving treatment and services for people with co-existing mental health and addiction problems as one its highest priorities.
- SAMHSA has identified integrated treatment of severe mental health and addiction problems as one of six evidence-based practices for mental health services.
• SAMHSA has established the Co-occurring Centre for Excellence to provide training, information, advice and guidance to services providing treatment and support to people with co-existing problems.

• Most states have developed and promoted co-existing mental health and addiction clinician-focussed treatment manuals.

• There is a substantial and growing body of research in the USA around co-existing mental health and addiction problems.

• The creation of a range of auditing tools to enable treatment providers to assess, for example, competency in respect of co-existing mental health and addiction problems and fidelity to particular treatment models. (Croton 2005a:27)

Comprehensive Continuous System of Treatment (CCISC)
The CCISC is a best practice model for system design for integrated mental health and substance-use services developed by Kenneth Minkoff. It was first used as a best practice for system design in a SAMHSA Community Action Grant in 1998-99. Subsequently, CCISC projects have been initiated throughout the USA, Canada and elsewhere. Key features are:

• It is designed to improve the capacity for treatment of co-existing mental health and substance-use problems at all levels of a treatment system (state, individual treatment providers, programmes) mostly from within existing resources.

• It is based on an integrated treatment philosophy and is designed around the needs of all population groups with co-existing mental health and addiction problems. It is built on the recognition that co-existing problems are the expectation throughout the treatment system. (Croton 2005a:28)

Summary
Other comparable countries have dedicated considerable resources to help the mental health and addiction systems make the organisational changes required to deliver optimal treatment to people with co-existing mental health and addiction problems. Conversely, in New Zealand, there is no budget attached to Action 7.17 of Te Kokiri to develop a coherent national approach to co-existing mental health and substance-use disorders, and the expectation is that DHBs respond to this challenge from within their baseline funding.

Integrated Services
The public management literature on “joined-up” or integrated services makes it clear there are many areas of social need that cannot be adequately responded to by just one agency within its existing resources and knowledge, but that service integration or co-ordination can be extraordinarily difficult to realise. It is likely that many of the key stakeholders in the mental health and addiction sectors underestimate the challenges involved in bringing together the two sectors to offer integrated treatment for people with co-existing problems.

The SAMHSA Report to Congress on the Prevention and Treatment of Co-occurring Substance-use Disorders and Mental Disorders provides a neat
summary of the differences between the mental health and addiction systems, most of which is directly applicable to New Zealand –

The public mental health service system tends to address individuals with severe and chronic mental illnesses such as schizophrenia, bipolar disorder, borderline personality disorder, and major depression. Typically, it is not equipped to address the treatment of concurrent substance abuse disorders. The substance abuse treatment system addresses all types of substance abuse disorders at all levels of severity; when necessary many providers in this system are able to respond to mild to moderate forms of mood, anxiety, and personality disorders. The public substance abuse and mental health service systems differ markedly with respect to staffing resources, philosophy of treatment, funding sources, community political factors, regulations, prior training of staff, credentials of staff, treatment approaches, medical staff resources, assertive community outreach capabilities, and routine types of evaluations and testing procedures performed. (SAMHSA 2002: 4)

There are a range of resources applicable across a number of domains to assist agencies wishing to work together in pursuit of outcomes that are not possible for any one agency to deliver on its own. For example, the States Services Commission has recently published Factors for Successful Co-ordination – A Framework to Help State Agencies Co-ordinate Effectively (the Framework) (SSC 2008). The Framework can help agencies plan co-ordinated activities. It groups nine factors for successful co-ordination according to three dimensions as follows:

| Mandate | Leadership commitment  
|         | Ministers’ and stakeholders buy-in  
|         | Defined and agreed outcomes  |
| Systems | Appropriate and documented governance and accountability frameworks  
|         | Sufficient and appropriate resources  
|         | Process to measure performance from established baselines  |
| Behaviours | Right representation, skills and team leadership  
|           | Organisational cultures that support co-ordination  
|           | Shared culture, language and values  |

Action 10.2 of Te Kōkiri charges DHBs with strengthening the partnership relationships between mental health and addiction services. The Framework set out above can serve as a minimum check list of what is entailed. The most significant challenge is changing behaviours, especially in light of the high levels of ill feeling that exist between the two sectors. Time and commitment will be required to develop trust and a shared culture.

To embark on this journey, stakeholders need to be persuaded that the benefits/advantages of doing so outweigh the costs/disadvantages. Given that people with co-existing mental health and substance-use problems are the norm rather than the exception in both mental health and addiction treatment settings, there can be little disagreement on this count. Expected results include:
• People with co-existing mental health and addiction problems will receive treatment that assists them on their journey towards recovery.
• Mental health and addiction practitioners will be better supported in their work and will enjoy closer and more respectful relationships with practitioners from the other discipline.
• The wellbeing of the wider community will be improved and sustained as more people recover from mental illness and/or addiction.

It should be noted that practitioners in the mental health and addiction treatment sectors frequently respond to the idea of integration with the view that what is proposed is a merging of the two sectors. This is not the case. Internationally there are no examples of health systems that have opted to merge the two sectors to respond to co-existing problems. In most cases, the mental health and addiction sectors provide services to different groups of people with co-existing problems. In practical terms, a merging of the two sectors is likely to mean that addiction services would be subsumed within mental health services, and this is likely to operate as a significant barrier to achieving better outcomes for people with co-existing problems (Croton 2005b).

Ways Forward

There is much work to be done to ensure that people with co-existing mental health and addiction problems, across the spectrum of need, receive the treatment and care they require in order to live well and meaningfully.

The Ministry of Health, in conjunction with DHBs, under the auspices of Te Kōkiri, is developing a much-needed coherent national approach to co-existing mental health and addiction problems which, together with the increased focus on addictions, will help improve services for people with co-existing problems.

This report contends, however, that no matter how well conceived the national plan is for responding to co-existing mental health and addiction problems, success will be limited without a fundamental shift in understanding and attitudes across the mental health and addiction sectors. Practitioners in these sectors need to respect each other’s expertise, talk in a common language, trust each other and be well supported to do so by both management and systems. Fostering the behaviour and practice changes necessary will require an intense effort over an extended period of time, and rely on committed, consistent leadership.

The Role of the Alcohol Advisory Council of New Zealand and the Mental Health Commission

ALAC and MHC, in partnership, are uniquely placed to help drive these changes, particularly with regard to influencing attitudes and behaviours. To do so is wholly consistent with the Mental Health Commission’s vision as set out in Te Hononga and in keeping with the Alcohol Advisory Council’s Strategic Direction 2008-2013, which includes the following priorities—
• Working to identify, implement and monitor programmes to meet the specific needs of Maori, Pacific and young people.
• Ensuring that those with established alcohol problems receive appropriate treatment.
• Ensuring that people who are beginning to experience problems as a result of alcohol misuse are identified and assisted (ALAC 2007).

If the Alcohol Advisory Council and the Mental Health Commission were to assume this role it would complement and enhance the Ministry of Health’s work in this area.

Recommendations

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<tr>
<td>1</td>
<td>That ALAC and MHC continue to resource the mental health and addiction project</td>
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<td>2</td>
<td>That ALAC and MHC, in consultation with key stakeholders, including the Ministry of Health Co-existing Disorders Project, use the State Services Commission ‘Framework to Help State Agencies Co-ordinate Effectively’ to develop a plan to support and enable effective co-ordination across the mental health and addiction sectors.</td>
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<td>3</td>
<td>That ALAC and MHC prepare a joint communications plan in relation to this report that is aligned with the Ministry of Health Co-existing Disorders Project.</td>
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<td>4</td>
<td>That this report is provided to the Minister of Health, the Hon Mr David Cunliffe and the Associate Minister of Health, the Hon Mr Damien O’Connor.</td>
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Endnotes

1 The Assessment and Management of People with Co-existing Substance Use and Mental Health Disorders. Wellington is currently being updated and the draft version is referred to in this report as the Clinical Guidelines for the Assessment and Management of People with Co-existing Mental Health and Substance Use Problems 2008 (Draft).
A behavioural addiction is a non-substance related compulsion such as problem gambling, overeating and sex addiction. The term addiction is used to describe a recurring compulsion to engage in some specific activity despite harmful consequences. These problems are generally not recognised as problems of addiction by the medical community.

There is good evidence that Te Rau Hinengaro significantly underestimates the true population prevalence of opioid dependence in New Zealand due to the characteristics of the opioid population (distrust of mainstream society, no land line telephone connection, the stigma attached to the disorder) (Sellman et al 2008).

Alcohol and other drug funding in 2005/06 represented 10% of the total DHB Mental Health Blueprint funded service levels, the same proportion as in 2004/05. Alcohol and other drug services were 68.4% towards full achievement of Mental Health Blueprint funding target levels in 2005/06, which is less that the overall mental health average of 76.6%. If alcohol and other drug services had achieved the overall level of 76.6%, then AOD services would have received an additional $10.4 million of funding in 2005/06.


APPENDIX

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.

Guiding principles in treating whaiora with co-existing disorders

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 whaora mind early in the treatment.
5 Adapt talking therapy to whaora 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 whaïora 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 whaïora’s mind early in the treatment
To try to impose our own well-meaning health-giving agendas onto the whaïora can be fraught with risk if the whaïora 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 whaïora’s mind and need to be at least acknowledged, at best addressed, before most whaïora can focus on our agenda.

Working on these issues is an important first step toward achieving engagement with the whaïora 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 whaïora 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.

References


