Canterbury
District Health Board
Te Poari Hauora ō Waitaha

DRAFT CANTERBURY PLAN

For

CO-EXISTING MENTAL HEALTH AND ADDICTION PROBLEMS

2012 -2015

November 2011

Introduction (from the South Island Plan):

One of the tasks of mental health and addiction services is to provide interventions for people with co-existing problems of mental illness and alcohol and/or other drug misuse. These services are for people who have a mental health problem that is exacerbated by the misuse of substances and also for those who have a significant substance abuse issue when there is also a co-existing mental health issue. This is often referred to as Co-Existing Problems, or 'CEP'.

In June 2010, the Ministry of Health wrote to Mental Health & Addictions General Managers, Clinical Directors, Regional Directors and Planners & Funders requesting that

"each DHB develop a comprehensive plan detailing how you will demonstrate CEP responsiveness within your provider arm and NGO sectors across mental health and addiction treatment services."[1]

Working with people with co-existing mental health and addiction problems is one of the biggest challenges facing frontline mental health and addiction services in New Zealand and overseas. The co-occurrence of these problems adds complexity to assessment, case planning, treatment and recovery[2]. Strategic planning to assertively address our responses to CEP is warranted by the prevalence of, and harms associated with, co-existing problems and the difficulties that all treatment systems have in responding effectively[3]. The expectation is that mental health and addiction services will address the needs of CEP clients in a coordinated and complementary manner. Many elements of the South Island DHB plans may be implemented at negligible cost - they represent a tuning of existing services in recognition of the realities of CEP rather than the development of new systems and infrastructures.

[1] Letter of 14th June 2010 from Office of the Director of Mental Health, the Ministry of Health to DHB Mental Health & Addictions General Managers, Clinical Directors, Regional Directors and Planners & Funders.

[2] Report to the Mental Health Commission Board and the Alcohol Advisory Council of New Zealand: Getting it Right for People with Co-existing Addiction and Mental Health Problems September 2008

[3] Gary Crotton, 2005. Response to State of Victoria Senate Select Committee on Mental Health Public Hearing.

National Direction (from South Island Plan)

Te Kokiri, The Mental Health and Addiction Action Plan 2006 - 2015 identified the need for a coherent national approach to co-existing mental health and substance use/abuse disorders and the need to strengthen partnerships between mental health and addiction services. The nationwide Co-Existing Problems Project was initiated as an action within Te Kokiri[4].

The nationwide project has promoted the expectation that services become more CEP capable. Services are encouraged to examine their systems and processes, identify workforce development requirements and to plan to work towards sustainable change. The Ministry of Health released the following documents in 2010 to guide DHBs to develop a comprehensive framework to ensure services become CEP capable:

1. Service Delivery for People with Co-existing Mental Health and Addictions Problems - Integrated Solutions.
2. Te Ariari o te Oranga – The Assessment and Management of people with Co-existing Mental Health and Substance Use Problems.

A number of treatment approaches have been developed to meet the needs of people with co-existing substance use and mental health problems. One of the most common components of these approaches is treatment integration, meaning treatments that integrate mental health and substance use resources and models. Treatment for CEP clients and family/whanau is dependant on integration occurring along a continuum and requires integration between multiple services. Integration can occur at a number of points in the clinical pathway. All services are expected to aim for integrated screening and assessment, most services should aim for integrated assessment and case formulation and some services should aim for full integration[5].

[4] Te Kōkiri: The Mental Health and Addiction Action Plan 2006-2015
[5] Ministry of Health. 2010. Te Ariari o te Oranga – The Assessment and Management of people with Co-existing Mental Health and Substance Use Problems

Canterbury's approach:

A workshop supported by Ministry of Health, Matua Raki, Te Pou and the Werry Centre commenced in Christchurch on 22 February 2011 to provide national project updates and detail the range of support options available through the national project initiative. This workshop was disrupted by the earthquake and during the following months there was little opportunity to focus specifically on this area. However, a mentoring project did commence and staff from CADS began working across some of the mental health teams to increase the AOD expertise in mental health assessment and intervention.

A working group of interested and/or expert people (including people from specialist services, NGOs, consumer roles) met for the first time in August to consider how best to develop and implement a plan for increasing the CEP capability across the mental health and addictions system in Canterbury. In general the group agreed on a strategy of creating opportunities for services to determine the needs of their client group regarding CEP, identifying their ideal status, then developing and implementing plans to achieve this status. This is considered an approach that has good potential for engaging clinicians, managers and consumers.

The following is a draft action plan that will be presented to the Mental Health Leadership Group, Access Canterbury and other groups early in 2012. Primary care and Maori were unable to participate directly in the development of the plan so particular emphasis will be placed on consultation with both groups.

It is envisaged that from the working group a governance/oversight group will be developed for the implementation. This group will continue to update the other bodies.

Please note that Canterbury adopts a ‘whole of system’ approach to health service delivery so ‘service’ or ‘provider’ in the plan encompasses primary, specialist and NGO.

Canterbury DHB CEP ACTION PLAN

Goal 1: All services become client and family, whanau centred and CEP responsive				
Objective	**Actions**	**Measure/outcomes**	**Responsibility**	**Time frame**
A shared understanding for CEP is developed across the AOD and MH system.	CDHB endorses CEP as core business across the care system, including primary, specialist and NGOs.. An advisory group is established to champion this work and review progress. Individual providers commit to CEP as core business. Policy and Practices are CEP responsive across the AOD and MH system.	The CEP plan is endorsed by the Mental Health Leadership Group, Access Canterbury and other advisory/oversight bodies. This group meets regularly and keeps the MH Leadership Group etc informed about progress. Contracts for all MH and AOD services include expectations regarding CEP capability and audit outcomes support this. CEP capability is built into audit processes. Service policy is client centred and includes working definitions of CEP, integrated care and best practice protocols.	Planning and Funding Clinical and management leaders	2012/13

Objective	Actions	Measures/outcomes	Responsibility	Timeframe
Mental Health and Addiction services including advocacy and peer support services, collaborate to ensure integrated treatment.	CDHB adopts a whole of system approach to planning.	Documented system of care incorporates an integrated response to people with CEP.	P&F/Service leaders	2012/14
	The AOD specialist service supports other services/teams with expertise and case manages people with complex needs.	SMHS AOD has a focus on CEP in their documentation and staff workforce development plans incorporate CEP enhancement.	Service leaders	2012/14
	Services have staff skilled in assessing for MH and AOD, and co-ordinating, integrated care planning.	All services have documented processes that describe procedures for responding to and managing people with CEP, including staff skills.	Service leaders	2012/14
	Peer based advocacy, and recovery support services complement addiction and mental health services and have capacity for people with CEP.	Access rates to peer services increase and consumer feedback endorses the approach.	Community service leaders/peer organisations	2012/14
	Pathways/linkages are established between central co-ordination points for entry into NGOs and specialist services.	Documented protocols describe the pathways and linkages.		
	Relationships are developed between consumer support services and treatment services to support responsiveness to consumers with CEP.	Consumer support services are able to access clinical support for people with CEP when needed.		
Review Specialist CEP Resource.	Review current roles and identify if there is a need for specialist CEP resource. Implement if required.	Performance activity monitored and reviewed by oversight group.	Service leaders, P&F	2012/14

	Free up people to participate in oversight group			

Goal 2: Integrated Systems of Care – systems are to acknowledge and incorporate CEP approaches				
Objective	**Actions**	**Measures/outcomes**	**Responsibility**	**Timeframe**
Services are responsible for ensuring systems acknowledge and incorporate CEP. Services develop a strategy to meet the CEP needs of their service users.	CEP is included in professional development frameworks. CEP champions and/or CEP clinicians are available for supervision. CEP diagnoses are recorded in NHI reporting. There are mechanisms in place to elicit client feedback for ongoing monitoring and reviewing. Services will undertake a self- audit of their CEP capabilities (eg. policy on CEP, CEP inclusive assessment, staff role descriptions, staff skills etc.), identify their desired position and develop an implementation plan that moves them towards it.	Workforce development plans include CEP. There are lists of supervisors with CEP expertise available. NHI reports analysed and reported to oversight committee show increased identification of CEP. Tangata whaiora feedback endorses approach. Services have identified the CEP needs of their client group and have a documented record of their current status, desired position and plan to achieve (e.g. as a quality improvement initiative).	Service leaders	2012/14
Service Leaders facilitate development of relationships, collaboration and dialogue at all levels across the community.	Managers (primary, specialist, NGOs) value collaboration across the community and support staff to engage with other parts of the system. Service providers work together to identify	Protocols exist across the system for strengthening relationships, information sharing and responsibilities, including lead service etc. Staff and client wellbeing improves.	Service leaders	2012/14

	opportunities for changing organisational culture and utilise existing leadership support.			

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Goal3: Workforce Development – a highly skilled workforce that is CEP responsive and effective.				
Objective	**Actions**	**Key Performance Indicator**	**Responsibility**	**Timeframe**
Specialist CEP expertise is retained and consideration given to recruitment of CEP FTE/team.	Existing CEP specialists/champions are freed up from their main role to progress this work. Whole teams work towards being CEP capable with assistance from the CEP specialist role.	Key people are able to commit to this work in a sustainable way. Regular CEP training is provided across the system. Training delivery is part of the CEP specialist job description.	Service leaders/P&F	2012/14
Services support training initiatives provided nationally regionally and locally.	Implement and support national, regional and local initiatives utilising available resources, including those that target values and attitudes. Include teams of peer workers, MH and AOD clinicians together to strengthen relationships.	Number of people trained, including peer roles. Number of people providing mentoring/coaching post training.	Service leaders/P&F in collaboration with workforce development organisations	2012/14
	Roll out training/mentoring CEP package to develop champions across specialist services and NGOs. Formulation training provided to clinicians across the system. Collaboration skills are enhanced	Numbers of people engaged in training initiatives. Increased CEP capability demonstrated through access rates and care plans.	Service leaders	2012/14