

Chapter 12

Supporting People Who Experience Co-Existing Mental Health and Addiction Problems: A National Approach to Improving Responsiveness in Aotearoa New Zealand

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ABSTRACT

Meeting the needs of people with co-existing mental health and addiction problems is a challenge faced by many mental health and addiction services and providers. A compounding factor has been the separation of mental health and addiction services which has meant that many people with co-existing mental health and addiction problems have fallen through the cracks between services or had issues not recognized or responded to, leading to poor health outcomes. This chapter describes the approach taken by New Zealand's workforce development centers to support services to improve responsiveness and workforce capability to work with people with co-existing mental health and addiction problems. International research on implementation is briefly summarized before discussion about the impact of the national approach and the barriers to implementation that have emerged. Recommendations for next steps conclude this chapter.

INTRODUCTION

Aotearoa New Zealand has recognized for the past two to three decades that people with co-existing mental health and addiction problems are likely to have the poor outcomes in terms of well-being, engagement with treatment, physical health, employment and housing (Minister of Health, 2006; The Mental Health Commission, 2007). Integrated care has been recognized as the best practice approach to meet the needs of people with co-existing mental health and addiction problems (Chow, Wieman,

DOI: 10.4018/978-1-5225-1874-7.ch012

Cichocki, Qvicklund, & Hiersteiner, 2013; Priester, Browne, Iachini, Clone, DeHart, & Seay, 2015). Integrated care is the provision of care for both mental health and addiction problems at the same time by individuals who have the knowledge and skills to work with mental health and addiction problems and/or teams working collaboratively to provide holistic care based on a single plan. Providing integrated care requires a workforce that has both mental health and addiction knowledge and skills, or the ability to work collaboratively, in systems that support and encourage person-centered care (Addiction and Mental Health Collaborative Project Steering Committee, 2014).

The separation of mental health services and addiction services and the development of specialist workforces with specific knowledge, skills and treatment approaches in each area has meant that many people with co-existing mental health and addiction problems have fallen through the cracks or have not had issues recognized or responded to when they have tried to access assistance. For example, people might go to a mental health service for assistance with depression to be told that they needed to deal with their drinking problem before they would get help for depression. On the other hand, they might receive treatment for their depression without ever being asked about substance use or gambling. People might also go to an addiction service for help about their cannabis use and their problems with anxiety might never be recognized or it may be considered likely that they will resolve on abstinence.

In New Zealand prior to 2010 the general approach to developing a workforce capable of addressing both mental health and addiction problems was to provide local and regional training and clinical practice guidelines. This approach came from a supposition that it was lack of knowledge and skills about addiction in the mental health workforce, and mental health in the addiction workforce, that reduced responsiveness. This approach had little apparent impact as it was piecemeal, uncoordinated, voluntary, and did not fully take into account systemic barriers to workers being able to practice in a way that integrates mental health and addiction knowledge and skills (Ministry of Health, 2010).

In 2010, a nationwide approach was taken to address systemic issues alongside workforce development needs. As part of this process the term *co-existing problems*, often abbreviated to CEP, has been coined in New Zealand to encompass the issues that in the past have been described as co-occurring disorders, co-morbidity, and dual diagnosis. The broadening of the definition to include *problems* rather than disorders, morbidities, or diagnoses, was in recognition of the need to take a more holistic view of well-being. This definition encompasses the social determinants of health and also takes into account the impact of sub-clinical mental health and addiction problems which have a negative impact on a person's well-being when they occur simultaneously.

This chapter will explore the approach taken to improve the responsiveness of mental health and addiction services and enhance the capability of the mental health and addiction workforce to support people with co-existing mental health and addiction problems in New Zealand. It will examine how this is related to international implementation research and the impact of the approach taken. Support provided by the mental health and addiction workforce development centers, barriers to implementation, and suggestions for steps to continue the momentum for change will also be discussed.

BACKGROUND

The separation of mental health and addiction treatment delivery appears to be a function of philosophical, funding and systemic differences and professional silos (Todd, 2010). Mental health and addiction problems, however, clearly share common aetiological pathways (Eaton, Rodriguez-Seijas, Carragher,

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