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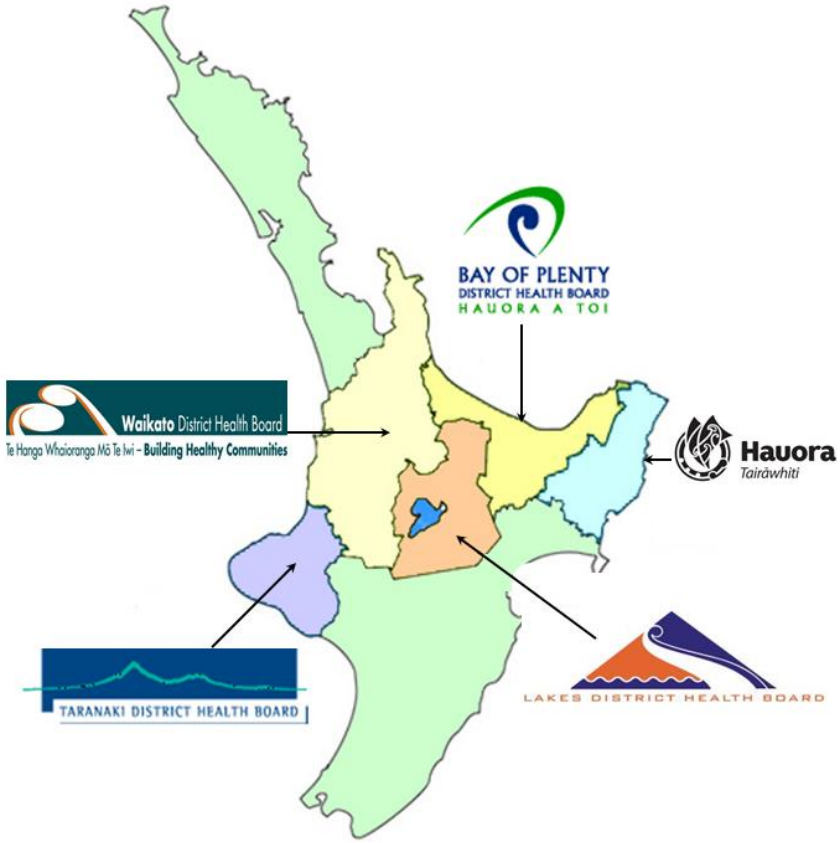
Midland Region Mental Health and Addictions

2017 Co-Existing Problems Survey: Results Analysis



FINAL: January 2018

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1. Executive Summary:

1.1. Background:

As requested by the Mental Health & Addictions regional Clinical Governance network, a survey was undertaken to ascertain if the investment in Co-existing Problems (CEP) training undertaken over the last five years was value for money. This document is an analysis of the survey conducted across the Midland Region through the latter part of 2017.

Whilst the response rate was lower than we had hoped, the consideration that went into the responses produced very useful information. This will help to shape future workforce development in this crucial area.

1.2. Recommendations:

a) The findings from the survey will be discussed at the Clinical Governance Forum and other relevant Network meetings and opportunities for future development will follow

b) Midland Regional Mental Health & Addiction Network (MRMHAN) will a) notify when a survey is imminent and; b) quantify how many staff are being responded on behalf of.

c) A reminder to all staff to at least scan-read each e-mail would be greatly appreciated.

d) All staff should complete the Matua Raki CEP e-learning module[1], or equivalent learning.

e) All staff should have personalised training and development plans that have considered the organisation's response to CEP issues.

f) Clinical pathways and responsible leads need to be clearly defined and communicated to all staff and other stakeholders. Pathways need to be simple to access and use.

g) Services will do better to become more integrated and community-based, whilst maintaining specialist clinical input when and where it is needed.

h) Service Users and their Whānau representative input needs to be sought, considered and incorporated into delivery wherever possible.

1.4. Acknowledgement:

The MRMHAN team wish to thank all those who participated in the survey for the thoughtfulness of responses and the time taken to complete the questionnaire. We also wish to acknowledge the services that allowed time for busy staff to undertake the survey.

[1] https://www.matuaraki.org.nz/initiatives/cep-e-learning/170

2. Introduction:

The MRMHAN team agreed to seek to identify current issues with CEP practice and provision. The aim was to review several years of investment in workforce development, including training in CEP and to determine what further workforce development was sought after across the Midland Region.

MRMHAN circulated a questionnaire via Survey-Monkey. The survey was sent to 107 Practitioners, Managers and other related MH&A staff in Provider Arm Services, Non-Government Organisations (NGOs) and Kaupapa Māori Providers.

A total of 107 surveys were sent out and 36 (34%) completed surveys were returned. Of the 36 replies, 8 were returned via second parties indicating that the survey had been forwarded onward. We have no way of knowing how many others this was sent to.

Overall the response rate is disappointing. However, 53% of the returned surveys were also completed by senior staff-members (Team Leaders, CEP Lead Practitioners) on behalf of other staff. Unfortunately we are unable to ascertain how many staff respondents were responded to on behalf of others. This is because questions such as *"How many of your staff attended CEP training?"* some answered *"about half"*, or *"a few"*. Future questions of this type will need to mandate actual numbers in the response fields. Our analysis of the responses indicated that possibly as many as 270 staff may have been answered on behalf of by those who completed the questionnaires.

Of note is that 54% of the e-mails inviting stakeholders to participate in the questionnaire remained unopened. Whilst we recognise that our stakeholders are busy, we were confident that CEP workforce development issues would generate at least a scan of the message.

The following report provides analysis of those who responded to the questionnaire and analysis of their commentary. A series of recommendations based on the findings from the survey and from discussion with Regional Stakeholders are then provided.

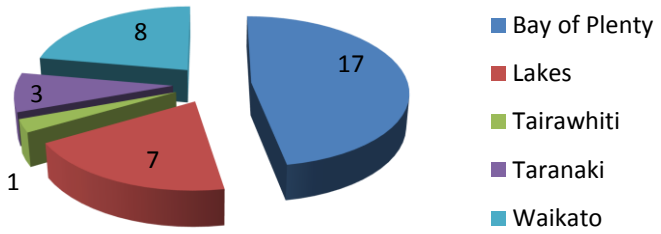
We trust that the report presents an accurate analysis of the commentary and that it informs further discussion towards improving our overall response to the complexity that CEP issues present us with.

3. Respondent Demographic Data:

Questionnaires were returned from each of the DHBs in the region, with the highest response rates from BoP 47%, Waikato 22%, Lakes 19%, Taranaki 8% and Tairāwhiti 3%.

3.1 Response Rate by DHB Area

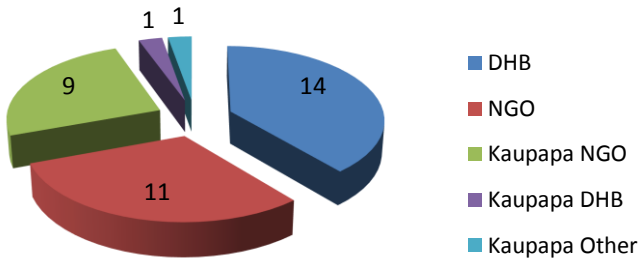
Table 1: Response Rate by DHB Area



Overall, 56% of the respondents were from NGOs and 39% were from DHBs. 31% were from Kaupapa Māori providers, the majority of which 82% of the Kaupapa Māori providers were NGOs.

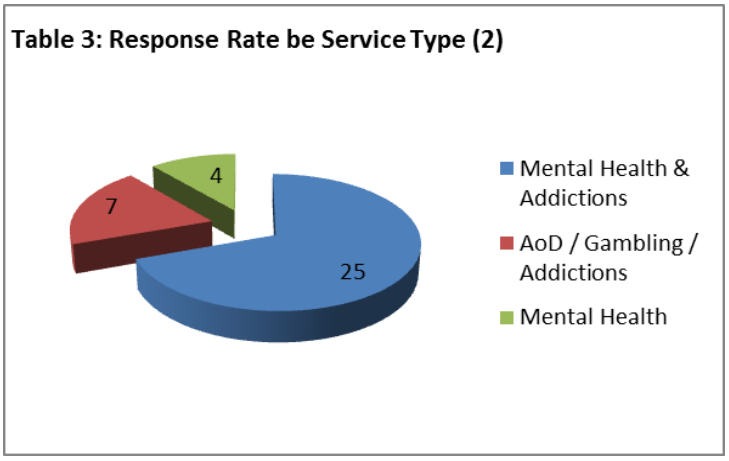
3.2 Response Rate by Service Type (1)

Table 2: Response Rate by Service Type (1)



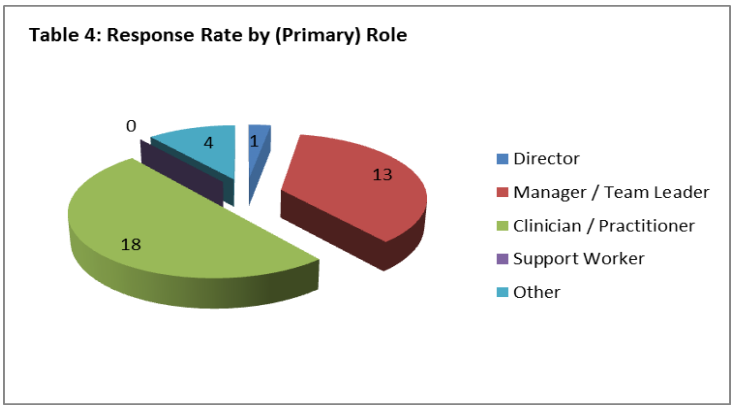
The majority of respondents were from Mental Health and Addictions Services 69%, followed by AoD, Gambling and Addictions Services 19% and then Mental Health Services 11%.

3.3 Response Rate by Service Type (2)



The majority of the respondents were Clinician / Practitioners 50%, closely followed by Manager / Team Leader roles 36%. No support, Peer Support, or Service User Involvement Coordination roles appear to have responded to the questionnaire.

3.4 Response Rate by (Primary) Role



4. Findings:

4.1. Response Rate and Survey Bias:

Due to the low return rate for the survey, the following findings can hardly be thought to be definitive. Whilst we will always try to get the views of as many of our stakeholders as possible, low response rates need not necessarily lead to biased results[2]. In fact, it could be argued that those who felt strongly enough about the subject to take the time to respond to the survey, may be better placed to comment, due to their attention to the issues raised.

4.2. Kaupapa Māori Provision:

Responses from Kaupapa Māori Providers reflected a better sense of organisational ability to respond to CEP issues. A higher level of CEP case discussion was reported, particularly in multi-disciplinary teams (MDT) and in supervision. There were also significantly higher reported numbers of staff trained both via the Matua Raki e-learning and other equivalent training.

4.3. Examples of Good Practice:

There were reassuring examples of good practice responding to the increased complexity that CEP presents, since the trainings. These included a *"requirement to present all cases at team meetings"*, *"whānau/family inclusion"* and "*encouragement of staff to undertake training".*

A total of 173 current staff has attended CEP training. Of those that indicated their staff had completed the Matua Raki e-learning module, 62 indicated that they had. Eleven of those were from Kaupapa Māori Services. 169 indicated that they had completed equivalent training and 62 of those were from Kaupapa Māori Services.

4.4. Challenges and Barriers:

Challenges and barriers to delivery were more thoroughly recorded and more complex than the examples of good practice. The comment *"Experts are not available to discuss case across MDT, resources limited, inability to have information and advice on hand"* was typical of those responses.

Comments, such as *"having referrers understand what our criteria is and what is the primary issue with CEP clients"* indicated challenges in definition of care-pathways, that effective CEP (and MH&A in general) treatment relies upon.

4.5. Clinical Leadership:

Only 25% of respondents indicated that their service had a dedicated CEP Champion / Senior Practitioner (Kaupapa Māori Services were slightly higher at 27%). However, of those who indicated that they did, several indicated that they had more than one: *"Not just one person assigned to this role…"*, *"Two out of four in the rural team…"* It was concerning to note one respondent answering *"if we have, I have no knowledge of them"* and another *"no, due to*

[2] Rindfuss, Choe, Tsuya, Bumpass and Tamaki. "Do low survey response rates bias results? Evidence from Japan". 2015. in Demographic Research. V.32, Article 26, pp.797-828. Pub 25 March 2015. DOI: 10.4054/DemRes.2015.32.26

restricted resources" There is work to be done towards ensuring role-clarity, not only within services, but also for those accessing services from other providers and from the community.

4.6. Service User and Whānau Involvement:

The Service User / Peer Support Worker and the Whānau Advocate voice was notably absent in completing the questionnaire. Furthermore, when asked about service-user/carer perspectives, those who did respond struggled to provide them. One service indicated that this was *"an area of weakness that was being worked towards"*.

Those issues that were identified by respondents, on behalf of service users included *"MH clients using meth"*, *"Housing issues"* and *"Accessibility to resources… funding and continuity of care"*.

4.7. Future CEP Workforce Development:

Issues respondents wish to see examined in future CEP workforce development can be summarized as a need to develop comprehensive coordinated care across the continuum. The approach needs to be collaborative and systematic. The comments *"a Tikanga based system [such as that] in Tairāwhiti"* and *"support workers to work alongside of clinicians"* call for more peer-led approaches in community settings. Furthermore *"strengthening integration between services"* and *"all health services need to know the capabilities of the other, need to have some relationship at service level and individual level…."* supported more joined-up provision.

4.8. Further Comments:

Respondents were invited to provide further commentary that they wished to contribute to the theme and nine respondents chose to do so. Many of the additional comments have been incorporated into the discussion above and some individuals are being followed up for more focused discussion. There were a number of requests for more training and for guidance on managing CEP.

5. Recommendations:

5.1. Survey Response Rate:

a) Given the response rate for the survey, in future MRMHAN will a) send notification to Team Managers that a survey is imminent and ask them to consider who might be appropriate to respond on behalf of the organisation and; b) ask organisations to quantify how many staff they are responding on behalf of.

b) A reminder to all staff to at least scan-read each e-mail would be greatly appreciated.

5.2. Workforce Development Issues:

a) The findings from the survey will be discussed at the Clinical Governance Forum and other relevant Network meetings and opportunities for future development will follow.

b) One very simple step towards improving staff's understanding of responding to the complexity that CEP presents, is for all staff to complete the Matua Raki CEP e-learning module[3].

c) All staff should have personalised training and development plans that have considered the organisation's response to CEP issues.

d) Clinical pathways and responsible leads (both lead-practitioner and lead-services) need to be clearly defined and communicated to all staff and other stakeholders. Pathways need to be simple to access and use.

e) Services will do better to become more integrated and community-based, as per Kaupapa Māori provision (holistic care across the continuum), whilst maintaining specialist clinical input when and where it is needed.

5.3. Service User and Whānau Involvement in Planning and Provision:

a) Service Users and their Whānau are crucial to shaping delivery of client-centred services. Representative input needs to be sought, considered and incorporated into delivery wherever possible. This also supports delivery of the MH&A Workforce Action Plan 2017-21 "a workforce that is the right size and skills mix, reflecting the diversity and experience of service users, and works in collaboration with the service user and their family and whānau (MoH, 2017 p.15)"[4]

[3] https://www.matuaraki.org.nz/initiatives/cep-e-learning/170
[4] Ministry of Health, 2017. *Mental Health and Addiction Workforce Action Plan 2017–2021*. Wellington: Ministry of Health

Appendix 1 – Full Responses to All Questions:

NOTE: Identifiable comments have been anonymised to protect the identity of the respondent.

1) How would you rate your organisations ability to respond to CEP Issues?

All Services:

Outstanding	2	6%
Well	10	28%
Average	13	36%
Not so well	5	14%
N/A	6	17%

Kaupapa Māori Providers:

Outstanding	1	9%
Well	4	36%
Average	4	36%
Not so well	1	9%
N/A	1	9%

2) In what ways has your practice changed in your organisation since the workshop?

- Able to access resources easier and provide more informative information
- Wider choice of interventions/tools/skills, more confident
- more integrated service delivery between kaupapa and clinical practice
- More knowledge and better networking re pathways
- Not sure
- Not yet, may be in process?
- Dealing with increased referrals from MH as substance use increases across all walks of life
- nothing
- The practice of colleagues has not changed
- I'm not sure which workshop is being referred to exactly as I have been involved in various CEP initiatives. We have a [specific cohort] CEP specialist, separately branded service that sits within our [branded service] and as Team Leader for [branded service] I also act as a resource person re- [specific cohort] CEP issues for the wider team and wider [specific cohort] sector
- Awareness of CEP practice. We have designated CEP practitioners
- Very little
- Not significantly much
- All MH and Addiction staff have minimum CEP Diplomas, there knowledge in working with co-existing disorders has increased significantly
- More awareness of clinical presentations

- Improved knowledge and application / presentation of practice. Interventions are focused more on CEP practice
- Stand-alone, no supervision, less experience people to discuss cases or concerns
- It has been more due to tertiary studies the members of the team have undergone as well as the above
- Having worked in NGO initially, moving to DHB then back to NGO, all services acknowledge CEP but practice has minimally changed since the beginning of these workshops
- Difficult to comment as I am now on permanent night shifts
- Our workplace CEP practice was in line with the workshop philosophy, it was a re enforcement of that
- Increased understanding of coexisting problems
- Making work more visible
- This organisation has a strong resistance to change
- more as an advisor to other nurses
- It has brought more awareness of the importance of treating all the needs the whanau bring into our service. And the importance of having CEP Practitioners on-board
- Specific CEP trainings for non-clinical roles that have CEP clients
- I have been disseminating the knowledge and awareness gained amongst my team to aid their practice.

3) Are CEP issues regularly discussed within your organisation?

All Services

Yes	21	58%
No	10	28%
N/A	5	14%

Kaupapa Māori:

Yes	8	73%
No	2	18%
N/A	1	1%

Frequency (sub-question):

- During MDT when certain cases come up
- During most discussions at MDT meetings and generally day to day in relationship to new referrals
- Not often enough
- The team have MDT weekly and discuss all cases
- Most people with AoD are presenting with CEP
- informal discussion with staff
- at handover/team meetings weekly or more

4) **If CEP issues are regularly discussed - what context are these discussed in?** (more than one response was appropriate)

All Services:

Clinical Team Meetings MDT	21	58%
Supervision	19	53%
Informally with Colleagues	21	58%
Training	10	28%
Case by case	12	33%
Other*	1	3%
N/A	5	14%

* They are always being discussed- integrated CEP care is what we do

Kaupapa Māori Providers:

Clinical Team Meetings MDT	9	82%
Supervision	8	73%
Informally with Colleagues	7	64%
Training	4	36%
Case by case	4	36%
Other	0	0%
N/A	0	0%

5) **What examples of good practice has your organisation adopted or developed or participated in since the CEP workshops?**

- Become more [specific cohort] friendly
- Requirement to present CEP clients at team meeting
- My training is from previous work place. In the current placement not much training on this area
- Obtaining a thorough and as accurate history as possible from the client/family
- Nothing
- We have people training at Christchurch and Auckland Post Graduate Co-Existing Problems and Diploma in health Science Funded by our Service
- We implemented robust training in 2013. Very little impact on the floor has resulted which is disappointing. Strong historical beliefs are held that addiction is separate
- We have an integrated CEP care model with a [specific cohort] friendly, engagement focused CEP service able to accept all referrals and provide the full continuum of care needed and willing to be engaged with by [specific cohort] people, including Psychology and Psychiatry
- Dedicated CEP practitioners and written CEP practice into the new department guidelines
- Not sure, due to restructuring and staff leaving
- None that I am aware of

- Our MH Clinicians have all professionally developed, all clinical staff work with CEP clients on their caseloads
- Actively encouraging staff to do training
- MH Awareness Week Promoting Service that cater for CEP - Radio Community Presentations [branded service] Model of Care; Service Alcohol & Other Drug Forums Midlands Leadership Network Advisory Group
- Nil
- Clinical case management to an extent with some clients
- Training exposure has given recognition and is advantageous, but dependant on collegial skill mix, all clinicians, but discipline / specific, it constantly reverts back to MH or Addictions, which comes first (chicken or egg)?
- More awareness
- Encouragement of staff to access online training. Dissemination of assessment & brief intervention options Limited training pitched at "capable level"
- Nil
- Increased use of MI with clients, co-working with A&D services and MH clinicians

6) What are the main challenges/barriers that your organisation experiences when responding to CEP issues?

- That most [specific cohort] do not want to stop smoking weed and are happy to carry on smoking.
- No documented pathway, no cep champion, limited list of suitable people to discuss issues with
- Need more education for the whole MH team. May be finding good resources and finance the training could be an issue.
- Having referrers understand what our criteria are and what is the primary issue with CEP clients
- Management not doing anything outside of what is funded and their personal limited understanding of CEP
- Adherence to treatment, engaging whanau
- As above limited resources and expertise limited willingness
- Engagement and consistent engagement is always the first and foremost barrier/issue. Risk is often present and complex but balanced with this engagement. Multiple needs is also an issue with a constant balance needed between what intervention to introduce when in light of these wide ranging needs (and balanced with engagement of course)
- Persuading clinicians whop have been a in the service for a long period of time to change their thinking
- Systems not geared for CEP and lack of skilled staff
- Lack of training, commitment and planning
- Whanau requiring immediate interventions and housing
- Lack of resources
- Communication issues with referrer and client regarding engagement Justice / Court requirements
- Experts are not available to discuss case across MDT, resources limited, inability to have information and advice on hand.

- Difficulty getting support from DHB MH services
- Discipline 'precious' lens, medical model versus psychological models, increased perception from Whaiora with the belief culture of 'fix it' with a pill or abstinence
- Not sufficient training for all staff to manage CEP
- Rigid organisational structures and culture. It seems our addictions team get little support from MH teams - i.e. one way referrals. Under resourced clinicians don't tend to get to workforce development training. Stretched educational FTE to roll out CEP consistently with teams - (only 3 of 7 teams at [DHB] & none at [sub-DHB] have had CEP capable training)
- Contracts
- Reluctance of staff to accept advice including managers
- Access to A&D service, client's reluctance to engage as it means going up to hospital, community outreach model would be good.

7) What CEP issues have been raised by your service-user and/or carer representatives and how have they been responded to?

- That most [specific cohort] do not want to stop smoking weed and are happy to carry on smoking. Peer pressure to smoke weed or cigs
- Clients with high level MH dysfunction referred on
- Clients are presented regularly with MH issues. We usually deal with mild to moderate level of MH issues. Other cases are referred to DHB
- Why there is not an easier solution to their presenting problems
- As above in question 11
- Avoidance of follow up appointments
- Aware of the issues
- This is an area of weakness with our [branded] service. We have [cohort] voice represented in individual projects rather than consistent feedback at this time
- No issues have been raised others that the clinicians who refuse to change their practice. However the team lead is working on change
- As previously mentioned
- I don't believe this has been part of our conversations
- MH clients using Meth has been raised and the team are responding to each case individually. They have worked alongside the client and made many referrals to Rx re-hab.
- Need quicker response. Better triage
- Housing issues – [branded services] issues - Trauma - referrals to specialist providers
- Ability to seek rehabilitation quickly
- Nil
- Accessibility to resources, GP services, funding for initial assessments in these services or continuity of care impeded on due to financial restraints. Commencement but aftercare challenges that create recidivism
- N/A
- Unknown as I don't work with clients
- Clients suffering with drug related psychosis being put on MHA and the act continuing even when it has been proved that once drug use stops or reduces the

psychosis no longer exists. We are making MH patients out of substance users. The response has been 'we are a MH and drug service'

- Limited co-working between MH & A&D services, communication still poor depending on the people involved. Client recently reported feeling that all the DHB services were geared to be the 'ambulance at the bottom of the cliff' and he had to be in a really bad space before help kicked in

8) What treatment system issues do you think should be explored in future CEP workshops?

- Not sure
- How to strengthen integration between services
- Opportunities for more training and those who had some ongoing training
- The fact that there are too many community nurses /workers who have little knowledge of addiction issues. CEP training should be across the board for all community workers. Found to be a little one sided at the moment. As in being a CEP trained person I can take care of issues with in MH but those community workers who have not had any CEP training do not know what to do if someone in crisis from substance use presents at the clinic and there is no CEP trained person available
- Supervision process for clinicians working with CEP
- Not currently
- Revisit/recap training with a focus on recognising the link between substance use and MH issues and assessing addiction alongside MH
- I think one of the things that new workers to our team constantly struggle with is the issue of engagement balanced against clinical 'drivers'. There is often a sense of carrying risk and carrying multiple needs and some anxiety around this given a clients mixed engagement and willingness to take up offers of intervention, with the need for workers to learn to be comfortable with this engagement/risk balance and about learning to prioritise interventions (the client might have several needs but realistically can only engage with one or two interventions at a time so which ones?). I also think learning how to provide integrated care and the 'dance' that this can be in terms of sessions with [cohort] people (e.g. doing AOD work one session and MH the next, both within the same session, responding to crisis etc). For newer clinicians this 'dance' can sometimes leave them feeling a little lost in terms of their goals/plans with [cohort] people
- A tikanga based system in [DHB]
- I am not sure
- Therapeutic interventions for CEP clients using Meth
- Not sure
- New model of care approach to include Support Workers to work alongside Clinicians
- Better and increased use of formulation in case presentations and at initial assessment using to guide interventions with more complex clients, rather than more vague notions of what might help. Working differently as acknowledging and including the effects co-existing problems have on clients. Now identify strengths rather than problems. More effective when summarising clinical findings to clients

and families. Not really changed, but my attitude towards working with people with CEP has changed
- Easy access to M/H services
- Time: to read the amazing resources received, only read in dire times or crisis or study Resources: to ensure teams rather than just the Champions and Management have an understanding for the necessity of a CEP Lens and overall benefits
- Just more training
- Better co-operation with addictions and MH teams - systems analysis with managers and Dr's. Whole service discussion well led inclusive of DR's
- I think that drug services should be a stand-alone service, not linked to MH services. In [other country] they have [branded service] which deals with AOD. It works very well and all staff are substance trained MH nurses so any MH issues can be picked up if they manifest. Having Methadone services as a stand-alone service is a waste of money, amalgamate all drug services into a stand-alone service.

9) Does your service / team have a dedicated CEP Champion / Senior Practitioner?

All Services:

Yes	9	25%
No	5	14%
Don't know	1	3%
Other (see comments)	7	19
N/A	14	39%

Kaupapa Māori Providers:

Yes	3	27%
No	1	9%
Other (see comments)	2	18%
N/A	5	45%

Comments:
- I suppose that's me!
- Not just one person assigned to this role but we have few clinicians who have some training on this
- Two out of the four practitioners in our Rural team are CEP trained and as senior nurses of many years-experience we believe we champion that part of nursing
- The whole [branded service] but in particular my role as [specific role]
- If we have, I have no knowledge of them
- Although some are more skilled than others which is recognised
- No due to restricted resources.

10) How many of your organisations staff have attended CEP training?
- 2 most of the time as both work in this area
- 3

- 1
- 3. Not sure. I have.
- 2
- 1
- 5 Staff
- Nearly all of those employed at the time 116
- At least half would have completed the Werry Centre online CEP modules
- 4
- 2
- I have no idea
- Unknown
- 6
- 2 – I know of
- All except one as they have arrived at the service after the training was offered
- Unsure, I would assume the majority as our organisation and managers are amazing like that!
- 4-5
- I have trained exactly 20 staff at capable level. Unknown number have done online (foundational level) I don't have access to this data.
- All
- Not many
- 3

(Total Identifiable = 182)

11) How many of your organisation's staff have completed the Matua Raḵi e-learning module (or equivalent) CEP training?

Attended Training	All Services	Kaupapa Māori
Matua Raḵi e-learning	62	11
Equivalent Training	269	62

12) Any further comments you wish to make?

- No
- Believe all health services need to know the capabilities of the other, need to have some relationship at service level and individual level. Cannot be only relationship between managers
- More training on Co existing issues will surely help when dealing with clients.
- Have said it all
- Our staff working in community MH would like training on CEP and it would be great offer MH & Addiction Teams opportunities to learn to use these skills in their practice
- We have had a number of staff come from adult AOD services into [branded service] and who are very [specific cohort] friendly staff and yet have commented about not

anticipating the level of adjustment they would need in terms of working with [specific cohort] people and realizing why my constant emphasis on engagement and balancing this against clinical drivers is so important in working with a [specific cohort] CEP population

- No
- Not at this time
- No
- No
- Compulsion or time frames of implementation. I could be on the wrong track but with the benefits, support would be beneficial, like auditing only better
- We lack guidance in management of CEP
- We are looking at making the online course required by all
- As a MH nurse who has [xx] years of experience in mainly opiate substitution and then further experience in other drugs, I find that often working with clients with CEP issues very difficult as their drug use often takes precedence over any MH issues. There is no facility apart from an acute MH ward that can be used to try and establish if these clients have a true MH issue; the ward is not a suitable environment. I think probation, police, government and Ministry of Health should be looking at joint funding to get these clients into proper treatment. I worked with the [branded service] in [other country] which were joint funded and saw MH substance use trained nurses working within the custody blocks at police stations our sole remit was to get drug affected prisoners into treatment. It takes pressure off MH services because we were a stand-alone service with a ring fenced budget. NZ has to admit that just making drug use a health issue or legalising some drugs is not going to solve the problem we face today. It has to be addressed when these clients are a 'captive audience' either in custody or in ED departments. I could go on about providing services to these clients but if people do not want to listen to experienced nurses who have worked around the world then we will never achieve much listening to politicians and so called drug advisors
- The training stats above are for my team of support workers 4/8 team members have completed CEP training.