Executive Summary

In the first half of 2007, Matua Raki undertook a project to ask the mental health and addictions sectors for their views on integrated practice and to look to ways collaborative partnerships between the workforces of mental health services and alcohol and drug services could be improved. Open-ended discussions were held with one hundred and sixty-five people in mental health and alcohol and drug services and funding and planning services.

The principle of an integrated service is popular among most mental health managers. Alcohol and drug services are overall more cautious about integration with advocates across the whole spectrum from full integration to full separation. Some services have moved towards or achieved an integrated experience for whaiora.

Many alcohol and drug practitioners believe mental health practitioners hold negative attitudes about alcohol and drug whaiora and that this inevitably extends to their services and practices.

Alcohol and drug team leaders found a challenge both in getting people to up-skill and accessing funding for ongoing education, training and development.

Mental health practitioners' comments reinforced the notion that the two sectors had different skill-sets and ways of working.

Funders and planners generally feel that sufficient and enabling policy is in place, but people with leadership skills who know and understand policy and can put it into practice are needed.

Professional boundaries, patch protection, and clinical accountability kept within professional groupings are seen as barriers to change. The Health Practitioners Competence Assurance Act 2003 (HPCA) creates an immediate barrier between the two sectors. Some services reported difficulties in co-ordinating whaiora care. Disputes over who has a duty of care and case management responsibilities often arise in mental health services. Alcohol and drug services commonly complain about the difficulties they have liaising with mental health services.

Mental health practitioners are not motivated to think about alcohol and drug problems and alcohol and drug practitioners are not skilled enough to assess for mental health problems were common perceptions. The common practice is for mental health and alcohol and drug practitioners to do their own assessments and repeat them when cross-referring. Good integrated practice appears to happen only when individuals know each other well.

Some alcohol and drug managers think there is a need to look again at training: are we training people long enough? Why do we not have a national approach? It

was suggested, for example, perhaps training providers could sit down with employers and align training with required skills. However, there is reluctance, at times full resistance, to combined sector training. The sector orientation of the trainer will often determine the sector that will attend.

Recommendation 1: Train the future workforce by ensuring that all post-graduate tertiary training courses include comprehensive dual diagnosis training.

Recommendation 2: Train the current post-graduate workforce by ensuring that clinicians at registered competent practitioner level have access to either postgraduate programmes in co-existing disorders or provide them with focused skills-based training.

Recommendation 3: Train the current un-trained workforce/support workforce by ensuring that clinicians below the registered competent practitioner level receive training in their mental health or alcohol and drug specialism, preferably to graduate level.

Recommendation 4: Include consumer educators in all levels of training to support de-stigmatisation in the sector workforces.

Recommendation 5: Identify supervisory and mentoring structures to support transfer of learning.

Recommendation 6: Fund and implement a national training programme in clinical supervision.

Recommendation 7: Review the alcohol and drug practitioner competencies to strengthen the requirement for practitioners to work competently with people with co-existing disorders.

Recommendation 8: Matua Raki to work collaboratively with the other workforce programmes to support the above recommendations.

Recommendation 9: Fund a continuum of services with the goal of ensuring a spectrum of need is responded to by a spectrum of service.