

**Service Delivery for People with
Co-existing Mental Health
and Addiction Problems**

Integrated Solutions

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MANATŪ HAUORA

Foreword

For many years there have been much discussion and many strategic statements urging mental health and addiction services to respond equally to mental health and addiction issues in a co-ordinated and complementary manner. Recent surveys of the respective services have shown a variety of approaches to these issues with poor communication and coordination between the two services, with the result that clients continue to fall between the gaps. This document has been produced as a guide to assist services to plan practically and implement a range of different approaches to becoming ‘co-existing problems capable’.

It is not easy to shift the current service culture with its narrow focus to address multiple elements of a person’s presentation. However, mental health and addiction services are both inter-related and both are core business of mental health and addiction services. There is a high prevalence of co-existing problems in clients presenting to the services, and to address one issue and ignore the other constitutes poor clinical practice. This also should include ‘problem gambling’ identification within mental health and alcohol and drug services in recognition of the growing acceptance of including problem gambling treatment within addiction services.

The development of a clinical companion document, *Te Ariari o te Oranga: The Assessment and Management of People with Co-existing Mental Health and Substance Use Problems* (Todd 2010), which replaces the 1998 clinical guidelines *The Assessment and Management of People with Co-existing Substance Use and Mental Health Disorders* (Todd et al 1998), provides detailed clinical guidance to services and health professionals.

Building on relationships across services is fundamental to the success of anything shared in common. Leaders in all positions should identify opportunities to engage, plan and work together. I encourage you to reflect on your service’s current capabilities to be able to respond to co-existing mental health and addiction problems.

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Notes on this Guidance Document

This guidance document is aimed at all those who have an interest and responsibility for planning, funding and providing mental health and addiction services including District Health Boards, Non-governmental organisations and the Ministry of Health. The content will be of interest to staff working in services, consumers and service users, carers and others who have contact with these services.

1. This document is designed to:
 - encourage and disseminate good practice
 - assist, over time, the achievement of greater consistency in quality and how services are delivered across the country
 - provide guidance on more cost-effective models of care to assist DHBs to make best use of existing funding
 - inform future planning where funding does become available either through reprioritisation from other services, or from efficiency gains.
2. This is a guidance document and not a policy document or accountability document. It does not form part of the funding agreements between the Crown and the DHBs.
3. Release of this document does not signify that there will be any additional funding for implementation. However, it is anticipated that, where the guidance is implemented, enhanced models of care will enable services to respond to peoples' needs in more cost-effective ways, potentially leading to efficiency gains and, in some cases, the capacity to provide increased volumes of services within existing funding pathways.
4. This work was identified in *Te Kōkiri, The Mental Health and Addiction Action Plan 2006–2015* and was prioritised by the joint DHB/Ministry Te Kōkiri Work Group.
5. In addition, DHBs and other stakeholders have been involved in development of this document and have identified this as an area where many of them are current doing some developmental work. Having a document to guide them will support regional and national collaboration and assist in avoiding duplication of effort across the country.

The key directions in this document are supported by the Minister of Health.

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1. Introduction

1.1 Background

Co-existing substance use and mental health problems (often abbreviated to ‘co-existing problems’, or CEP) are common in those presenting to both mental health and addiction services in New Zealand. Despite innovative and sustained efforts in some parts of New Zealand to serve the needs of people with these complex health issues, there remains an absence of guidance for services and District Health Boards (DHBs). Good practice, where it has developed, has been the result of the outstanding commitment of individuals and agencies, but there is still no consistent framework.

In 2008 the Ministry of Health and mental health and addiction service providers gathered together in four regional workshops to discuss priorities and to share promising initiatives for responding to the diverse needs of people with CEP. These meetings confirmed that there are challenges at many levels.

- Models of individualised mental health recovery support may have overlooked or excluded the needs of tangata whaiora with substance use issues.
- Peer-led models of service delivery have been inconsistently established, especially in the addiction sector.
- There have been guidelines for clinical practice for responding to co-existing disorders available for a decade, but they have not been accompanied by clear expectations of services.
- Clinical mental health and addiction service practitioners have recognised the need to integrate service provision at the client level. However, sustained and committed policy, service management and clinical leadership have been lacking.
- Service delivery and development pressures have inhibited the proactive planning and development necessary for a co-ordinated response.
- Current service delivery highlights tensions between the mental health and addiction sectors.
- There are particular and significant challenges in justice settings, including youth justice, forensic mental health and prisons.

Service Delivery for People with Co-existing Mental Health and Addiction Problems in New Zealand – Integrated Solutions (here referred to as *Service Delivery – Integrated Solutions*) is based on a combination of the outcomes of the four regional workshops, the work of a project reference group and meetings with key sector groups, and is informed by the evidence base for responding to co-existing problems, including available data on service access. It is one element of a national approach to developing a more coherent response to CEP. The publication is consistent with the efforts of other countries to develop national responses to these issues and aims to:

- provide support for mental health and addiction services to move towards more integrated care
- improve the CEP capability of all mental health and addictions services
- provide an information resource to inform service development.

1.2 Purpose

National approach

Service Delivery – Integrated Solutions provides practical suggestions in four key areas for those responsible for commissioning mental health and addiction services (DHB planners and funders), as well as those responsible for delivering mental health and addiction services (managers and clinical leaders). The

emphasis is on secondary and tertiary mental health and addiction services, including problem gambling, while recognising the high prevalence of CEP in primary healthcare settings. The four areas of focus are:

- client centred
- service development
- integrated systems of care
- workforce development.

This guidance document is not prescriptive. It provides tips, tools, links to other publications and descriptions of existing initiatives, with the goal of improving service responsiveness to people with co-existing problems. Agencies need to demonstrate alignment and responsiveness at the level of the client. There are indicators that are capable of measurement, but there are no particular requirements for how alignment at the client level is to be achieved. It should be noted, however, that the Ministry has a broad monitoring function in respect of the implementation of *Te Kōkiri*.

This guidance document may raise expectations about increasing resources to mental health and addiction services in order to better meet the needs of tangata whaiora with CEP. However, the focus is on providing tools to refine current service structures and equip the workforce through training and systems changes that do not necessarily require additional funds. Collaborative approaches across agencies are also recommended in order to maximise expertise and positive outcomes for clients, in recognition of the fact that a large number of clients experiencing CEP are already known to services. Nationally, some resources will be provided to assist in workforce development and service planning. *Service Delivery – Integrated Solutions* does suggest recruiting to some specialist CEP positions where these do not currently exist, which may require service reconfiguration to achieve.

The intended audience for the guidance document are planners and funders as well as service leaders. Where service and contract reconfiguration is implied, any possible additional resourcing is at the discretion of these roles.

Summary of conceptual framework

The Ministry of Health has a general expectation that all mental health and addiction agencies will become ‘co-existing problems capable’. This translates to an ‘any door is the right door’ approach, where people in need are welcomed and assisted to connect with services that can assist them, regardless of whether the agency is a mental health or an addiction one. A challenge for all mental health and addiction services is to identify when to:

- integrate treatment for co-existing problems independent of other services
- develop shared care or integrated approaches across services
- develop a small, specialist co-existing problems resource.

The quadrants of care (see Figure 4 on page 13) is a conceptual framework that can be used in a variety of ways, including:

- acknowledging the diversity of the addiction and mental health problems experienced by tangata whaiora
- understanding and describing service roles and responsibilities in the delivery of integrated care
- guiding improvements in systems integration, including the efficient allocation of resources.

Integration of care involves developing a coherent and comprehensive understanding of the needs of tangata whaiora, whānau and families, and is aimed at enhancing overall wellbeing rather than the treatment of specific disorders or problems. Integration at the level of services and systems needs to function to support integrated care. Partnership between health professionals, co-operation and co-ordination across services,

and systems that support the integration of care are the natural consequence of an integrated understanding of the needs of tangata whaiora, whānau and families.

Mental health services have a priority to address the top 3 percent of those in the community with serious mental health issues. Should tangata whaiora enter a specialist mental health door with mild mental health and severe addiction issues, the mental health response would be to engage the person, briefly assess the situation, identify the key issues and provide links to appropriate services. In other words, there is no expectation or requirement for the mental health service to provide treatment, but there is a strong expectation that the door is a welcoming one where initial engagement and assistance will be provided.

Partnership and dialogue between health professionals, mental health and addiction service managers, clinical and consumer leaders, and funders and planners will assist in identifying service capabilities, including the boundaries of initial interventions, thresholds for co-working, consultation and referral, and the systems changes needed to support integration of care.

Te Ariari o te Oranga

The CEP clinical practice guidelines, *The Assessment and Management of People with Co-existing Substance Use and Mental Health Disorders* (Todd et al 1998), have been revised. The new clinical practice guidelines, *Te Ariari o te Oranga: The Assessment and Management of People with Co-existing Substance Use and Mental Health Problems* (Todd 2010), and *Service Delivery – Integrated Solutions* are complementary but independent guidance documents: one has a clinical focus, the other a service delivery focus. Throughout the remainder of this document the clinical guidance document will be referred to in short form as *Te Ariari o te Oranga*.

Te Ariari o te Oranga (Dynamics of Health) was a term coined by students and tutors of Te Ngaru Learning Systems in 1996 to reflect the metaphors and experiences related to wellbeing, rejuvenation and recovery. Rather than pathology it is a term that expresses transition, strength and hope.

Making it happen

The end part of *Service Delivery – Integrated Solutions* consists of the following sections:

- tips for mental health and addiction planners and funders
- tips for mental health and addiction service managers and clinical leaders
- suggested actions for local planning.

These are tools designed to be utilised as checklists for service planning and development, to stimulate thinking about the changes needed to support an ‘any door is the right door’ approach where tangata whaiora are connected with needed services, and as a source of referral to more detailed sections in this publication and elsewhere. They are designed to assist with the systematic establishment of responsiveness to CEP as core business across New Zealand mental health and addiction services.

1.3 Policy context

Mental health and addiction have been priority areas for a number of years, as reflected in the *New Zealand Health Strategy* (Minister of Health 2000) and *The New Zealand Disability Strategy* (Minister for Disability Issues 2001), and as set out in *Te Tāhuhu – Improving Mental Health 2005–2015* (Minister of Health 2005). *Te Tāhuhu* broadens the Government’s interest in mental health and addiction from people who are severely affected by mental illness and addiction to all New Zealanders, while continuing to ensure that people with the highest needs can access mental health and addiction services.

Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015 (Minister of Health 2006) identifies specific actions, key stakeholders and organisations responsible, outlines milestones, and sets timeframes for achieving the 10 leading challenges identified in *Te Tāhuhu*. Action 7.17 of *Te Kōkiri* (page 58) 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 specific measures are that within one to five years a national approach will be developed and implemented, and DHBs will demonstrate how service delivery is aligned for people with co-existing disorders. Measurement will involve data analysis, qualitative analysis of the consumer experience, and demonstration of tangible service initiatives of better working together and responding. *Te Kōkiri* identifies the target for the years 2005–2010 that ‘DHBs demonstrate how service delivery is aligned (at the level of the service user) for people with co-existing disorders’.

Another of the leading challenges in *Te Tāhuhu* is ‘working together’. The associated action point in *Te Kōkiri* (action 10.2, page 69) has direct bearing on improving service responsiveness for people with CEP:

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.

Māori mental health and addiction policy context

An overarching aim of the health and disability sector is to improve Māori health and disability outcomes and reduce Māori health inequalities. *He Korowai Oranga: Māori Health Strategy* (Minister of Health and Associate Minister of Health 2002), together with *Te Tāhuhu* and *Te Kōkiri*, provide a platform to achieve whānau ora, defined broadly as a principal source of strength, support, security and identity, which plays a central role in the wellbeing of Māori individually and collectively.

Te Puāwaiwhero: The Second Māori Mental Health and Addiction Strategic Framework (Ministry of Health 2008) is a framework to guide the mental health and addiction sector towards the overall aim of whānau ora. *Te Puāwaiwhero* acknowledges that whānau ora outcomes will not be realised by health services alone. A broad context for improving Māori mental health is given, including a whole-person and whole-whānau perspective, along with participation in te ao Māori and the wider New Zealand society. *Te Puāwaiwhero* has three key principles:

- prioritise Māori – act on evidence of health inequality of Māori mental health and addiction need to ensure that new and existing initiatives are responsive to and effective for Māori
- build on the gains – current initiatives to improve the response to Māori mental health and addiction needs are sustainable
- responsive to Māori – build on the link between health and culture to ensure initiatives are responsive to the unique needs of Māori.

The Māori mental health and addiction sector has been a leader in innovation and a catalyst for new standards of responsiveness that have changed the way that many health organisations have delivered services as a consequence of understanding that integration of care follows naturally from a holistic understanding of the person in their social context.

The Mental Health Commission

The Mental Health Commission’s single unifying picture of the mental health and addiction sector in 2015 is set out in *Te Hononga 2015: Connecting for Greater Well-being* (Mental Health Commission 2007). *Te Hononga* complements and builds on *Te Tāhuhu* and *Te Kōkiri* by aiming to:

Connect physically, socially and spiritually – achieving connectedness and synergies whenever people come together, whether as families/whānau and communities, or as part of services, systems and sectors (Mental Health Commission 2007)

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

The Commission is working with the Ministry of Health to achieve better integration of services for people with co-existing problems. It intends to further develop the recommendations of its report *Getting it Right for People with Co-existing Mental Health and Addiction Problems* (Mental Health Commission 2008) and to identify and analyse critical success factors in promoting recovery for tangata whaiora with high and complex needs – a group that includes people with co-existing mental health and addiction problems. The Commission expects that findings from this study will inform and foster the further development of integrated approaches within the mental health and addiction sector.

Legislation and treatment

There are key pieces of legislation that guide mental health and addiction services. The Mental Health (Compulsory Assessment and Treatment) Act 1992 guides mental health service provision for those who are acutely mentally unwell. The Act does not provide for those whose problems are solely substance use-related.

The Alcoholism and Drug Addiction Act 1966 provides for people who are chronically unwell as a consequence of substance dependence and is the subject of review. At the date of this publication there are only four certified institutions across the whole of New Zealand that can accept people under this Act. Unlike the Mental Health (Compulsory Assessment and Treatment) Act, the Alcoholism and Drug Addiction Act does not take account of human rights considerations through mechanisms such as appeals and independent advocates. A view expressed at some of the four regional workshops is that the artificial separation between mental health and addiction services is maintained and perpetuated by the current legislative framework, because neither of these Acts adequately addresses co-existing problems in their current form.

Problem gambling treatment is delivered under the Gambling Act 2003, which places responsibility for developing an integrated problem gambling strategy focused on public health, which must include:

- measures to promote public health by preventing and minimising the harm from gambling
- services to treat and assist problem gamblers and their families and whānau
- independent scientific research
- evaluation.

Contracting framework

With the exception of problem gambling services, mental health and addiction services are planned and organised by DHBs, either through direct service provision or contracts with providers – typically non-government organisations (NGOs). The Nationwide Service Framework (NSF), which has recently been revised, is part of the mechanism through which services are contracted. The NSF includes detailed specifications for people's access to mental health and addiction services and what these services are expected to provide. The revised NSF has a significant focus on CEP, including physical health problems, and strongly emphasises that 'any door is the right door'.

Problem gambling service provision is funded and delivered differently, with different accountabilities. The Ministry's national problem gambling team manages the funding and co-ordination of problem gambling services through the provision of contracts both nationally and locally, and undertakes research and policy work.

1.4 Language and definitions

Defining concepts accurately and usefully is a matter of ongoing discussion and development across both the mental health and addiction sectors. Finding language that is acceptable and meaningful to tangata whaiora, service users, consumers, families and whanau, funders and planners and the vast range and variety of service providers across the mental health and addictions sectors is inevitably challenging.

Service Delivery – Integrated Solutions uses substantially the same definitions as *Te Ariari o te Oranga*, with the goal of ensuring that the clinical and service delivery guidance documents are complementary.

Addiction: The National Committee for Addiction Treatment (2008) provides the following description of addiction.

- Addiction is a complex disorder that is caused by multiple genetic factors interacting with multiple environmental factors. Addiction is often a 'chronic and relapsing' condition. Addiction is also used as an inclusive term referring to the entire range of harmful, hazardous and dependent patterns of alcohol, other drug use and problem gambling. (page 7)
- Those needing treatment for addiction related issues can be at various stages in the development of their problems, from early stages through to severe dependence or compulsion. (page 10)

Alcohol and drug problems: Alcohol and drug problems, substance use problems and problematic use of alcohol and drugs are all used interchangeably. The concept of problematic use means the use of a substance that may cause or exacerbate problems, based on individual physiology and psychology, including mental illness. This concept may include use that meets DSM-IV¹ criteria for abuse and dependence, but substance use may affect the course of a mental disorder without strictly meeting DSM-IV criteria for a diagnosis of substance abuse or dependence. Examples include the heavy use of alcohol by a tangata whaiora prescribed antidepressant medication for a major depressive illness, or occasional cannabis use by a tangata whaiora with schizophrenia. Problematic use, therefore, is included in the concept of co-existing problems.

Clinician, practitioner, health professional: Various terms are used to describe a mental health or alcohol and drug worker. Within the alcohol and drug sector the term 'practitioner' is preferred by many, while within mental health services 'clinician' is often the preferred term. 'Practitioner' may be seen as a looser term and can be applied to workers at various levels of competence and qualification, while 'clinician' is usually reserved for those who are registered health professionals. In this document the term 'health professional' is used to capture the range of clinicians and practitioners within alcohol and drug and mental health services.

Co-existing mental health and addiction problems (co-existing problems, or CEP): There are many terms coined to capture the interaction of addiction and mental health problems. In *Service Delivery – Integrated Solutions* the term 'co-existing' has been used due to its historical use in New Zealand. The focus is on problems that occur at the same time and interact with each other as opposed to mental health and addiction problems that an individual experiences in their lives but not necessarily at the same time.

The term 'problems' has been preferred over 'disorders' in recognition that significant addiction and mental health symptoms may occur at levels that do not meet DSM-IV criteria for disorders in their own right. The term 'addiction' has been employed in preference to other alternatives, such as alcohol and drug or substance use problems, because it encompasses problem gambling. It is important to note that addiction in the sense of dependency or compulsion does not reflect most young people's experience of problematic alcohol or drug use, so it is better and more appropriate to use terminology that emphasises problematic use in relation to youth.

Other terms used synonymously in *Service Delivery – Integrated Solutions* include dual diagnosis, co-occurring alcohol/drug/substance use and mental health disorders, co-existing disorders and co-morbidity.

1 Diagnostic and Statistical Manual of Mental Disorders, fourth edition.

Mental health: *Te Tāhuhu* considers the links between mental illness and addiction, and between mental health and mental illness. *Te Tāhuhu* states that: ‘mental health and addiction problems, such as depression, anxiety disorders, and substance misuse, can reduce an individual’s sense of belonging and participation in society’, and ‘mental health and wellbeing is more than the absence of mental illness or addiction; it is vital to individuals, families and societies’ (Minister of Health 2005:8). In this document mental health problems and addiction problems are distinguished. When ‘mental illness’ is used in *Service Delivery – Integrated Solutions*, addiction is not included because addiction is discussed separately. Again, the concept of ‘problem’ is taken to mean mental health problems that may cause or exacerbate other problems, including addiction, and that may or may not meet the threshold for diagnosis according to the DSM-IV.

Problem gambling: Problem gambling is one of a range of behaviours falling within the scope of addiction and CEP. People who gamble problematically have been found to have disproportionate rates of mental health and alcohol and drug problems. *A Problem Gambling Resource for Local Government* (Ministry of Health 2009b) includes a section on co-morbidities and notes that:

Some mental disorders are highly comorbid with pathological gambling. There is a large body of research, including methodologically sound general population studies, indicating particularly high co-morbidity with alcohol and other substance abuse disorders. (page 34)

Recovery from addiction: The addiction sector in New Zealand and overseas has had a long association with the term ‘recovery’. One similarity with the concept of recovery in mental illness is the recognition that it is a process rather than an end point, but control of substance use or problematic gambling is an important aspect of recovery from addiction. The National Committee for Addiction Treatment (2008) notes that in the addiction sector recovery has meant aiming for a lifestyle of abstinence when used within the framework of a 12-step programme. They highlight that there is an emerging discourse in the addiction sector around the principles and terminology of recovery that allows for different meanings. This approach is aligned with the descriptions of recovery given by the United Kingdom Drug Policy Commission, <http://www.ukdpc.org.uk>:

- Recovery is about building a satisfying and meaningful life, as defined by the person themselves, not simply about ceasing problem substance use.
- Recovery involves the accrual of positive benefits as well as the reduction of harms.
- Recovery includes a movement away from uncontrolled substance use and the associated problems towards health, wellbeing and participation in society.
- Recovery is a process, not a single event, and may take time to achieve and effort to maintain.
- The process of recovery and the time required will vary between individuals. It may be achieved without any formal external help or may, for other people, be associated with a number of different types of support and interventions, including medical treatment. No ‘one size fits all’.
- Aspirations and hope, both from the individual drug user, their families and those providing services and support, are vital to recovery.
- Control over substance use is a key part of recovery, but is not sufficient on its own. Positive health and well-being and participation in society are also central to recovery.

Recovery, then, is not just an expectation placed on the individual (eg, to become abstinent). It is a process that is fluid, and unique to each individual engaging in the process of recovery. For some it will mean abstinence from substance use or from gambling, or controlled use of particular substances; for others it may mean taking a harm minimisation perspective towards a variety of addictions at the same time. For all it will mean something above and beyond a simplistic focus on their addiction/s, because it will encompass a process towards building satisfaction, health and wellbeing for oneself and one’s whānau.

Recovery from mental illness: Adopting the concept of recovery has been a central concept in mental health sector development in New Zealand over the past decade and more. The Mental Health Commission (1998) provided the following definition.

Recovery is a journey as much as a destination. It is different for everyone. For some people with mental illness, recovery is a road they travel on only once or twice, to a destination that is relatively easy to find. For others, recovery is a maze with an elusive destination, a maze that takes a lifetime to navigate.

Recovery is happening when people can live well in the presence or absence of their mental illness and the many losses that may come in its wake, such as isolation, poverty, unemployment, and discrimination. Recovery does not always mean that people will return to full health or retrieve all their losses, but it does mean that people can live well in spite of them.

Tangata whaiora: 'Tangata whaiora' is a Māori term for a person, or people, seeking health and has come to represent the users of health systems. It is used in this document to represent the person who is the subject of health care services. Other terms used synonymously include patient, client, consumer and service user.

2. Prevalence

2.1 Overview

A considerable proportion of people who experience addiction problems also experience a range of mental health problems and vice versa. People with co-existing mental health and addiction problems are a large and heterogeneous group, who present both clinical and organisational challenges.

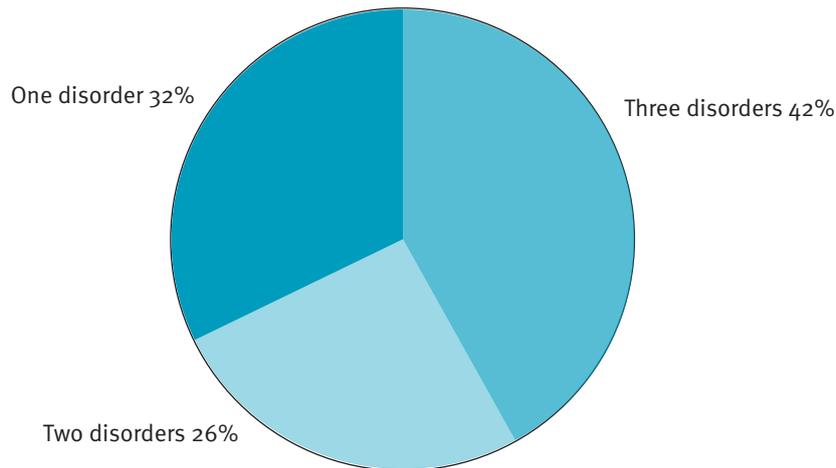
Improving the effectiveness and efficiency of the way mental health and addiction treatment services respond to people with CEP will make a tangible difference to the lives of an estimated 7.7 percent of New Zealanders who have experienced two or more disorders at the same time in the last 12 months (Oakley Browne et al 2006). Early detection and treatment of CEP affecting children and young people can prevent a lifetime of adverse experiences for the individual.

Prevalence rates of CEP are present in some groups disproportionately.

- Co-existing alcohol and other drug problems are common rather than exceptional among people with serious mental health problems.
- Many people with substance use problems experience a range of mental health problems at higher rates than in the general community, most commonly depression and anxiety.
- Māori and Pacific peoples carry a higher burden of mental health and addiction problems than the general population.
- Problem gambling often co-exists with mental health and/or alcohol and other drug problems.
- Those in the criminal justice system have been found to have higher prevalence rates than the general population for mental health disorders, including alcohol and/or drug addiction, and higher rates for CEP.
- Co-existing mental health and addiction problems are associated with underachievement or failure across a number of key life domains, including academic, employment, relationship, social and health.
- People with severe CEP experience greater involvement with the criminal justice system, higher rates of institutionalisation, more failed treatment attempts, poverty, homelessness and risk of suicide.
- The incidence of CEP for young people is typically higher than for adults. There are strong associations between regular cannabis use and mental health problems in young people and a strong correlation between having a conduct disorder and a co-existing substance use disorder.
- Violence may also be associated with co-existing mental health and addiction problems.
- People may have co-existing conditions, such as foetal alcohol spectrum disorders, that can contribute to mental health and drug and alcohol problems.

Te Rau Hinengaro: The New Zealand Mental Health Survey (Oakley Browne et al 2006) (*Te Rau Hinengaro*) found that in the general population, 40 percent of those with substance use disorders had an anxiety disorder in the past 12 months and 29 percent met criteria for any mood disorder. *Te Rau Hinengaro* also found that of those with severe mental health or substance use problems, the majority had more than one disorder and many had three disorders (see Figure 1). For Māori with any substance use disorder in the past 12 months, 39.7 percent had an anxiety disorder and 26 percent had a mood disorder. (For rates of co-existing problems in clinical settings in New Zealand, refer to *Te Ariari o te Oranga*).

Figure 1: Proportion of co-existing disorders among those with high severity



A significant number of people attending New Zealand general practices have co-existing mental health and addiction problems. A study carried out by the Mental Health and General Practice Investigation (MaGPIe) Research Group into the prevalence and types of common mental disorders among patients seeing their GP found that more than one-third of people 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). The study also suggests that rates of mental disorder (anxiety, depressive and substance use disorders) among Māori are higher than for non-Māori (MaGPIe Research Group 2005).

2.2 Diagnosis rates in mental health and addiction services

To ascertain whether access to mental health and addiction services improves for people with CEP, it is important to establish a baseline estimate of current service access (including specialist dual diagnosis services). The best national information we have is what is collected through the Mental Health Information National Collection (MHINC). However, a Ministry of Health-funded project to make more information available to the mental health and addiction sector to improve the quality of services, called PRIMHD (Programme for the Integration of Mental Health Data), may provide an opportunity to capture more refined CEP data.

Figure 2 depicts service totals by mental health services (77.4 percent), alcohol and other drug services (21.5 percent) and specialist dual diagnosis services (1.1 percent) in the year ending 30 June 2008, with a prior to 30 June 2008 diagnosis date. Figure 3 details those seen by both mental health and alcohol and other drug services (5.5 percent of service totals).

Figure 2: Service totals, by service type, 2007/2008

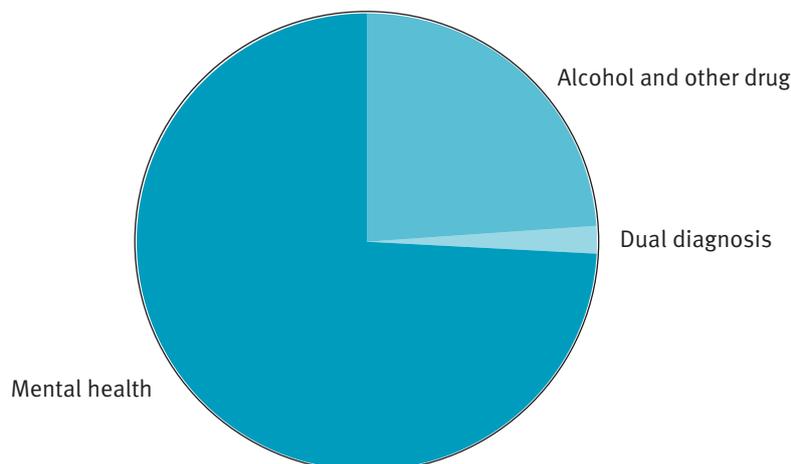
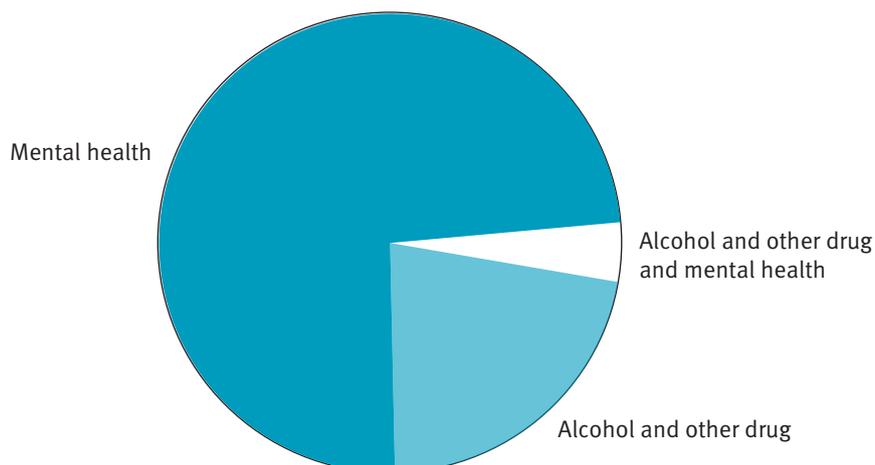


Figure 3: Attendance at addiction and mental health services, 2007/2008



The MHINC data, when analysed from a diagnostic perspective, shows that the 5.5 percent of tangata whaiora seeing both an addiction and a mental health service is much lower than the numbers in each service with a provisional or confirmed secondary diagnosis, as follows.

- Of those seeing a mental health service, 19 percent have a confirmed or provisional substance use diagnosis.
- Of those seeing an alcohol or other drug service, 32.3 percent have a confirmed or provisional mental health diagnosis.

For example, according to *Te Rau Hinengaro*, 69 percent of people with a substance use disorder also experienced an anxiety or mood disorder (previous 12 months). Evidence of a mental health or addiction service responding to this common combination of disorders would be a care plan that includes access to interventions provided elsewhere (the work is integrated between services), or a service providing a secondary diagnosis and in-house intervention. Note that where the threshold for a diagnosis is not reached, but a mental health or addiction problem is identified, the same criteria would apply.

The fact that only 5.5 percent of tangata whaiora are seeing both addiction and mental health services is indicative that there is a significant gap between services identifying secondary diagnoses and responding to them. It should also be noted that the MHINC data almost certainly understates the prevalence of CEP as a consequence of factors such as under-recognition and under-diagnosis of problems, poor quality of diagnostic data, and under-reporting (many NGOs do not report to MHINC and NGOs are not required to provide diagnoses; for example, only 8 percent of NGOs reported to MHINC in the 2007/08 reporting period).

It should be emphasised that not every instance of a person attending either a mental health or an addiction service and receiving a confirmed or provisional secondary diagnosis is indicative of a lack of an integrated response to a co-existing problem. Other possible interpretations are:

- the client's needs are being met by one service
- there is a secondary or provisional diagnosis and no intervention is required
- the client declines the recommended intervention.

However, in many instances there is a secondary or provisional diagnosis and no apparent interventions, where an integrated treatment or integrated service response would almost certainly be recommended.

3. Conceptual Framework

A challenge for mental health and addiction services is to identify when to:

- integrate treatment for co-existing problems independently of other services
- develop shared care or integrated approaches across services
- develop a small, specialist co-existing problems resource.

Te Ariari o te Oranga emphasises that integration of care involves developing a coherent and comprehensive understanding of the needs of tangata whaiora, whānau and families, and is aimed at the enhancement of overall wellbeing rather than the treatment of specific disorders or problems. Integration at the level of services and systems needs to function to support integrated care. Partnership between health professionals, co-operation and co-ordination across services, and systems that support the integration of care are the natural consequence of an integrated understanding of the needs of tangata whaiora, whānau and families.

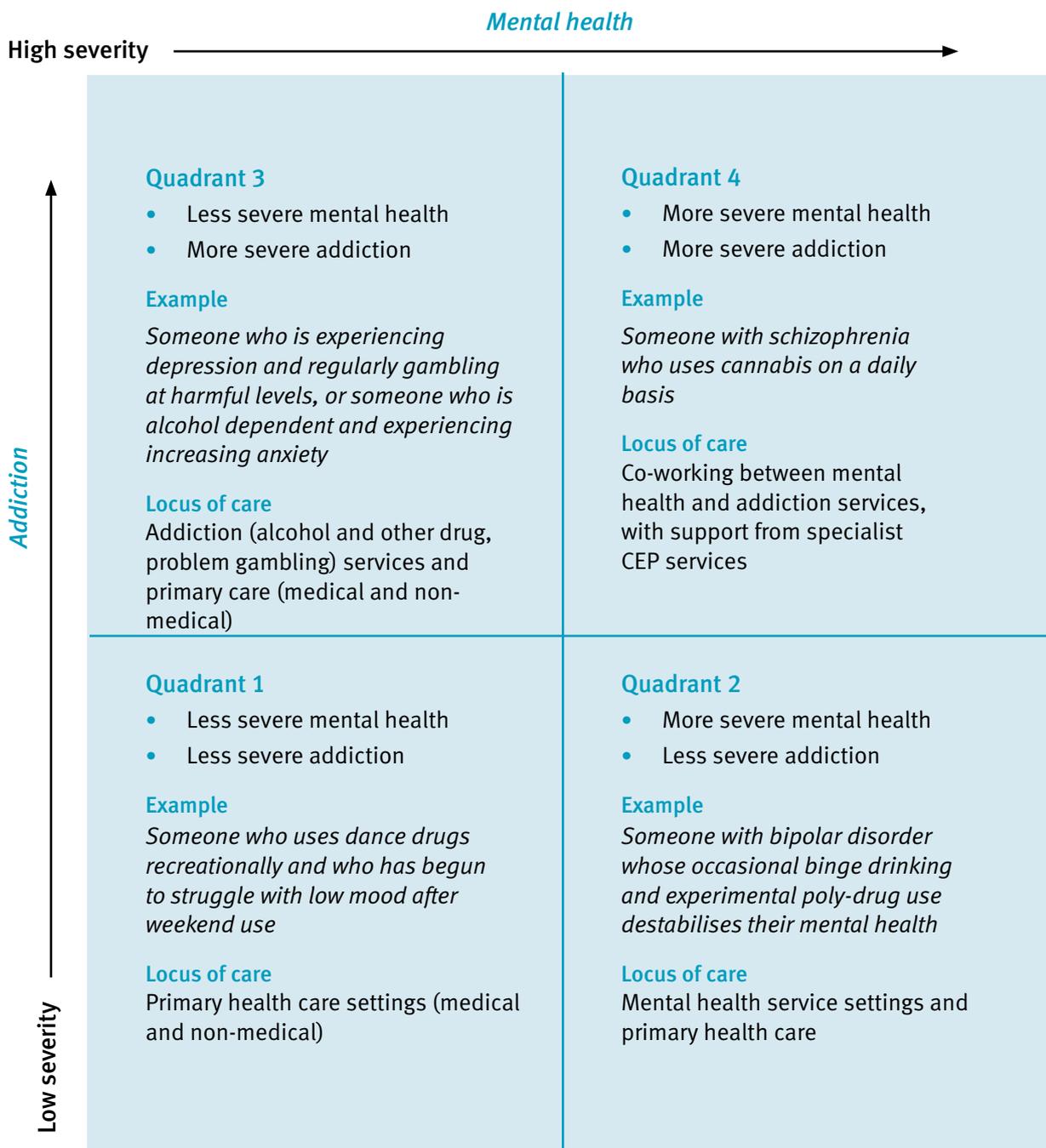
For the above reasons, *Te Ariari o te Oranga* is specific in its use of the terms ‘integrated’ and ‘integration’, such that:

- ‘integrated care’ describes integration at the level of tangata whaiora
- ‘treatment integration’ describes service-level integration
- ‘integrated systems’ describes systems-level integration (Todd 2010).

The quadrants of care (Figure 4) is a conceptual framework that can be used in a variety of ways, including:

- acknowledging the diversity of the addiction and mental health problems experienced by tangata whaiora
- understanding and describing service roles and responsibilities in the delivery of integrated treatment
- guiding improvements in systems integration, including the efficient allocation of resources.

Figure 4: Quadrants of care



Mental health services have a priority to address the top 3 percent of those in the community with serious mental health issues. If tangata whaiora enter a specialist mental health ‘door’ with mild mental health and severe addiction issues, the mental health response would be to engage the person, briefly assess the situation, identify the key issues and provide links to appropriate services. In other words, there is no expectation or requirement for the mental health service to provide treatment, but there is a strong expectation that the door is a welcoming one where initial engagement and assistance are provided.

Some mental health and addiction services have incorporated the quadrants of care model into their local clinical pathway modelling as a way of acknowledging their own and other services’ core business and responsibility to provide treatment and care.

4. Four Areas of Focus

The Ministry of Health has a general expectation that all mental health and addiction agencies will become 'co-existing problems capable'. This translates to an 'any door is the right door' approach, whereby people in need are welcomed and assisted to connect with the services they need, regardless of whether the agency is a mental health or an addiction one.

Four fundamental areas, equally applicable across mental health and addiction services, have been identified to focus services on becoming co-existing problems capable. The four areas were tested and endorsed at the four regional workshops held throughout 2008 and reflect similar priorities to overseas CEP initiatives. They are:

- client centred
- service development
- integrated systems of care
- workforce development.

Client centred means developing a comprehensive and integrated understanding of tangata whaiora and the broad range of problems they experience – not simply their addiction and mental health problems – and providing care that enhances wellbeing as opposed to simply responding to disorders or problems. *Service development* means mental health and addiction services are to redevelop themselves around the needs of tangata whaiora, incorporating an 'any door' approach and ensuring the correct composition of staff. *Integrated care* is to be collectively defined and service-level agreements are to be developed by mental health and addiction services working together. Systems are to acknowledge and incorporate CEP approaches (eg, comprehensive assessments). Finally, *workforce development* is to address the skill needs of staff, and to seek ways to train across the mental health and addiction sector.

4.1 Client centred

A client-centred approach means developing a comprehensive and integrated holistic understanding of tangata whaiora and the broad range of problems they experience – not simply their addiction and mental health problems. A client-centred approach acknowledges that managing CEP involves a range of strategies, some of which are common to people with CEP and others of which are specific to the particular combination of mental health problem, substance used and the nature of the interaction. A client-centred approach highlights the importance of engagement and motivation in influencing outcomes over and above specific interventions and systems of care, and the need to respond to the positive aspects of a person's life by focusing on enhancing strengths instead of addressing deficits.

Te Ariari o te Oranga sets out seven key principles of optimal treatment for CEP developed from an extensive literature review and from clinical practice with tangata whaiora with CEP.

Seven key principles of optimal treatment

1. **Cultural considerations:** Consider the cultural needs and values of all tangata whaiora throughout the treatment process.
2. **Wellbeing:** Take a wellbeing perspective by considering problems as barriers to wellbeing and seeing a state of positive wellbeing as the key outcome variable rather than the absence of dysfunction.
3. **Engagement:** Actively incorporate strategies to increase and maintain engagement with the clinical case manager, the management plan and the service.
4. **Motivation:** Actively incorporate strategies to enhance motivation including, but not limited to, CEP-adapted motivational interviewing techniques.

5. **Assessment:** Screen all tangata whaiora presenting in mental health and alcohol and drug services for CEP, and where they screen positive undertake a comprehensive assessment that gives equal weight to diagnoses, individualised problems and an integrated aetiological or causal formulation.
6. **Management:** Use clinical case management to deliver and co-ordinate multiple interventions appropriate to the phase of treatment.
7. **Integrated care:** Integrate care by placing the needs of tangata whaiora first, and deliver care driven by the integrated formulation in a single setting and ensuring close links between all services and workers involved.

The following sections set out ways in which services, including those responding to special needs service areas, can endeavour to provide a welcoming and client-centred approach.

Peer-based roles

The importance of peer-based leadership and participation in the delivery of addiction and mental health services is well established. Peer-based roles are complementary to mental health and addiction services and can make a special contribution to the recovery process for tangata whaiora. Peers who have lived experience of mental health and/or addiction treatment can fulfil a number of important cross-over roles, including:

- advocacy on behalf of individuals and families who are attending mental health and addiction services
- service-level and system-level advice – influencing service and systems development
- peer-based recovery support – the giving and receiving of non-professional, non-clinical assistance by people who are experientially credentialed to assist others in initiating and maintaining recovery (White 2009).

For example, peer-based recovery support services may be able to offer a welcoming, supportive relationship that is perceived as less threatening to tangata whaiora, especially where there has been an ambivalent relationship with clinical services in the past. In some instances it may be appropriate for peer-based services or NGO mental health and addiction services to take the lead role in co-ordinating care, with clinical services providing essential clinical care. Non-clinical kaupapa Māori services may also be able to fulfil this role, especially where there is a pre-existing relationship of trust.

The four regional workshops held in 2008 identified the following important considerations.

- Peer-based recovery support and service-user advocacy are essential, but they have not been well supported in the addiction sector.
- There is a role for tangata whaiora to help people trust and access services and to educate clinicians.
- There is a great diversity of tangata whaiora views and experiences.

Involving families and whānau

Family environment has a great influence as a source of support, or as an obstacle to recovery, for tangata whaiora with CEP. Family members play an important role in prompting tangata whaiora with mental health and/or addiction problems to seek treatment and can play an integral part in co-ordinating care based on their in-depth knowledge of the person. Post-treatment family and social environments play significant roles in maintaining wellbeing. It is also important to acknowledge that families are often damaged through years of assisting a family member with CEP and may need assistance to begin their own recovery journey.

The National Committee for Addiction Treatment (2008) notes that:

There is growing recognition that addiction treatment is more effective when family members are involved. This is more than just keeping family informed and in some cases may require intensive work with a consumer's support systems. (page 13)

For young people with CEP, the recognition, validation and enlistment of family resources to support sustainable change is vital. However, families are often seen as the problem, and it can be difficult to reveal their strengths. Family-inclusive practices that build strength and resilience help families to play a stronger role in supporting good mental health and wellbeing for the whole family and whānau and enhance therapeutic outcomes for young people. It is important, also, that mental health and addiction services engage with the network of other services and agencies that the young person is in contact with, including the wider health sector, Child, Youth and Family, and the criminal justice and education sectors.

Māori recognise whānau as the foundation of Māori society and as a ‘principle source of strength, support, security and identity’ (Minister of Health and Associate Minister of Health 2002). Whānau ora involves supporting Māori families to achieve their maximum health and wellbeing. Whānau ora occurs when services recognise and build on the strengths and assets of whānau. A whānau ora approach will include:

- whānau supported to care for whānau – as carers in their own right, and as part of care and treatment services
- whānau, hapū, iwi and Māori community development
- intersectoral responses to addressing the determinants of health and mental health
- integrated, seamless, responsive Māori service provision across social, cultural, health and mental health and addiction services.

Specialist populations

Justice sector

The prevalence of tangata whaiora with CEP in justice sector settings, including prison and forensic mental health services, is high. Tangata whaiora are in justice sector settings as a consequence of some level of coercion by the police or the Court. There is good evidence internationally that coerced treatment within a justice setting can result in reductions in drug use and related crime.

The context in which substance use screening and assessment occurs in community settings does not apply to forensic settings. Assessments in the community assume current access to alcohol and other drugs, whereas tangata whaiora in forensic units in theory do not have ready access to alcohol and other drugs, although it is clear they are obtainable.

In 2008 the Mason Clinic developed a substance use assessment tool and a companion document to assist staff to understand and address substance use issues.

Infants and children

Some tangata whaiora with CEP struggle to respond to the needs of their children, and assessment must take account of the safety and wellbeing of dependent children. It is important to understand that the infants and children of tangata whaiora with CEP are particularly vulnerable to poor outcomes, including mental health and substance use problems. Children of mothers who have drunk alcohol during pregnancy – in particular, heavy binge drinking – may have children with foetal alcohol spectrum disorders who have higher parenting needs and make additional demands on parents living with CEP.

A client-centred approach will include ensuring that tangata whaiora are receiving their full entitlements to income support, assisting with the development of parenting skills and coping strategies, as well as linking tangata whaiora with additional family and whānau and community supports where needed. Kaupapa Māori mental health and addiction services that incorporate whānau ora approaches may be adapted for other non-Māori populations.

Young people

The issue of responsiveness to CEP is equally significant in youth mental health and addiction services as in adult services. In addition, mental health and addiction services are not particularly accessible to young people for reasons of cost, appropriateness and concerns about privacy.

It is important to address mental and substance abuse problems in young people early, because those who experience such problems are more likely to be at risk of dropping out of school, mixing with peers who display antisocial behaviours, and experiencing alcohol and/or drugs or self-inflicted harm. Young people's health is affected by a range of factors, including prenatal exposure to alcohol and other drugs, early childhood experiences, their families and whānau, peers, school, and the wider social and economic environment. Targeted and youth-friendly services are those most effective for meeting young people's needs.

There are a number of opportunities to improve mental health and addiction services and enhance CEP responsiveness for young people, including:

- devolving (in whole or in part) mental health and addiction services into less stigmatising, youth-friendly environments such as community-based youth one stop shop (YOSS) services that can provide client-centred wrap-around services
- providing mental health and addiction training and support to YOSS and school-based health services to improve detection, treatment and referral processes
- recognising the importance of positive youth development, strengths-based practices and the need to facilitate to access a broad range of other services
- ensuring that young people's confidentiality and privacy are assured
- improving uptake of services by involving youth in service planning and development
- recognising that young people 'snack' or 'graze' on services and are less likely to follow up on referrals between services
- recognising the role that youth workers provide in active support in order to link young people into services.

Older people

The ageing process presents significant issues for some people. For example, older adults' vulnerability to both mental health and substance use (mainly alcohol) problems may be increased by physiological changes; changes in mental capacity; losses in ability; loss of social networks; other losses; pain, insomnia and stress; other physical conditions; and a reduction in financial resources.

The Ministry has a project underway known as the Mental Health and Addiction of Older People and Dementia project and is in the process of developing a guidance document supporting integrated approaches to better meet the needs of:

- all people affected by dementia
- people aged over 65 years affected by mental health and/or substance use problems
- people with an intellectual disability who are ageing and develop symptoms of dementia and/or mental health and/or substance use problems
- family/whānau/carers of the people identified above.

Domestic violence

It is not uncommon for tangata whaiora with CEP to be victims or perpetrators of domestic violence, including sexual violence. Clinicians need to be alert to the presence of domestic violence in the lives of tangata whaiora and focus on providing safety and support. Family violence intervention co-ordinators are located in all DHBs and offer advice and training support.

4.2 Service development

Destination: Recovery Te Unga ki Uta: Te Oranga describes the Mental Health Foundation's vision of transformed mental health services delivering wellbeing for all. It identifies a number of key factors necessary for successful organisational change, including:

- a focus on the internal as well as the external – organisational culture that is oppositional to change is often hidden and hard to quantify, and so change processes need to focus on intangibles such as internal experience and culture, as well as the more tangible strategies, plans, visions, policies and agreements
- getting leadership support – sustained and highly visible governance and management support are essential for organisational change to succeed
- using dedicated change management staff – it is unrealistic to expect staff with other responsibilities to manage significant organisational change, and success is more likely if there is a dedicated change management team. (Mental Health Advocacy Coalition 2008)

Services need to be responsive to CEP and work towards being CEP capable. This may involve staffing reconfiguration, the appropriate mix of specialist CEP (dual diagnosis) resources, nominating staff to 'champion' CEP within their teams, and ensuring the skill mix and composition of the multidisciplinary team complement mental health and addiction knowledge and experience. The section in this document called Tools for service development (page 22) includes a description of an agency self-assessment tool that can assist services with their planning and service development.

In some parts of New Zealand there are sole CEP specialist staff based in NGO addiction and mental health settings. It is questionable whether such settings can provide adequate support to sole CEP specialist staff in terms of supervision, professional development and ensuring they carry small case loads to enable co-working with and mentoring of other staff. In response to these issues, the Nationwide Services Framework has redefined the role of 'dual diagnosis' clinical staff.

Serial, parallel and integrated approaches

Interventions for AOD problems, and interventions for mental health problems provided 'in series', involve the treatment and resolution of one condition in one service and setting with one clinician before the other condition is treated in another service and setting with another clinician. Mental health interventions and AOD interventions provided in parallel mean concurrent treatment and care in separate services and settings, with different clinicians.

A serial approach to CEP may not help because the conditions are likely to be mutually interactive. Both serial and parallel approaches are unlikely to produce good outcomes where separate mental health and addiction services have differing priorities and philosophies and deliver inconsistent and even incompatible messages. Even where approaches to treatment are well integrated, the need for tangata whaiora to attend appointments with different clinicians in different settings creates barriers that threaten engagement and can result in the delivery of inadequate care.

Integrated service provision is based on the reality that CEP is core business for both mental health and addiction services. In general, better outcomes are likely to be achieved when care is well co-ordinated and complementary, where access barriers are minimised, and when agencies, services and staff understand each others' roles and work together closely.

Expert best practice advocates for integrated approaches to CEP, but this is not currently supported by a strong evidence base. The Substance Abuse and Mental Health Services Administration (SAMHSA) *Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders* states:

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)

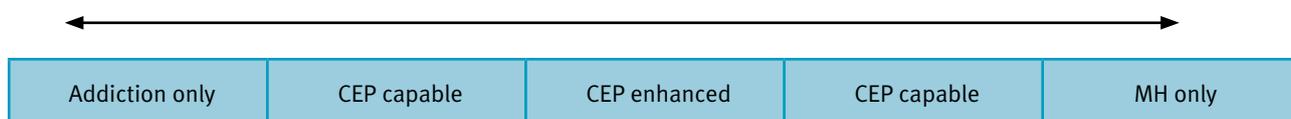
Integrated assessment, treatment and care may involve a variety of strategies. For example, there are times when a serial approach is indicated. The example given in *Te Ariari o te Oranga* is that people with antisocial personality disorder and substance use problems may do better when the substance use problem is addressed first (Conrod and Stewart 2005, cited in Todd 2010). It is important that thoughtful consideration be given to the approach likely to be most effective based on the individual needs of tangata whaiora.

Continuum of service capability

Treatment integration occurs along a continuum, and involves integration within a single or across multiple services for any of the key areas of screening, assessment, treatment planning, treatment provision and continuing care (Minkoff 2006; SAMHSA 2007). Services may be integrated in a variety of ways, depending on local needs and circumstances.

Te Ariari o te Oranga states that integration can be thought of as occurring at a number of points in the clinical process and suggests that all services should aim for integrated screening and assessment, most services should aim for integrated assessment and case formulation, and some services should aim for full integration, in accordance with the continuum below.

Figure 5: Continuum of service capability to deliver integrated care



Sources: SAMSHA 2005; MacEwan 2007

Addiction or mental health only

Addiction-only services deal primarily with addiction issues and do not detect the presence of many mental health problems, while mental health only services primarily manage mental health problems and frequently do not detect the presence of addiction problems.

CEP-capable services

CEP-capable services would usually have either addiction or mental health problems as their primary focus but would readily detect the presence of the other group of problems, understand the relationship between them and be able to develop an integrated formulation and management plan. They may even be able to undertake basic interventions for the problems they do not specialise in, especially the treatment of depression or early management of alcohol and drug problems.

For more intensive middle and late treatment interventions, CEP-capable services can bring in a clinician from the other specialty to co-work, or refer to other services. Where possible, the former option will be preferable because it facilitates engagement, decreases administration and supports workforce development. For example, a CEP-capable service response may include a clinician providing a brief specialist intervention, with ongoing follow-up and referral to a visiting clinician, based on the best match.

Mental health and addiction services are expected to work towards becoming CEP-capable.

CEP-enhanced services

Specialist dual diagnosis services

The development of CEP-enhanced services requires a critical population and clinical resource mass, but can work well in main centres. CEP-enhanced services have a similar capability to CEP-capable services in terms of assessment skills but are also able to deliver complex treatments for many of the substance use and mental health problems they are likely to see. Where the complexity of problems exceeds their capabilities, they are able to refer to other specialist clinicians, incorporating them into the treatment team in a seamless way.

Specialist CEP or dual diagnosis clinicians

An important issue for local service development is the role of specialist CEP or dual diagnosis clinicians. There are existing contracts for single full-time equivalents with a 'dual diagnosis' function based in rural environments. Consideration needs to be given to the purpose of such a role, the skills required, and whether it is positioned in a place that provides the most benefit to tangata whaiora with CEP.

Specialist CEP clinicians may be sited in either CEP-enhanced or CEP-capable services. The extent to which specialist CEP clinicians can become isolated and overloaded with case work is well documented. It is therefore vital that specialist CEP clinicians have the opportunity to develop and enhance the CEP capability of mental health and addiction services through the exercise of strategic influence and the provision of training, mentoring, supervision and co-working across services. The role of specialist CEP clinicians is important, but their use needs to be carefully planned in consultation with specialist CEP clinicians themselves as well as the services with which they interface.

Primary health care

The management of co-existing problems in primary care is an important issue. As acknowledged in *Te Ariari o te Oranga*, many of the problems with CEP arise from difficulties in the interface between mental health and addiction services at a tertiary level of care, and initial efforts at service improvement do need to focus on the responses of secondary- and tertiary-level mental health and addiction services to people with co-existing problems. However, primary care health professionals are often insufficiently alert to the needs of those with common mental health and alcohol and other drug problems, let alone those with co-existing problems. Primary care health professionals may also face conflicting priorities to routinely check for in their practices, and may lack the confidence and tools to attempt to assess co-existing problems.

Primary care health professionals caring for people with co-existing problems need to have a long-term perspective. A doctor–client relationship based on honesty, trust and respect will form the basis of effective treatment. Active listening skills and a patient-centred clinical method should be used to establish rapport, gather a common understanding of the problems and develop an agreed management plan (Holmwood 2003).

Delivering integrated care

There is a range of mechanisms to identify CEP in addiction and mental health settings and to facilitate the delivery of integrated care so that tangata whaiora seeking help with CEP are welcomed, whether they present in mental health or addiction services, and their experience is one of seamless service provision.

Service policy

A service policy for CEP may form a useful platform from which services can further organise themselves and improve practice. It is important that the process of developing policy for these issues involves all key stakeholders, including tangata whaiora and their families and whānau. Service policy incorporates a commitment to viewing CEP as core business, to client-centred pathways and to the responsiveness expected of systems. The Nationwide Service Framework has incorporated a CEP focus in most mental health and addiction service descriptions and contract specifications. This requires all services to become CEP responsive.

Service-level agreements

Service-level agreements should be agreed between mental health, alcohol and other drug and problem gambling teams that cover:

- locally agreed implementation approaches for CEP and integrated care that include NGOs
- referral mechanisms for people who fall outside the definition for CEP so that they can access the support they need
- defined mechanisms for liaising between services
- explicit agreements on multidisciplinary and multi-agency working, including co-working, so that agencies are clear about their individual roles and take responsibility for fulfilling them
- systems in place on confidentiality and information sharing clarifying what information can be shared, and in what circumstances
- agreement on when help should be sought from other agencies
- promoting practical ways to improve integration (eg, through the establishment of local CEP networks).

Screening and assessment

Screening that incorporates both mental health and addiction is essential for services to obtain detailed information in order to provide an integrated response and care to tangata whaiora. The content of the screening will vary depending on whether the setting is an addiction or mental health one. Regardless of the setting, all clients should be screened for past and present victimisation and trauma.

Substance use screening in mental health treatment settings should look for:

- acute safety risk related to serious intoxication or withdrawal
- past and present substance use, substance-related problems and substance-related disorders
- whether a woman is pregnant.

Mental health screening in addiction treatment settings has four major components. Screens identify:

- acute safety risk – suicide, violence, inability to care for oneself
- HIV and hepatitis C virus, risky behaviors, and danger of physical or sexual victimisation
- past and present mental health symptoms and disorders
- cognitive and learning deficits.

See Appendix 2 for links to commonly used substance use and mental health screening tools.

Service training strategies

Good practice standards that aim to develop and enhance CEP capability include ongoing education and training. The training strategy needs to:

- identify the needs of all staff and professional groups working in the DHB and NGOs, including consumer, service-user and peer roles
- draw attention to the lived experience of tangata whaiora with CEP – ideally, tangata whaiora should participate in training delivery
- include adequate, supportive supervision structures and mechanisms that are consistently applied to ensure training influences practice
- include mechanisms for information exchange, inter-agency training and skills sharing
- develop education and training partnerships to ensure tangata whaiora, carers, whānau/families and staff have access to up-to-date information and advice

- recognise that skill acquisition is both formal and informal (eg, creative approaches such as job shadowing can be considered)
- recognise transferable skills
- include ethical and legal issues, medication and interaction with other substances, relapse prevention, care co-ordination and an understanding of the impact of cultural factors.

Tools for service development

There are a variety of service development tools that provide a clear framework for measuring how well local arrangements serve tangata whaiora with CEP. While useful, the needs of particular populations, including Māori and young people, must inform the use of these tools.

Process mapping

Process mapping has been used in some mental health and addiction services in New Zealand as a method for service improvement. Process mapping puts tangata whaiora at the centre of service delivery and utilises a workshop approach to track the pathway of clients through services. It highlights, in a systematic way, opportunities and needs for service improvement. Process mapping can be undertaken by a single agency, but more fruitfully is undertaken by all key stakeholders in a system of care. Once developed, process maps should be reviewed as part of the funding and planning cycle to ensure they are functioning correctly and services are meeting tangata whaiora needs, because population requirements will change over time.

Planning and funding managers may be able to bring together local mental health and addiction services to complete a CEP process mapping workshop. Background and preparation material for this can be found on the Te Pou website online: <http://www.tepou.co.nz/file/PDF/Pink-Section.pdf>

The Seven Helpful Habits of Effective CAMHS and the Choice and Partnership Approach

The Seven Helpful Habits of Effective CAMHS (7HH) and the Choice and Partnership Approach (CAPA) are tools that were introduced into CAMHS in New Zealand in 2007. There are two distinct aspects of the work.

- 7HH is a framework of ideas based on capacity and demand theory that can be introduced piecemeal or all at once to an existing service.
- CAPA is a service redesign model encouraging consumer choices in their dealings with CAMHS, and partnership between the consumer and CAMHS clinicians during the treatment process.

CAPA is particularly relevant for adult as well as youth mental health and substance use settings, with its client-centred approach and focus on engagement, and has the potential to strengthen the interface between services.

The Werry Centre has initiated a project to support DHBs to implement the 7HH and CAPA models by providing free on-site training, consultation, liaison and support to services as they plan and implement changes in service design and delivery. More information can be found on the Werry Centre website online: <http://www.werrycentre.org.nz/>

Dual Diagnosis Capability Checklists (Victoria, Australia)

The Dual Diagnosis/Co-morbidity Capability Checklist Tools – Agency & Clinician have been developed by Gary Croton and the Eastern Hume Dual Diagnosis Service (Victoria) for assessing the CEP capabilities at both the service and clinician level. The checklist was designed to support the implementation of the Victorian dual diagnosis policy: *Dual Diagnosis: Key directions and priorities for service development* (State of Victoria 2007). The tool is described as follows.

- It is best used as an agency-level, internal, all-staff-inclusive review of agency progress towards developing agency and clinician dual diagnosis capability.

- The principal benefits of using the tool are the team discussions and group reflection around agency progress towards dual diagnosis capability, so it is important to involve as many members of the team as possible in completing the checklist.
- Completion of the checklist may be regarded as a team quality improvement process and an activity that may be cited as evidence of the development of agency dual diagnosis capability.
- The checklist may also be used to develop an action plan and assign responsibilities for further developing a service's dual diagnosis capability.

More information can be found online at: <http://dualdiagnosis.ning.com/page/2247398:Page:1121>

Implementation resource kit

SAMHSA (2003) has produced an implementation resource kit for co-occurring disorders, which is another resource for developing plans and improving capability locally. The kit can be electronically downloaded from:

http://download.ncadi.samhsa.gov/ken/pdf/toolkits/cooccurring/IDDTUsersguideAJ1_04.pdf

4.3 Integrated systems of care

Extending the capacity of the mental health and addiction treatment system to meet the needs of tangata whaiora with CEP is dependent on improving links between services, especially between substance use and mental health services. Negative attitudes between mental health and addiction health professionals are arguably one of the biggest barriers to overcome and are the consequence of a multitude of factors, including differing philosophies, treatment approaches, funding sources, training and qualifications, and staffing. Although mental health and addiction health professionals have recognised the need to integrate service delivery at the client level, there is a corresponding need for service leadership to bring about enduring attitude change and ensure committed and sustainable service and system development.

It is vital that service managers and planning and funding managers recognise the need to improve responsiveness to tangata whaiora with CEP, take time to familiarise themselves with the available evidence and resources, and plan developments systematically. The time and commitment involved in facilitating collaborative working between mental health and substance use services can be hard to justify given the demands of front-line work, but such investment in integrated service provision is fundamental to success.

Leadership needs to be supported by:

- national boards, clinical governance and advisory bodies to DHBs
- regional mental health and addiction networks, including regional advisory bodies
- mental health and addiction planning and funding managers
- mental health and addiction service managers, including NGOs
- clinical directors of DHB mental health and addiction services
- mental health and addiction local leadership and advisory groups
- service-user leaders and agencies
- workforce development agendas.

Nationwide Service Framework

The recently revised Nationwide Service Framework (mental health and addictions) (the NSF) sets out detailed service specifications for incorporation into national, regional and local contracts with mental health and addiction services. The NSF describes expectations of client access to mental health and addiction services and what services are expected to provide. It strongly emphasises the need for services to

be CEP capable and responsive, and that ‘any door is the right door’. The NSF is a vital tool for funders and planners to influence service development through the contracting process and to facilitate increased CEP responsiveness across mental health and addiction services.

Governance

Most, if not all, DHBs continue to operate mental health and addiction leadership and advisory bodies. These groups may be able to provide strategic governance to improve systems and service responsiveness to CEP. Governance structures within NGO settings may require review, with a view to ensuring CEP are acknowledged and supported. In some instances NGOs may benefit by seeking senior clinical expertise in a very part-time capacity from a DHB.

DHB plans and strategies

Increasingly, DHBs are taking the initiative to develop sector-wide mental health and addiction strategic plans at both regional and local levels. Such plans may provide a platform for needed change by articulating the needs of tangata whaiora with CEP and core common principles that can shape and inform services. It is important, however, that the signal for leadership and integration does not simply translate into addiction services being subsumed within the mental health context. The development of plans may be an important function of mental health and addiction planning and funding managers, as well as service managers and consumer and service-user leaders.

Information sharing

Tangata whaiora express a variety of views about the sharing of information between agencies involved in their care. These range from it being an intrusion into privacy and representing a breach of confidence, to being valued as a means of integrating care. Information-sharing protocols enable information about tangata whaiora to be exchanged in a sensitive and respectful way and will include seeking written consent from tangata whaiora that explains clearly what information is being collected and shared, for what purpose, and with whom.

Some DHB mental health and addiction services have already established electronic filing systems that enable a single-file approach and are readily accessible from multiple points in the service, including in-crisis and out-of-hours services. Mental health and addiction services can formulate a joint, comprehensive and complementary assessment to which both services contribute, when required.

Currently the mental health sector uses HoNoS (Health of the Nations Outcome Scale), including the child and adolescent version (HoNoSCA), as an outcome measurement tool. The addiction sector developed ADOM (Alcohol and Drug Outcome Measurement), and it has now been endorsed for implementation by the Ministry of Health. There is currently no CEP outcome measurement tool available, either nationally or internationally. Co-existing problems specialist services can utilise a range of tools that address both mental health and addiction needs.

4.4 Workforce development

Key Ministry of Health documents that relate to workforce development are *Te Kōkiri*, *Te Puāwaiwhero* and *Tauawhitia te Wero – Embracing the Challenge: National Mental Health and Addiction Workforce Development Plan 2006–2009* (Ministry of Health 2005). These government strategies all acknowledge the fundamental importance of a highly skilled workforce that is responsive and effective.

A Ministry of Health project, *Let's Get Real* (<http://www.moh.govt.nz/letsgetreal>), provides a framework that describes the essential knowledge, skills and attitudes required to deliver effective mental health and addiction treatment services. It is explicit in stating the expectations for people who work in mental health and addiction treatment services, irrespective of their role, discipline or position in the organisational structure.

Workforce development across the mental health and addiction sector is one of the key challenges for the future. It is essential that a core of specialist expertise is retained, supported and further developed. It appears unlikely there will be extensive uptake of further formal education by clinicians. Skill-based training in the workplace is likely to be an important strategy for the majority of those working in the mental health and addiction sectors.

Specialist CEP clinicians/ Dual diagnosis clinicians

The role of the specialist CEP clinician is an important one. It is recommended that training delivery be included as a requirement in position descriptions, taking into account the resources for and expectations of the position. The specialist CEP clinician can specialise in key functions such as case management, and providing training, coaching and supervision. This specialised workforce will require its own dedicated training. It is imperative that CEP clinicians receive adequate support to carry out their roles to avoid burnout.

Some services have nominated staff with a special interest in CEP as a team resource. This approach has its uses, but caution is advised that these staff not become the lone CEP champions. If staff are designated specialist CEP clinicians, it must be with the understanding that the entire team works towards being CEP capable.

Regional and local workforce development

It is recommended that the CEP training needs of the existing workforce be thoroughly evaluated in the development of policy, strategy, and local and regional service planning. Needs analysis must include the NGO sector, including providers of kaupapa Māori services and service-user and peer-based recovery initiatives.

Regional and local workforce development training initiatives are encouraged. It is also recommended that mental health and addiction workforces receive training opportunities as a combined audience. Wherever possible, staff should be encouraged to liaise across services, encourage participation in in-service trainings, and generally form close working relationships.

A peer-based recovery support workforce is encouraged to assist tangata whaiora to persist with treatment and to navigate service systems, especially when accessing services through a door they are not comfortable with. One of the many benefits of peer-based support is that workers can challenge erroneous perceptions about mental health and addiction services, counter some of the stigma generated, and reframe concepts and content so that they have meaning to tangata whaiora.

The Ministry of Health is looking to create opportunities for CEP training through its workforce development programmes. The Ministry of Health is also influencing a majority of Ministry-funded workforce development opportunities to incorporate a CEP focus (eg, training for clinicians working with justice sector clients).

Matua Raki

Matua Raki is the Addiction Workforce Development Programme. A Matua Raki report on co-existing disorders (Matua Raki 2007) identifies a variety of recommendations for future workforce development, most of which are in the process of being implemented, including ensuring that all postgraduate tertiary training courses include comprehensive CEP training, a national training programme in clinical supervision, and reviewing the alcohol and drug practitioner competencies to respond to tangata whaiora with CEP. The recommendations from the Matua Raki report that can inform planning for regional and local workforce development are copied below.

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

- Train the current untrained workforce including the peer-based workforce by ensuring that health professionals below the registered competent practitioner level receive training in their mental health or alcohol and drug specialty, preferably to graduate level. Note that these health professionals should not be undertaking assessment and case management with people with CEP without undergraduate studies.
- Include peer based educators in all levels of training to support destigmatisation in the sector workforces.
- Identify supervisory and mentoring structures in each region and, where possible, each local area, to support transfer of learning.
- Fund a continuum of services with the goal of ensuring a spectrum of need is responded to by a spectrum of service, that is, there is no one treatment which fits all.

Whole-team training

The benefits of training entire teams rather than individuals can not be overstated. Staff who learn new skills often find on return to their workplace that the environment is not conducive to integrating new learning into practice, nor do the service structure and systems support the new learning. Whole-team training provides a focus on changing attitudes at both an individual and an organisational level.

A benefit of training an entire team is that it provides an opportunity for the team to consider what supports it needs to ensure the learning is retained and is sustainable, and how the workplace can support the training by, for example, local policy, clinical pathways, service flowcharts, supervisory structures and professional development plans.

The Dual Diagnosis Service at Waitemata DHB piloted an innovative way of training mental health clinicians using a model, Whole Team Training, that has been offered in Birmingham (England) since early 2003. The aims of Whole Team Training are to provide:

- a specialised training package in substance use disorders that meets the needs of the team
- the theoretical underpinnings of working with service users who have CEP
- training on how to screen and assess for CEP and provide interventions such as motivational interviewing, relapse prevention and working with families
- an understanding of harm reduction principles and strategies
- ongoing supervision and coaching for mental health staff within their own clinical environment.

The Whole Team Training in Waitemata DHB was evaluated (Waitemata DHB 2006), and at six months there were noticeable differences in clinical practice relating to how clinicians assessed, planned and implemented interventions for problematic substance use. One of the strongest predictors of health professionals developing skills and knowledge in working with AOD issues was the amount of time they had spent in ongoing supervision and coaching from a skills coach/trainer.

Conferences and sector meetings

It is important for mental health and addiction services to have the opportunity to present progress at conferences such as THEMHS (the mental health services conference) and Cutting Edge (the alcohol and addiction treatment conference), both annual. Other opportunities to exchange ideas and discuss these issues are the Addiction Treatment Leadership Days (triannual); Building Bridges, the Australasian Community Mental Health Conference (biennial); and the International Problem Gambling Conference (held every 18 months).

5. Making it Happen

The following sections are tools designed:

- to be utilised as checklists for service planning and development
- to stimulate thinking about the changes needed to support an ‘any door is the right door’ approach, whereby tangata whaiora are connected with needed services
- as a source of referral to more detailed sections in this publication and elsewhere that can help with the systematic establishment of responsiveness to CEP as core business across New Zealand mental health and addiction services.

Section 5.5, called ‘Nationally led projects’ describes actions and initiatives under way at a national level that will support CEP responsiveness.

5.1 General principles

The overall goal is to embed CEP responsiveness as standard practice within mental health and addiction services. This will involve addressing local systems and policies to ensure sustainability, both within agencies and across them.

Let’s Get Real (<http://www.moh.govt.nz/letsgetreal>) is a framework that describes the essential knowledge, skills and attitudes required to deliver effective mental health and addiction services. It is explicit in stating the expectations for people who work in mental health and addiction services, irrespective of their role, discipline or position in the organisational structure.

As part of building the right knowledge, skills and attitudes, a workforce development goal is to increase the capacity, competence and confidence of all addiction and mental health practitioners, including CAMHS (and, ideally, allied services such as youth health services) to look for, recognise and undertake basic assessments for both addiction and mental health problems: to know what questions to ask and what to do with the answers. Service managers, clinical and consumer leaders and other health professionals must be encouraged and supported to develop networks across addiction and mental health services. These relationships will operate at various levels, and will benefit both tangata whaiora with CEP and services by sharing good practice, providing peer support, and facilitating seamless and integrated service provision.

The funding of treatment for tangata whaiora with CEP needs to be adequate, secure and long term, although it may come from different funding streams. Contracts with providers and service specifications need to address CEP explicitly.

5.2 Tips for mental health and addiction planners and funders

Because of their role in aligning planning and contracting, planning and funding managers can play a pivotal role in improving the responsiveness of mental health and addiction services to tangata whaiora with co-existing mental health and addiction problems.

Suggested actions for local planning

- Identify CEP as an important area for mental health and addiction sector development in local and regional strategic plans.
- Carry out a stocktake of existing local and regional arrangements, both formal and informal, responding to CEP.
- Identify local and regional potential leaders to foster CEP service development, and formalise this as a workstream.

- Develop an understanding of the scale of CEP, and the associated complexities and poor outcomes (when untreated or treated in isolation).
- Gather local, regional and national practice-based evidence as well as published research on CEP.
- Include requirements for CEP capability (or plans towards this) in new service contracts, with timelines and pathways to monitor compliance.
- Ensure (in discussion with regional networks) there is regional specialist CEP capability for training (both whole-team and ongoing) and case supervision. Training initiatives need to reflect *Let's Get Real* to assist the development of the right knowledge, skills and attitudes to work with CEP.
- Utilise the experience of existing initiatives that are responding to CEP (for more information, see Appendix 1) and adapt these to regional and local contexts.
- Seek out contacts in other regions or sectors with experience of developing effective models of good practice that can assist with establishing integrated responses to CEP (for more information, see Appendix 1).
- Use virtual team models where this would work in a local/regional area.
- Ensure special consideration is given to the issues of CEP in forensic settings, especially secure settings, where systems integration must be designed specifically.
- Where local CEP initiatives are already occurring, ensure these are evaluated in line with the spirit of this document.
- Note the incorporation of CEP within the Nationwide Services Framework (NSF) describing client access to mental health and addiction services and what these services must provide understanding that the NSF is not intended to limit opportunities for funding and contracting unique, local CEP initiatives.

Suggested actions for young people

- Build joint case-working across young people's addiction, mental health and, ideally, allied youth health services and projects into all contracts.
- Recruit/second health professionals in pairs, ensuring support from same-discipline supervisors, accompanied by a change management process or whole-team training.
- Co-locate young people's services, where practicable (or plan towards this).
- Consider varying service configurations for young people (eg, an addiction youth specialist focus within CAMHS, including coaching and co-working, and vice versa).
- Consider devolving (in whole or in part) mental health and addiction services into less stigmatising, youth-friendly environments such as community-based youth one stop shop services (YOSS) that can provide client-centred wrap-around services.
- Recognise the importance of positive youth development, strengths-based practices and the need to facilitate access to a broad range of other services.
- Improve the uptake of services by involving young people in service planning and development.
- Recognise the role that youth workers provide in active support in order to link young people to services.

5.3 Tips for mental health and addiction service managers and clinical leaders

Suggested actions for local planning

- Consider mapping a client pathway for people with CEP to identify where current systems do not support an integrated service response (eg, the interpretation of access to services).
- Develop a plan of action for responding to people with CEP, possibly as a subset of a regional or local mental health and addictions plan.
- Discuss with planning and funding managers your proposals for becoming CEP capable and how best to equip your services.
- Consider how services are configured – if building development or service relocation is planned, consider co-locating services.
- Ensure workforce development plans include targets for increasing CEP capability.
- Identify and articulate the service philosophy and key expectations for working with people with CEP in service policy documents, which may include:
 - addiction services routinely use standard mental health screening tools
 - addiction services are able to provide mental health assessments and brief interventions for common mental health issues
 - addiction services include risk assessment tools
 - mental health services routinely use addiction screening tools
 - mental health services are able to provide a thorough addiction assessment and brief interventions
 - clear supervision arrangements are in place for practitioners working with people with co-existing problems.
- Introduce one comprehensive assessment across addiction and mental health services to reduce the need for people to have to repeat their stories.
- Build relationships across mental health and addiction services at a leadership level and encourage staff to form relationships at team and individual practitioner levels. Suggested activities are:
 - use the core business strengths and knowledge of each service to educate the other
 - seek opportunities to be trained together across services
 - encourage staff to attend external workforce development opportunities and conferences across mental health and addiction themes.
- Work jointly across mental health and addiction services with peer-based and family involvement on defining client pathways.
- Encourage and support cross-discipline exchanges (eg, secondments and joint training sessions).
- Develop a virtual team model where mental health and addiction services are closely linked, with regular communication and shared activities such as case management, training and support across services.
- Identify where specialist CEP (dual diagnosis) or co-working opportunities occur, based on the high severity of mental health presentations and the high severity of addiction client presentations.

- Invest in a specialist CEP (dual diagnosis) resource with a small case load and the role of co-working and coaching with other practitioners, with the goal of increasing CEP responsiveness and capability in the service.
- Engage with local support services and contribute to process-mapping exercises for various client groups, including Māori, Pacific peoples and young people, ensuring the involvement of service users.
- Develop protocols and/or memoranda of understanding and/or written agreements with key agencies based on clear client pathways, an agreed understanding of ‘integrated care’ (including agreements for joint working) and referral.
- Ensure the acute mental health inpatient unit has access to specialist addiction support for those experiencing withdrawal within the inpatient setting.
- Ensure mental health residential providers liaise with addiction mental health residential providers about managing addiction problems.
- Identify opportunities to align future design, planning and funding of mental health and addiction services.

Suggested actions for young people

- Recognise that young people may have other co-existing conditions (such as foetal alcohol spectrum disorders) that can affect both young people’s own ability to effectively manage their co-existing problems as well as the ability of health professionals to help.
- Consider varying service configurations for youth (eg, an addiction youth specialist focus within CAMHS, including coaching and co-working, and vice versa).
- Consider devolving (in whole or in part) mental health and addiction services into less stigmatising, youth-friendly environments, such as community-based youth one stop shop services (YOSS) that can provide client-centred wrap-around services.
- Provide mental health and addiction training and support to YOSS and school-based health services to improve detection, treatment and referral processes.
- Recognise the importance of positive youth development, strengths-based practices and the need for facilitation of access to a broad range of other services.
- Ensure young people’s confidentiality and privacy are assured.
- Improve uptake of services by involving young people in service planning and development.
- Recognise that young people ‘snack’ or ‘graze’ on services and are less likely to follow up on referrals between services.
- Recognise the role that youth workers provide in active support in order to link young people into services.

5.4 Suggested actions for local planning

Goal 1: Client centred – a coherent and comprehensive understanding of the needs of tangata whaiora, whānau and families

How	Who	Examples	Measures/outcomes	Tools and resources
Policy and practice are CEP responsive	Mental health and addiction service leaders – clinical and management Mental health and addiction services health professionals Peer-based workers and families and whānau DHB planners and funders	Service policy includes: – commitment to CEP as core business – working definitions of CEP and integrated care – client centred pathways – best practice interventions (for CEP-capable and enhanced services) – information sharing and confidentiality protocols.	Service policy is: – oriented to tangata whaiora with CEP (the person comes before the system) – reviewed and updated. Peer-based workers and whānau and families are involved in policy development and review. Ways to measure progress are formulated.	<i>Service Delivery – Integrated Solutions:</i> Client centred (pp. 14–17): – seven key principles of optimal treatment – peer-based roles – involving families and whānau – specialist populations <i>Service Delivery – Integrated Solutions:</i> Tools for service development (pp. 22–23): – Process mapping http://www.tepou.co.nz/file/PDF/Pink-Section.pdf – The Seven Helpful Habits of Effective CAMHs and the Choice and Partnership Approach http://www.werrycentre.org.nz/
Documented client pathway that reflects service access (see also Goal 3)	Mental health and addiction service leaders – clinical and management Mental health and addiction services health professionals Professional supervisors	Client pathway identifies service development opportunities: – how the triage process is configured – team composition – involvement of peer-based workers – whānau and family involvement. Ongoing review of client pathway to understand: – what works well – barriers to progress.	Tangata whaiora service access is measured by: – qualitative analysis – PRIMHD data – case-load reporting – in-house file audits.	– Dual Diagnosis Capability Checklists http://dualdiagnosis.ning.com/page/2247398:Page:1121 – SAMHSA implementation resource kit http://download.ncadi.samhsa.gov/ken/pdf/toolkits/cooccurring/IDDTUsersguideAJ1_04.pdf – Appendix 2: Screening and Assessment Tools (pp. 41–42) – <i>Te Ariari o te Oranga: The Assessment and Management of People with Co-existing Mental Health and Substance Use Problems</i> (Todd 2010)
Services promote client-centred treatment and recovery	Mental health and addiction service leaders – clinical and management Mental health and addiction services health professionals Peer-based workers and families and whānau	The whānau ora approach is integrated as part of the service delivery model. Peer-based advocacy, advisory and recovery support roles services complement addiction and mental health services.	Care plans incorporate a whānau ora approach and illustrate flexibility around how to respond to progress and to relapse. Peer-based roles participate in service planning.	

Goal 2: Service development – services need to be responsive to CEP and to work towards being CEP capable

How	Who	Examples	Measures/outcomes	Tools and resources
CEP prioritisation within service planning	Mental health and addiction service leaders: – clinical and management	In-house and cross-sector training in CEP initiatives	Progress and improvement along the continuum of service capability.	<i>Service Delivery – Integrated Solutions:</i> – quadrants of care (p. 13) – continuum of service capability (p. 19) – service training strategies (p. 21)
Review need for specialist CEP resource (dual diagnosis FTE)	Mental health and addiction service leaders: – clinical and management – planners and funders	Review of current roles and to identify future opportunities Planning to improve service access, capability and responsiveness	Capture the outputs and usefulness of this resource across both addiction and mental health services. Non-CEP specialist staff are provided with training, skills-coaching and co-working.	<i>Service Delivery – Integrated Solutions:</i> – quadrants of care (p. 13) – specialist CEP clinicians (pp. 20 and 25) – Nationwide Service Framework (p. 23)
Development of comprehensive local and regional plans and strategies to increase CEP responsiveness	Planners and funders Mental health and addiction service leaders – clinical and management Regional managers	Plans are devised that: – have input from key stakeholders – incorporate systems that enhance collaboration across mental health and additions services – identify FTE resource requirements.	Regional and local plans: _ – include aspects of the four goal areas – identify measures and outcomes – how do we know it is working? Strategies for increasing CEP responsiveness are clearly identified in the district annual planning process.	<i>Service Delivery – Integrated Solutions:</i> – tools for service development (pp. 22–23): – Dual Diagnosis Capability Checklists http://dualdiagnosis.ning.com/page/2247398 : Page:1121 – SAMHSA implementation resource kit http://download.ncadi.samhsa.gov/ken/pdf/toolkits/cooccurring/IDDTUsersguideAJ1_04.pdf – Tips for mental health and addiction planners and funders (pp. 27–28) – Tips for mental health and addiction service managers and clinical leaders (pp. 29–30) – This plan – suggested actions for local planning (pp. 31–35)
Contracts to reflect ‘any door is the right door’	Planners and funders Mental health and addiction service leaders – clinical and management	Inter-agency integrated care plans for tangata whaiora with CEP Service-level agreements Involvement of peer-based advocacy, advisory and recovery support roles and services	Tangata whaiora experience of integrated care is measured by qualitative analysis. Increases in the number of secondary diagnoses and inter-agency integrated care plans.	<i>Service Delivery – Integrated Solutions:</i> – quadrants of care (p. 13) – continuum of service capability (p. 19) – service policy (p. 20) – service-level agreements (p. 21) – screening and assessment (p. 21) – Appendix 2: Screening and Assessment Tools (pp. 41–42)

Goal 3: Integrated systems of care – systems are to acknowledge and incorporate CEP approaches

How	Who	Examples	Measures/outcomes	Tools and resources
<p>Services are responsible for ensuring systems acknowledge and incorporate CEP</p>	<p>Mental health and addiction service leaders</p> <ul style="list-style-type: none"> – clinical and management 	<p>CEP components are incorporated into professional development and supervisory frameworks.</p> <p>Local preceptor (buddy) professional development systems incorporate CEP.</p> <p>CEP diagnoses are recorded in PRIMHD.</p> <p>Clinical pathways inform systems adjustments.</p>	<p>Supervisors are skilled in CEP-specific supervision.</p> <p>Individual professional development plans demonstrate the objectives of CEP.</p> <p>Service policy reflects systems responsiveness to CEP.</p> <p>Data reflects an accurate account of CEP volume.</p>	<p><i>Service Delivery – Integrated Solutions:</i></p> <ul style="list-style-type: none"> – integrated systems of care (pp. 23–24): – service policy (p. 20) – service-level agreements (p. 21) – information sharing (p. 24) – tips for mental health and addiction service managers and clinical leaders (pp. 29–30)
<p>Service leaders collaborate</p>	<p>Mental health and addiction service leaders</p> <ul style="list-style-type: none"> – clinical and management 	<p>Managers identify:</p> <ul style="list-style-type: none"> – the shifts in organisational culture required to facilitate successful and sustainable change – the leadership support essential for change to succeed. 	<p>Managers:</p> <ul style="list-style-type: none"> – recognise the need to improve responsiveness to tangata whaiora with CEP – familiarise themselves with the available evidence and resources, and plan developments systematically. 	<p><i>Service Delivery – Integrated Solutions:</i></p> <ul style="list-style-type: none"> – tips for mental health and addiction service managers and clinical leaders (pp. 29–30) – integrated systems of care (pp. 23–24) <p><i>Destination: Recovery Te Unga ki Uta: Te Oranga</i> (Mental Health Advocacy Coalition 2008) http://www.mentalhealth.org.nz/file/downloads/pdf/Destination%20Recovery_FINAL_low%20res.pdf</p>
<p>Services dialogue</p>	<p>Mental health and addiction service leaders</p> <ul style="list-style-type: none"> – clinical and management – mental health and addiction service health professionals, both formal and informal networks 	<p>Practice differences are acknowledged and worked into service policy and service-level agreements.</p> <p>Peer-based advocacy, advisory and recovery support roles are included.</p> <p>Regular inter-agency exchanges between mental health and addiction health professionals.</p> <p>Development of inter-agency information-sharing protocols.</p>	<p>Increased contact between mental health and addiction health professionals.</p> <p>The use of documented inter-agency information-sharing protocols.</p>	<p><i>Service Delivery – Integrated Solutions:</i></p> <ul style="list-style-type: none"> – quadrants of care (p. 13) – continuum of service capability (p. 19) – service policy (p. 20) – service-level agreements (p. 21) – service training strategies (p. 21) – Process mapping http://www.tepou.co.nz/file/PDF/Pink-Section.pdf (p. 22) – The Seven Helpful Habits of Effective CAMHs and the Choice and Partnership Approach http://www.werrycentre.org.nz/ – information sharing (p. 24) – tips for mental health and addiction service managers and clinical leaders (pp. 29–30) – Appendix 1: A selection of NZ examples of CEP initiatives and services (pp. 37–40)

How	Who	Examples	Measures/outcomes	Tools and resources
Collaborative approaches to integrated care	Mental health and addiction service leaders – clinical and management Mental health and addiction service health professionals	Cross service Initiatives aimed at developing collaboration involving peer-based roles and whānau and families that: – document a client pathway – identify roles and responsibilities across services.	‘Integrated care’ is clearly defined and applied. Tangata whaiora experience of integrated care is measured by qualitative analysis. Increases in the number of secondary diagnoses and inter-agency care plans.	See Services dialogue section above (p.33)
Clinical support for CEP and inter-agency working	Mental health and addiction service leaders – clinical and management Discipline-specific professional leaders Professional associations Workforce development programmes	Professional disciplines are knowledgeable, competent and active in CEP. Professional and cultural supervision addresses CEP caseloads.	There is an agreed process (at intake or after assessment) for determining the lead service and who is responsible for case management. Increased use of service-level agreements and inter-agency information-sharing protocols.	<i>Service Delivery – Integrated Solutions:</i> – service-level agreements (p. 21) – service training strategies (p. 21) – information sharing (p. 24) – workforce development (pp. 24–26).

Goal 4: Workforce development – a highly skilled workforce that is CEP responsive and effective

How	Who	Examples	Measures/outcomes	Tools and resources
Specialist CEP ('dual diagnosis') expertise is retained, and where not already in place consideration is given to recruitment	CEP FTE	Skills-based training in the work place is provided by a CEP specialist role. Whole teams work towards being CEP capable, with assistance from the CEP specialist role.	CEP training is scheduled within and across services. A training delivery component is included in the position description for the CEP specialist role.	<i>Service Delivery – Integrated Solutions:</i> – specialist CEP clinicians (pp. 20 and 25) – workforce development (pp. 24–26)
Services support training initiatives provided nationally, regionally and locally	Training opportunities provided by Ministry of Health through its workforce development programmes and/or tertiary training institutions Regional and local responsibilities to provide training Mental health and addiction service leaders – clinical and management Peer-based advocacy, advisory and recovery support workers	Staff of mental health and addiction services are trained and supported to be CEP capable. Where possible, whole teams (or across-team groups) are trained to ensure shifts in organisational culture. Training includes values and attitudes (eg, <i>Let's Get Real</i>), and knowledge, including assessment and clinical interventions.	Number of people trained. Post-training skills coaching opportunities provided. Increase in health professional confidence (through workforce development activities). Uptake of relevant training acknowledged through the Drug and Alcohol Practitioners Association of New Zealand (DAPAANZ) points system.	<i>Service Delivery – Integrated Solutions:</i> – workforce development (pp. 24–26) – staff professional development plans – staff training budgets – Let's Get Real: http://www.moh.govt.nz/letsgetreal – Dual Diagnosis Support Victoria: http://dualdiagnosis.ning.com/
Regionally and/or locally identified training opportunities	Regional workforce development co-ordinators Regional clinical networks Local training roles and functions	Locally and regionally driven opportunities. In-service and cross-service training opportunities. Training delivery to a combined audience of mental health and addiction services health professionals.	Identified within regional and local workforce development plans.	Tools and resources include: – the Ministry will lead some training – regional workforce development co-ordinators – workforce development programmes – services can provide in-service topics across teams Dual Diagnosis Toolkit http://www.turning-point.co.uk

5.5 Nationally led projects

How	Who	Examples	Measures/outcomes
Tertiary training institutions incorporate working with CEP within their curriculum	Ministry of Health Workforce development programmes, including problem gambling	The graduate mental health and addiction workforce is qualified to address CEP.	Evidence that CEP is formally within the curriculum throughout undergraduate and postgraduate training.
Sustained and highly visible leadership support for the development of CEP responsiveness across services and systems	Ministry of Health Workforce development programmes, including problem gambling Mental health and addiction service leaders – clinical and management Planners and funders Consumer leaders Mental Health Commission	Leaders acknowledge CEP when addressing strategic, planning, service development, workforce and systems issues. Leaders model positive values and attitudes to co-existing problems.	Leadership courses/ training incorporates CEP issues.
Formal workforce development initiatives incorporate a CEP focus	Workforce development programmes, including problem gambling	Planned workforce initiatives incorporate CEP (eg, Brief Mobile Training – Matua Raki)	Workforce programme work plans.
Research	Te Pou Matua Raki Mental health and addiction service leaders – clinical and management Mental Health Commission	New Zealand CEP practice models are evaluated.	NZ evidence demonstrates service effectiveness.

Appendices

Appendix 1: A Selection of New Zealand Examples of Co-existing Problems Initiatives and Services

The initiatives, programmes and services described below were all reported at the four regional workshops held in 2008. The list does not purport to be complete and it cannot be assumed that the initiatives and services have been evaluated.

Northern Region

Odyssey House provides a co-existing disorder service for individuals with psychiatric disorders who also experience problems related to substance abuse or gambling. It operates in three locations: Auckland City, Counties Manukau and Whangarei. Odyssey House provides psychiatric services while maintaining close liaison with mental health services. It encourages family members to be actively involved at all stages of the treatment process. Opportunities to do this include monthly community dinners, weekend visits, and a forum for family members to provide feedback and suggestions. Additional visits can be arranged in consultation with the Odyssey House staff. There is also a selection of group opportunities such as multi-family therapy and education groups, a treatment planning group (where the client identifies the goals they would like to achieve), and client case reviews (where the client and their family have an opportunity to discuss the client's progress).

Northland DHB

The Mental Health and Addiction Service is working towards integrating care for people with CEP. The addiction service does not need to refer to mental health because they are capable of addressing mental health problems and an addiction person works within the mental health team. The services are on a pathway to integration.

Waitemata DHB

Waitemata DHB is the contract holder for Community Alcohol and Drug Services (CADS) throughout the Auckland region.

CADS Altered High Youth Service is a mobile, tertiary young people's alcohol and drug specialist service within Auckland CADS. There is a multidisciplinary team that includes a psychiatrist, dual diagnosis clinicians, referral co-ordinator, same sex attraction clinician, and AOD youth clinicians. Family-inclusive practice is integral to service provision. Altered High promotes routine screening for substance use problems. It also offers training, liaison and sharing of skills to other DHB CAMHS services with the aim of enabling mental health services to eventually deliver the treatments required for dually diagnosed clients from within their own teams.

The Dual Diagnosis Service has a team of 12 and provides clinical work and training across the region. Training (either five-day or whole-team) begins with examining attitudes and beliefs around addictions, facts and effects, motivational interviewing skills, pharmacology, assessments, screening tools, relapse prevention and the 'wheel of change'. The Whole Team Training approach was developed to respond to the lack of support experienced by clinicians who had attended individual training on return to their work place and the unmanageable number of referrals to the service. The Dual Diagnosis Service has been supported to implement a project for the Waitemata Early Psychosis Intervention team, involving the development of a tailored programme. Pre- and post-audit of clinical files demonstrated the project was successful.

Tupu Pacific Team has dedicated dual diagnosis clinicians. Tupu operates a satellite clinic one day per week at Counties Manukau Faleola Mental Health Services.

Mason Clinic (the forensic mental health service) has developed an assessment tool for problematic substance use and a companion document that assists staff to understand substance use issues.

Auckland DHB

Auckland DHB has expanded access across mental health services and developed a dialectical behavioural therapy programme for tangata whaiora with personality disorders, noting that many of these clients have substance use issues also.

The Māori Mental Health Service has developed an integrated model of service delivery based on Ngā Pātū e Whā, the four internal walls of the whareniui (meeting house), representing clinical intervention, the kaupapa of the service, mental health and addiction infrastructure, and quality components that support and guide service delivery for tangata whaiora with CEP. The current comprehensive assessment tool, Tupurea Aromatawai, has been further developed to integrate AOD information within the dimensions of wairua, whānau, tinana and hinengaro.

Waitemata DHB and Counties Manukau DHB

Waitemata Dual Diagnosis Service and Counties Manukau DHB have embarked on a collaborative project to train all DHB mental health staff to be dual diagnosis capable. Some of the Waitemata Dual Diagnosis Service positions are embedded within Counties Manukau DHB mental health teams but managed by Waitemata DHB. Also, NGOs working with mental health clients have been trained to respond to substance use problems by ABACUS.

Midland Region

Rongo Atea, Youth Alcohol and Other Drugs Rehabilitation Programme is a service operated by Te Rūnanga o Kirikiriroa, a kaupapa Māori service provider. Rongo Atea is a 24 hour, 7 day a week, abstinence based, kaupapa Māori alcohol and other drug programme that embraces all adolescence, including tangata whaiora with co-existing mental health problems.

Tairāwhiti DHB

Tairāwhiti DHB is using traditional Māori healing and complementary therapies that acknowledge CEP relating to physical health. As a DHB serving a very high Māori population, Tairāwhiti offers a cultural assessment at the first point of engagement. This has helped with gaining the confidence of Māori communities.

Lakes DHB

The Dual Diagnosis Service has a strategy of working with the whole person, not only their mental health and addiction issues, and has developed memoranda of understanding between clinical and non-clinical agencies in the Lakes district.

Central Region

Multi Systemic Therapy (MST) is an 10-week programme for young people aged 10–17 years operating in the central region for young people with many issues, including CEP. There is no clinic and teams are highly mobile, carry very small case loads and are available 24 hours a day to families. The focus is on rural areas, and clinicians work flexible hours and visit homes and communities, removing barriers.

Te Whatuiapiti Trust, Te Waireka Alcohol and Other Drug Service is residential service for rangatahi, including those with CEP, between 14 and 19 years of age referred from Hawke's Bay and the Central Region.

Hawke's Bay DHB

Kina Trust have developed a project called Sharing the Kete: Family Inclusive Practice Project, Youth and Cannabis, recognising the capacities of families to be viewed as 'agents of change' in responding to young people's cannabis abuse. Cannabis use is a concern in Hawke's Bay, where it has a significant impact on the health and wellbeing of youth presenting to mental health and addiction services. Involving families is seen as valuable, but intervention frameworks are required to support this in practice.

MidCentral DHB

MidCentral DHB has funded non-clinical support services for people with CEP for a number of years. The service operates by identifying support needs and linking clients to services. It has also developed a Regional Dual Diagnosis Collective and developed practice guidelines. This group has been running for a number of years.

In 2008 a project was initiated to improve service responsiveness to CEP across both provider arm and NGO services. Activities include gap analysis, planning, service structure, evidence-based best practice models, a staff survey, developed consumer pathway, assessment of training needs, the development of assessment and screening tools, and an implementation plan. Mental health clinicians assess alcohol and other drug use history.

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

Capital & Coast DHB

Evolve Youth Service is a 'one-stop-shop' for young people aged 10 to 24 offering primary health care, sexual health, social support, counselling, peer support and activity-based projects. Evolve is youth-owned and youth-led, governed by a trust and funded by the DHB via a local PHO. The activities and programmes provide opportunities for young people to form supportive relationships with their peers, and foster positive youth participation, by engaging young people with issues affecting their health and wellbeing. Evolve accepts youth with mental health and AOD problems.

Southern Region

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

Nelson Marlborough DHB

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

Canterbury DHB

All clients receive a comprehensive mental health and AOD assessment. When a mental health client is referred to CADS, their case manager sits in on the assessment and is involved throughout their treatment. Clinical nurse specialists have been trained to screen for substance use problems. There is consultation/ liaison between mental health services and psychiatrists who specialise in addiction. Previously, dual diagnosis specialist roles were swamped with mental health work and addiction was neglected. All forensic clients receive an alcohol and other drug assessment, but staff changes and lack of resources have been problematic, so the current approach is to obtain funding to place addiction staff into the forensics team.

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

Otago DHB

Mirror Counselling in Dunedin is a community service providing assessment, counselling (including motivational interviewing) and mentoring for children and young people up to 20 years of age who require assistance for a wide range of reasons, including drug and alcohol use, mental health issues, personal, relationship and family challenges, abuse and violence.

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

Appendix 2: Screening and Assessment Tools

This appendix provides a selection of tools for use across addiction and mental health settings. It is not exhaustive and has not included tools that each setting would already be familiar with and uses on a regular basis.

General

Tip 42

A variety of tools for screening are included in TIP 42 and can be downloaded electronically. The first link below is to a full, free copy, and the second link is to a site where each chapter can be opened individually:
<http://download.ncadi.samhsa.gov/prevline/pdfs/bkd515.pdf>
<http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.74073>

Te Ariari o te Oranga (Todd 2010)

Te Ariari o te Oranga includes a section on screening tools to identify substance use problems in mental health settings and screening tools to identify alcohol and other drug problems in a mental health setting.

Mental health screening tools for use in addiction settings

A range of tools has been developed that can be used to screen for mental health in settings other than mental health services.

BSI-18 (Brief Symptom Inventory-18)

This tool quickly measures the type and severity of psychological distress. It can be used for an initial assessment and as a monitoring tool and takes approximately four minutes to complete.

K10 (The Kessler Psychological Distress Scale)

Ten responses are added up and the total score is the score on the Kessler Psychological Distress Scale (K10). It can be used for an initial assessment and as a monitoring tool.

Mental Health Screening Form-III (MHSF-III)

This is a screening tool with 18 questions, used to identify mental health problems in an addiction treatment setting.

Psycheck

This tool detects the likely presence of mental health symptoms that are common and can feasibly be addressed within specialist addiction treatment services. It is not designed to be a diagnostic assessment and does not yield information about specific disorders.

SDQ (Strengths & Difficulties Questionnaire)

This is a brief behavioural screening questionnaire for 3–16-year-olds that can be completed by the young person, their parents or their teachers. It exists in several versions to meet the needs of researchers, clinicians and educationalists. Child and adolescent mental health services and other specialist services can use an ‘added value’ score based on the SDQ as one index of how much help they are providing to the young people they see.

Substance use screening tools for use in mental health settings

ADOM (Alcohol and Drug Outcome Measure).

This tool was developed in New Zealand and is endorsed for use by the Ministry of Health.

ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test)

This was developed for the World Health Organization (WHO) by an international group of substance abuse researchers to detect and manage substance use and related problems in primary and general medical care settings.

AUDIT (Alcohol Use Disorder Identification Test)

This has 10 questions focusing on a person's past 12-month drinking habits, including the frequency of alcohol consumption, drinking behaviour and alcohol-related problems. The answers are scored on a point system.

CAGE/CAGEAID

This is a modified version of the CAGE screen for alcohol problems, adapted to include drugs by adding a four-item conjoint screen for alcohol and substance use.

DAST (Drug Abuse Screening Test)

This is a screening tool for drug use only: it does not include questions about alcohol. It involves a series of yes/no questions, each question scores either 0 or 1, and a score of 6 or more indicates a substance use problem.

MAST (Michigan Alcohol Screening Test)

This is a simple self-administered test to assess a person's alcohol consumption. The screening focuses on alcohol consumption only.

SACS (Substances and Choices Scale)

SACS was designed for use with young people aged 13–18 years. Three sections address alcohol and drug use and tobacco.

SSI-SA (Simple Screening Instrument for Substance Abuse)/MSSI-SA (modified version)

This tool assesses past six-month alcohol and drug use.

WHO – ASSIST v3.0

This assesses lifetime and past-three-month substance use, looking at symptoms of abuse and dependence of drugs, alcohol, and nicotine.

Screening tools for use in both mental health and addiction settings

HEADSS (Home, Education, Activities, Drug use and abuse, Sexual behaviour, Suicidality and depression)

This is an interview instrument for young people that includes questions across a variety of domains.

MINI (Mini International Neuropsychiatric Interview)

The MINI encompasses a variety of tools, including the MINI, MINI Screen and MINI Plus. The MINI itself screens for 20 past or present mental health disorders, including substance use disorders. It is a short, diagnostic, structured interview.

Problem gambling screening tools

Lie-Bet

The Lie-Bet screen consists of two questions related to DSM-III-R and DSM-IV criteria.

PGSI

The Canadian Problem Gambling Index (CPGI) includes over 30 items assessing gambling involvement, gambling problems, correlates and demographics. The Problem Gambling Severity Index (PGSI) is a subscale of the CPGI with nine scored items, which assesses problem gambling directly.

Appendix 3: Resources

The following list of resources is a selective rather than an exhaustive list, and while every effort has been made to source links that are useful and appropriate, the resources are not Ministry of Health endorsed.

Australian General Practice Network (AGPN)

The Can Do Initiative: Managing Mental Health and Substance Use in General Practice, is an Australian national initiative, funded through the National Comorbidity Initiative. The initiative promotes a 'can do' approach to general practice to meet the challenge of mental health and substance use and focuses on education, training and networking. Can Do comprises several components, including Teams of Two, clinical education, and eight population-specific modules. <http://www.agpncando.com/>

Australian Government Department of Health and Ageing – National Comorbidity Project

The National Comorbidity Initiative aims to improve service co-ordination and treatment outcomes for people with co-existing mental health and substance use disorders. <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-strateg-comorbidity-index.htm>

Centre for Addiction and Mental Health (CAMH)

CAMH is Canada's largest mental health and addiction teaching hospital as well as one of the world's leading research centres in the area of addiction and mental health. CAMH combines clinical care, research, education, policy development and health promotion to help transform the lives of people affected by mental health and addiction issues. The CAMH website has a large section on concurrent disorders containing many useful resources, including:

- *Best Practices Concurrent Mental Health and Substance Use Disorders* (2002)
- *Beyond the Label: An educational kit* (2005) – an educational kit promoting awareness and understanding of the impact of stigma on people living with concurrent mental health and substance use problems
- *A Family Guide to Concurrent Disorders* (2007) – a resource that clearly outlines mental health and substance use issues, impacts on family, self-care, navigating systems and recovery. Although some of the document refers to the Canadian health care system it contains valuable insights and information.

The above publications and others can be accessed at:

http://www.camh.net/About_Addiction_Mental_Health/Concurrent_Disorders/index.html

Children of Parents with a Mental Illness (COPMI)

COPMI provides information for family members across Australia where a parent has a mental illness, and for people who care for and work with them. COPMI has published a resource for people working with children of parents with dual diagnosis.

http://www.copmi.net.au/gems/files/copmi_gems_4_march_09.pdf

Co-occurring Mental Health and Substance Use Disorders

This is an American site, described as a co-occurring resource and information centre, containing an abundance of information relevant to the assessment, management and care of people with CEP.

<http://www.pa-co-occurring.org/index.php>

Dual Diagnosis Australia and New Zealand

Dual Diagnosis Australia and New Zealand is a resource repository created to contribute to better outcomes for people with co-occurring substance use and mental health disorders. The site contains a huge range of dual diagnosis resources.

http://www.dualdiagnosis.org.au/home/index.php?option=com_frontpage&Itemid=1

Dual Diagnosis Support Victoria

This is an online community of people interested in contributing to better outcomes for people with co-occurring substance use and mental health disorders. It has been developed by the Victorian Dual Diagnosis Initiative as a support for students, clinicians, managers and other people interested in contributing to better outcomes for people with dual diagnosis. The site contains a huge range of dual diagnosis resources and offers weekly, free, online tutorials on CEP approaches to treatment and care.
<http://dualdiagnosis.ning.com/>

Kina Trust

Family mental health services may have particular workforce development needs regarding substance use problems. Kina Trust provides training in family-inclusive practice to agencies working with families, promoting the fact that CEP raises complex issues for families to cope with. Further information on family-inclusive treatment and practice in a New Zealand context is available from the Kina Families and Addictions Trust. <http://www.kinatrust.org.nz>

Mental Health Coordinating Council (MHCC)

The MHCC in Australia has one CEP initiative underway currently. The No Wrong Door project is a partnership with the Network of Alcohol and Drug Agencies (NADA) to increase the confidence and capacity of community mental health organisations and workers in responding to the needs of people with both mental health and substance use problems. The project uses an organisational change management approach involving training and service development to improve skills in responding to substance use issues.
<http://www.mhcc.org.au/documents/Projects/No-Wrong-Door-Project-overview.pdf>

An earlier project, The Mind the Gap research project provides individual literature reviews on the effects of substance abuse and mental illness on parenting, family dynamics, accessing services and levels of child abuse and neglect. <http://www.mhcc.org.au/documents/MichelleHegarty.pdf>

New South Wales Health (NSW Health)

Co-morbidity Framework for Action: NSW health mental health/drug and alcohol (2008).
http://www.health.nsw.gov.au/pubs/2008/pdf/comorbidity_frame.pdf

Mental Health Resource for Drug and Alcohol Workers (2007)
http://www.health.nsw.gov.au/pubs/2007/pdf/mh_resource.pdf

Winstock A, Molan J. 2008. *The Patient Journey Kit 2: Supporting GPs to manage comorbidity in the community*. Sydney: NSW Health.
<http://www.health.nsw.gov.au/resources/drugs/pdf/patientjourneykit2.pdf>

New South Wales Department of Community Services (DoCS)

DoCS has published a series of downloadable resources to help carers and families where there is parental dual diagnosis. The resources include two story books written for children.
http://www.community.nsw.gov.au/about_us/news_and_publications/dual_diagnosis_resources.html

Queensland Government, Queensland Health

The link is to Queensland Health's succinct health policy *Service Delivery for People with Dual Diagnosis (co-occurring mental health and alcohol and other drug problems)*.
http://www.health.qld.gov.au/atod/documents/dual_diagnosis.pdf

Roundup

Roundup is an occasional web-based bulletin of recent events, developments, research, training and websites, both national (Australia) and international. It is supported by Dual Diagnosis Support Victoria and Dual Diagnosis Australia and New Zealand, and is edited by Gary Croton. Published since 2005, back issues contain an absolute wealth of information relevant to co-existing problems. <http://dualdiagnosis.ning.com/>

SAMHSA

Substance Abuse and Mental Health Services Administration, a section of the United States Department of Health and Social Services, has published the following *Treatment Improvement Protocols* (TIPS) relevant to the assessment, treatment, care and management of people with CEP:

- TIP 42 (1) – *Substance Abuse Treatment for Persons with Co-Occurring Disorders*
- TIP 42 (2) – *Quick Guide for Administrators Based on TIP 42: Substance abuse treatment for persons with co-occurring disorders*
- TIP 42 (3) – *Quick Guide for Clinicians Based on TIP 42: Substance abuse treatment for persons with co-occurring disorders*
- TIP 48 – *Managing Depressive Systems in Substance Abuse Clients During Early Recovery*
- TIP 50 – *Addressing Suicidal Thoughts and Behaviours in Substance Abuse Treatment.*

All these TIPS are downloadable from: <http://www.ncadi.samhsa.gov/>

State Department of Victoria, Department of Health

The Victorian Government's *Dual Diagnosis, Key Directions and Priorities for Service Development* is referred to often in Service Delivery-Integrated Solutions.

<http://www.health.vic.gov.au/mentalhealth/dualdiagnosis/dualdiagnosis2007.pdf>

Turning Point UK

The *Dual Diagnosis Good Practice Handbook* contains practical information designed to help practitioners and those involved in service design to learn from, and apply, good practice in dual diagnosis.

<http://www.turning-point.co.uk/inthenews/Documents/DualDiagnosisGoodPracticeHandbook.pdf>

Dual Diagnosis Toolkit is a practical guide and reference source for front-line staff working with adult clients who have a combination of substance use and mental health problems.

<http://www.turning-point.co.uk/inthenews/Documents/Dualdiagnostoolkit.pdf>

UK Government

A Guide for the Management of Dual Diagnosis for Prisons (2009)

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_097694.pdf

Dual Diagnosis in Mental Health Inpatient and Day Hospital Settings

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_062652.pdf

Mental Health Policy Implementation Guide: Dual diagnosis good practice guide (2002)

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4060435.pdf

Appendix 4: Further Reading

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