

**A study of practices and attitudes of a
local Community Alcohol and Drug
Service Workforce in relation to
consumers with coexisting mental
health and addiction problems**

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ABSTRACT

The first comprehensive national study on the opinions and attitudes of the New Zealand addiction workforce in addressing coexisting problems (CEP) was carried out by Gilbert (2010) using a telephone survey. The aim of this current research was to explore the views and practices of a local Community Alcohol and Drug Service (CADS) workforce, in relation to working with consumers who have coexisting addiction and mental health issues, using a survey-questionnaire (survey) and conducting clinical file audits to compare what is reported versus what is recorded.

A survey was adapted from the Gilbert (2010) study and Matua Raki, Coexisting Problems Service Checklist (2012). The survey, completed by seventeen participants, focussed on four areas: 1. Demographics, 2. Mental health knowledge and confidence in recognising disorders, 3. Use of knowledge of mental health screening and assessment tools and 4. Attitudes towards consumers with CEP. The purpose of the clinical file audit was to apply a set of pre-determined indicators (to a sample of 138 clinical files) that would identify and assess data within clinical files, which demonstrated mental health assessment by alcohol and other drug (AOD) practitioners.

Findings from this study highlighted differences in level of knowledge, confidence, attitudes and practices between participants and differences in what participants reported conducting compared to what was evident in the clinical files.

This study indicates the need to not only deliver mental health education to AOD practitioners and provide resources to achieve this, but to provide coaching and supervision post training in the workplace. By upskilling the workforce this could lead to an increase in knowledge on assessment and treatment practices for consumers with CEP and in turn achieve better outcomes for consumers.

PREFACE

Having worked as a psychiatric nurse in a variety of mental health settings I was always drawn to individuals struggling with addiction problems. This was mainly due to the stigma associated with being an ‘addict’ and what I believed to be unfair and unnecessary negative comments from my peers toward this consumer group.

Early in my career I was fortunate to get a job in a new Addiction Service headed by Professor Ilana Crome. Working with (Prof.) Crome completely changed my career path from general psychiatry and ignited my passion for working in the addiction sector. I was struck by how tirelessly she worked to educate junior doctors about addictions even though they had chosen a career in general psychiatry. She was completely dedicated to the world of addiction psychiatry and I developed as a addictions nurse and learned so much during my time in Wolverhampton (England).

Working in this service staff were always encouraged to attend research meetings and addiction forums, which is where I heard Dr Alex Copello and Hermine Graham describe a new specialist programme called COMPASS (Combined Psychosis and Substance Use) which had been set up to help individuals with coexisting psychosis and substance use problems. This lecture and working with (Prof.) Crome was what started my interest in the assessment and treatment of CEP.

I reluctantly resigned from this service to further my career and take up a new role as the first consult-liaison addiction nurse in the largest general hospital in the West Midlands. As a psychiatric nurse what struck me was being told that my role was to assess for addiction problems in the general hospital but the consult liaison psychiatric nurse would deal with all the mental health issues. Having worked in an integrated model with (Prof.) Crome’s team, I was suddenly faced with working in isolation with addiction and mental health services being in silos. I chose to ignore the directive of only working with the addiction problem and built up a strong professional relationship with my likeminded colleague in psychiatry who was only too happy to work alongside someone who didn’t try and fragment the individual requiring assistance. I also took the opportunity to review individuals with him using this time to impart some addiction education to my colleague.

Moving to New Zealand in 2004, I first worked in a Community Alcohol and Drug Service which did not follow an integrated treatment model. My second job in New Zealand was a part time mental health nurse and part time addiction worker in the same team, which still makes me smile that even in employment the roles were segregated.

Over the past five years in the District Health Board I now work for, a lot of focus has been put into upskilling the mental health workforce to become 'CEP capable', but there has been little focus on the local addiction workforce to upskill and be able to assess for common mental disorders. Being curious as to the opinions and knowledge of the alcohol and other drug workforce gave me the initial idea for this research.

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Secondly, a big thank you to my academic supervisors, Dr Dave Carlyle and Dr Daryle Deering who I'm sure are just as pleased as I for this journey to be over. Thank you for your support, guidance and expertise in getting me to this point, I have learned and developed academically because of both of you.

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Finally, but most importantly, I thank my husband and best buddy, Ian. I know I'm difficult to live with most of the time let alone during years of studying - but Honey...it's over now...time for a holiday.

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CHAPTER ONE

INTRODUCTION

1.1 Introduction

This thesis explores the practices of a local Community Alcohol and Drug Service (CADS) workforce working with individuals with coexisting problems (CEP). Individuals who endure both mental health and addiction issues (known as CEP) have an increase in social, health, economic and psychological effects above those already associated with a single diagnosis or problem (Adamson, Sellman, & De Zwart, 2004; Boden, Fergusson, & Horwood, 2012; Deering, Adamson, & Sellman, 2001; Haskell, Graham, Bernards, Flynn, & Wells, 2016; Hipwell, Singh, & Clark, 2000; North, Eyrich-Garg, Pollio & Thirthalli, 2010; Oh & Devylder, 2014; Patel et al., 2016; Stockdale et al., 2007; Walker, Mcgee, & Druss, 2015). Research also shows a link between suicide attempts and substance abuse, with completed suicides being associated with depression and substance abuse (Aharonovich, Liu, Nunes, & Hasin, 2002; Beautrais, Joyce, & Mulder, 1999; Bohnert, Roeder & Ilgen, 2011; Dhossche, Meloukheia, & Chakravorty, 2000; Ries, Yuodelis-Flores, Comtois, Roy-Byrne, & Russon, 2008; Wilcox, Conner, & Caine, 2004). The complex nature of CEP and the associated difficulties (namely social, health, economic, psychological and risks of harm to self) provides challenges to the mental health and addiction sector, with clinicians from both sectors requiring skills, knowledge and capabilities to be able to effectively engage and treat these individuals. However, research highlights clinicians' lack of skills and knowledge to adequately assess and treat CEP (CSAT [Centre of Substance Abuse Treatment], 2006; Hunter et al., 2005; McGovern, Xie, Segal, Siembab, & Drake, 2006; Minkoff & Ajilore, 1998; Rassool, 2006; Saunders & Robinson, 2002; Tobin, Matters, Chen, Smith, & Stuhlmler, 2001).

The document Scope it right (Te Pou o Te Whakaaro Nui, 2015) reviews the international literature of working to top of scope of clinical practice and identifies information to support workforce planning and development, retention and recruitment processes, and

enhanced practice. It is a useful document which encourages discussion in the workplace for services to reflect on how they work in terms of their model of care, roles, capability and professional boundaries in order for the workforce to work to the top of their scope of practice and improve outcomes for consumers. The document places emphasis for a workforce of skill mix, specialised knowledge and expertise rather than professional disciplines.

Over the past 30 years progress has been made in the development of treatment models for CEP (Ries, 1993), with a push for an integrated model of treatment being seen as optimal practice (Biegel, Kola & Ronis, 2007; CSAT, 2005; Mueser, Noordsy, Drake, & Fox, 2003; Staiger, Long & Baker, 2010). In New Zealand mental health and addiction treatment strategies should have been a priority over the past 15 years initiated by the *New Zealand Health Strategy* (MOH [Ministry of Health], 2000) and *The New Zealand Disability Strategy* (MoDI [Ministry of Disability Issues], 2001). *Te Tahuhu – Improving Mental health 2005 – 2015* (MOH, 2005) provided a strategy for how investment in mental health and addiction would be addressed and *Te Kokiri: The Mental Health and Addiction Action Plan* (MOH, 2006) specified actions and responsibilities for stakeholders with associated time frames to implement Te Tahuhu. Within these documents was the call to align service delivery for individuals with CEP and improve collaborative working to improve responsiveness for these individuals. Next in 2010, *Integrated Solutions: Service delivery for People with Coexisting Mental Health and Addiction Problems* (MOH, 2010) and *Te Ariari o te Oranga: The Assessment and Management of People with Coexisting Mental Health and Substance Use Problems* (Todd, 2010) set out guidance on how to improve CEP capacity and capability for government funded District Health Boards (DHB).

Overseas and in New Zealand research and health policy initiatives have emphasised the need to upskill and improve the capability of the addiction workforce to address CEP (Hannifin & Gruys, 1996; Kavanagh et al., 2000; MacEwan, 2007; Todd, Sellman, & Robertson, 2002). Gilbert, Adamson, and Deering (2013) investigated the opinions, knowledge and practices of addiction workers in addressing CEP with individuals accessing alcohol or other drug (AOD) treatment services in New Zealand by conducting a national workforce telephone survey, which was the first comprehensive survey of its kind. Their findings included the need to build the capability of the addiction workforce to be

able to assess consumers entering AOD treatment, as well as be able to recognise and inquire for common mental disorders such as depression and anxiety when carrying out comprehensive AOD assessment. Overall findings showed that AOD workers were highly aware of what optimal treatment for CEP looked like, but their skill and knowledge required further development to match best practice guidelines.

Due to varying regional configurations of AOD treatment services and the results of the national telephone survey indicating areas for improvement, an in-depth examination of local practices and service provision was identified as a possible area for workforce development. The aim of this study was to describe specific regional practices for individuals with CEP from a local CADS AOD workforce and to identify comparisons with Gilbert et al's., (2013) results.

1.2 Terminology

1.2.1 Coexisting Problems

There are various terms used to describe the interaction of a mental health disorder and substance abuse problem such as co-occurring, dual diagnosis and comorbidity. For the purpose of this thesis the term coexisting problem consistent with that used in the New Zealand guidelines, *Te Ariari o te Oranga: The Assessment and Management of People with Coexisting Mental Health and Substance Use Problems* (Todd, 2010) will be used to describe the combination of a mental health disorder and substance use disorder.

1.2.2 Alcohol and Other Drug Practitioner

Alcohol and other drug (AOD) practitioner is the term used to describe health professionals working within the community alcohol and drug service.

1.2.3 Consumer

In this study consumer will be used to refer to service users, patients or clients of addiction and mental health services.

1.3 Thesis Overview

1.3.1 Chapter One

Chapter one provides an introduction to the research.

1.3.2 Chapter Two

Chapter two first provides a review of literature in relation to prevalence rates of CEP in general, clinical and Māori populations, risk and suicide associated with CEP, social, psychological and health perspectives on CEP, followed by perspectives on the management and treatment models of CEP including assessment of CEP. This is followed by the New Zealand context of mental health and addiction policy, barriers to providing optimal care and the addiction treatment workforce. This chapter ends with the rationale for the research and the aims and objectives of the research undertaken.

1.3.3 Chapter Three

Chapter three (methodology and methods) is divided into three parts, with the first part focussing on the methodology of a survey questionnaire, design, data collection and analysis, part two focussing on the methodology using an audit tool again describing design, data collection and analysis, and part three describing ethics approval and considerations.

1.3.4 Chapter Four

Chapter four describes the results of the study, in two parts, with the survey questionnaire results presented first in narrative and tables, followed by the clinical files audit results.

1.3.5 Chapter Five

The final chapter, five, reflects on the study's findings, provides recommendations for workforce development and clinical practice and suggests areas for potential further research before concluding the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews the literature on CEP, examining the prevalence rates in the general population and clinical populations both internationally and in New Zealand, inclusive of the indigenous, Māori population. The chapter expands to examine psychosocial influences on CEP, issues and barriers to care, models of care and education needs of the addiction workforce. The chapter concludes with the rationale and purpose of the research, and reporting on the ethical approval process and considerations, DHB consent processes and consultation with Māori.

A literature review was performed at the beginning of this study by searching keywords in EBSCO, OVID, and psycINFO databases. Keywords included addictions, substance use/abuse, mental health problems, mental disorders, addiction workforce, alcohol related problems, drug problems, illicit drug use, treatment, models of care, psychological interventions, talking therapies, dual diagnosis, co-occurring, comorbidity, integrated treatment, education, training as well as a combination of all keywords. Additional searches for information included searching the websites of Matua Raki, Te Pou o Te Whakaaro Nui and the New Zealand Ministry of Health. (pg 3 para 2)

2.2 Prevalence of Coexisting Problems in the General Population

The significantly high rates of coexisting mental health and substance use problems in the general population are well documented in international research (Cuijpers, Smit, Ten Have, & de Graaf, 2007; Do & Mezuk, 2013; Frisher, Collins, Millson, Crome, & Croft, 2004; Grant & Harford, 1995; Grant et al., 2004; Hall, Lynskey, & Teeson, 2002; Kessler

et al., 1996a; Lukassen & Beaudet, 2005; Regier et al., 1990; Staiger et al., 2011; Warner, Kessler, Hughes, Anthony, & Nelson, 1995; Wittichen, Nelson, & Lachner, 1998). In the late 1980s the well-cited US, Epidemiologic Catchment Area (ECA) study, found lifetime prevalence rates of 22% for any non-substance abuse mental health disorder, 13% for alcohol dependence and 6% for other drug dependence abuse. Of those with a mental disorder 29% had a coexisting addictive disorder (Regier et al., 1990). Subsequent to the ECA study, in 1991 the National Comorbidity Survey (NCS) revealed around 10 million people in the USA had CEP. The NCS found just under half of respondents, 48%, who met criteria for a substance use disorder at some time in their life also met criteria for one or more lifetime mental disorders (Harris & Edlund, 2005).

Closer to New Zealand, data from the 2007 Australian National Survey of Mental Health and Wellbeing (NSMHWB) found that one in five Australian adults had an anxiety, mood or substance use disorder in the previous year representing just over three million adults. Approximately 25% of those with a mental disorder had two or more classes of mental disorder. Also, 35% of adults with a substance use disorder had at least one coexisting affective or anxiety disorder.

Whilst data in New Zealand is limited, Te Rau Hinengaro, the first national mental health survey (inclusive of substance use disorders) provided data in agreement with overseas prevalence data, as well as specific data related to Māori, the indigenous population of New Zealand (Oakley-Browne, Wells & Scot, 2006). Findings from this survey showed that 21% of the adult population studied had experienced a mental health disorder or substance use disorder within the previous 12 months. Nearly half, 45%, experienced a drug-use disorder, 31% met the criteria for alcohol dependence and a third of those with any disorder had more than one disorder.

2.3 Prevalence of Coexisting Problems in Clinical Populations

Sellman (2010) provided a perspective on the 10 most important things known about addiction and stated, “Most people with addiction who present for help have other

psychiatric problems as well” (p. 7). International studies have shown a high prevalence of substance use and mental health disorders in addiction and mental health services consumer populations (Abou-Saleh, 2004; Addington & Addington, 2007; Barnett et al., 2007; Compton, Cottler, Jacobs, Ben-Abdallah, & Spitznagel, 2003; Di Forti et al., 2014; Farrelly et al., 2007; Koskinen, Löhönen, Koponen, Isohanni, & Miettunen, 2010; Leeson, Harrison, Ron, Barnes, & Joyce, 2012; Marmorstein, 2011; Munro & Edward, 2008; Volkow, 2009; Weaver et al., 2003).

The US, ECA study (Reiger et al., 1990), also addressed prevalence rates of coexisting mental health and substance use disorders amongst patients treated in mental health and addiction clinical settings. Higher rates of coexisting disorders were found in this group, with 29% having a diagnosis of any mental disorder with either an alcohol or other drug disorder. Of those patients with an alcohol disorder, 37% had a coexisting mental health disorder and 53% had a drug disorder combined with a mental health disorder.

In the UK, addiction services were separated into drug teams and alcohol teams due to government funding arrangements. The 2002, Co-morbidity of Substance Misuse and Mental Illness Collaborative (COSMIC) study estimated the prevalence of CEP amongst patients of substance use and mental health services (Weaver et al., 2003). The results from the COSMIC study for the drug and alcohol treatment services are presented in table 1. below, showing a high prevalence of coexisting mental health disorders.

Table 1: Results from COSMIC study showing prevalence of mental disorder in AOD treatment service users (Weaver et al., 2003)

Mental Health Disorder	Drug Treatment Service User	Alcohol Treatment Service User
Psychotic Disorder	8%	19%
Personality Disorder	37%	53%
Severe Depression	27%	47%
Mild Depression	40%	34%
Severe Anxiety	19%	32%
Depression and/or anxiety disorder	68%	81%

Within mental health services in the COSMIC study, 31% of patients reported problem drug use in the past year, with cannabis being the most frequently reported drug of choice and a quarter reported problematic alcohol use (Weaver et al., 2003).

In an Australian study Burns, Teesson and O'Neill (2005) found that 69% of adults undergoing outpatient treatment for alcohol dependence had at least one coexisting depressive or anxiety disorder. The most common occurring disorder was depression followed by generalised anxiety and social phobia. In the past 15 years there has been an increase of psychotic symptoms amongst consumers of AOD services in Australia due to the increasing use of methamphetamine (Baker, Lee & Jenner, 2004; Topp, Degenhardt, Kaye & Darke, 2002). Baker et al. (2004) study of Australian amphetamine users found that 13% had been diagnosed with psychosis.

Information on the prevalence of CEP in clinical populations in New Zealand is limited. Adamson, Todd, Sellman, Huriwai, and Porter, (2006) recruited 105 service users presenting at two outpatient CADS to investigate the extent of psychiatric disorder and mental health service usage. The results showed that 74% of the sample had a current non-substance axis I disorder, which is similar to the findings of the COSMIC and ECA studies. Most commonly diagnosed coexisting psychiatric disorders were Major Depressive Episode (34%), Social Phobia (31%) and Post-Traumatic Stress Disorder (31%).

In a recent New Zealand mental health service study, Dharmawardene and Menkes (2015) interviewed individuals who were admitted as in-patients with severe mental illness to the Henry Rongomau Bennett Centre at the Waikato Hospital in Hamilton, to determine prevalence of coexisting substance use disorders amongst this population. Out of 141 patients interviewed, 88% reported alcohol use, 60% cannabis use, 12% amphetamine use and 10% non-therapeutic benzodiazepine use in the previous 12 months prior to admission. Whilst not a diagnostic study this is one of the few studies to include tobacco use, finding high rates of nicotine use in that 81% of the participants were smokers and 93% of these were Māori.

2.3.1 Māori

In New Zealand, Te Tiriti o Waitangi/Treaty of Waitangi necessitates that treatment provided is inclusive of addressing the cultural needs of Māori the indigenous people of New Zealand (Alcohol Advisory Council of New Zealand, 1999; Huriwai, Ram, Deering & Sellman, 1997; Huriwai, Sellman, Sullivan & Potiki, 2000; Huriwai, Robertson, Armstrong, Kingi, & Huata, 2001; Robertson et al., 2001). As a group, Māori are over represented in addiction services ranging from 23% to 35% of consumers in some services (Adamson, Sellman, Deering, Robertson, & de Zwart, 2006; Adamson et al., 2000; Ebbett & Clarke, 2008; Huriwai et al., 1998; Ministry of Health [MOH], 2006; Schroder, Peka & Mulder, 2005).

Baxter's (2008) findings highlight that mental health needs of Māori are complex and they experience differing mental health problems than non-Māori. Te Rau Hinengaro (Oakley-Browne et al., 2006) found that prevalence rates of mental disorder for Māori were higher than non-Māori, at 29%. Rates of substance use disorders in Māori were also 6% higher than non-Māori and Māori were also found to experience higher rates of CEP with 26% of Māori compared with 8% of non-Māori experiencing two CEP, and 19% Māori compared with 5% of non-Māori experiencing three or more disorders. For Māori with CEP, the main drug disorder was marijuana dependence or abuse, and one in three Māori with an alcohol disorder also had a drug disorder (Baxter, 2008). These high rates of substance use and mental disorder highlight the need for training mental health and addiction workers in assessment and treatment of CEP as well as the need for Māori consumers to have access to culturally responsive and effective treatment services. Over the past 20 years in a positive move due to the specific needs of Māori, dedicated Māori addiction services and a Māori addiction trained workforce have developed (Huriwai et al., 1998; Robertson, Gibson, & Adamson, 2005).

2.3.2 Summary of General Population and Clinical Studies

The literature examined corroborates the notion that CEP is the norm among individuals seeking treatment for addiction issues, with the limited New Zealand data consistent with international findings. Comorbid anxiety and depressive disorders are commonly experienced by AOD treatment consumers internationally. In New Zealand Māori consumers are over represented in addiction services with higher rates of substance abuse compared to Pākehā.

2.4 Risk and Suicide

In general, people who experience CEP are recognised to have a longer course of illness, higher rates of psychological stress, physical health problems, a range of socio-economic problems and poorer treatment outcomes compared to those with a single diagnosis (Adamson et al., 2004; Compton et al., 2003; Deering et al., 2001; Deering, Frampton, Horn, Sellman, Adamson, & Potiki, 2004; Greenfield, Weiss, & Tohen, 1995; Gafoor & Rasool, 1998; Prochaska, Delucchi, & Hall, 2004; Sheerin, Green, & Sellman, 2003; Teesson, Hall, Lynskey, & Degenhardt, 2000; Todd et al., 2004). Assessment and management of risk in relation to harm to self or others and from others is an expected area of competence for all mental health and addiction treatment health professionals (Crawford, Crome & Clancy, 2003).

There is extensive documented evidence of an increased risk of suicide among individuals currently receiving addiction treatment or on completion of treatment (Dhossche et al., 2000; Erinoff et al., 2004; Kolves, Varnik, Tooding & Wasserman, 2006; Mattieu & Hensley, 2013; Pompili et al., 2010; Ries et al., 2008; Souminen et al., 1996; Wilcox et al., 2004). Alcohol consumption is also a well-established risk factor in studies of suicidal indicators (Cherpitel, Borges, & Wilcox, 2004; Powell et al., 2002; Schaffer, Jeglic, & Stanley, 2008) and there is evidence of completed suicides being associated with both depression and substance abuse (Aharonovich et al., 2002).

Dhossche et al., (2000) carried out a review study of 1136 adult general hospital patients who had been referred for psychiatric assessment over a three year period. They found that those that attempted suicide were diagnosed more often than not with co-morbid substance abuse. Depression and substance abuse were the most common CEP found in 37% of the sample. Older age, male gender and a diagnosis of depression and substance misuse were associated with high suicide intent. A recommendation from this study was to encourage thorough assessment of this consumer group by health professionals.

Bohnert, Roeder and Ilgen, (2011) conducted a large American national study of 5892 participants seeking to engage in addiction treatments. One of their findings was that marijuana users were less likely to have attempted suicide compared to injecting drug users, suggesting a correlation between suicide attempts and more severe drug-related problems.

As referred to above, it is important given the evidence of suicide attempts in individuals with addiction problems that staff who work in AOD treatment settings are able to recognise, assess and address risk. In the US in 2009, the Substance Abuse and Mental Health Services Administration (SAMHSA) commissioned a Treatment Improvement Protocol (TIP) to provide guidelines to assess suicidal thoughts and behaviours in people receiving substance abuse treatment (Mattieu & Hensley, 2013). Of note in this TIP is the recommendation for suicide specific interventions targeted at consumers receiving substance use treatment services.

In New Zealand, Beautrais, Joyce and Mulder (1999) reviewed 302 individuals who made serious suicide attempts in Christchurch and compared this group with a control group. The results suggested that individuals with cannabis abuse or dependence had a higher risk of serious suicide attempt than those without. They estimated those with cannabis abuse or dependence were at ten times higher risk of a serious suicide attempt than those without a cannabis disorder. Furthermore, this increased risk group had experienced social disadvantages and detrimental childhood family circumstances. It is also worth noting that the authors considered the increase in risk amongst those with a cannabis use disorder may also have been influenced by co-morbid disorders such as mood disorders, alcohol abuse/dependence or anti-social behaviours.

2.4.1 The Impact of CEP on Social, Psychological and Health

Many studies specific to severe mental disorders have shown an increase in social, health, economic and psychological consequences above and beyond those already associated with substance abuse (Drake, Mercer-McFadden, Mueser, McHugo, & Bond, 1998; Hipwell et al., 2000; Kovasznay, Fleischer, & Tanenberg-Karant, 1997; Patel et al., 2016; Walker, McGee, & Druss, 2015). Mueser, Drake, and Noordsy (1998) argued that substance use exacerbates all the negative outcomes that occur with many severe mental health problems. It is known that individuals who experience CEP often have a variety of associated social and personal functioning problems such as housing instability and homelessness (Drake, Osher, & Wallach, 1991; Koegel & Burnam, 1988; North, Eyrich-Garg, Pollio & Thirthalli, 2010; Oh & Devylder, 2014; Regier et al., 1990; Soyka et al., 1993), family conflict (Dixon, McNary, & Lehman, 1995; Haskell et al., 2016), reduced social contact (Drake et al., 1998; Stockdale et al., 2007), violent behaviour (Boden, Fergusson, &

Horwood, 2012; Cuffell, Shumway, Choulhan, & MacDonald, 1994a; Sacks et al., 2009; Scott et al., 1998; Smith, Frazer, & Boer, 1994) and financial difficulties (Bond, Chalmers, Jorm, Kitchener, & Reavley, 2015; Drake et al., 1998).

Individuals with CEP may also experience problems in mental and physical health (Jackson, Felstead, Bhowmik, Avery, & Nelson-Hearity, 2015), such as earlier onset of mental health problems (Kovaszny et al., 1997), exacerbation of mental health symptoms (Moos, Nichol, & Moos, 2002; Noordsy et al., 1991; Schumay, Chouljian, & Hargreaves, 1994), increased risk of HIV (Blank et al., 2014; Carey, Weindhardt, & Carey, 1995; Kalichman, Malow, Dévieux, Stein, & Piedman, 2005) and higher chance of sexual and physical abuse history (Alexander, 1996; Bellack & Gearon, 1998; Langeland, Draijer, & Brink, 2004; Rosen, Ouimette, Sheikh, Gregg, & Moos, 2002). Lower levels of physical ability/activity and high rates of injecting related health problems have also been associated with poor general and psychological well-being (Chi, Satre, & Weisner, 2006; Deering et al., 2004; Primm et al., 2000; Watkins et al., 2004). Treatment outcomes for people with CEP have also been shown to be influenced by lack of medication adherence (Buckley, 2006; Owen, Fischer, Booth, & Cuffel, 1996), increased use of services (Bartels et al., 1993; Hipwell et al., 2000) and increased hospitalisation rates (Cuffel & Chase, 1994; Graham et al., 2001).

A US study, conducted by Bartels et al. (1993), provides an example of these associated problems described above. For three groups of patients with schizophrenia, those with current substance abuse, those with past substance abuse and those with no history of substance abuse, they found that the current substance abuse group accounted for all episodes of incarceration and substance abuse hospitalisation and had a greater rate of mental health inpatient admissions. This group was also twice as likely to use emergency services over the period of the study compared to the other two groups. Examining economic costs, the study suggested a trend towards greater costs for this group.

In another more recent study from the UK, Hipwell et al., (2000) compared two groups of 16 consumers attending a community mental health day centre. The first group had schizophrenia or schizo-affective illness and problem substance use and the second group comprised people with only a diagnosis of schizophrenia or schizo-affective illness. Consumers in the first group were more likely to miss appointments at the day facility and

failed to attend on the days they were expected. This group also had more inpatient admissions in the previous year due to psychotic relapse and were found to be more likely to have had multiple inpatient stays.

2.4.2 Summary of Risks, Social, Psychological and Health Associated with CEP

Studies have consistently shown that individuals with CEP have higher rates of a range of health and other problems including higher rates of suicide, poor physical and psychological health, social problems, family and whānau conflicts and financial difficulties. There is very good evidence of a link between CEP and an increase in substance use and greater severity of mental disorder symptoms, as well as issues with treatment adherence. Due to the complexity of issues experienced by this consumer group, thorough assessment and management of individuals with CEP by qualified or experienced health professionals is considered vital.

2.5 Perspectives on the Management of CEP

Considerable research has focussed on attitudes of mental health professionals towards consumers who experience CEP and their capability of recognising coexisting drug or alcohol problems rather than on their counterparts in addiction services (Adams, 2008; Coombes & Wratten, 2007; Edward & Munro, 2009; Gafoor & Rassool, 1998; Moore, 2013; Munro, Watson & McFadyen, 2007). However, a large Australian study across Queensland, conducted by Kavanagh et al. (2000), compared views on the management of substance misuse and mental disorders between mental health service staff and addiction service staff in Queensland. It must be noted in this Australian study, there was a greater participation by addiction service staff, 79%, in contrast to mental health service staff, 42%. A noticeable finding from this study was a report by both services of insufficient collaboration between facilities in managing consumers with CEP. Unsurprisingly, both services reported greater difficulty managing problems related to the other service speciality than their own, but addiction service staff reported a greater range of difficulties in addressing consumers' mental health problems and accessing mental health services

than mental health service staff did in accessing addiction services for their consumers. This was especially related to legislation and criteria for use of the mental health act. The addiction service staff felt that accepting an addiction service consumer under the mental health act depended on the particular mental health clinician on duty or the local policy around intoxicated consumers who expressed suicidal thoughts. Curiously given the information on prevalence rates in clinical populations (already discussed), the mental health service staff estimated only 21% of their current consumers had a substance abuse problem, however staff acknowledged their lack of usage of screening tools. In asking the participants of the study for suggested solutions to these issues both services agreed on the need to utilise screening tools for mental health and substance use problems, joint case conferencing and development of shared treatment plans, and that the provision of consultation or supervision across services would be valuable.

Internationally, relatively few addiction consumers with anxiety or depression are suitable for referral onto mental health services, due to the relative high frequency across the community of these conditions in comparison with psychosis, and because mood and anxiety disorders are commonly associated with intoxication or withdrawal from a number of substances. In recent times, anxiety and depression have frequently been seen as outside the priority focus of specialist mental health services either because they have not been sufficiently severe in intensity or because the priority given to 'serious mental disorders' by mental health services has been misunderstood by addiction workers to mean excluding their consumers from consideration (Kavanagh et al., 2000; Merikangas et al., 1998; Raimo & Schuckit, 1998). However, most mental health service consumers with substance use issues are suitable for addiction treatment. As a result, staff working in addiction services require both AOD and mental health screening, assessment and treatment competencies particularly pertaining to commonly presenting issues such as anxiety and depression (Farrell & Marshall, 2007).

In an Australian study by Cameron, Lee and Harney (2010) the attitudes of addiction service staff towards consumers with CEP following participation in a brief training program were examined. Staff participated in a two day training, covering mental health screening, assessment and formulation. Results showed an improvement in participants' attitudes to people with CEP, as well as improvement in knowledge, skills and confidence in working with this consumer group. What this study and similar studies (e.g. Hunter et al, 2005)

demonstrated is that attendance at brief mental health training can positively influence attitudes towards these consumers, with the potential to improve services for consumers.

2.5.1 Treatment Models

Over the past 20 years the growing literature in the area of CEP has led to a realisation of the need to improve treatment and services for individuals with CEP. Several models of care have been developed focussing on clinical practice as well as the health care system.

Quadrant I		Quadrant III	
Coexisting Problems	Locus of Care	Coexisting Problems	Locus of Care
Low substance use severity Low psychiatric severity	Primary care settings	High substance use severity Low psychiatric severity	Addiction treatment system
Quadrant II		Quadrant IV	
Coexisting Problems	Locus of Care	Coexisting Problems	Locus of Care
Low substance use severity High psychiatric severity	Mental health system	High substance use severity High psychiatric severity	Mental health system/hospital/emergency services/police

Figure 1: Quadrants of care model (Ries, 1993)

The Quadrants of Care Model (Ries, 1993) provided a conceptual framework for understanding a range of co-occurring conditions and the level of coordination required by health service systems to address them (see figure 1.). This was a dynamic model in that individuals could move between the quadrants, for example someone with acute mental illness symptoms and a substance use disorder could be assigned to quadrant IV for a brief time, then be allocated to a less severe quadrant due to a reduction in acuity and/or severity of symptoms. The Quadrant model provided a structure to foster consultation, collaboration and integration among systems and providers in order to deliver appropriate care to people with CEP (CSAT, 2005; McGovern et al., 2006; Ries, Mullen, & Cox, 1994). However, at a practical level the framework fails to define each level of severity, making it difficult for health professionals to match treatment to the specific needs of individuals (Keyser, Watkins, Vilamovska, & Pincus, 2008).

Existing treatment models for consumers who experience CEP include serial, parallel, shared care/collaborative liaison and integrated treatment services (Staiger, Long & Baker, 2010). In general, up until recently, mental health and addiction services across the US (Drake & Mueser, 2000), the UK (Edeh, 2002), and Australia (Donald, Dower & Kavanagh, 2005) have operated separately, in a serial or parallel system. In a serial system the consumer is expected to address one problem first, normally the substance issue before being accepted into a mental health service i.e. mental health and addiction services are not offered concurrently (Edeh, 2002; Drake & Mueser, 2000). The reasoning behind this is that mental health services are not equipped to deal with substance affected consumers and that mental health symptoms might reduce once there is a reduction in the substance use. However, vulnerable consumers risk being refused treatment from both services due to exclusion because of the 'other' issue and if they are accepted, their treatment excludes those components that address the compounding effects of having both problems (Staiger et al., 2010).

In a parallel service model the consumer receives treatment from the mental health service at the same time as receiving treatment from addiction services without a coordinated treatment plan or one designated case manager and often with no communication between services. The problem with a parallel approach is that the consumer is not supported to negotiate their clinical pathway and often experiences irregularities, repetitions or contradictions in treatment delivery (Drake & Mueser, 2000). With the parallel model the consumer is also more like to 'fall' between the gaps (Donald et al., 2005).

A shared care or collaborative model is one in which mental health services and addiction services remain separate, but work in partnership with clear communication between both services and synchronised, coordinated treatment plans are determined by agreed protocols (Edeh, 2002, Flanagan, 2002, Grella & Gilmore, 2002). The benefit of this approach is that it provides a realistic and practical approach within the current resources and within existing health services (Lowe, 2002, Weaver et al., 2003).

Recognition of CEP as 'the norm' or core business of both mental health and addiction services has over the past 10 to 15 years gained traction in service delivery and government initiatives (Staiger et al., 2010). There is increasing recognition of the need for an integrated evidence based model which is often cited as the 'gold' standard for CEP treatment (Minkoff & Cline, 2004). Minkoff (2000) outlined key principles which

integrated CEP treatment needs to be based on, to take full advantage of the potential for positive outcomes. These principles include:

- a focus on the importance of the treatment relationship between the consumer and health professional
- the need to consider both mental health and addiction disorders as dual primary disorders
- the requirement of individualised treatment and interventions that can be applied at any level of care

Integrated treatment involves health professionals trained in both addiction and mental health, providing integrated, inclusive services directed at both disorders simultaneously in the same venue with the goal of recovery from both disorders (Biegel, Kola, & Ronis, 2007, Mueser et al., 2003). Numerous controlled studies of integrated practices have identified positive outcomes across consumer domains for individuals with severe mental disorder and coexisting substance abuse leading to decreased hospitalisation rates, improved legal and functional status and quality of life (Barrowclough, Haddock, Fitzsimmons, & Johnson, 2001, Drake et al., 1998). However, Tiet and Mausbach (2007) reviewed 59 studies of integrated treatment practices and found an overall lack of data and diversity within integrated treatment teams providing only weak data in support of integrated practices.

2.5.2 Assessment of Coexisting Problems

Assessment is the process of gathering and analysing information by a clinician in order to gain understanding and formulation of the presenting issues (Matua Raki, 2012). A review of the literature in this area shows a lack of routine screening for CEP by AOD practitioners despite acknowledgment that a comprehensive assessment is required to assist in effective treatment (CSAT, [Centre of Substance Abuse Treatment], 2006, Minkoff & Ajilore, 1998, Rassool, 2006, Saunders & Robinson, 2002, Tobin et al., 2001). The CSAT (2006) in the US and Rassool (2006) in the UK suggested the knowledge and skills required to assess individuals with CEP, including:

- Risk assessment and management
- Ability to identify common mental health disorders

- Inclusion of the family/whānau
- Recognition of the importance of cultural assessment
- An understanding of the complexity of CEP

In New Zealand, good practice guidelines for carrying out a comprehensive assessment utilising appropriate screening tools is clearly and comprehensively laid out in Te ariari o te oranga: The assessment and management of people with coexisting mental health and substance use problems (Todd, 2010).

Within the Todd (2010) guidelines, are seven key principles;

- | | |
|----------------------------|--------------------|
| 1. Cultural considerations | 5. Assessment |
| 2. Well-being | 6. Management |
| 3. Engagement | 7. Integrated care |
| 4. Motivation | |

The key principle of cultural consideration includes information on Pacific people, Asian people, Pākehā cultures and lesbian, gay, bisexual, transgender, takataapui and fafafine with Todd (2010) recognising the national importance of Te Tiriti o Waitangi guaranteeing access for Māori to culturally appropriate health care, and therefore focussing in detail on identifying key knowledge and skills for health professionals. Todd's (2010) cultural considerations are congruent with the CSAT (2006) and Rassool (2006) recognition of the importance of cultural assessment. The next principle is well-being, where the focus of care is not just to focus and alleviate the problem but also to enhance positive attributes, which fits into the already well recognised strengths model used in mental health services. A well-being focus in the treatment of consumers with CEP is seen as important for enhancing recovery and reducing relapse from problems such as depression; it also fits in with enhancing engagement in services and increasing motivation to change. In New Zealand it is important to acknowledge there are cultural differences in well-being, as western approaches focus on the individual, whereas Māori models of well-being focus on the capacity of the whānau to carry out its key functions therefore attaining optimal health and wellbeing (Durie 2001). The third principle, engagement, is important for consumers with CEP, as failure to engage in treatment leads to poor outcomes. The fourth principle,

motivation, is specific to those consumers without severe mental health problems such as psychosis as there is little evidence to suggest it is particularly effective in changing substance use or mental health symptoms in this consumer group (Carroll et al. 2006, Drake et al. 2008). Martino et al. (2006) suggest adaptations to motivational interviewing (MI) when working with consumers with CEP, such as targeting the substance use problems and mental health problems with MI, using simple language and open ended questions, using repetition, simple verbal and visual materials in sessions, and avoiding focussing on negative life events. The fifth principle, assessment, is discussed in greater detail next. The sixth principle, management, looks at implementing management plans formulated during the assessment phase and involves strategies common to consumers with CEP (for example, case management, techniques for stabilising acute substance use and mental health, and integration of care) and specific strategies targeting the combination of mental health and substance use problems (for example, specific cognitive behavioural interventions for anxiety and substance). The final principle, integrated care, as discussed in the previous section involves more than just mental health and alcohol and drug use. Providing integrated care relies on putting the needs of the consumer ahead of those of the system, providing a comprehensive formulation and treatment plan, and enhancing the capabilities of health professionals to deliver integrated care (Todd, 2010).

In the document, *A Guide to the Addiction Treatment Sector in Aotearoa New Zealand*, by Matua Raki (2014) a comprehensive assessment is described as “...an in-depth holistic assessment of a person’s bio-psycho-social and spiritual background and current functioning and can include medical, psychological and biochemical testing...” (Matua Raki, 2014, p. 20). A comprehensive assessment helps to develop a formulation of aetiology of the substance issue and any contributing factors such as mental health problems in order to create a specific treatment plan for the individual.

The document also goes on to promote other forms of information gathering when specialist treatment services are assessing someone for CEP, such as information from friends, family or whānau, the referral source (for example the general practitioner), screening and assessment tools especially for screening of the common mental health issues such as depression, anxiety and bipolar disorder. Following assessment of the individual is the formulation and treatment planning. Due to the complexities of individuals with CEP the comprehensive assessment and formulation period can take

several sessions and assessments by more than one discipline (for example, psychology, nursing or psychiatry) (Matua Raki, 2014).

According to Todd (2010) the key features of a comprehensive assessment are, firstly, comprehensiveness where all areas of problems are screened for, secondly, equal weight is given to the main approaches of conceptualising an individual's problems (they are diagnostic, individualised and aetiological formulation), and finally integration. Components of a comprehensive assessment include data collection from the consumer, for example history taking and mental state examination, followed by opinion, where a diagnostic statement and aetiological formulation occurs, thirdly management plan and goals are set, the fourth component is prognosis and finally feedback to the consumer and negotiation on treatment or therapy is the final component.

A New Zealand telephone survey conducted with nurses who had completed the national survey of AOD workers commissioned by Matua Raki (2008) and agreed to a follow up survey (Deering 2008), surveyed nurses working in the addiction sector (not all with mental health specific education and training) on their clinical practice. In response to confidence in working with consumers with CEP only 59% rated themselves at eight or above (10 being extremely confident and 0 being no confidence) in completing a mental health assessment and 62% in working with individuals with CEP.

2.5.3 New Zealand Mental Health and Addiction Services and Policy Context

Within New Zealand, mental health services have evolved from large institutional hospitals to primarily community based outpatient treatment services (Mental Health Commission, 1998). Through the development of health policies (Ministry of Health, 2005), specialist services such as forensic and addiction services have developed. Addiction services are provided by District Health Boards (DHB) and Non-Government Organisations (NGO), delivering a range of community based treatments with DHBs providing more specialist programs such as opioid substitution treatment and detoxification programs.

Overseas, 'Dual Diagnosis' teams have been developed to provide integrated, unified services to meet the needs of individuals with CEP (Graham, Copello, Birchwood, &

Mueser, 2003; Ries, et al., 1994; Zimberg, 1999). In New Zealand, there are few of these specialist ‘dual diagnosis’ treatment services. However, DHB CADS have multi-disciplinary teams that include mental health consultant psychiatrists, psychologists and mental health nurses with a special interest and/or expertise in addictions.

Over the past 15 years, mental health and addiction treatment strategies have been a priority in New Zealand, initiated by the *New Zealand Health Strategy* (MOH 2000) and *The New Zealand Disability Strategy* (MoDI 2001). In 2005, the government set out priorities for mental health and addiction in the document, *Te Tahuhu – Improving Mental Health 2005 – 2015* (MOH 2005). Te Tahuhu also provided a strategy for how future investment in mental health and addiction will be addressed. Following Te Tahuhu came *Te Kokiri: The Mental Health and Addiction Action Plan* (MOH 2006) which was developed to directly implement Te Tahuhu, with specified actions and responsibilities for stakeholders, with clear timeframes. One target identified in Te Kokiri was the alignment of service delivery for people with coexisting disorders and one challenge of Te Tahuhu was improvement in working collaboratively which had a direct bearing on improving service responsiveness for people with CEP.

The New Zealand Mental Health Commission (MHC) set out their vision of the mental health and the addiction sector in *Te Hononga 2015: Connection for greater well-being* (MHC 2007). A key point in Te Hononga was that by 2015 mental health and addiction services would be integrated and a full range of mental health and addiction services would be available and accessible to people.

In 2010 a significant impetus for improving CEP capacity and capability began with the publication of two documents, *Integrated Solutions: Service delivery for People with Coexisting Mental Health and Addiction Problems* (MOH 2010) and *Te Ariari o te Oranga: The Assessment and Management of People with Coexisting Mental health and Substance Use Problems* (Todd, 2010). Integrated Solutions (MOH 2010) was developed as a guidance document for DHB planners and funders, and the managers of mental health and addiction services, with the emphasis on secondary and tertiary mental health and addiction services. There were four areas of focus within this document:

1. Consumer centred
2. Service development

3. Integrated systems of care
4. Workforce development

The second document (as discussed previously in section 2.4.2), Te Ariari o te Oranga (Todd, 2010), is the revised 1998, CEP clinical practice guidelines *The Assessment and Management of people with Coexisting Substance Use and Mental Health Disorders* (Todd et al., 1998). Integrated Solutions has a service delivery focus whereas Te Ariari o te Oranga has a strong clinical focus, which provides two complementary documents.

2.5.4 Summary of Management and Models

Over the past 20 years there has been a move towards recognising the increasing impact of CEP on mental health and addiction services and staff competencies. A key factor in providing effective care for people who experience CEP is having a CEP capable workforce who have received training in both appropriate assessment and interventions for this consumer group. Treatment models have been developed to meet the needs of consumers with CEP but provide challenges for organisations, funding models, health professionals' education and training as well as individual service cultures. Within New Zealand, over the past 20 years the government has brought about significant developments in mental health and addiction services, and there is now a greater focus on providing services to individuals with CEP in community settings.

2.6 Barriers to Providing Best Care for Consumers with Coexisting Problems

With progress has also come difficulties or barriers to care. Multiple barriers to high quality care have been identified overseas and in New Zealand in the treatment of people with CEP, for example, clinician attitudes, commissioning of clinical services, stigmatisation and availability of appropriate training for health professionals (Batliwala, 2013; Hudson, Hardy, Henwood, & Wistow, 1997). Negative or judgemental clinician attitudes to consumers with CEP are a specific barrier to optimal treatment for consumers (Chater, 2004; Hamilton, Brown, Grella & Cooper, 2002; Roberts, 2012; Todd et al.,

2002). As discussed in the previous section, lack of integrated treatment can be a barrier to care. Consumers may find their condition is not deemed serious enough or feel shunted between services, whilst clinicians are preoccupied with trying to establish whether the mental health problem or substance abuse is the primary or secondary issue (Chater, 2004; Hudson et al., 1997; Roberts, 2012; Todd, 2010).

The funding structure provides a further barrier, with mental health services receiving the lion's share of funding over addiction services, which maintains the divide between the two. Services are commissioned in silos with consumers having to build relationships with numerous services in a disjointed system (ALAC & MHC 2008; Batliwala, 2013; Roberts, 2012). The inadequate resourcing of the addiction sector in New Zealand has been recognised in both of the Ministry of Health Reports, *Te Tāhuhu* (2005) and *Te Kōkiri* (2006).

There are two important pieces of work that examined barriers to providing optimal care for consumers with CEP in New Zealand. Todd et al., (2002) describe results of a qualitative research study undertaken to aid in drawing up a series of guidelines for the assessment and management of people with coexisting problems. Barriers were categorised into three groups: systems, clinical and attitudes. System barriers included regional planning of services, with the lack of inclusion of service users, family and whānau, health professionals' views, service provision including lack of resources to provide proven interventions such as family work and issues within large rural areas and access to specialist services locally being lacking. The second category, 'clinical', included health professionals having a lack of clinical skills, lack of knowledge around coexisting problems and how the conditions interact, again, inadequate family/whānau inclusion, lack of assertive follow-up and cultural issues specific to working with Māori. The final category, 'attitudes', related to judgemental attitudes and beliefs of health care workers in responding to consumers with substance use issues, the view that 'addiction is not the business of the mental health sector' and rivalry between professional groups and services (Todd, 2002).

The second project was undertaken in 2007 by Ian MacEwan for Matua Raki (MacEwan, 2007). Matua Raki is the National Centre for Addiction Workforce Development in New Zealand. MacEwan visited twenty one DHBs and interviewed both mental health and

addiction staff. One important finding was that addiction workers were not good at identifying mental health problems and vice versa. Both staff groups demonstrated discrimination and stigmatisation towards other services. They experienced difficulties liaising with each other over shared cases. Some of the addiction workers had received some training in mental health but lacked any ongoing supervised training, preventing them from becoming adequately skilled. The addiction services managers found getting staff to up skill and gaining funding for ongoing education, training and development a challenge. These findings were similar to the findings of the Australian study by Kavanagh et al., (2000) discussed earlier in the chapter.

2.6.1 Summary of Barriers

New Zealand data on the barriers to providing treatment for people with CEP concurs with international findings. Barriers to optimal care include systemic barriers, clinical barriers and attitudinal barriers. The barriers are shown to be significant and enduring and in turn affecting the service received by individuals. To address these barriers it is important to examine the addiction and mental health workforce more closely.

2.7 Mental Health and Addiction Treatment

Traditionally the mental health system and addiction treatment system developed separately and remain somewhat disjointed today (Mueser et al., 2003). Each system developed through government legislation and funding pathways. The addiction treatment system developed to have separate policies, administrative and legal requirements compared to the mental health system (Osher & Drake, 1996; Ries, 1993; Ries et al., 1994; Zimberg, 1999).

Historically, Jellinek (1960) saw alcoholism as having a biological basis and addiction as a 'disease', which led to an increased responsiveness and awareness of the necessity for treatment. Like mental health treatment, addiction treatment took place in asylums before moving into mental health institutions (Osher & Drake, 1996). A further difference between the two systems was the value placed upon staff having lived experience of recovery versus formal qualifications (Brown, Grella, & Cooper, 2002). Addiction treatment services were initially based on the 12 Step philosophy of Alcoholics

Anonymous (AA) with AOD practitioners bringing their own experience of recovery to inform their practice (Grella, 2003; McCarty et al., 2007; Mulvey, Hubbard, & Hayashi, 2003; Osher & Drake, 1996).

As well as having different expectations placed upon clinicians from the two separate systems, clinicians had a differing understanding in the interaction between substance use and mental health disorders, for example, mental health clinicians typically viewed mental health disorders as the primary disorder and substance use as a way to self-medicate the symptoms, compared to AOD practitioners viewing substance use disorders as the primary disorder and mental health as an indicator of substance abuse (Mueser et al., 2003).

In New Zealand, mental health and addiction treatment systems have developed similarly to those overseas, from large institutional residential hospitals to largely community based outpatient care (Mental Health Commission [MHC], 1998), with specialist services such as forensic, dedicated Māori services, youth services, dedicated pasifika services and eating disorders services arising from subsequent government health initiatives (MOH, 2005). Resembling overseas systems, initially addiction treatment was provided by medium to long-term residential (12-step based abstinence model) services, and specialist outpatient medical model systems such as opioid substitution treatment programs (primarily methadone treatment) being provided by DHBs (Hannifin & Gruys, 1996; MOH, 2004). Contemporary mental health and addiction workforces in New Zealand are in general similar to those government funded overseas services employing a range of health professionals with health, social services or a recovery background (Matua Raki, 2008).

The variety of professions within the New Zealand addiction treatment workforce supports the notion that a bio-psycho-social approach is required for the complexities of addiction (Matua Raki, 2012). With an increased focus on professionalisation of the addiction workforce in New Zealand a higher proportion now have graduate and post-graduate addiction related qualifications (Adamson, et al., 2004; Matua Raki, 2008; Robertson et al., 2005). Despite this increase in overall level of qualifications, findings from the National Addiction Treatment Workforce Development Programme (NATWDP) (2007) survey found that AOD workers were not good at identifying mental health conditions, which concurs with the earlier findings of Todd et al., (2002) on barriers to optimal care i.e. workers lack of knowledge and skills in this area.

Educating the addiction workforce overseas has comparable issues to that of New Zealand, with research highlighting the need to educate workers about CEP and integrated treatment (Centre for Substance Abuse Treatment [CSAT], 2005; Minkoff & Cline, 2004). In general, undergraduate health professional training programs such as medicine and nursing are generalist in nature requiring more specific addiction training and CEP education (Murdock, Wendler, & Nilsson, 2005). Throughout New Zealand there are a variety of specialised AOD tertiary postgraduate papers available. The Ministry of Health supports professional development by providing access to funds for training courses as well as some travel and accommodation assistance, through organisations such as Te Pou o Te Whakaaro Nui, Workforce development centre for the mental health, addiction and disability sectors in New Zealand (Matua Raki, 2012).

As reported above over the past 20 years there has been a strong push for staff working in addiction services to become competent in certain skills and attitudes pertaining to CEP (Matua Raki, 2008, 2009; MOH, 2004, 2008; NATWDP, 2007). Although not compulsory within the locality district of this research study, it is an expectation that staff will be competent in assessment of people with CEP as well as culturally competent. Competency frameworks (including cultural competency frameworks) include Real Skills (MOH, 2008), Real Skills plus Seitapu: working with pacific peoples (Te Pou, 2009), Working with Māori – Real Skills (Te Pou 2008), Addiction Intervention Competency Framework (DAPAANZ, 2011) and Aotearoa New Zealand Addiction Speciality Nursing Competency Framework (Drug and Alcohol Nurses of Australasia (DANA), 2012). This tidal movement towards competencies is aligned with the move as previously noted towards greater professionalisation of the addiction treatment workforce and at this time the Drug and Alcohol Addiction Practitioners' Association of Aotearoa/New Zealand (DAPAANZ), a professional body for people working in the addiction sector, was established where clinicians apply to register their competency against the Practitioner Competencies for Alcohol and Drug Workers in Aotearoa – New Zealand (Matua Raki, 2012).

In 2015, Te Pou o Te Whakaaro Nui published findings from a national mental health and addiction services workforce survey. Of note, one of the major differences in the workforce is that the DHB mental health services have a greater number of clinical nursing and medical roles compared to the addiction treatment services, which have a higher proportion of staff who are addiction practitioners/counsellors. These differences reflect

the contrasting historical developments of the addiction sector. Despite a huge push from the Ministry of Health and Ministry funded workforce organisations such as Te Pou o Te Whakaaro Nui and Matua Raki over the past 20 years, 77% of respondents in the 2015 survey identified needing skill development in working with individuals who experience CEP and 60% recognised the need to increase their therapeutic skills including in psychological interventions and risk assessment.

According to a stocktake of the addiction treatment workforce in New Zealand in 2008, there were 1370 funded positions (Matua Raki, 2008). In 2011, Matua Raki reported on the addiction sector and clinician professions showing 52% (454 full time equivalents - FTE) of the workforce identified as addiction practitioners or counsellors, 16% (136 FTE) as nurses, 5% (45 FTE) as social workers, 3% (30 FTE) as medical practitioners and 1% (9 FTE) as psychologists.

In 2013, Gilberts et al., large national telephone survey of the addiction workforce showed the workforce to be a majority of female, middle aged, Pākehā with a minority of 34 Māori. Over half the sample (58%) was made up of counsellor/therapists, followed by social workers (16%), nurses (15%) then psychologists (5%) and medical practitioners (2%) with approximately 50% having a tertiary qualification. Findings included the lack of assessment for common mental health problems, overall probable under-detection of CEP, high referral rates to mental health services and worker endorsement for further mental health education. A key limitation to the study was the reliance on AOD practitioner self-report on their practice.

2.7.1 Summary of the Addiction Treatment Workforce

The New Zealand addiction workforce competencies and education themes are similar to US and UK frameworks. Over the past 10 years there has been a push by government to improve services for individuals experiencing CEP, but despite this health professionals are still reporting to require an increase in confidence and capability in working with this consumer group. Also, although there is evidence of an increase in the level of qualification in the workforce, there remain gaps in the capability of health professionals to address CEP. Promisingly, competency frameworks have been established in New Zealand to outline attitudes, values, knowledge and skills necessary for addiction workers,

providing best practice guidelines for the assessment and management of individuals with CEP (Todd 2010).

Gilbert et al., (2013) provided the first comprehensive study of CEP capabilities of the New Zealand addiction workforce. Given this national survey of New Zealand practices and opinions of AOD practitioners in relation to CEP, the next section (Study Aim) describes the researchers' focus of examining local AOD practitioner practices and opinions in relation to CEP by also comparing self-reports to evidence of CEP practices in clinical files.

2.8 Study Rationale

In reviewing the literature, it is clear that CEP are the norm not the exception for individuals presenting to addiction services, with depression and anxiety being the most common mental health problems. There is evidence that people with CEP have reduced physical and mental well-being, difficulties with social functioning and poorer treatment outcomes with poorer treatment adherence when compared to their counterparts experiencing one issue, either mental health or addiction. Using alcohol and drugs when experiencing mental health issues is known to increase the risk of suicide and violence. With siloed funding and criteria for entry to DHB addiction services, some individuals with CEP are discriminated against and 'pushed' from one service to another in serial or parallel treatment models. Nationally and internationally the gold standard approach is an integrated model, despite the limited research on treatment outcomes to support this model at present. Recognising the need to improve the addiction workforce's capability to assess and treat CEP, guidelines and competency frameworks have been developed over the past six years and have included culturally responsive practices/recommendations.

The literature review has highlighted a lack of New Zealand research on the impact of the national policy and practice guideline recommendations in the area of CEP on the addiction treatment workforce, and whether such reports and guidelines produced by government, workforce and research centres have made a difference in upskilling the workforce. This study was designed to investigate the practices, attitudes and competencies of a local DHB addiction workforce in working with individuals experiencing CEP.

CHAPTER THREE

METHODOLOGY AND METHOD

3.1 Introduction

As discussed previously, research based evidence and opinions on the importance of assessing CEP and treating the consumer holistically are widely accepted (Minkoff, 2000; Todd, 2010). Within New Zealand and internationally, a vast amount of literature with a variety of subtopics related to CEP demonstrates the importance of this area of research for improving consumer outcomes. Local DHB policies and frameworks for assessing CEP demonstrate that mental health service managers place importance on improving outcomes for this consumer group. Over the past two years the local DHB has interwoven CEP concepts within its workplace development training initiatives, and the aim of the DHB Mental Health Directorate is that all AOD practitioners will be capable of CEP assessment. Given the lack of information on AOD practitioner practice and taking into account that the researcher was also a clinician working in the locality, research methods for the study were given careful consideration. The aim and objectives of the study are stated and then the methodology, research design and methods by which the study was conducted are described next.

3.2 Aim and Objectives

The overall aim of this study is to describe regional addiction service workforce practices in relation to CEP.

The objectives of the study are to:

- Investigate AOD practitioner views, level of knowledge and confidence in working with people with CEP

- Explore evidence of CEP practices within the clinical health files of CADS consumers
- Identify areas for development locally in regards to CEP practice

3.2.1 Setting

Five years ago the DHB merged from two smaller DHBs, resulting in a merger of team cultures and different ways of working. CADS operates across a large geographical area, having two CADS (referred to as Team One and Team Two from here on) city bases and four smaller outreach sites venued in local community mental health team buildings. The CADS is a secondary level mental health service, providing assessment to consumers with moderate to severe addiction problems. Referrals to the service are mainly by general practitioners (GPs), other health professionals or self. Consumers are initially screened via phone or face to face to see that they meet the criteria for the service and if not they are referred on to the most appropriate service. The services operate Monday to Friday 8.30am – 5pm and employs a variety of health professionals such as nurses, doctors, social workers and AOD practitioners. Both CADS have different Service Provision Frameworks (SPF), hence separating CADS to Team One and Team Two. The key difference being Team One, provide assessment and a variety of treatment in house, whereas Team Two provide assessment and refer on to other treatment agencies where possible.

3.3 Methodology

In keeping with the aim of the study and objectives and the context of investigating the CEP practice of AOD practitioners, careful consideration was given to the research methodology and methods. Qualitative methodology was considered but discounted. For example methods such as in-depth interviews or focus groups were considered and discounted as these may have prevented less experienced or less confident AOD practitioners from expressing their views openly and reporting on their practice in conducting assessments of consumers with mental health disorders. Parker and Tritter (2006) report that limitations of focus groups are the uncontrolled nature of the process as well as potential dynamics.

Beanland, Schneider, LoBiondo-Wood and Haber (1999) describe quantitative research as employing strategies that deliver numerical data to answer the research questions with conclusions drawn from the data. Quantitative research can comprise experimental, quasi-experimental or non-experimental designs. A non-experimental design was chosen to answer the research question as there was no manipulation of the variables required.

The researcher reflected on which research methods would be the most appropriate to answer the research question. Research conducted interviews were not chosen due to the research context and geographical considerations. Clinical teams were spread across a large geographical area and the time it would take to carry these out was prohibitive for a part time, employed research thesis student. Triangulation of two methods, a file audit and survey questionnaire, was chosen and each method is discussed in more detail in sections 3.3 and 3.4. The two methods were chosen because they were feasible and were considered to have a high possibility of providing important information in keeping with the research aim and question.

Casey and Murphy (2009) explain method triangulation is simply where more than one method of data collection from the same design is chosen to measure the same variables. Begley (1996) provide two reasons for triangulation, 1. Confirmation of data and 2. Completeness of data. By conducting a clinician survey and carrying out file audits the researcher hoped to gain more robust data and identify any incongruities between what AOD practitioners report they do as common practice and what is documented in the clinical file. Thurmond (2001) recommends researchers describe how triangulation will add to their study. Complementing an audit with a survey questionnaire, the researcher expected to yield a more comprehensive set of results, in turn, providing a more comprehensive explanation of the subject area. Also using two methods, the researcher trusted that as Sim and Sharp (1998, p.23) stated, "...the strengths of one [method] will compensate for the weakness of another, thereby improving the quality of data...".

PART I

3.4 Survey as a Method

Sinkowitz-Cochran (2015, p.1159) describes surveys as a tool “...to determine the behaviour or opinions of a particular population...”. A survey was chosen as one method as the researcher wanted to focus on CADS AOD practitioners and their ability, attitudes and knowledge of mental health issues and assessment of their consumer group. A survey would also complement the data found in the clinical file audit. Choosing a survey would allow for anonymous feedback on current practices to the health care providers which was important given the researcher worked within the Mental Health Service locally and would have been known to the AOD practitioners.

3.4.1 Questionnaire

Adapted from the survey conducted by Gilbert et al., (2013) and the Matua Raki, Coexisting Problems Service Checklist (2012), a questionnaire (see appendix one) comprising open and closed questions requiring a mix of narrative and Likert scale responses was developed and comprised four sections:

- (A) Demographics including work setting, profession, experience, qualifications, formal education and training.
- (B) Mental health knowledge and confidence in recognising common mental health disorders.
- (C) Use of knowledge of mental health screening and assessment tools.
- (D) Attitudes towards consumers with CEP.

Using a mix of open ended and closed questions would allow the researcher to drill down and gain the specific information required to address the research aim and objectives. Closed questions were asked with some having a Likert rating scale of five points used, allowing for the middle point to be interpreted as ‘neutral’, e.g. neither ‘agree’ or

‘disagree’ (Likert 1952). Due to the specific area of research no exact survey template already published was adequate.

3.4.1.1 Section A

Section A comprised questions regarding location of work, gender, ethnicity, profession, formal qualifications, experience in the addiction field and any prior experience in other mental health settings (to identify staff members’ mental health work experience) as well as the function of the participant’s current position. As the DHB has provided training opportunities to all staff on CEP and associated topics the participants were asked if they had attended particular sessions or had wished to but were unable to attend. If participants answered ‘yes’ to wanting to attend training but were unable to attend they were asked to comment on any barriers they experienced.

3.4.1.2 Section B

Section B focussed on mental health knowledge and confidence in recognising mental health disorders. Question 1(a) asks the participant if they had completed an initial assessment or comprehensive assessment in the past month, with subsequent questioning around this assessment. Questions in this section sought to identify whether participants had enquired about mental health symptoms or particular mental health disorders. The purpose of such questions was to ascertain the participant’s confidence in mental health enquiry of specific mental health conditions which are known to be prevalent amongst people with substance use problems. The final question in section B enquired about the participant’s confidence in assessment of mental health conditions and other related tasks. Response requirements for section B were a mixture of categorical ‘yes/no’ and Likert scale responses.

3.4.1.3 Section C

The third section, C, focussed on screening tools and what specific activities the participant carried out once assessment had been completed with the consumer. As evidenced further in Part II, screening tools were also identified within the clinical file audits enabling a comparison between what participants reported they did and what was recorded in the clinical file.

3.4.1.4 Section D

The focus of the final section, D, was to gain participants' views on CEP topics and participants' attitude towards CEP. A number of statements with Likert scale responses were provided for participants to respond to, worded from 'strongly disagree' to 'strongly agree'.

3.4.2 Questionnaire Pre-test

The questionnaire was pre-tested by two senior AOD practitioners with experience of working with addiction consumers with mental health problems, but who were not currently working for participating teams. The purpose of pre-testing the questionnaire was to check interpretation of the questions and the format. As a result the format was altered to provide more space for comments where requested.

3.4.3 Sample

All AOD practitioners in paid employment at CADS within the DHB were eligible for selection. AOD practitioners who had had no face to face consumer contact in the previous 12 months were excluded from participation as the survey required information on their assessment and screening knowledge. Having clinical contact in the previous 12 months was identified as a requirement in the participant information sheet (See appendix two).

3.4.4 Sample Selection

In January 2015, initial contact was made by letter with the managers of the two CADS (Team One, Team Two) seeking their formal support for the study. The letter outlined the study proposal, and should they support it the study requested a list of their AOD practitioners. Both managers responded within a week with a list of their staff. On receipt of the two lists a phone call was made to the managers to check their understanding of the study and the accuracy of the list of names they had sent to the researcher. The backgrounds of the health professionals were a mixture of nurses, doctors, counsellors/AOD Practitioners, social workers and occupational therapists.

3.4.5 Sample Randomisation

The two lists of health professionals comprised twenty-one health professionals in Team One and twelve in Team Two, giving a total of thirty-three. In consultation with the University of Otago biostatistician and thesis supervisors, importance was placed on gaining both a realistic response rate and as representative a sample as possible of AOD practitioners, in order to avoid a potential response bias. A response rate of 100% was considered unlikely in that not all AOD practitioners may be willing to participate due to the research context. Bias could have been created by asking for volunteers to participate in the study which may have led to staff who are highly skilled and experienced being over represented, as clinicians with low confidence in their practice ability may feel inhibited to participate.

In addition to attempting to gain a representative sample, the sample was stratified across the teams as the numbers of staff in each team differed. This resulted in a 60% recruitment target for Team One being thirteen, and seven participants for Team Two. The randomised sample of 60% of the AOD practitioners for each team was computer generated by a non-health professional blinded to the study working in Health Information Management for the DHB. Under guidance the non-health professional used a computer system to allocate random numbers to potential participants' names which were then, using an Excel computer spreadsheet, ordered numerically (from one to 21 for Team One and one to 12 for Team Two) and then took the first thirteen participants (60%) for Team One and seven participants (60%) for Team Two. Figure 2. below shows the sample selection in a flow diagram format.

3.4.6 Recruitment

Following the randomisation process each team manager was sent participant information sheets (see appendix two) to circulate to all their staff. The information sheet gave details of the proposed research and the contact details of the researcher and primary research supervisor, should staff members have any questions or concerns about the research they wished to discuss. Selected participants were individually contacted via email by the researcher to advise of their selection, again including the participant information sheet, and inviting them to participate in the research. They were again invited to raise any queries that they may have regarding the research itself or participation in the research.

The researcher emphasised confidentiality and anonymity of response in that the survey questionnaires would have no identifying information recorded on them, instead having a number assigned to each

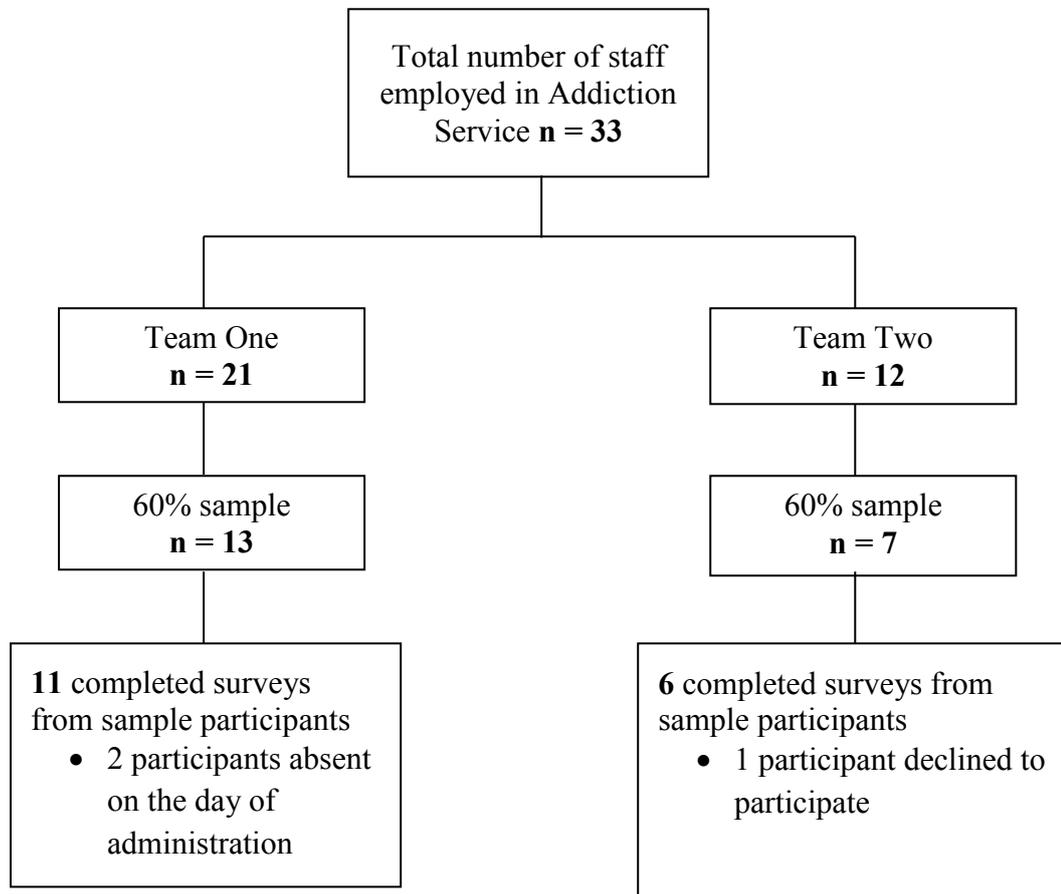


Figure 2: *Sampling process for staff survey participation sampling process for staff survey participation*

3.4.7 Data Collection

In association with the researcher and CADS managers, a date for administering the survey questionnaire was set when the majority of the workforce would be on-site and the researcher was available to travel. As the researcher completed the second part of the study (clinical file audits) on-site it was opportunistic to gain access to participants at the same time.

On-site in a private room, selected participants who indicated a willingness to participate each confirmed their understanding of the study and what participation involved. An opportunity to respond to any queries was provided prior to gaining written informed consent (see appendix three). The completed consent forms were handed to the researcher and placed in a file and then a questionnaire was handed to the participant to complete without the researcher present. Participants completed the surveys in their offices alone. The researcher set up a separate file for collection of anonymous (numbered) completed questionnaires outside the room (closed door) where the researcher was venued, i.e. the researcher did not see participants place the completed questionnaires in the file. Completed surveys were then transported in a locked case back to the researcher's office for safe storage.

3.4.8 Data Analysis

Data analysis was conducted separately for each (Team One. n=11, Team Two. n=6). Working through each team's participant questionnaires systematically, results were collated onto a blank survey tool (One for Team One, One for Team Two). Descriptive statistics were compiled manually due to the small numbers of participants (frequencies and percentages). Narrative responses/comments were compiled specific to each question.

PART II –

AUDIT METHODOLOGY AND METHOD

3.5 Audit

A retrospective audit of the CADS clinical files was one method deemed appropriate for this study. A search to find the theoretical underpinnings of audit was undertaken on CINAHL and Medline electronic databases as well as searching the University of Otago online thesis collection. The terms ‘audit’, ‘evaluation’, ‘records’, ‘clinical’, ‘review’ and ‘documentation’, both singularly and combined were used to search articles. Although numerous articles where researchers had carried out audits were found, none had an explanation of the theoretical underpinnings of an audit. However a definition was found and according to the National Ethics Advisory Committee (2012 p.4) “... Audits involve the systematic evaluation of aspects of health or disability support service delivery by considering measurable indicators of performance and/or quality”.

3.5.1 Clinical File Audit

The purpose of the audit was to apply a set of pre-determined indicators against which information within the clinical files could be assessed or evaluated which demonstrated mental health assessment by AOD practitioners. Initially a list of potential assessment approaches and procedures was identified by the researcher in accordance with New Zealand best practice guidelines (Todd, 2010). This was achieved by the researcher requesting and reading through each CADS Service Provision Framework (SPF) document, which provides a summary of the principles and practices of CADS, e.g. referral pathways (entry into the service is via GP, NGO providers or self-referral and consumers not meeting the criteria of having a moderate to severe addiction problem will be referred onto the most appropriate service), DHB AOD forms, screening tools and clinical assessment frameworks. The researcher also used her own work experience as well as knowledge gained from post graduate mental health and addiction papers to add to the list of endorsed CEP or mental health assessment approaches and procedures. From

the compiled list, six admission/assessment forms were selected for inclusion in the audit tool from which to ascertain participants' incorporation of mental health assessment and these six forms. These were:

- Single Point of Entry Triage Form
- Addiction Services Entry Assessment Form
- Initial Screening for Drug and Alcohol Form
- Comprehensive Assessment Form
- Urgent Assessment Form
- Community Alcohol and Drug Services Assessment Form (CADS Assessment Form)

These documents and forms are described in more detail below in section 3.5.4 Data Collection.

3.5.2 Audit Template

An audit tool template was developed appropriate for use in this audit following exploration of current literature and finding an absence of a validated audit tool with the specific indicators that the researcher wanted to examine. The researcher's primary focus was on evidence of mental health screening/assessment gained from examining data contained in any of the six forms specified in the previous section, which provided a pre-determined audit template, as shown in appendix four. The template listed the forms in the first column which were numbered one to five (NB. the Single Point of Entry Triage Form and Addiction Services Entry Assessment Form were combined and called Triage Form due to the similarities between the forms). The researcher could circle either 1 = 'yes' or 0 = 'no' in the related columns as to whether the documents were present. The next column, asked if these documents showed any evidence of mental health screening, again providing the option of 1 = 'yes' or 0 = 'no' response. The final column of the file audit template allowed for researcher comments to be recorded relevant to the type of evidence available, for example, 'a mental state examination has been performed', 'a mental state examination is recorded', 'a validated questionnaire has been used', for example the Beck Depression Questionnaire (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961).

On the reverse of the audit template (See appendix four) there was a space allocated for any other comments and the question: 'If there is no documented reference by the clinician to mental health disorders, is there evidence in the clinical file or documentation that questions pertaining to mental health conditions and or symptoms were asked?' allowing for a response of 'yes' or 'no'. This allowed for recording of mental health screening tools or questionnaires that a clinician may have administered but not referenced in their documentation. These tools can be filed in the Miscellaneous Section of the clinical file which is the last section of the file and easily accessible to the researcher for review.

The file audit template was pre-tested on three randomly selected CADS files. The three files were randomly selected from shelves in the clinical file room of a rural CADS team. The researcher systematically examined each clinical file and trialled the audit template to check if the template was easy to use, captured the information that was required and the time it would take to complete one template. The only change required to the template was to enlarge the comments section.

3.5.3 Sample

A two-step process for sampling was used.

3.5.3.1 Step 1 - Sample Pool

All consumer referrals to CADS that were accepted by either Team One or Team Two, regardless of presenting addiction issue in the year 2014, were deemed eligible for inclusion in the audit. A non-health professional blinded to the study, who held the position of Health Information Manager within the DHB, used the Information Patient Management System (IPM) to extract the number of admissions into CADS for the period January 1st to December 31st 2014. The research criterion for inclusion was that the consumer must have had at least one face to face contact recorded in IPM. Admissions that only had a telephone contact recorded were excluded from the study as it would not be an expectation that the clinician would have completed any of the six forms over the telephone. A total of 490 initial assessment contacts for Team One and 255 for Team Two were recorded in 2014.

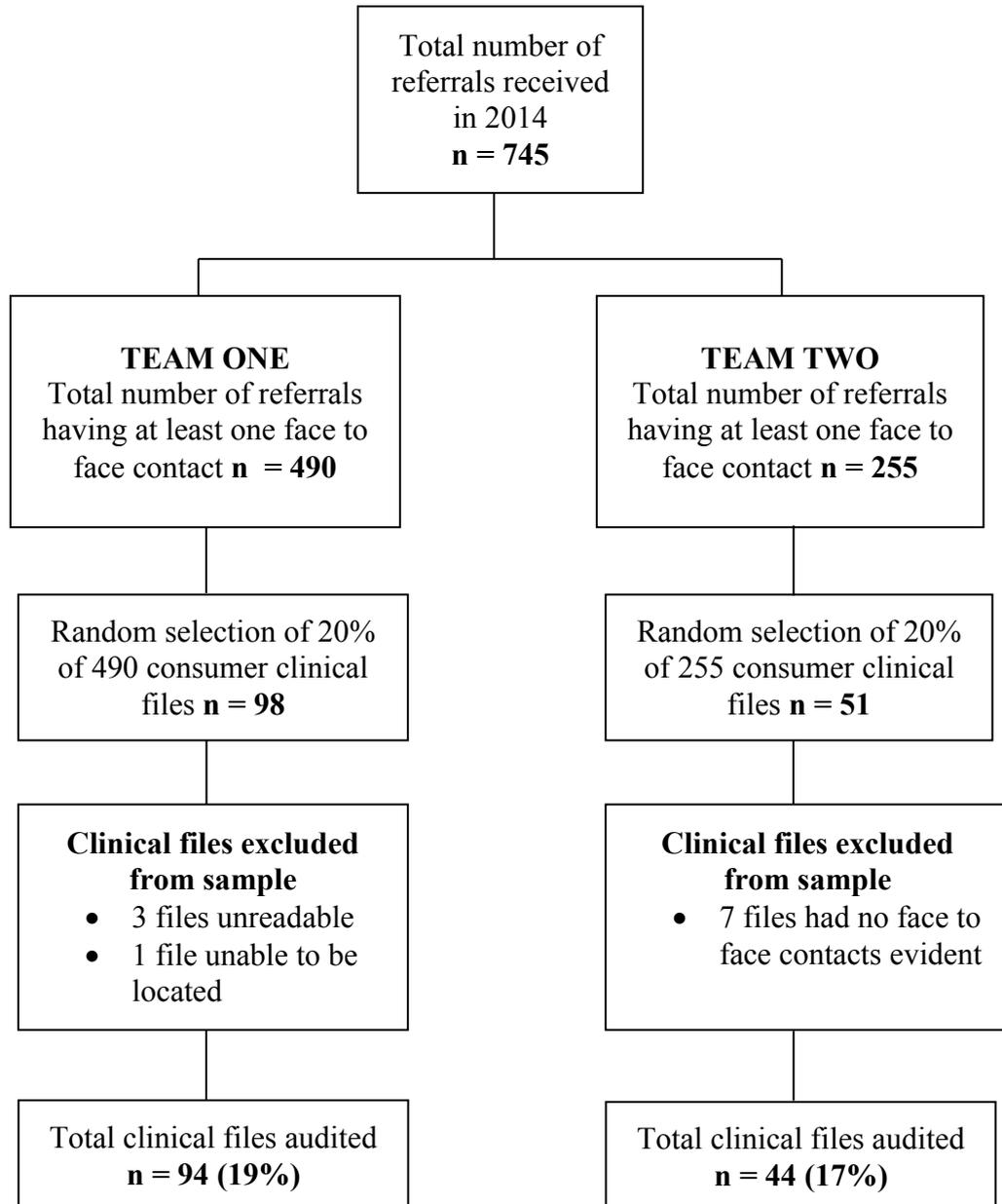


Figure 3: Clinical file audit sampling process

3.5.3.2 Step 2 - Sample Randomisation

Following consultation with the University of Otago biostatistician, importance was again placed on gaining a representative sample of 20% of total clinical files for each team, resulting in 98 Team One files and 51 Team Two files. The non-health professional blinded to the study used an Excel computer program which allocated a random number to each consumer National Health Index (NHI) number, then sorted the list into ascending numerical order, with the top 20% being selected for the file audit sample. Two

spreadsheets were given to the researcher, one for each team, with recorded NHI numbers and dates of entry in the Addiction Service. Three files had illegible hand writing and were unable to be read, one file was unable to be located by the clinical records clerk and seven files had no face to face contacts evident but had incorrectly been recorded on the IPM system as so. (Figure three shows the sampling process for the clinical files)

3.5.4 Data Collection

Information pertaining to each of the six assessment forms/tools referred to in the clinical audit template are described in more detail below.

3.5.4.1 *Single Point of Entry Triage Form and the Addiction Services Entry Assessment Form (See appendix five and six)*

Both forms ask for the same information so were labelled as ‘Triage form’ on the audit tool. Both forms have space available for the clinician to document evidence of how the consumer meets the criteria for entry into CADS and any other significant issues, including risk to self and or others.

3.5.4.2 *Initial Screening for Drug and Alcohol Form (See appendix seven)*

The form asks specifically whether the consumer had experienced any mental health difficulties in the past including seeking treatment for these difficulties, followed by asking does the consumer have current mental health difficulties, such as issues with their mood. As part of this form a risk statement on suicidality is required from the health professional completing the form.

3.5.4.3 *Comprehensive Assessment Form (See appendix eight)*

A comprehensive assessment form was the next document audited. This form gives AOD practitioners a framework to comprehensively gather data about the consumer, including the consumer’s mental well-being and mental health status.

3.5.4.4 Urgent Assessment Form (See appendix nine)

The form is often completed by the Emergency Mental Health Teams prior to admission to a Mental Health or Addiction Service but can also be completed if a person presents urgently to an Addiction Service. The assessment of mental health status and risk is a routine part of this form and categorised as such in the document.

3.5.4.5 Community Alcohol and Drug (CADS) Assessment Form (See appendix 10)

In the past 12 months this form has been adopted for use across the Addiction Services. Assessment of mental health and risk were required in completion of this form.

3.5.5 Procedure

The file audit was undertaken on-site in each of the six CADS, over four non-consecutive days due to the distance between each service, the travel time and the researcher also having a full time clinical position. As described in the Setting Section 3.1.2, the six services are made up of two city bases and four rural bases. Management engagement was elicited in advance during the research proposal stage of the study. The researcher communicated with each CADS manager (as well as the senior DHB management team) explaining the study and gaining support from them. Once managers had provided formal support for the audit, each manager and administrator were given advance notice of the date for the on-site file audit, via email and a follow up personal phone call. They were also provided with a list of the clinical files that were required for auditing. Service managers provided a quiet room on-site for the researcher to use to conduct the audit.

Due to the nature of private health information being held in the clinical files and the number of files required, the researcher travelled to each site to conduct the audits rather than have files sent to the researcher's clinical office and risk clinical files being lost in transit or being inaccessible to clinicians should a consumer still be engaged with CADS.

Clinical files that were closed (where treatment had been completed) were requested from the Clinical Records Department. These files were sent via courier (due to the small number of files and the consumer not being engaged in CADS) to the researcher for

auditing at their office. They were audited on the day of arrival and returned to the Clinical Records Department via courier the same day. This was to ensure if the consumer presented, AOD practitioners would have ready access to the clinical file. Due to different computer systems, the researcher did not have access to Team One computer records. This meant that the clinical file clerk in Team One's area was asked to identify the location of the files which were currently open (consumers currently in the service). Due to the number of files on each list being in no particular order, the location was written next to each file and once the file had been audited the file was crossed off the list.

The clinical file audits were conducted systematically and results collated on a separate audit form for each team. Any narrative was collated for each section separately. The researcher then methodically worked through the clinical files and completed the audit template for each clinical file. The researcher looked for evidence of forms and assessment tools in the clinical file section labelled 'Assessments', circling 'yes' or 'no', and if 'yes', any documented evidence of mental health screening, again circling 'yes' or 'no'. A narrative of evidence was written in summary on the audit form in the box provided. The researcher then worked through the reverse side of the audit tool. Each completed audit template was placed in a folder for either Team One or Team Two and transported with the researcher back to their office, where they were stored in a locked filing cabinet when not in use.

3.4.6 Data Analysis

Data analysis was performed manually for each Team and comprised compilation of descriptive statistics, frequencies and percentages. Narratives were compiled together. The use of a clinical file audit tool allowed for comparison of the survey data.

PART III

3.6 Ethics Approval and Considerations

The research proposal was submitted to and approved on the 11th December 2014 by the University of Otago Human Ethics Committee. Ethical issues related to informed consent, confidentiality and anonymity were considered. Informed consent has two components, as described by the National Ethics Advisory Committee (2012).

1. The decision is informed by adequate understanding of any information that is relevant to that decision.
2. The decision is voluntary, and is therefore free from undue influence such as manipulation or coercion.

Potential survey participants were given the participant information sheet followed by the opportunity to ask questions about the research so they were fully informed. The National Ethics Advisory Committee (2012) asserts that researchers "... should provide to study participants any information about who will have access to study data ...", this formed part of the information sheet. Once participation was agreed to by the participant, the consent form was signed. Consent forms were filed separate to the completed questionnaires to ensure no way of identifying the individual's survey. Numerical codes were assigned to each participant's survey to ensure anonymity.

No identifiable consumer information was recorded in the clinical file audit. Participant information is held in a locked cabinet within the office of the researcher and the researcher is the only person with access. All data, the audit, questionnaires, and consent forms will be held in storage for a period of seven years after which it will be destroyed. Due to the research being carried out locally and the risk of clinicians' practice being exposed, anonymity was of great importance so no names were recorded on the survey questionnaires.

This research respects the principles of beneficence and non-maleficence. All AOD practitioners had the right to decline participation without prejudice and no coercive methods to gain consent were used. Clinical file audits are typically seen as low risk research activities as they have more predictable benefits for consumers receiving health care, and they are aimed at improving the delivery of care (National Ethics Advisory Committee 2012). In the New Zealand Code of Rights (1996), Right 4 (4) “Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer” validates the use of file audits in this study.

3.7 DHB Consents

The DHB senior management team were consulted and gave signed approval to proceed with the research within the organisation. The researcher did not identify any conflict of interest in carrying out the research i.e. researcher was not part of either Team. However the researcher is known within the DHB as having addiction expertise and staff may have been concerned about exposing practice so anonymity and confidentiality was extremely important.

He Korowai Oranga: Māori Health Strategy, MoH (2002 p.2), states that “The Government is committed to fulfilling the special relationship between iwi and the Crown under the Treaty of Waitangi”. The National Ethics Advisory Committee (2012) advises investigators to respect this commitment in the design and conduct of studies. The researcher sought consultation from the local Māori DHB provider and through the local Iwi Research Consultation Committee. Protection of Māori rights is demonstrated in the study, for example, during the collection of data by respecting privacy and confidentiality with not recording any identifiable data.

3.8 Summary

This chapter commenced with reiterating the aim of the research undertaken, research objectives and consideration of methodology for the research followed by an explanation as to the chosen methods being a mix of a self-complete survey questionnaire and clinical file audits. Analysis was conducted manually and systematically for each team for the survey and for the file audit producing descriptive statistics, frequencies and percentages. The chapter included the ethical approval process and considerations and the DHB consent process and consultation with Māori. The next chapter provides the results.

CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter presents the results of the CADS participant survey and clinical file audit in two parts. The survey results are reported for each section of the survey: Section A covers participant demographics, education, work experience and training; Section B comprises participant knowledge and confidence in recognising specific mental health issues/conditions in an initial assessment which the participant has conducted, ending with any further education requirements participants would like in relation to CEP; Section C comprises questions related to the use of specific mental health screening and assessment tools, and components of the participant's clinical role; and Section D examines participants' attitudes toward a set of statements related to CEP. Part two presents the clinical file audit results.

4.2 Survey Results

As reported in the previous chapter, thirteen Team One and seven Team Two participants comprising 60% of clinicians from each team were estimated as required to provide an adequate representative sample for the survey. On the day of administration two participants from Team One were on study leave, and subsequently chose not to participate, and one selected participant from Team Two declined to participate. The final sample therefore comprised eleven Team One participants and six Team Two participants.

4.2.1 Section A

4.2.1.1 Demographics

According to Statistics New Zealand (2005, p.1.) ethnicity is defined as “...the ethnic group or groups that people identify with or feel they belong to. Ethnicity is a measure of cultural affiliation, as opposed to race, ancestry, nationality or citizenship. Ethnicity is self-perceived and people can belong to more than one ethnic group....”. Almost all participants identified as New Zealand European and the majority were female. (See Table 2.)

Table 2: Participants’ demographic characteristics

Subject’s demographics	Frequency	
	Team One n=11	Team Two n=6
Gender		
Male	2	1
Female	9	5
Ethnicity		
NZ European	11	4
Māori (Main identity)	-	2
Māori (Secondary)	-	2
European	-	-
Pacifica	-	-

(Participants can select more than one ethnicity group)

The next question asked participants to specify the qualifications they held or were working towards, followed by enquiry into their professional background which is reported in Table (3). Both teams demonstrated a variety of mental health and/or addiction qualifications. Figure (4) provides the number of qualifications held by each participant, showing four participants (three Team One, One Team Two) had no formal qualifications, one participant (Team Two) had four, three participants (one Team One, two Team Two) had three, four participants (three Team One, one Team Two) had two and five participants (four Team One, one Team Two) had one formal qualification.

Table 3: Education and professional qualifications held by participants

Qualifications	Frequency	
	Team One n=11	Team Two n=6
Certificate of Drug and Alcohol Counselling	1	-
Queen Mary Hospital AOD training course	2	-
Diploma in Social and community work	1	-
AOD Counselling Certificate	1	-
Diploma in Management	-	1
Human Resource Diploma	-	1
Certificate in Mental Health Support	-	1
Nursing Degree	-	3
Social Work Degree	-	2
Psychology Degree	1	-
Occupational Therapy Degree	1	-
MRCPsych	1	-
MBChB	1	-
FACHAM	1	-
PG Cert in Mental Health/MH Nursing	1	1
PG Cert. in Addictions	-	1
PG Cert. in Family Systems	-	1
PG Diploma in Health Science endorsed in MH and Addiction	3	-
PG Diploma in Nursing	1	-
PG Diploma in CBT	-	1
PG Diploma – Specialist Practitioner	-	1
Current Study		
Te Taketake Diploma in Applied Addictions Counselling with a Bicultural focus	1	-

Key: PG – Post graduate, PG Cert – Post graduate certificate, MRCPsych – Member of the Royal College of Psychiatrists, MBChB – Bachelor of Medicine and Surgery, FACHAM – Fellow of addiction medicine, MH – Mental health, AOD – Alcohol and other drugs

(Participants were able to select more than one qualification)

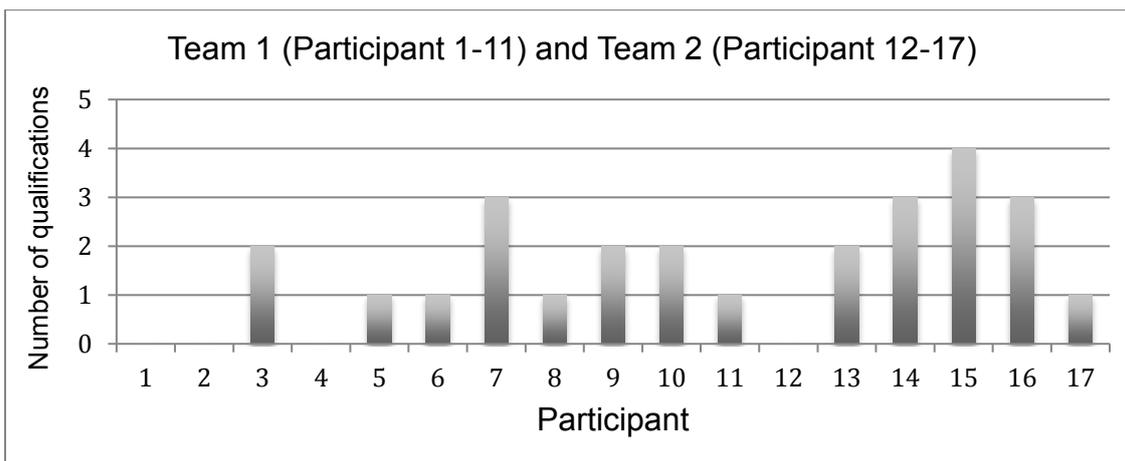


Figure 4: Number of degrees and formal qualifications held per participant

Table (4) below shows a wider variety of professions in Team One in comparison to Team Two of whom just over half were nurses. In Team One, the two addiction trained counsellors were also DAPAANZ practitioners.

Table 4: Professional background of participants

Profession	Frequency	
	Team One n=11	Team Two n=6
DAPAANZ Practitioner	4	-
Mental Health Nurse	2	1
Registered Nurse	3	3
Addiction Trained Counsellor	2	1
Occupational Therapist	1	-
Psychiatrist	1	-
Social Worker	-	1

Participants were then asked about their time spent working in an addiction setting and if they had any previous mental health work experience. Both teams' participants reported a high level of experience in addiction practice, i.e. only one participant from each team having less than five years' experience. (See table 5.)

Table 5: Years participants have worked in an addiction setting

Years in Addiction Practice	Frequency	
	Team One n=11	Team Two n=6
1 – 5yrs	1	1
6 – 10yrs	3	3
11 – 15yrs	3	-
16 – 20yrs	-	2
21 – 25yrs	3	-
Over 26yrs	1	-

As well as addiction work experience participants were asked about their prior mental health work experience. As can be seen from Table (6) below, participants had a wide variety of mental health experience and figure (5) shows the number of mental health settings worked in by participant.

Table 6: Participants' previous work experience in all mental health settings worked

Areas of Mental Health Worked	Frequency	
	Team One n=11	Team Two n=6
Community mental health team	6	1
Mental health acute inpatient setting	4	3
Forensic service	3	1
Crisis service	3	1
Dual diagnosis service	2	1
Child and adolescent service	1	1
Eating disorder service	1	-
Needs assessment	1	-
Maternal mental health service	1	-
Education and teaching role	1	-
Maori mental health service	-	1
Residential Rehabilitation	-	1

Six participants (four Team One, two Team Two) had no prior mental health work experience, four participants (two from each team) had worked in one mental health setting, two participants from Team One had worked in two settings with five participants (three Team One, two Team Two) having work experience in three to five mental health settings, with a variety of professional backgrounds: nurses (four from each Team), social worker and counsellor (one from Team One), and from Team Two psychiatrist (one), occupational therapist (one) and DAPAANZ practitioners (two).

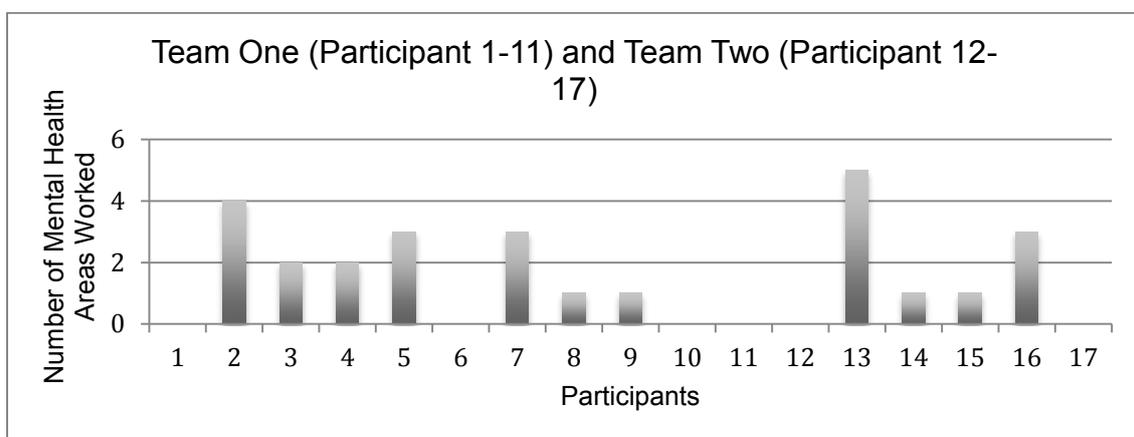


Figure 5: Number of mental health settings worked per participant

Results from enquiry into routine aspects of roles showed nearly all participants carried out brief interventions, comprehensive assessments, mental state examinations, clinical case management, individual therapy and mental status examination. Medication management was carried out by seven out of eleven (64%) Team One participants (two nurses, one DAPAANZ practitioner, psychiatrist and occupational therapist and two addiction trained counsellors) and five out of six (84%) Team Two participants (four nurses and one social worker/counsellor).

In 2013 and 2014 the DHB delivered or funded in-house education and training on a variety of mental health and addiction topics. They also funded external travel to conferences and study days. Participants were asked to specify what training they had attended as well as training they had wanted to go to but for some reason didn't attend. (See table 8.)

Table 7: Participation in routine aspects of current roles

Routine aspects of current role	Frequency	
	Team One n=11	Team Two n=6
Brief interventions	10	6
Comprehensive assessment	11	6
Clinical case management	11	6
Individual therapy	10	6
Mental state examination	10	6
Brief assessments or triage	5	6
Medication management	7	5
Triage	3	5
Management	-	1

Table 8: Attendance at mental health and addiction related training events (2013, 2014)

Education and training	Frequency			
	Team One n=11		Team Two n=6	
	Attended	Wished to attend	Attended	Wished to attend
Cutting Edge conference	10	-	4	1
CEP training workshop	5	1	3	-
CEP workshop (Specialist CEP trainers)	4	3	5	-
Addiction nurses update	4	-	1	1
Matua Raki - older people and addictions	4	2	4	-
Mother and baby training day	4	-	-	1
2 day advanced motivational interviewing	2	2	3	1
2 day motivational interviewing (Specialist MI trainer)	3	2	3	1
Solution focussed therapy	3	1	3	3
1 day introduction to motivational interviewing	2	2	3	1
AOD and aging	1	1	2	1
Young people and alcohol	-	-	1	1
Motivational interviewing with a Māori focus	-	3	2	-
Child & adolescence MH, alcohol and other drug training (Werry Centre)	-	2	1	2

As can be seen from table (8) above, the annual national addiction conference ‘Cutting Edge’ was well attended with a total of ten Team One and four Team Two participants attending. A local CEP workshop funded by Matua Raki (the National Centre for Addiction Workforce Development in New Zealand) presented by contracted specialist CEP trainers was attended by four Team One and five Team Two participants, with a further three participants (Team One) wanting to attend. Young people and alcohol was attended by one participant (Team Two), similar to the child and adolescence mental health, alcohol and other drug training provided locally and free of charge by the Werry Centre (National Centre for Infant, Child and Adolescent Mental Health, providing teaching and workforce development).

Looking at figure (6) below, Team Two participants attended more training events compared to Team One although one participant from Team One attended ten which was the most training events of any participant. One Team One participant attended no training, three Team One attended one event, one from Team Two attended three, five from Team One attended four or five events and seven (two Team One, five Team Two) attended six or more training events.

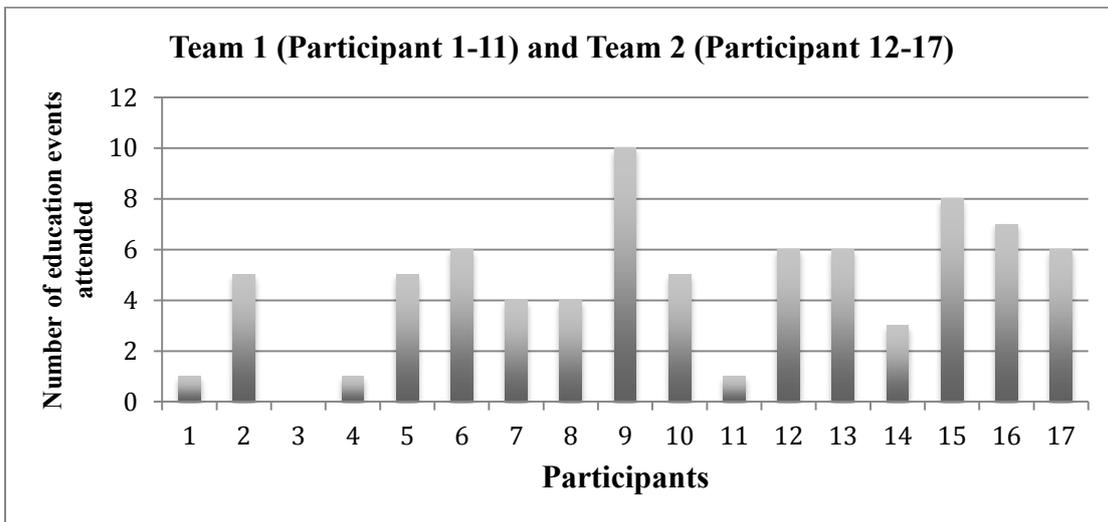


Figure 6: Number of training events attended per participant

Participants provided the following reasons as to why they didn't attend training that they would have liked to attend:

- Declined study application due to cost (one from Team One)
- Unaware the course was available (two from Team Two)
- Time factors including lack of time provided for travel, only working part time and work commitments (three from each Team)
- New to the addiction service (one from Team One)
- Working in a rural team alone due to a vacancy for one year, preventing time to study (one from Team One)
- Needed staff to stay behind so others could go (one from Team Two)

A third of participants stated a lack of time as a reason for non-attendance at training sessions, including time to travel to training venue. (Within the DHB region the longest travel time to a local, on-site training event would be three and a half hours which would also require overnight accommodation being provided by the DHB). Less than 20% (three participants) had applications for training turned down.

4.2.2 Section B

4.2.2.1 *Participant's Knowledge, Skills and Confidence in Clinical Assessment*

Section B of the survey focussed on participants' reported knowledge, skills and confidence in mental health assessment. Nine out of eleven Team One participants and all six of Team Two had completed an initial assessment in the previous month. Of the participants who did complete an initial assessment further enquiry was made in regard to presenting addiction problems (see table 9.), mental health status examination and assessment of risk. A Team One participant rated their consumer having both an alcohol and cannabis addiction as their main problem.

As part of the initial assessment participants were then asked if they had completed a mental status examination (MSE). Seven of the nine Team One participants and five of the six Team Two participants who had completed an initial assessment reported completing a MSE. Participants were then asked which mental health related conditions they enquired about during the initial assessment and any other conditions which were not stated in the survey.

Table 9: Main presenting problem for last consumer assessed by participants

Main alcohol or drug issue	Frequency	
	Team One n=9	Team Two n=6
Alcohol	5	4
Opioids	3	-
Methamphetamine	1	-
Cannabis	1	-
Synthetic Cannabis	-	1
Other Drugs	-	1

Table 10: Participant enquiry about specific mental health conditions

Mental health condition	Frequency	
	Team One n=9	Team Two n=6
Mental health condition		
Major depressive disorder	7	5
Generalised anxiety disorder	6	4
Post-traumatic stress disorder	6	3
Social phobia	5	4
Psychosis	4	3
Mania or bipolar	2	2
Childhood conduct disorder	2	2
Personality disorder	2	2
Other: clinician reported enquiry		
Sleep disorder	-	1
Eating disorder	-	1
Obsessive compulsive disorder	1	1

Table (10) above shows mental health related conditions enquired about. Major Depressive Disorder was the most common disorder enquired about (Seven (78%) Team One, Five (83%) Team Two), followed by Generalised Anxiety Disorder (Six (67%) Team One, Four (67%) Team Two), then other Anxiety Disorders namely Social Phobia (Five (55%) Team One, Four (67%) Team Two) and Post-Traumatic Stress Disorder (Six (67%) Team One, Three (50%) Team Two). The conditions least enquired about were Childhood

Conduct Disorder (Two (22%) Team One, Two (33%) Team Two), Mania or Bipolar Disorder (Two (22%) Team One, Two (33%) Team Two) and Personality Disorder (Two (22%) Team One, Two (33%) Team Two). Participants were then asked if they routinely enquired about any other disorder with one participant answering sleep disorder, eating disorder and Obsessive Compulsive Disorder.

Participants were then asked about questioning of consumers' risk to self, in either a face to face or telephone initial assessment, of which eight of Team One and five of Team Two had completed in the last month. The eight (100%) participants of Team One all asked the consumer questions around risk to self in relation to suicidality and mental health status. In comparison three out of five (60%) of Team Two participants enquired about risk to self, and two (40%) enquired of mental health status.

Participants were next asked to rate their confidence level in conducting assessments with consumers pertaining to specific mental health and addiction disorders and suicidality. Responding 'a lot' or 'very' indicated high confidence level compared to 'no confidence' or a 'little confidence'. All participants reported high levels of confidence in conducting assessments for alcohol and drug disorders. 'No confidence' for Team One participants was recorded for Schizophrenia (two), Bipolar Disorder (one), and Childhood Conduct Disorder (one). Assessing for Childhood Conduct Disorder was the only condition which one Team Two participant rated as having no confidence in assessing. Table (11) shows the spread of confidence levels for each disorder.

Table (12) shows the level of participants' confidence ratings next to eight statements around their clinical practice. Confidence was high (a lot, very) in both teams for completing a comprehensive assessment and enquiry around risk to self (suicidality) or others. Low confidence (a little) was shown for providing a mental health diagnosis (three (27%) Team One, two (33%) Team Two). One Team One member endorsed low confidence for working with family/whanau compared to Team Two participants who showed higher confidence in this area (67%). Performing a mental state examination and working with consumers with CEP and addressing the mental health disorder also showed relatively high confidence levels ranging from 'moderately' to 'very confident' for both teams.

Table 11: Participant rating of confidence in the assessment of mental health and addiction conditions

Disorders	Team One n=11					Team Two n=6				
	No Confidence	A Little	Moderately	A Lot	Very Confident	No Confidence	A Little	Moderately	A Lot	Very Confident
Alcohol dependence/abuse				2	9				1	5
Drug dependence/abuse				1	10				1	5
Suicidality				1	10			1	3	2
Personality disorders			5	5	1			4	1	1
Major depressive episode			2	2	7			2	2	2
Generalised anxiety disorder		1	3	3	4		1		2	3
Mania		2	3	4	2			3	2	1
Social phobia		1	3	4	3		1		2	3
Post-traumatic stress disorder		1	3	1	6		1		2	3
Childhood conduct disorder	1	5	2	1	2	1		2	1	2
Schizophrenia	2		4	3	2			3	2	1
Bipolar disorder	1	1	4	3	2			4	1	1

Table 12: Participants' estimated level of confidence in the following statements

Statements	Team One n=11					Team Two n=6				
	No Confidence	A Little	Moderately	A Lot	Very Confident	No Confidence	A Little	Moderately	A Lot	Very Confident
Asking questions related to risk/harm to self				1	10					6
Asking questions related to risk or harm to others				1	10					6
Carrying out a comprehensive MH and addiction assessment				4	7				1	5
Working with consumers with coexisting MH disorders			3	6	2				2	4
Performing a MSE			4	4	3			2	1	3
Working with consumers with coexisting MH disorders and addressing the MH disorder			5	5	1			2	2	2
Working with family/whanau		1	5	2	3				1	5
Providing a MH diagnosis		3	6	1	1		2		3	1

Following on from the focus on levels of confidence, participants were asked to specify any areas they would like further education or training in. Numerous subject areas were identified and these are listed below:

- Risk assessment (2 Team One, 1 Team Two)
- Mental state examination (1 Team One)
- Diagnosis and formulation, DSM-5 diagnostic system (1 Team One)
- Treatment and updates on CEP. Pharmacology for CEP. (1 Team One)
- Māori treatment modalities (1 Team One)
- Young people and addiction problems/treatment (1 Team One)
- Rational Recovery model (1 Team One)
- Solution Focussed therapy (1 Team One, 1 Team Two)
- Pain and addiction (1 Team One)
- Mindfulness (1 Team One)
- Social Anxiety, Phobia, Personality Disorder, Conduct Disorder, Schizophrenia and Bipolar (1 for each disorder from Team One)
- Telephone triaging (2 Team One)
- Forensic versus non-forensic disorders and treatment (1 from Team One)

In addition one participant from Team Two, noted the need for clarification of “...role requirements (by the employing service), acknowledging staff training and backgrounds are quite different...”.

4.2.3 Section C

4.2.3.1 *Mental Health Screening and Assessment Tools Used by Participants*

Section C of the survey focussed on mental health screening, assessment tools and processes utilised within the participant’s role. The Alcohol Use Disorders Identification Test (AUDIT) was the most commonly used tool by six (54%) of Team One participants and all Team Two

participants. On the whole Team Two participants reported a higher proportion of screening/assessment tools usage compared to Team One participants (See table 13.)

Table 13: Screening tools used in clinical practice by participants

Screening Tools	Team One n=11	Team Two n=6
AUDIT – Alcohol Use Disorders Identification Test	6	6
LDQ – Leeds Dependence Questionnaire	3	3
DAST – Drug Abuse Screening Test	3	6
GAF – Global Assessment of Functioning	3	-
RCQ – Readiness to Change Questionnaire	1	5
CUDT-R – Cannabis Use Disorder Test	1	5
SADQ – Severity of Alcohol Dependence Questionnaire	1	2
K10 – Kessler Psychological Distress Scale	1	-
SACS – Substance and Choices Scale	1	-
SDS – Severity of Dependence Scale	1	1
ASI – Addiction Severity Index	1	-
PHQ-9 – Patient Health Questionnaire	-	1
SDSS – Substance Dependence Severity Scale	-	2

Participants were asked if they used any other screening/assessment tools not stated in this category. Four Team One participants identified the DSM-IV-TR (APA 2000) screening questions for dependence and abuse and Team One participants also identified use of The Methadone Treatment Index (Deering et al., 2008).

In conjunction with enquiring about screening/assessment tools, participants were asked which of the assessment components listed they carried out routinely with consumers with CEP. The results of both teams showed that all participants reported undertaking the following tasks: a comprehensive assessment, request urine drug screen analysis, present to the multi-disciplinary team for review and request previous mental health notes. Less than half of Team One participants endorsed requesting a complex case review, CEP framework formulation and use of the local initial screening for drug and alcohol form. (See table 14.)

Table 14: Assessment components routinely carried out by participants

Assessment Components	Team One n=11	Team Two n=6
Comprehensive assessment	11	6
Urine drug screen analysis	11	6
Present to the multi-disciplinary team for review	11	6
Request previous MH notes	11	6
Refer onto MH services	8	6
Order blood tests	9	5
Request previous addiction notes	9	5
Request a psychiatrist appointment	8	5
Request 3 rd party information	8	5
MH screening questions	8	6
CEP framework formulation	5	5
Request a complex case review	4	4
Local initial screening for drug and alcohol form	2	6

4.2.4 Section D

4.2.4.1 Attitudes

The final section, D, of the survey addressed participants' attitudes to nine given statements about CEP which are shown in Table (15). Six (54%) participants from Team One and five (83%) from Team Two disagreed (disagreed/strongly disagreed) with the statement that consumers with CEP should be treated in a mental health team rather than addiction services, with nearly half of Team One providing a neutral response. Of the 17 participants the majority (eight (73%) from Team One and four (67%) from Team Two) agreed that the DHB promoted working in an integrated model for CEP consumers. Also worth noting is that two participants in Team Two strongly disagreed with this statement. In total 14 (nine from Team One and five from Team Two) participants felt encouraged by their workplace to become CEP capable. A minority of two from Team One and two thirds or four from Team Two felt it was important for consumers with CEP to be reviewed by a multi-disciplinary MH and CADS.

Table 15: Participants' responses to set statements

Attitude statements	Team One n=11					Team Two n=6				
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Consumers with coexisting MH disorders should be treated in a MH team not addiction service	1	5	4	1		3	2	1		
Placing addiction staff in MH teams would improve outcomes for CEP consumers	2	2	5	2		2			1	3
I am encouraged to attend MH focussed training sessions/days	1	1	3	4	2				2	4
Dealing with MH issues is not part of my role in addiction services	9	2				6				
MH training is not offered to staff working in addiction services	5	5			1	4	2			
MH Services and Addiction Services should jointly case-manage consumers with CEP		2	6	2	1		1	2		3
It is important for consumers with coexisting MH disorders to be reviewed by a multi-disciplinary MH and Addiction team		3	6	2			1	1		4
My workplace encourages me to become coexisting problem capable			2	6	3			1	2	3
The DHB actively promotes working in an integrated model for consumers with coexisting disorders			3	8		2			4	

All participants agreed dealing with mental health issues was part of their role. There was a range of perspectives in each team from disagree through to strongly agree for the notion of joint case management between MH and addiction services. Only two Team One participants agreed that placing addiction staff in MH teams would improve outcomes for CEP consumers, with the rest being neutral (five) or disagreed (four) compared to Team Two where four agreed and only two disagreed. All but one participant (Team One) disagreed that MH training was not offered to staff working within addiction services. A spread of responses from Team One participants (two disagree, three neutral and six agree) for feeling encouraged to attend MH focussed training compared to 100% agreement from Team Two.

4.3 Part II: Clinical File Audit Results

As described in Chapter 3, a representative sample of 20% of clinical files were selected for audit for each team, giving a total of ninety eight clinical files for Team One and fifty one clinical files for Team Two. The clinical files were generic to all team members.

Of the 98 Team One clinical files, four files were excluded leaving a sample of 94 clinical files for audit. Of the four excluded files, three were unreadable (illegible) and one file was unable to be located at the time of audit. This consumer file was jointly utilised in a co-working situation with another team and the file was assumed to be with that team but was not locatable. Of the 51 Team Two clinical files selected for audit, seven were excluded leaving a sample of 44 for audit. Four were rejected referrals but the clinicians had recorded telephone contacts as face to face contacts on the patient management system (known as IPM) so had mistakenly been randomised. A further three files did not record any face to face contacts and so were excluded. Therefore 19% of Team One files and 17% Team Two files were audited.

As can be seen in Table (16) below, just under half, 49%, of Team One clinical files and only 7% of Team Two clinical files had a drug and alcohol assessment form present. A triage or entry assessment form was only present in 28% of Team One files and 50% of files for Team Two, similar to the result of having an initial alcohol and other drug form present 23% and 52% respectively. A minority of 8% of Team One files and 16% of Team

Two files included an urgent assessment form. Comprehensive assessment forms were only present in 5% of Team One and 14% of Team Two files. Overall 1% of screening tools were found in Team One clinical files, and 13% of screening tools were found in Team Two files.

When looking for evidence for screening/assessment for mental health conditions, 83% of Team One clinical files had some form of written documentation e.g. completed clinical forms, written correspondence, reports, written file entries or completed screening tools, compared to 59% of Team Two clinical files. A MSE was present in around half of files (50% Team One, 48% Team Two). A mental health risk assessment was present in 70% of Team One files compared to 59% of Team Two files. Documented evidence for mental health risk assessment was met by finding a risk statement written on any of the clinical forms in the audit template or a DHB risk assessment form.

Table 16: Clinical file audit results

	Frequency (percentage)	
	Team One n=94 N %	Team Two n=44 N %
Clinical Form Type :-		
Drug and alcohol assessment form	46 (49%)	3 (7%)
Triage or entry assessment form	26 (28%)	22 (50%)
Initial alcohol and other drug form	22 (23%)	23 (52%)
Urgent assessment form	8 (8%)	7 (16%)
Comprehensive assessment	5 (5%)	6 (14%)
Screening Tools :-		
AUDIT – Alcohol Use Disorders Identification Test	3 (3%)	10 (23%)
LDQ – Leeds Dependence Questionnaire	3 (3%)	3 (3%)
MAST – Michigan Alcohol Screening Test	1 (1%)	-
DAST – Drug Abuse Screening Test	-	9 (20%)
RCQ – Readiness to Change Questionnaire	-	8 (18%)
CUDT-R – Cannabis Use Disorder Test	-	5 (11%)
Alcohol and other drug matrix	-	4 (9%)
Evidence of mental health screening	78 (83%)	26 (59%)
No evidence of mental health screening	16 (17%)	18 (41%)
Mental state examination present	47 (50%)	21 (48%)
Risk assessment present	66 (70%)	26 (59%)
Number of files with no forms completed	3 (3%)	3 (7%)

4.4 Summary

Participants consisted of predominately New Zealand European, female nurses who had experience in working in a variety of mental health settings. The majority of participants had formal qualifications (although not necessarily a specific addiction related qualification) and over 10 years work experience in the addiction sector with over half also having mental health work experience.

Participants were supported with time and financial contribution of training costs, to attend a range of professional development activities and training, with the majority attending the annual addiction conference ‘Cutting Edge’, CEP training workshops and skills focussed training. There were very few declined study applications. Participants would like a variety of mental health training in the future including training on mental state examination, risk assessment and specific mental health disorders.

In terms of mental health enquiry the majority of participants enquired about depression with a lower number enquiring into conditions commonly linked with substance use problems such as social phobia, PTSD and personality disorders. Examining confidence levels, the highest levels of confidence were found in assessment of alcohol and drug disorder, suicidal and homicidal risk, and finally carrying out a comprehensive assessment.

Examining use of mental health and addiction screening tools, overall Team Two used a greater number of tools than Team One. Looking at routine tasks all participants stated they carried out comprehensive assessment, urine drug screen analysis, presentation of consumers to the multi-disciplinary team for review and requesting mental health records. Exploring participant attitudes in response to a set of statements drew a varied spread of responses from both teams and these are discussed in more detail in the next chapter.

Results of the clinical file audits showed variable documented evidence, however evidence of mental health screening was found in 83% of Team One files and to a lesser extent (59%) in Team Two files. Evidence of screening tool use was only found in a small number of files with mental state examination and risk assessments being the most common evidence found in files.

CHAPTER FIVE

DISCUSSION

5.1 Introduction

Findings from the research are discussed in relation to the aim and objectives of the study in relation to findings from the New Zealand national workforce survey conducted by Gilbert (2010) and the international extant literature. The overall aim of the study was to describe local practices in relation to CEP, from a representative sample of CADS AOD practitioners. The objectives were to: 1. Investigate AOD practitioner views, level of knowledge and confidence in working with consumers with CEP, 2. Explore evidence of CEP practices within the clinical health files of CADS consumers and 3. Identify areas for development locally in regards to CEP practice. This is the first research conducted since the national AOD workforce telephone survey conducted six years ago (Gilbert et al. 2013), except with a specific focus on a local addiction workforce. This chapter discusses the findings of the research as well as implications for practice, workforce development and suggestions for future research.

Overall a total of seventeen AOD practitioners consented to participate and were surveyed about their practices and opinions around assessment and treatment of CEP. Evidence of CEP screening and assessment was sought in 138 clinical files by way of an audit tool and the findings were compared with the survey results.

5.2 Sample Characteristics

The survey sample was largely female, with the majority of participants identifying as New Zealand European, congruent with the findings of Gilbert et al. (2013). Two participants identified as Māori (both in Team Two) with Gilbert et al. (2013) finding 15% of the AOD practitioners surveyed identified as Māori. Seventeen per cent of total referrals across the

CADS teams identified as Māori (according to local DHB data), whereas in some studies Māori are over represented between 23% and 35% in addiction services (Adamson et al., 2006, Schroder, Peka & Mulder, 2005). This is not to conclude that Team One does not have any Māori health professionals, as though a representative sample was sought not all health professionals were surveyed. It is important that treatment provided is inclusive of addressing cultural needs of Māori in accordance with Te Tiriti o Waitangi/Treaty of Waitangi (Huriwai et al., 2001). Both the DHB and CADS have a commitment to being responsive to the needs of Māori and have close working relationships with the Māori Mental Health Team and local Māori NGO providers.

Registered nurses including those who identified specifically as mental health nurses were the largest professional group across both teams, followed by addiction trained counsellors, which differs from the prior national telephone survey (Gilbert et al., 2013) in which counsellors/therapists were the largest professional group. However, the current study was conducted with a DHB service whereas the survey conducted by Gilbert et al., (2013) included NGO services which had higher rates of Addiction Practitioner staff. Just under a quarter of Team One were DAPAANZ registered practitioners with no one in Team Two identifying as registered practitioners, which is incongruent with the national telephone survey findings of just under half of their sample were DAPAANZ registered, but again NGO services were included in the national telephone survey. A combined total of 76% of the participants held one or more formal qualifications. Four participants identified themselves as having no formal qualifications, however two of the four had previous mental health work experience.

Examining previous mental health work experience, although six participants had no mental health work experience, the majority had experience of working in an acute inpatient setting or a community mental health team, with only two participants reporting no formal qualifications as well as no prior mental health work experience. It is difficult to quantify how much work experience was gained in each mental health service area, as this was not reported in the survey. In retrospect, the question “Which areas (of MH) have you worked” would have provided more useful data if time spent in each setting was also requested.

As discussed in Chapter two, Māori the indigenous people of New Zealand are shown to have higher prevalence rates of CEP compared to Pākehā, and the need to upskill the Māori workforce to provide culturally responsive and effective treatment services has been identified (Huriwai et al., 1998, Robertson et al., 2006). The Māori workforce has become more qualified over the past 20 years (Robertson et al., 2005) and in this research three out of the four participants (including secondary ethnic identity) who identified as Māori had post graduate qualifications, of which two also had previous mental health work experience. One participant despite reporting not having any formal qualifications or prior mental health experience had over 15 years work experience in the addiction field. However, it has been recognised that addiction related and postgraduate education adds required value to which people with complex CEP issues present.

5.3 Participant Roles

The roles within each team were similar with all categories of ‘routine aspects of current role’ endorsed despite differences in the service provision frameworks (SPF) of each team. Of interest was that all participants across both teams reported that they carried out comprehensive assessments as routine aspects of their role. However the results of the clinical file audits displayed a clear lack of evidence for this with only 5% (5) of Team One and 14% (6) of Team two files containing a comprehensive assessment. Although all participants of Team One stated they carried out comprehensive assessments routinely, only ten reported conducting a mental state examination (MSE). This apparent discrepancy is an area for further inquiry. The MSE is routinely part of a comprehensive assessment. It may be that the participant that said they didn’t routinely conduct a MSE may have considered that they did this as part of a comprehensive assessment rather than a separate task. Medication management was seen as a lower endorsed routine component of work by participants, however people with CEP often receive medication as an aspect of their care. Those participants that responded they carried out medication management were two nurses, one DAPAANZ practitioner, one medical practitioner and two addiction trained counsellors from Team One, and five nurses and one social worker from Team Two. The issue of medication management has an implication for professional scopes of practice and what formal training in medication management practitioners who do not have

a medical background have. Only one participant highlighted the desire for formal pharmacology education in the future. Admittedly pharmacology education was not specifically enquired about and the formal pharmacology and pharmacotherapy education and training of practitioners other than medical doctors is unknown and another area for further investigation.

5.4 Education and Training

Overall the findings showed justification for the delivery of mental health training to improve the overall capability and upskilling of the workforce. A significant proportion of participants identified a need to attend mental health education (including those that wanted to attend but were unable), which is congruent with the findings of overall low rates of enquiry into some commonly experienced mental health conditions.

The DHB provides opportunities for staff to attend conferences and training provided by external providers. They also have a training calendar of in-house opportunities provided by specialist AOD practitioners as well as invited speakers from other organisations such as Te Pou o Te Whakaaro Nui, specialist Mother and Baby Unit and specialist Eating Disorders Service. Staff discuss training they wish to attend with their manager and put in applications for funding and study time for those which are external to the DHB. The DHB provides education topics which correspond to the Ministry of Health (2008) Let's Get Real: Real skills for people working in mental health and addiction document, and other recommended documents such as A Guide to Talking Therapies (Te Pou, 2009) and Talking Therapies for Māori – He Rongoa Kei te Korero (Te Pou, 2010).

The DHB gives the AOD workforce priority over mental health clinicians from other teams to attend the annual national addiction conference 'Cutting Edge'. A high number of participants recognised the value of attending the training at Cutting Edge with only one participant wanting to attend but unable to. Approximately half of both teams attended a locally run CEP training workshop, with slightly less participating in a CEP workshop presented by visiting CEP specialists, indicating the recognition by the workforce to upskill in this area.

Motivational interviewing or MI is seen nationally and internationally to be a therapy which can provide positive outcomes for people with addiction issues and CEP (Burke, Arkowitz & Menchola, 2003; Carr & Smith, 2014; Jensen et al., 2011; Miller & Rollnick, 2002; Miller & Rose, 2009; Tuccero et al., 2016; UKATT research Team, 2005). The DHB offered two programs of in-house training, and two sessions of training provided by external experts in the New Zealand field of Motivational Interviewing. Given the vast amount of research on the benefits of MI when working with people who want to or need to change behaviour it was unusual to see a low uptake of MI training. It is not possible to identify why six participants were unable to attend training as this question wasn't specifically posed regarding MI.

Another talking therapy with benefits in the addiction field is solution focused therapy (Ginerich & Peterson, 2013; Kim, Brook & Akin, 2016) which was popular with participants, although not all could attend. Young people and alcohol was the least popular training with only one participant from Team Two attending and only one from the same team wishing to attend. This may be due to the service providing alcohol and drug treatment for people over the age of 18 years and participants may have questioned the relevance of attending or not prioritised the training in their annual training plans.

Team Two participants on average attended twice as many training events as their counterparts, despite one Team One participant attending ten events. This may be due to over half of the training events being located within the district of Team Two and Team One members not wanting or being given the time to travel, however some of these sessions were provided by a video conferencing service that all urban and rural sites could access if they had booked the equipment. Only one participant attended no training stating they were newly employed in the service.

The results show that only a minority of participants were unable to attend a training day they had wished to attend. Enquiry around why this happened using an open ended question elicited only eleven responses out of a possible thirty two positive responses (thirty two occasions of wanting to attending training). Providing a variety of possible reasons for participants to tick would have possibly provided a higher response but would not have allowed for personal opinion.

Providing mental health training to health professionals working in an addiction setting has delivered positive outcomes, such as an increase in confidence in recognising mental disorder, an increase in confidence in talking with consumers about mental health and a significant positive change in attitudes towards consumers with CEP (Brooker, 2001; Ford & Rylie, 2000; Minkoff & Cline, 2004; Munro et al., 2007; Rani & Byrne, 2012; Rassool, 2004). Overall this study's findings, in particular lack of confidence in enquiry into some common mental health conditions and lack of written evidence in the clinical files, showed a continuing need to improve the capability of the AOD workforce to address CEP, which is consistent with international literature (CSAT, 2005; McGovern et al., 2006; MOH, 2004; Rassool, 2006; Todd, 2010).

5.4.1 Barriers to Attending Training

Firstly, the main barrier to attending training appeared to be the perception of not having enough time. Six participants stated time was an issue, of which three stated a lack of time given to travel to the course, suggesting they needed to travel in their own time if they wished to attend. One participant felt working part time was a barrier to attending due to prioritising their clinical work load, a similar response of one other participant also citing work commitments and one other stating working alone in a rural team with clinical work taking precedence over any training.

Secondly, having a study application declined was a barrier to attending. A manager will sign off staff applications taking into account for example the relevance of the course to clinical practice, any previous training the applicant has already completed that year, whether the applicant requires education hours for their professional registration or other need and who else in their team wishes to attend. Only three participants had applications declined which could be considered low given the current financial pressures in the health sector. One applicant didn't apply for the solution focused training due to their own perception that the cost of the training including the cost of travel and accommodation would be too high for the DHB to pay and hence would be declined. Two participants were unaware of training being available, maybe due to lack of advertising of the training within the workplace. Within the DHB training courses or education sessions are taken to a core education and training committee for authorisation to advertise to the wider mental health and addiction sector and on how many staff can be funded to attend.

Thirdly, the participant's own view or opinion could be seen as a barrier. For example, one participant from Team One felt being new to the addiction service was a reason for not attending training, rather than being a new worker who may benefit from upskilling and training locally. One participant from Team Two stayed behind in the workplace to allow other staff to attend. Another participant's own perception of their workload commitments was another example of a reason for not applying for training.

In summary, some participants recognised the importance of mental health education and training (which is consistent with the international literature (CSAT, 2005; McGovern et al., 2006; MOH, 2004; Ogbourne & Graves, 2005; Todd, 2010) of the need to upskill the AOD workforce) specifying what further training or education they would like. The majority of responses were around education on specific mental disorders, social anxiety, phobia, personality disorder, conduct disorder, schizophrenia and bipolar disorder. Diagnosis and formulation using the new Diagnostic and Statistical Manual of Mental Disorders (DSM-V) 5th Edition (APA, 2015) diagnostic system, risk assessment and MSE training were a requirement of some participants. Given the theme of the research and questions in the survey, only one participant wanted training on treatment, pharmacology and updates on CEP. In terms of therapies or modalities one participant requested education of Māori treatment modalities and the rational recovery model, and one participant from Team Two requested Solution Focused Therapy training. Given the high prevalence of CEP within the Māori population it is disappointing that only one participant requested more education in this area. One participant asked for education around the expectation of clinical role requirements with acknowledgement that staff discipline and training are different, which may be because the majority of CADS staff are employed in generic roles as either case managers or AOD health professionals.

Of note, one area omitted from participant responses to areas of training required was service user involvement in training, despite considerable evidence to support positive learning through experiential human account (Forrest et al., 2004, Rani & Byrne, 2012, Simons et al., 2007, Townsend et al., 2008). Over previous years the DHB has utilised the expertise of the consumer and family representatives in their training sessions.

Overall, these findings indicate the need to upskill the local AOD workforce in the areas of mental health and in particular conducting comprehensive assessments. In New Zealand

there are several profession based knowledge and skill competency frameworks available to build the AOD workforce's capability e.g. for Alcohol and drug practitioners (DAPAANZ, 2011), addiction nurses (DANA, 2012) and for all professions (MOH 2008) that could be incorporated into individuals' annual performance reviews and Professional Development Recognition Programmes (PDRP). Within the DHB each employee participates in a performance review once a year which incorporates the employee's training desires and requirements for the following year. Nurses within the DHB have the opportunity to participate in PDRP and complete a portfolio of evidence from their practice including evidence of upskilling. There is remuneration for nurses, other than those in senior roles, to participate in PDRP.

5.5 Clinical Assessment

Focusing on examining assessment practices for CEP, an important finding is under-reporting of CEP supported by the findings of the audit of clinical files. Enquiry into assessment practices in relation to commonly co-occurring mental disorders, i.e. depression, generalised anxiety, post-traumatic stress disorder, social phobia, psychosis, mania or bipolar disorder, childhood conduct disorder and personality disorder, found that less than one third of survey participants reported enquiring about a number of these disorders during their last assessment. This finding is consistent with that of Gilbert et al's., (2013) findings where less than a third of AOD workers nationally reported enquiring into these five common mental disorders (depression, mania/bipolar disorder, PTSD, social phobia and childhood conduct disorder).

Enquiry into depression was the most commonly assessed for mental disorder which is consistent with the literature which emphasises the need for AOD practitioners to routinely enquire about depression (CSAT , 2005; Minkoff & Cline, 2004; Ogborne & Graves, 2005). However, given the literature on high prevalence rates of depression in AOD populations (Adamson, Sellman et al., 2006; Burns, Teesson & O'Neill, 2005; Weaver et al., 2003) and national documents on CEP (ALAC & Te Kaitātaki Oranga MHC, 2008; Todd, 2010) one could have reasonably expected 100% enquiry into depression.

Rates of enquiry into other disorders were less than that of depression (apart from social phobia for Team One which was equal to depression). Enquiry into PTSD and social phobia are congruent with the national telephone survey results (Gilbert et al., 2013). However, enquiry into mania/bipolar disorder and childhood conduct disorder appeared lower in this survey compared to the national telephone survey.

In addition, results from this study also showed apparent lower rates of enquiry in relation to psychosis and personality disorders. The lower reported rates of enquiry may be due to participant competence or confidence in assessing for mental disorder given five participants had no prior mental health work experience and four had no degree level or postgraduate level training. These lower rates of enquiry into PTSD, mania/bipolar, childhood conduct disorder, psychosis and personality disorders suggest significant gaps in assessment practices and are areas worthy of focus for specific training.

Finally assessment and management of risk is seen as an expected area of competence for all mental health and addiction workers (Crawford, Crome & Clancy, 2003; Dhossche et al., 2000). A further assessment question focussed on enquiry into the consumer's risk to self and mental health status in the participant's last brief assessment, either face to face or telephone in the previous month. All of the eight Team One participants who had completed the task, reported they enquired about risk and mental health status compared to 60% (3) of the five Team Two participants who had completed this task reporting enquiring about risk and 40% (2) reporting enquiring about mental health status. In comparison, the clinical file audit showed only 70% (66) of Team One and 59% (26) of Team Two clinical files having evidence of a risk assessment. Given the importance of assessing risk and suicidality, with the link between suicidality and CEP (Dhossche et al., 2000; Erinoff et al., 2004; Kolves, Varnik, et al., 2006; Matthieu & Hensley, 2013; McGovern et al., 2006; Ries et al., 2008) the lack of evidence in the clinical files, especially in assessment documentation, would suggest AOD practitioners could benefit from further professional development in this area.

5.5.1 Use of Screening and Assessment Tools

Use of screening and assessment tools was reportedly higher in Team Two. This was consistent with the Service Provision Framework (SPF) for Team Two which recommends

the use of the AUDIT, DAST and RCQ as tools that should be used in clinical practice. The participant with the least amount of addiction work experience reported use of the most screening tools, which maybe relates to a lack of confidence, experience or lack of knowledge with clinical assessment frameworks or a greater tendency to follow guidelines. In comparison, fewer Team One participants reported use of screening tools which was consistent with evidence found in the audit of Team One files of more use of clinical assessment frameworks.

In contrast to the survey results, evidence found in the clinical file audit was limited with less than a quarter of Team Two files showing evidence of screening tools. It may be that the scores for screening tools are documented within the progress notes section rather than a completed copy of the screening tool being filed in the clinical file. However, progress notes were not examined in this study due to time commitments of completing the file audits and the large number of files being audited.

5.5.2 Routine Aspects of Participant's Clinical Role

When faced with consumers with CEP, participants were asked what tasks they would routinely carry out as part of their clinical role. All participants agreed they conducted a comprehensive assessment, sent a urine screen for drug analysis, presented the case to the multi-disciplinary team for review and requested any previous mental health notes.

Given the evidence of barriers to accessing mental health services for AOD consumers (Chi, Satre & Weisner, 2006; Flynn & Brown, 2008; McGovern et al., 2006) it was unexpected to find all of Team Two agreed they would refer the consumer onto mental health services as well as using mental health screening questions. It may be that these services have strong clinical pathways for joint collaborative working between services as promoted in the national documents, Te Tahuhu, Improving Mental Health 2005-2015 and Te Kokiri, the Mental Health and Addiction Action Plan 2006 – 2015 (MOH, 2005, 2006). However, all participants agreed that dealing with mental health issues is part of their role working in addiction services but it is not known whether participants co-worked with these consumers alongside their mental health colleagues. Two of 11 Team One participants reported utilising the CADS screening drug and alcohol form, compared to 100% from Team Two corresponding to higher rates of screening tool use by Team Two

and also higher levels of confidence in assessment which may also suggest a more prescriptive nature of carrying out screening.

Only five participants from each team reported they wrote up a CEP framework formulation with only four from each team reporting requesting a complex case review. There was no evidence of CEP framework formulation in any of the clinical files audited. Requesting third party information was reported by eight participants from Team One and five from Team Two which reflects the higher levels of confidence in family and whānau inclusive practice, with the same numbers also for requesting a psychiatrist appointment.

The results of the file audit also highlighted a lack of assessment or screening for mental health conditions. Half of Team One files had a DHB ‘drug and alcohol assessment form’ present compared to only 3 out of 44 Team Two files. Similar numbers of files for Team One contained a DHB ‘triage or entry assessment form’ (28%), or DHB ‘initial alcohol and other drug form’ (23%). A greater number of Team Two files had a DHB ‘triage’ or ‘entry assessment form’ (50%) or DHB initial alcohol and other drug form (52%). Incongruent with the file audit results, the survey results showed all of Team Two reported using local initial screening forms, compared to only two participants from Team One.

5.5.3 Confidence Levels in Assessment of Conditions and Related Tasks

As expected 100% of the sample were confident in assessing alcohol or drug dependence and abuse with over 80% of total participants being ‘very confident’. Suicidality, personality disorders and major depression also produced a 100% confidence rate which is incongruent with what participants reported they assessed for in their last brief assessment or triage as discussed previously. The area rated as the least ‘confidence’ for Team One was in assessing for childhood conduct disorder (one), schizophrenia (two) and bipolar disorder (one) compared with Team Two having ‘moderate confidence’ or greater in assessing for schizophrenia and bipolar disorder with only one participant having ‘no confidence’ in childhood conduct disorder. There appears to be no correlation with lack of confidence in assessing for childhood conduct disorder and years of practice, with these participants having between six and fourteen years’ experience working in a multi-disciplinary addictions service, as well as prior experience of working in a mental health setting. The lack of confidence in assessing for childhood conduct disorder, schizophrenia

or bipolar disorder was consistent with lack of participant reported enquiry into these conditions. It is important to assess for childhood conduct disorder to be able to make a diagnosis of anti-social personality disorder in the future which is highly prevalent amongst addiction treatment consumers (Todd, 2010).

Interestingly when asked about confidence levels in regard to asking questions related to risk or harm to self or others almost all participants said they were 'very confident'. The response for Team One is congruent with earlier findings of high confidence in assessment of suicidality, however a number of Team Two participants reported lesser levels of confidence in assessment of suicidality somewhat in contrast with all being 'very confident' in enquiry related to risk to self or others.

Confidence levels were high for both teams in carrying out a comprehensive mental health and addiction assessment. However, performing a MSE which is part of a comprehensive assessment showed lower rates of confidence. The difference between confidence levels in carrying out a comprehensive assessment and performing a MSE could indicate a misunderstanding of the term MSE. Despite survey participants reporting high confidence in carrying out a comprehensive assessment this was not evident within the clinical file audit as stated earlier, with only 5% of Team One and 14% of Team Two files actually having a comprehensive assessment present. There were higher rates of evidence of mental health screening for both teams and with less evidence of a MSE having been carried out this is consistent with the lower rates of confidence reported in the survey.

Moderate levels of confidence and above for both teams were noted in working with consumers with CEP and addressing the mental health disorder. All participants were at some level confident in being family or whānau inclusive in their practice, which research suggests is part of the knowledge and skills needed to assess individuals with CEP (CSAT, 2006; Rassool, 2006). The importance of whānau inclusive practice is also emphasised in the national document *Te Ariari o te Oranga : The Assessment and Management of People with Coexisting Mental Health and Substance Use Problems* (Todd, 2010). Further education and training would be beneficial to increase confidence levels in this area.

Given the lack of confidence of participants in assessment of specific mental disorders it was unexpected to find 100% of participants were confident in providing a mental health

diagnosis with over 70% having confidence levels of ‘moderately’ or higher. This result is also surprising given the professional background of participants and qualifications held. Of note is that only one participant scored ‘very confident’ in assessing for all stated mental health conditions and ‘very confident’ in performing all tasks in question 3(a) section B, related to assessing consumers and family/whānau inclusive practice. This participant is a registered nurse with eight years’ experience working in the addiction sector, and has a post graduate certificate in mental health.

5.6 Participant Views and Attitudes Towards CEP

Faced with nine statements concerning CEP, participants from both teams disagreed or strongly disagreed with the statement that ‘dealing with mental health issues is not part of my role in addiction services’, agreeing that mental health is part of their role. This is incongruent to earlier reports from Team Two who referred all consumers with CEP onto mental health services. However, there is evidence to support the importance of working with consumers with CEP and health professionals seeing this as part of their clinical role (Adams, 2008, Maslin et al., 2001, Richmond & Foster, 2003). Similar responses from both teams positively endorsed the statement ‘my workplace encourages me to become CEP capable’ reflecting the emphasis placed nationally (MOH, 2010; Todd, 2010) and local DHB policy direction. Not all participant responses ‘agreed’ that ‘the DHB actively promotes working in an integrated model for consumers with coexisting disorders’, with further work required in this area to meet national requirements in accordance with national policy (MOH, 2010).

The majority of participants disagreed that ‘mental health training is not offered to staff working in addiction services’. When asked whether they agreed with the statement ‘I am encouraged to attend mental health focussed training sessions/days’, Team Two provided the corresponding response given to the previous statement with six participants ‘agreeing’ but Team One provided a spread of responses with one ‘strongly disagree’, one ‘disagree’, three ‘neutral’, four ‘agree’ and only two ‘strongly agree’ opposing the previous statement responses. This could perhaps indicate participants believing that although mental health training is offered to them, they didn’t feel encouraged to attend.

Differing opinions as to whether ‘placing addiction staff in mental health teams would improve outcomes for CEP consumers’ was apparent across both teams and similarly in response to the statement ‘consumers with coexisting mental health disorders should be treated in a mental health team not addiction’. Comparing responses to ‘mental health and addiction services should jointly case manage coexisting disordered consumers’ participants gave a variety of responses from strongly disagree to strongly agree. The final statement, ‘it is important for consumers with coexisting mental health disorders to be reviewed by a multi-disciplinary mental health and addiction team’ also gave a spread of responses. This is in contrast to Maslin et al’s., (2001) study where participants wanted improved joint working and availability of specialist support as well as improved services in order to provide less compartmentalised treatment to this consumer group.

5.7 Documented Evidence

The second objective of the study was to identify evidence of CEP practices within the clinical health files. In summary, and to add to what has already been discussed in relation to the clinical files, Team One clinical files had a greater amount of evidence for mental health screening (83%) than Team Two (59%). The lack of any form of comprehensive assessments (5% Team One, 14% Team Two) is surprising given the push of assessing for and recognising CEP within the DHB over the past six years, and with the publication of the national guidelines *Te Ariari o te orange: The Assessment and Management of People with Coexisting Mental Health and Substance Use Problems* (Todd, 2010) of which copies of the document were circulated to all CADS teams district wide. The lack of documentation may be due to a ‘culture’ within the services that ‘addictions’ may be seen as core business and mental health may not be perceived as of the same high priority, but progress notes were not examined given the time constraints of the study.

5.8 Areas for Development in Regards to CEP Capability

Finally, the DHB has the opportunity to continue to upskill the AOD workforce by providing ongoing training on mental health topics, as well as other resources such as

ongoing informal mental health education and supervision. Thinking ‘outside the square’ and providing ongoing brief education opportunities, for example at multi-disciplinary review time, could be done with no extra cost to the DHB. Continuation of encouragement to participate in post graduate mental health papers for nurses should remain but the same level of encouragement would be beneficial to all disciplines. It is important given the mainly experienced workforce that this experience is supported with the depth of academic clinically related knowledge. Revisiting the document Te Ariari o te oranga within CADS teams should also be promoted by service managers within the DHB.

Developing a programme for integrated practice should be considered, such as having AOD workers participate in mental health multi-disciplinary team reviews and vice versa, will not only upskill the workforce but provide the best treatment for the consumer.

Given the absence of comprehensive assessments in the clinical file audit, a recommendation for mandatory completion of comprehensive assessment for all consumers enrolled in CADS is hereby suggested.

5.9 Strengths and Limitations of the Study

A strength of this study was the nature of this research in a clinical setting, with the focus on a specific CADS and carrying out both a survey and clinical file audit. Surveys can be perceived as of limited value as they rely on self-report. However a strength of this study was to randomly recruit a feasible representative sample which mitigated against bias of having only experienced clinicians participate and gaining a representation of disciplines. Aiming for 60% sample of thirteen Team One and seven Team Two participants, eleven and six respectively were recruited. Additionally auditing a random sample of clinical files provided the researcher the opportunity to compare self-report with actual written evidence. A strength of the audit was successfully auditing 19% (Team One) and 17% (Team Two) of files when 20% was the target sample. Having a simple template to methodically work through was a further strength, which enabled the researcher to easily record data. Comparing data from the survey and audit provided a depth of information not available before in this DHB.

One limitation to the study was resource constraints for the researcher. Working full time in clinical practice meant reviewing clinical files needed to be time limited and specific. Due to this time constraint, it was not possible to review whole clinical files meaning there may have been evidence of CEP practices in other areas of the clinical file. A second limitation is that each AOD practitioner enters data into the patient information management (IPM) with some inconsistencies in interpretation of categories apparent, given seven files were omitted from the study due to AOD practitioners recording face to face contacts in IPM when there was only evidence of telephone contacts in the clinical file. A third limitation is the difficulty in working in the area of the research, as most of the participants knew of the researcher and may have felt somewhat obliged to complete the survey despite reassurances of participation being voluntary. This may also have led to participants providing answers they thought the researcher would expect. This leads onto the fourth limitation of team culture which could impact on the survey results as well as audit, for example the team culture may be to not file completed screening/assessment tools in clinical files or as a team to focus only on their core business of addictions, which in turn would impact the results and so should be taken into consideration.

Despite the limitations, the findings from this study do provide the DHB with information on their AOD workforce practices and capabilities in relation to CEP and can assist in addressing their education and training needs. The study also provides the DHB with a benchmark of practices to develop should they choose.

5.10 Further Research

Finally, this study provides information on a local AOD workforce and their practices and opinions of CEP as well as a snapshot of evidence held in clinical files. Given the lack of evidence in clinical files of CEP capabilities, further research to audit a larger sample of files and with an extended focus to gain a more accurate picture is recommended. Regular audits of CEP capabilities should become part of local quality assurance practices. Inclusion of consumer participation in the evaluation process should also be welcomed.

It is known that training alone doesn't ensure new practices are adopted, but resources, leadership, consultation and coaching on an ongoing basis are also required (McCarty et al.

2007). The DHB already provides a varied education and training program which could be further improved by using consumer and whānau participation. Further research on the effectiveness and impact of local education and training sessions following participation is required to identify benefits to consumers.

In conclusion, this was the first study to investigate CEP evidence and practices within this local DHB. Since the national telephone survey was completed and in light of the emphasis nationally and locally to improve treatment for individuals with CEP, staff attitudes in relation to the topic were positive towards this group. In line with the national focus nearly all participants of this study considered the DHB workplaces were encouraging of participants enhancing their skills as needed to become CEP capable. Since this research began there has pleasingly been a local focus on implementing national CEP guidelines, with the formation of a CEP interest group with specialist practitioners participating in developments in this area. With a continuation of focus on this consumer group the outlook appears bright.

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APPENDICES

- Appendix 1: Survey Questionnaire
- Appendix 2: Participant Information Sheet
- Appendix 3: Consent Form
- Appendix 4: Audit Template
- Appendix 5: Single Point of Entry Triage Form
- Appendix 6: Addiction Services Entry Assessment
- Appendix 7: Initial Screening for Drug and Alcohol Form
- Appendix 8: Comprehensive Assessment
- Appendix 9: Urgent Assessment Form
- Appendix 10: CADS Assessment Form

Appendix 1: Survey Questionnaire

Coexisting problems in the addiction field research project

Participant Questionnaire

Participant ID _____ Date _____

Section A

1. Please record your current location

A 1	B 2
C 3	D 4

2. Please record gender

Male	1
Female	2

3. Which of the following ethnic groups do you belong to or identify with? If more than one, please identify your main ethnic identity.

	Yes	Main
NZ Maori	1	2
NZ European Pakeha	1	2
Other European	1	2
Samoan	1	2
Tongan	1	2
Niuean	1	2
Chinese	1	2
Indian	1	2
Other, please specify _____	1	2

4. Which of the following best describes your professional registration? (Circle all that are applicable)

Social Worker	1
Mental Health Nurse	2
Registered Nurse	3
Medical Practitioner	4
Psychiatrist	5
Occupational therapist	6
Psychologist	7
Addiction Trained Counsellor	8
DAPAANZ Practitioner	9
Other, please specify _____	10

5. Please specify below any formal qualifications relevant to your current position (for example, degree level qualifications, post graduate papers/qualification and current papers/qualifications you are studying for if not complete)

6. How long have you worked in the addictions field, in years?

7. Prior to your current role, have you worked in a mental health setting?

Yes	1
No	0

7(a). If yes, which area(s) have you worked?

Mental Health inpatient setting

(a) Acute inpatient service	1
(b) Other, Please specify _____	2

Forensic Service	3
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Community mental health team	4
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Child and Adolescent Service	5
------------------------------	---

Crisis service	6
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Dual diagnosis service	7
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Maternal mental health service	8
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Eating disorder service	9
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Other, please specify _____	10
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8. Which of the following functions are you involved in as a routine part of your work?

Brief assessment	1
Triage	2
Individual therapy	3
Management of Addiction Service	4
Comprehensive assessment	5
Clinical case management	6
Mental state examination	7
Medication management	8
Brief interventions	9

9(a). Over the last 2 years, XXXXX DHB has provided the following training opportunities.

Please circle all that you attended, or wished to attend but did not.

	Attended	Wished to
Child & Adolescence : mental health, alcohol & other drug training (Werry Centre)	1	2
Matua Raki 2 day motivational interviewing with Tipene Pickett	1	2
Young people and alcohol (PHO)	1	2
1 day introduction to motivational interviewing with Gen Numaguchi and/or Velda Raybone-Jones	1	2
2 day advanced motivational interviewing with Gen Numaguchi and/or Velda Raybone-Jones	1	2
Matua Raki: Older People and addictions	1	2

	Attended	Wished to
CEP training workshop Dunedin	1	2
2 day motivational interviewing with Joel Porter	1	2
Alcohol, other drugs and aging	1	2
Matua Raki: Coexisting problems workshop with Fraser Todd, Joel Porter And Ashley Koning	1	2
Solution Focussed therapy training	1	2
Addiction nurses update with Daryle Deering	1	2
Mother & Baby training day with Christchurch mother & baby unit staff	1	2
Cutting Edge Conference	1	2

9(b). If you were unable to attend training please list the reasons why you were unable to attend:

Section B

1 (a). Have you completed an initial assessment or comprehensive assessment in the last month?

Yes 1

No 2 If no go to Question 2

1 (b). Thinking of your last client interview, what was the person's main alcohol or drug problem?

1 (c). Did you complete a mental state examination?

Yes 1

No 0 If no go to question 2

1 (d). During the interview did you specifically ask the client questions directly related to any of the following conditions

	Yes	No
Major depressive disorder	1	0
Post-traumatic stress disorder	1	0
Bi-polar disorder	1	0
Social phobia	1	0
Generalised anxiety disorder	1	0
Childhood conduct disorder	1	0
Personality disorder	1	0
Psychosis	1	0

Other mental disorder – please specify _____

1 (e). Did you specifically ask questions around the clients risk to self?

Yes 1

No 2

2. Have you completed a triage screen either by phone or face to face in the last month?

Yes 1

No 0 Go to question 3

2 (a). If yes, did you ask about the following: (Circle all that apply)

	Yes	No
Risk to self	1	0
Mental health status	1	0

3. Please circle your confidence level in assessing for the following conditions:

	No confidence	A little	Moderately	A lot	Very Confident
Alcohol dependence	0	1	2	3	4
Drug dependence	0	1	2	3	4
Drug Abuse	0	1	2	3	4
Major depressive episode	0	1	2	3	4
Generalised anxiety disorder	0	1	2	3	4
Social phobia	0	1	2	3	4
Post-traumatic stress disorder	0	1	2	3	4
Childhood conduct disorder	0	1	2	3	4
Mania	0	1	2	3	4
Schizophrenia	0	1	2	3	4
Personality Disorders	0	1	2	3	4
Bipolar disorder	0	1	2	3	4
Suicidality	0	1	2	3	4

3 (a). Please circle how confident you are in the following tasks:

	No confidence 0	A little 1	Moderately 2	A lot 3	Very Confident 4
Performing a mental state examination	0	1	2	3	4
Working with consumers with coexisting mental health disorders	0	1	2	3	4
Working with consumers with coexisting mental health disorders <u>and</u> addressing the mental health disorder	0	1	2	3	4
Working with family/whanau	0	1	2	3	4
Providing a mental health diagnosis	0	1	2	3	4
Carrying out a comprehensive mental health and addiction assessment with consumers	0	1	2	3	4
Asking questions related to risk/harm to self	0	1	2	3	4
Asking questions around the clients thoughts of risk or harm to others	0	1	2	3	4

Thinking of your knowledge of coexisting problems, please specify what areas of mental health and or addiction, you would like further education or training on:

Section C

1. Which of the following screening tools do you regularly complete with consumers:-

(Circle all that apply)

Audit	1
LDQ – Leeds Dependence questionnaire	2
SADQ – Severity of alcohol dependence questionnaire	3
PHQ-9 – Patient health questionnaire	4
K10 – Kessler psychological distress scale	5
GAF – Global assessment of functioning	6
SACS – substances and choices scale	7
SDSS – Substance dependence severity scale	8
SDS – Severity of dependence scale	9
DAST – Drug abuse screening test	10
ASI – Addiction Severity index	11
Readiness to change questionnaire	12
CUDIT – R - Cannabis Use Disorder Test	13

Others (please state) :

2. Which of the following assessment and other activities do you carry out, during or following consumer contacts for those people with a coexisting mental health issues:-

Comprehensive assessment	1
Urine drug screen analysis	2
CEP framework formulation	3
Present to the multi-disciplinary team for review	4
SDHB Initial Screening for drug and alcohol form	5
Refer on to mental health services	6
Request previous mental health notes	7
Mental health screening questions	8
Order blood tests	9
Request 3rd party information e.g.: from Whanau	10
Request a complex case review	11
Request a psychiatrist appointment	12
Request previous addiction notes	13

Other – please list:

Section D

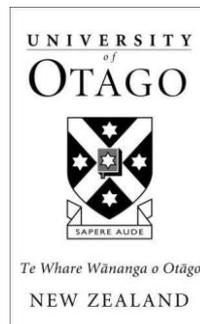
Please circle your response to the following statements:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Consumers with coexisting mental health disorders should be treated in a mental health team not addiction services	1	2	3	4	5
The XXXX DHB actively promotes working in an integrated model for consumers with coexisting disorders	1	2	3	4	5
It is important for consumers with coexisting mental health disorders, to be reviewed by a multi-disciplinary mental health <u>and</u> addiction team	1	2	3	4	5
Dealing with mental health issues is not part of my role in addiction services	1	2	3	4	5
Mental health services and addictions services should jointly case-manage co-existing disordered consumers	1	2	3	4	5
My workplace encourages me to become Coexisting problem (CEP) capable	1	2	3	4	5
Placing addiction staff in mental health teams would improve outcomes for CEP consumer	1	2	3	4	5
I am encouraged to attend mental health focussed training sessions/days	1	2	3	4	5
Mental health training is not offered to staff working in addiction services	1	2	3	4	5

Thank you for participating in this research project.

Appendix 2: Participant Information Sheet

Reference number allocated by Human Ethics Committee H14/141



Addiction workforce recognition and understanding of coexisting mental health problems

INFORMATION SHEET FOR PARTICIPANTS

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

What is the Aim of the Project?

This project is being undertaken as part of the requirements for Velda Raybone-Jones Masters in Health Science. The aim of the project is to identify clinician's ability to recognise and understand mental health issues with addiction consumers.

What Type of Participants are being sought?

Participants have been recruited by randomly selecting 60% of the current XXXXX District Health Board addiction workforce. Only clinical staff who have consumer contact are being recruited. A total of 22 participants are being asked to participate.

What will Participants be asked to do?

Should you agree to take part in this project, you will be asked to complete a survey, which should take no more than 10 minutes to complete. The survey will be given to you to complete in your workplace.

Please be aware that you may decide not to take part in the project without any disadvantage to yourself of any kind.

What Data or Information will be Collected and What Use will be made of it?

No identifiable data will be collected on the surveys. Consent forms will be kept separately from surveys. Velda Raybone-Jones, her supervisors Dr Dave Carlyle and Dr Daryle Deering will have access to the completed surveys.

The data collected will be securely stored in such a way that only those mentioned above will be able to gain access to it. Data obtained as a result of the research will be retained for at least 5 years in secure storage. Any personal information held on you may be destroyed at the completion of the research even though the data derived from the research will be kept for 5yrs.

The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) every attempt will be made to preserve your anonymity.

You may withdraw from participation in the project at any time by informing Velda Raybone-Jones and without any disadvantage to yourself of any kind. If you had commenced completing the survey it will be destroyed at time of withdrawal.

If you have any questions about our project, either now or in the future, please feel free to contact either:-

Velda Raybone-Jones

Dr Dave Carlyle

XXXXX Community Mental Health Team

Dept. of Psychological Medicine

Telephone Number: 03 XXXXX

Telephone Number: - 03 372 0400

velda.raybone-jones@XXXXXdhb.govt.nz

dave.carlyle@otago.ac.nz

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph +643 479 8256 or email gary.witte@otago.ac.nz). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.

Appendix 3: Consent Form

Consent to Participate in Survey

Date:

Study Title: Addiction workforce recognition and understanding of coexisting mental health problems

Researcher: Velda Raybone-Jones, MSc Candidate, Otago University

Purpose of the research: The purpose of the research is to explore attitudes, knowledge, ability and confidence in recognising mental health issues within drug and alcohol consumers. There are no perceived risks to your participating in the study. The benefit of the study will be contribution to the current body of research in this area and may also feed into XXXXXX District Health Board Coexisting problem policies.

What you will be asked to do in the research: You are asked to complete a survey which should take no more than 10 minutes.

Voluntary Participation: Your participation in the study is completely voluntary and you may refuse to answer any question or choose to stop participating at any time.

Withdrawal from the study: You can stop participating in the study at any time for any reason if you so decide. Should you decide to withdraw from the study all data generated as a consequence of your participation will be destroyed.

Confidentiality: Your personal information supplied during the research will be held in confidence and will not appear in any report or publication of the research. Your data will be safely stored in a locked facility and only the researcher will have access to this information.

Questions about the research: If you have any questions about the research in general or about your role in the study, please feel free to contact Velda Raybone-Jones, MSc candidate in Health science at Otago University, telephone 027 600 4083, or by email velda.raybone-jones@xxxxxdhb.govt.nz . This research has been reviewed and approved for compliance by the Department of Psychological Medicine, Christchurch and to be decided ethics committee.

Signatures:

I consent to participate in the above study conducted by Velda Raybone-Jones. I have understood the nature of this project and wish to participate. My signature below indicates my consent.

Signature_____ Date_____

Signature_____ Date_____

Appendix 4: Audit Template

File Audit No. File Code Date of Audit..... Profession of casemanager

Which of the following are evident and completed in the assessment/treatment section of the clinical file:	Yes	No	Is there documented evidence of mental health screening?		Comments eg: specify what is the evidence, is there a mental state examination
			Yes	No	
1. Triage form	1	0	1	0	
2. Comprehensive assessment (DASS)	1	0	1	0	
3. Initial screening for drug and alcohol form	1	0	1	0	
4. Urgent assessment form	1	0	1	0	
5. CADS assessment form (CADS)	1	0	1	0	

If there is no documented reference by the clinician to mental health disorders, is there evidence that questions around mental health conditions were asked?

Yes 1

No 0

If yes, specify the evidence below: -

Any other comments: -

Appendix 5: Single Point of Entry Triage Form

Triage Form – SPoE MHAID Service

Surname:		NHI:	
Other names:		DOB:	Age:
Ward:		Consultant:	
Address:		Phone number:	

Section 1					
Initial contact information:		Time:		Date:	
Completed by:					
Ethnicity: Maori Mental Health Services offered Accepted Declined			Referral source:		
Occupation:			Immigration status:		
GP details:					
Name:					
Address:					
Phone:					
Previous presentations: <i>(Year/s in service, diagnosis, medications, last contact, treating clinicians.)</i>					
Primary contact information: <i>(Reason for referral)</i>					
Risk indicators					
Suicide risk:			Harm to others:		
Self harm:			Vulnerability:		
Risk comments:					
Initial contact outcome: <i>Consent, confirm information in referral, A&D issues, medications current risk, EPOA</i>					
iPM status:	Contact:	Log entry:	Ackn ltr sent:	Healthviews file pulled	Referral ackn in file
Section 2					
Single Point of Entry Team Meeting:			Date:		
Accept:					
Defer:					
Decline:					
Additional MDT Meeting :			Date :		
Notes:					
Referral accepted: Yes <input type="checkbox"/> No <input type="checkbox"/>					

Triage Form – SPoE - MHAID Service (Southland)

MR1235 V2

Appendix 6: Addiction Services Entry Assessment

Outcome of this Session:

Assessment Conducted by:

Name:

Designation:

Signature:

Surname:		NHI:
Preferred name:	DOB:	Age:
Ward:	Consultant:	
Address:	Phone number:	

Cell Phone:

E-Mail:

Ethnicity:

Date and Time of Assessment:

Presenting Problem:

Current Living Situation:

Dependents:

Safety: Risk assessment and formulation

In the last six months, have you been physically harmed or threatened by your partner or anyone else?

In the last month, have you felt like harming yourself or harming anyone else?

(If “yes”, explore in detail previous attempts/incidents, current plans, presence of risk factors, safety of dependants.)

GP: (Name and location)

Current Medications:

Other Agencies Involved:

Substance Use:

Current Use:

Substances used in the last 12 months:

Problematic Consequences:

Previous Treatment:

Suggested Options:

Initial Screening for Drug & Alcohol MHAID Service (District)	SURNAME:		NHI NO:
	OTHER NAMES:	DOB:	AGE:
	WARD:	CONSULTANT:	
	ADDRESS	PHONE NUMBER:	

General health issues	
<hr/> <hr/> <hr/> <hr/> <hr/>	
Current supports	
<hr/> <hr/> <hr/> <hr/>	
Referrer's Name	Phone / fax
Email	Agency
Address	
Are you currently being seen, or have you previously been seen by any other AOD/ Mental Health Service? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, what agency / agencies?	
<hr/> <hr/>	
Mental Health / Alcohol and Drug diagnosis?	
<hr/> <hr/>	
Legal status	Nature of offence
<hr/> <hr/>	<hr/> <hr/>
Risk assessment, including self harm, suicidality, violence, neglect (complete Mental Health Risk Assessment form)	
Initial Treatment Plan?	
<hr/> <hr/> <hr/> <hr/>	
This Form Completed by	
Assessor (print name)	Consumer (print name)
Designation	
Signature Date	Signature Date
General Comments	
<hr/> <hr/> <hr/>	

Initial Screening for Drug & Alcohol – MHAID Service (District) MR 1098 V1

Appendix 8: Comprehensive Assessment

Clinical Assessment Form
MHAID Service (District)

Surname:		NHI:
Preferred name:	DOB:	Age:
Ward:	Consultant:	
Address:	Phone number:	

Clinical Assessment Form [Manual Completion] MHAID Service (District)

Service/team assessing:
Usual team:
Date and time of assessment:

Specific requirements for assessment:
(Interpreter/communication aids, advocate/family; mobility needs, child care during assessment.)

Indicate if Māori-specific cultural assessment indicated? Yes No N/A
If "Yes" include in the initial treatment plan pg. 4.

Sources of information/mode of referral: (Indicate if corroborative history obtained, interpreter used, old notes accessed, details of people present at assessment.)

Presenting complaints and duration:

History of presenting complaint:
Precipitating stressors/events, consequences, pre-morbid personality.

Psychiatric history:
Other services, admissions, history of harm to self or others, past compulsory treatment.

Medical history:
Significant events, hospital admissions, head injury, epilepsy, adverse medication reactions, impact of illness, communicable diseases, allergies, nutritional status, special dietary requirements.

Current medications:

Current medications (use generic)	Dose/frequency/route	Comments (e.g. prescriber, side effects, adherence)

Substance Use:
Current use, past use, tobacco use, consequences, past treatment history
Indicate if substance use screening completed Yes No

MR1444 V1

Name: _____ NHI: _____

Forensic:

Current legal orders e.g. guardianship, protection orders past, current, pending court cases, conviction for violent offences Youth Aid, police contact.

Family background and dynamics:

Genogram, family structure, ages, occupations, psych and medical history, drug and alcohol use, quality of relationship, positive times, conflict, communication, roles, losses, discipline, parental style, agency involvement.

Indicate if Family Focussed Assessment (COPMIA) completed/required?

Yes No N/A

Are there concerns about the safety of the child, young person or other dependent?

Yes No

If risk identified, where is the management plan documented?

Early development:

Pregnancy, birth, developmental milestones, significant events, trauma, separation, temperament, abuse or neglect, bullying, family violence, agency contact.

Education, employment & vocation:

Academic, extra-curricular, learning problems, special needs assistance, attendance, social, subjects, testing, work history.

Relationship history:

Number, length, stability, psychosexual history.

Cultural and spiritual:

Age and gender issues, sexual orientation, spirituality and/or religious, political beliefs, ethnicity, disability issues, values system.

Current situation

Living situation:

Living arrangements, self-care abilities, dependant care responsibilities, child protection issues, domestic stressors.

Social functioning:

Communication skills, daily activities, use of time, school/employment/vocation, financial & social service needs, support systems.

Strengths and resources:

Personal strengths, skills and abilities, community and family supports.

Name: _____ NHI: _____

Mental State Examination

Appearance and behaviour:

Physical, clothing/grooming, maturity, level of arousal, intoxication, motor activity level, involuntary movement, psychomotor retardation, agitation

Rapport:

Eye contact, relatedness to interviewer, reciprocity/empathy, social inhibition.

Speech:

Volume, rate, flow, spontaneity, impediments, vocabulary.

Thought process/language:

Acceleration/slowed, dissociation, disorganisation, circumstantial, thought blocking.

Mood: mood = sustained, pervasive, subjective

Anxiety/panic, perplexity, vegetative features, sleep/appetite, libido, enjoyment.

Affect: affect = observable, objective

Quality, stability.

Thought content:

Ruminations, obsessions, compulsion, magical thinking, homicidal/suicidal, Ideas of reference, overvalued ideas, delusions, poverty, passivity, insertion, withdrawal, broadcasting.

Perception:

Illusions/hallucination, pseudo-hallucinations, five modalities.

Cognition:

Orientation, concentration, attention, memory – short and long term, confabulation, intellectual functioning, mini mental state, level of consciousness.

Insight and judgement:

Risk assessment and formulation: Consider: risk to self, risk to others, risk from others (refer to Risk Tool Kit) risk management system – presence of risk factors, previous/recent history of self-harm or aggression, depression/psychosis/mania/personality disorder, other psych or medical condition, active substance abuse, forensic history, made/voiced threats to others, identifiable victim, hopelessness, suicide note/preparation for death, plan and means available, socially isolated, recent loss/stressor, family history suicide (or other role model), vulnerability, risk/safety of partner, children or dependant, other identifiable risk factors vulnerability, risk/safety of partner, children or dependant.

FVI screen completed

(If a positive screen discuss at MDT meeting.)

Yes No N/A

Name: _____ NHI: _____

Physical examination:
Completed:
Attached: Yes No

Consumer's perception of needs, expectations of service:

Summary/formulation: (Predisposing, Precipitating, Perpetuating, Protective factors - consider biological, temperamental and experiential factors, the family situation, the wider environmental situation and strengths)

Diagnosis/preliminary diagnosis: (using DSM-IV or ICD10)

Initial treatment plan: (including timeframes and person responsible - biological, psychological, social and clients goals)

Intervention/treatment	Timeframe	Responsibility

Assessment conducted by:
Name:
Designation:
Signature:

Other clinicians involved in assessment:
Name:
Designation:
Signature:

Note: If completed electronically, please ensure this form is signed and filed in the comprehensive file.

Medications: (current)

Allergies:

COPMIA: Children / Dependents initial SCREEN Date:			
Name	Age	Other agencies involved	Contact details
Full-time primary carer <input type="checkbox"/> Part-time carer <input type="checkbox"/> Other (specify) <input type="checkbox"/>			
Alerts / Risks Indicators identified <input type="checkbox"/> No No further action required			
<input type="checkbox"/> Yes Complete COPMIA assessment MIDAS 81619			
Immediate actions :			
Alternate care options:(if unable to care for dependents) the following person(s) can be contacted:			
Name	Relationship / Role	Contact detail	

Substance Abuse: (Consider use of CEP: Addiction Screening – MIDAS 83312)

Mental State:

- **B & A:** _____

- **Speech:** _____

- **Mood:** _____

- **Affect:** _____

- **Thoughts:** _____

- **Perception:** _____

- **Cognition:** _____

- **Function:** _____

- Sleep: _____

- Appetite _____

- Energy & motivation: _____

Additional Information

Appendix 10: CADS Assessment Form



Surname:		NHI:
Other names:	DOB:	Age:
WaPI:	Consultant:	
Address:	Phone number:	

Preferred Name:

Date and time of assessment:

By:

Referral Source

Current Presentation

History of presenting problems and expectations, current living situation and financial situation and needs, current social supports and self care.

Substance Use

Current Substance Use: Last use, circumstances of drug use and method of use, dependence/abuse status according to DSM IV, last use over last 5 days.

Past substance use Lifetime use or at least 10 times in a month, age of first use and age of first regular use, heaviest period of use and longest periods of abstinence.

Consequences of substance use Infections, overdose or injury, mental health, crime and finances, relationships and employment.

Past treatment history Hospital, residential and detox, alcohol and drug service, self-help e.g. AA, NA etc.

Gambling Including B Screen, DSM IV, previous treatment, relationship with substance abuse.

Readiness to change Pre-contemplation, contemplation, preparation, action, maintenance and relapse.

Dependant Care responsibilities Names, DOB & living situation, other agencies involved, care and protection issues.

CADS Assessment (District)

MR1465 V1

Personal History: Childhood development, significant events during childhood, adolescence and adulthood, education and work attainment, personality description inc. evidence of personality disorders, ethnic and spiritual identity, relationships with family of origin and enduring friendships.

Cultural/Spiritual Age and gender issues, sexual orientation, spirituality and/or religious, political beliefs, ethnicity, disability issues, values system.

Family/Whanau History Structure of family of origin, current relationships and significant family events, family disorders, genogram.

Medical History Significant illnesses including head injuries, treatment and hospitalisations, risk of communicable diseases e.g. hepatitis B, hepatitis C, or HIV, contraceptive use, sexual health, allergies.

Mental Health History
Admissions, treatment received, past compulsory admissions. Screening of other Mental Health problems including anxiety, eating disorders, OCD, mood disorder and psychoses.

Prescribed Medication Generic medicine name, dose, adherence to treatment.

Legal Issues Convictions, charges pending, current legal status.

Mental State Examination:

Appearance and Behaviour:

Physical appearance, clothing and movements, intoxication level & state of consciousness, restlessness, psychomotor agitation or retardation, eye contact and ease of rapport.

Speech: Rate, flow, volume, vocabulary, impediments & spontaneity.

Mood and Affect: Signs and symptoms of depression or elation, sleep/appetite, libido and enjoyment, anxiety and range of facial expression Mood = sustained, pervasive & subjective, Affect = observable and objective.

Thought Form and Content: Accelerated/slowed and disorganisation, delusions & over-valued ideas, thought withdrawal/broadcast/insertion, homicidal and suicidal ideation, preoccupations & ideas of reference.

Perception: Illusions and hallucinations

Cognition: Orientation and attention/concentration, more formal testing if required

Insight: Degree of understanding of the situation

Physical Health Examination: Attach physical examination if completed

Completed: Yes No

Investigations: Attach investigations if completed e.g. blood, urine etc.
Completed: Yes No

Risk Assessment and Formulation (refer to Risk Sheet): Risk of self harm, risk to others (safety of children or dependent partner etc.); risk from others e.g. partner abuse (nature, intensity, frequency, plans and past history, recent stressors, social isolation)

Summary A brief overview of the main points noted in the assessment.

Diagnosis (DSM IV)

Axis I: Clinical syndromes

Axis II: Developmental and personality disorders

Axis III: Physical conditions

Axis IV: Psychosocial stressors

Axis V: Level of functioning as GAF score

Problem List

Strengths and Resources list

e.g. social support, treatment adherence, motivation et.

Formulation Answer the question "Why is this person presenting in this way at this time?"

Initial Treatment Plan Including time frames and person responsible.

Prognosis Based on protective factors, condition and strengths.

Assessment by:

Designation:

Signature:

Others involved in assessment: