

# APPENDIX 1

## Extended Qualitative Data Summary: The Five Focus Questions.

*Data collected across the questions was entered by focus questions and prompts. This means the data available in each of the questions varies. Each person attending the sector forums (6 groups totalling 33 people) were also given the opportunity to provide written responses, in addition to the shared group responses. This means that for some questions, we have more individual responses than the number of people (37) who were involved in the one on one interviews.*

Additionally, some individuals made comments across several themes. Individuals comments were counted once only for each of the themes. The percentages are used therefore to show how many of the total group responding made a comment about the particular theme being discussed. The graphs in this document, on the other hand, demonstrate the number of comments made to each of the questions according to themes. This provides a picture of the weighting placed on each of the themes by the number of individuals who commented on that particular theme. Group comments have been counted once only for these graphs.

# Themes

**‘Working together’:** comments that discussed relationships between any part of the service system were placed in this group. These included interagency, services and consumers, AOD, mental health and General health and community services and the government and non-government sectors.

**‘Strategic direction:** comments referring to process, protocols, direction and vision were placed under this theme. This included overarching policy for co-morbidity and guiding processes and standards for service delivery.

**‘Split system’:** comments about the separation in management and service delivery in AOD and mental health were placed under this theme.

**‘Approach’:** comments about philosophy and value and theory of approaches were placed under this theme. This included ideas about service delivery and service delivery models.

**‘Access & more resources’:** comments about accessing services were placed under this theme. Sometimes access is not about the need for additional services and sometimes it is. Sometimes it is not always clear if this is the case. The theme of ‘more resources’ attempted to separate out identified services requiring additional resources.

**‘More knowledge & information’:** comments related to information and knowledge were placed under this theme. This included basic information such as who does what, and knowledge about current best practices in the area of co morbidity.

**‘More skills & training’:** comments related to increasing service delivery competency by increasing skills or through training were placed under this theme. Where possible distinctions were made in skill development and training specific responses.

**‘Nature of the work’:** comments related to the intrinsic complexity of co morbidity, including the challenges and difficulties placed under this theme.

**‘Human resource management’:** comments related to workforce planning and development, recruitment and retention, staffing issues and leadership development and workforce support were placed under this theme.

# Focus Question 1: What did you say the issues for your work areas were?

**Total Data Set: 44 individual commentators and six groups (33 people)**

- What are the issues for your work area?
- What do you think about these issues?
- How do you feel about these issues?

**Question 1: Comments by Frequency**



## **‘Working together’**

**34.1% of the individual commentators and 3 Groups (60.6% of total group Participants) said how we worked together were issues for them. These responses were fairly evenly balanced from people working in government and non-government settings.**

The most important thing shared was the desire to provide services in a coordinated way with other agencies (x9-plus group 5), including shared care in service delivery and the need for common approaches.

*‘improvements have been made, employing people from other sectors, providers networks and different practice wisdom, knowledge and experience, not medical model. This creates not going through the correct channels, but does improve access’*

Formalising a process for information sharing was stated as an issue by five of you.

*‘not enough networking amongst providers-government and non-government’*

In the area of service provision you said ‘working together’ was an issue and impacted on how referrals and assessment requests occurred.

History and politics were noted to have contributed to strained relationships between AOD and mental health

*‘can’t negotiate AOD and mental Health to work together’.*

## **What did you think about this?**

**30% of individual commentators focused on ‘working together’ in relation to how they think about the issues and 1 Group (25% of group participants) providing information related to this focus question. People responding to this were working in mental health and AOD in both government and non-government settings.**

People said they thought that working together happened when there was a good relationship with a service, the strengths of each service are utilised, there is a common goal, focus and approach, a common ‘bar’ is ‘set’, and a common plan for service delivery exists. Additionally, holistic services are provided to people, resulting in policy alignment and formal processes.

Ideally you said NGO’s would be supported by government services for complex client work. Opportunities to combine resources: IT, administration, clinical and medical, would allow NT to take advantage of strengths-smaller numbers, and less bureaucracy and create innovative programs.

## **'Strategic direction'**

**27.3% who provided individual responses and 2 Groups (39.4% of group participants) said the lack of strategic direction was an issue. These responses were across the range of work settings and were evenly balanced between those working in Government and those working in Non-Government settings.**

The main difficulty shared by participants was the lack of common goals in vision, goals, and planning across the two areas service delivery models and the inflexibility of funding for co-morbidity (as they are either AOD or Mental health) and have restrictive guidelines.

*'funding expectations ignore co-morbidity'*

Shared care was also highlighted:

*'my concern is are we really implementing the shared care model. I know some services tried to align with that and then Bath report said the same thing...'*

*'there is not clear path for these people'*

Other things noted as issues were the lack of priority on mental health within the health care budget, an observation that departmental structure impedes working together, the lack of legislation around AOD treatment, the lack of access to data for population needs, duplication of services, and the lack of flexibility in organisational policies,

## **'Split system'**

**The way services are organized and delivered separately in AOD and mental health. The identification of 'split system' being a current issue for you was made by participants from across all of the sectors. This was highlighted as an issue by 50% of individuals providing comments and 75.4% of total group participant numbers across four of the five focus groups.**

The most common reasons provided about why the Split System caused issues was due to the different approaches and philosophies of AOD and Mental Health and the desire for taking one more holistic approach.

Service delivery issues as a result of the two systems operating separately were shared concerns demonstrated by the comments. This included the guidelines for people being able to get services in either one area or the other, or able to access neither, and lack of coordinated approach to providing services.

*'service sharing - very few examples of blended care'*

*'treating the two separately in remote areas',*

*'lack of the two working together',*

*'chicken or the egg-prioritise one over the other*

Another factor shared by many of you, was the difficulty in establishing the lead role and in knowing who is responsible for service delivery.

The lack of shared vision, goals, and plans and disjointed information exchange between government and sectors were common things noted as issues for working in your areas.

*'no organised time work out an MOU between AOD and Mental Health',*

*'after years of agreeing that there is a need to formally align service provision between AOD and mental health providers, it still seems in dialogue stage....we concede there are issues with AOD and mental health, but don't do anything to bring the two together'*

Reasons in understanding why these are issues were noted to be poor historical relationships, lack of collaborative planning and service delivery and the fact that funding is separate for AOD and mental health.

### **What did you think about this?**

***30% of individual commentators in talking about the issues, talked about the way AOD and mental health are separate programs and provided their thoughts about this.***

The difficulty in the different approaches and resulting intervention to the presentation of AOD and mental health and the need for a holistic approach was raised. Concern was expressed for the level of complexity this creates for the clients and what this means for the expectations service providers place on people requiring services from more than one program or service, the lack of continuity resulting from..... 'I've done my bit...in and out..',

Thinking about how it is always about guessing what issue to address first, and difficulty in planning strategy when there are different agendas and focus, using one service guideline to cut off persons needs in other areas in order to restrict access to service in an environment of tight resources, were all observations made.

The incongruence of the dislocation given our small size was raised and it was suggested that our responsibility to work closely as we have no excuse not to.

## **‘Approach’**

***35% of individual commentators and 1 group (25% of group participants) thought issues in the area were related to ‘approach’.***

The most common approach identified as beneficial was the adoption of a holistic approach. Other ideas were to do more outreach, to think in terms of continuity where a long term approach was required rather than a short term fix and to have some common understandings of the best approach.

## **‘Access & more resources’**

***Access was identified by 43.2% of people providing individual responses and five of the six groups (93.9% of total group participants). Participants from all sectors and work settings commented on this theme.***

The most common issues related to access shared by commentators was the inability for people to access or receive services due to service guidelines not incorporating both issues and the fact that existing services are not flexible or appropriate to meet needs of population.

Difficulties in accessing existing services that were commented on by four people or more were

- Difficulty in accessing GP’s and,
- Rehab-detox waiting times and lack of availability.

Accessing services, as related to co morbidity specific services were noted by four or more of you were:

- Lack of mental health assistance for people experiencing high prevalence mental health issues such as anxiety and depression-anything not major mental illness-acute, hard to get advice or input PD, depression: whereas suicide OK,
- No co morbidity specialist services,
- Lack of co morbidity detox services and;
- Lack of access to co morbidity early screening or assessment.

General service gaps also identified were:

- Lack of and inappropriate mental health services currently in remote areas and;
- Lack of available continuity of support and care options.

Difficulty in accessing existing services was identified in the following areas:

- Difficult to access mental health assessments in timely fashion,

- Lack of mental health specialist support including lack of psychologists and alternate services,
- Low cost affordable housing,
- Mental health services generally,
- After hours mental health services,
- Difficulty in getting psychological professional input for AOD clients,
- If someone gets into a service, they can't get the level of service required,
- Lack of consistent person in service,
- Lack of support services and;
- Lack of inpatient detox facilities.

**Balancing resources (mostly related to 'access and more resources' above: *The balances required due to limited resources were identified by 25% of individual commentators and 1 group (21.2% of group participants).***

The most common resources you said were required, in order of frequency, were more AOD resources. All of these comments were made by people working in mental health.

It was recognised the problem of balancing the expectations placed on mental health services with available resources was constant.

*'Ridiculous caseloads on tertiary mental health services- current services full and crisis orientated..'* said someone from the health and community non-government sector.

*'..What mental health should provide and what mental health is resourced and funded to provide are two different things'*

Funding levels related to staffing were raised and staffing shortages recognised as issues. An observation of an issue for the funding provided is the high administrative priority placed on staff time.

Other comments about what additional services were required were; low cost accommodation and housing options, more support services and the need for a central agency/expertise point/one stop shop.

## **'More knowledge & information'**

***40.9% of individual commentators and 3 Groups (60.6% of group participants identified the need for increased knowledge as a major issue.***

Some of this was recognition of feeling lacking in information. The types of knowledge most commonly identified, was awareness education to reduce stigma associated with AOD in mental health and health promotion in AOD.

*'so people can understand health issues affecting them',*

Additionally, wanting knowledge about screening and assessment options and tools and information across both AOD and mental health-co morbidity was commented on.

Issues regarding the lack of sharing of existing information within government departments, evidence based knowledge about the issue and needs of the community and best practice information. Some of you said you did not know what services are available.

## **'More skills & training'**

***Although closely aligned with knowledge, 13.6% of those who provided Individual responses and 3 of the 6 Groups (51.5% of group participants) believed the need for more skills was an issue.***

Those of you who identified lack of skills are employed in AOD and Mental Health Government and Non-Government service provision settings. The Health and Community Services Non-Government group also identified lack of skills to be an issue.

The most common skills identified as necessary were skills and confidence specific to working in co-morbidity.

Other areas noted were skills in complex case management and skills in mental health and prevention eg; de-escalation of anxiety, depression, etc).

## **How did you think about more knowledge, skills and training?**

You thought an increase of AOD knowledge for MH sector, an increase of clinical mental health expertise in AOD settings and the creation of more training options were all suggested as areas of focus.

It was also observed that there was perhaps an undervaluing of existing Indigenous knowledge in our workforce, and of the clinical mental health service work by the department overall.

### **'Nature of the work'**

***33.3% of group participants in two of the six groups acknowledged commented on the nature of the work as issues.***

This included the high interrelatedness and prevalence of co-morbidity which, confused treatment process and a feeling of a high 'failure rate' for not treating the whole person and/or situation.

### **How did you say you feel in relation to the issues?**

**Total data set: 19 individual commentators and two groups (14 people)**

***73.7% of individual responses to this focus question and both groups (92.8% of group participants) providing responses in this focus question said you felt frustrated.***

The most common reasons provided for the frustration were noted to be a result of: the nature of the work, which is complex and hard, the difficulty accessing services for people and feel nothing is happening and you are not doing anything to improve the situation, even when you want to do more.

Others who attributed causes of frustration said the feeling was related to difficulty accessing AOD and Withdrawal services, feeling they have no control over the situation and feeling the government has not recognised the priority and size of the problem.

Feelings of helplessness, powerlessness and apathy were also reported by 5% of individuals and 1 group (35.7% of group participants). Employment settings were mental health government, AOD non-government and mental health non-government and Health and Community Services government.

Why you felt these things were described to be due to seeing tokenism due to lack of consultation and inconsistency in government departments and a lack of priority placed on co-morbidity by departments and governments.

*'feeling pushed from pillar to post',*

Some of you described these feelings to be a result of direct service delivery work and due to not having collaborative work so plans don't happen, the complexity of problem and the inability to find solutions when working with people.

Less frequent feelings people reported were resentment in staff, which was noted to be expressed in different ways by different people, and defensiveness due to people protecting themselves. A few of you commented on feeling undervalued in mental health within government and AOD staff feeling undervalued by mental health. Feelings of inadequacy due to lack of control, and angry and annoyed due to loss of energy used up by system and lack of government priority when data is available to demonstrate need were also expressed.

Whether it was the way the questions were asked, heavy workloads people are carrying, or the true general feeling-no-one expressed any positive feelings towards the professional and personal challenges of thinking about the issues and the opportunities for learning in relation to the issues they raised about working in the area of co-morbidity.

## Focus Question 2: What did you say the issues were for you as workers and individuals?

Full data set: 45 individual commentators and five groups (26 people)

### Q2. Comments by Frequency



### **'Working together'**

***24.4% of you providing individual responses and two groups (53.8% of group participants) responding to this question, said working together was a major issue for individual workers/professionals.***

The reason working together is an issue was identified to be due to the following:

- Services are driven by informal and reactionary processes and need agreed processes,
- Although personal efforts for relationships are required, this does not develop into a clarity of understanding between services,
- Sometimes feels like there is no reciprocation,

- Commonwealth & NT government and non-government do not talk with each other for service planning,
- Organisational change processes are complicated by lack of bigger picture or direction and;
- We need real direction in getting sectors to work together.

The need to improve integration to support shared care models was raised. Comments included:

- we don't know when or who to refer to for client support,
- guidance and support from cross sector client focussed meetings is really beneficial, but not formalised,
- There is no common meeting ground,
- there is no agreement on the best approach,
- Currently information sharing and working through confidentiality issues is non-existent,
- Sometimes we receive inappropriate referrals and;
- Sometimes the other services intervention disrupts or changes our treatment plan and we are not informed.

Observations included that some partnerships with MOU's are really effective as is co-case management.

### **'Strategic direction'**

***As workers and professionals 31.1% of you providing individual responses and two of the five groups (53.8% of group participants) thought 'strategic direction' was an important issue. Commentators' backgrounds were quite balanced across government and non-government and mental Health, AOD and Health and Community Services.***

The most common comments about the issues around strategic direction made were that too much focus was on bureaucracy and administration instead of services. Other shared observations were that evidence of how big the problem is are not being taken note of and government is not placing any priority on co-morbidity. The fact that no policies or procedures for service delivery or how clients can access treatment services exist, and that strategy and planning is not being applied to funding of programs or projects, was commented on. An observation was made that people are restricted in doing more of what you know is necessary by the policy and funding restrictions.

Further comments included the observations:

- Service response is reactive and driven by informal relationships, instead of processes,
- no overall direction exists,

- NT and Commonwealth governments were observed to not agree on direction or responsibilities and;
- there is no plan and no targets that we are working towards.

With respect to strategic direction opinions that new models need to be explored and changes in organisational approaches are necessary to meet the needs of people were expressed.

## **‘Split system’**

***13.3% of the individual responses highlighted the ‘split system’ as reasons for issues to exist for individuals and workers. Most of the individual responses were from government employees.***

Comments about the split system were:

- Funding is ‘siloes’,
- Non streamlined services, therefore placing greater expectations on clients to negotiate multiple systems and;
- No one set of policy and procedures, and as a result it is very hard to assist people get their desired outcomes.

## **‘Approach’**

***31.1% of you providing individual comments said a different approach was required, as the current approach created issues for you as professionals.***

Shared comments on what approach needs to happen were:

- Movement from short term to continuity of care and support,
- Integration and development of structures and formal processes to support shared care model,
- Movement towards early intervention and support for grief and loss at an early age,
- The need to resite service delivery models,
- Holistic approach required ,
- Client focussed/client directed and including clients in discussions,
- More flexibility and;
- More outreach models.

Other things in terms of approach said were that what approach dominates is directly impacted by any individual clinical leader and can change with the appointment of a new one and the current system addresses the most acute need only.

## **'Access & more resources'**

***Issues were identified as a major issue by 37.8% of you providing individual responses and 2 groups (26.9% of group participants) identified access related issues as a major issue for you in the workplace.***

The main issues related to access were identified in service delivery areas. These were barriers to referring clients for review and assessment,

*'have to use informal relationships for referrals and call favours',*

The need to balance resource creates tightening in criteria for services which does not fit with inclusion policy. The need to balance resources via entry criteria, does not allow for inclusion was observed.

Access issues also noted related to where services exist, but were hard to access or are only available in a limited way. These were hard to access GP's, limited accommodation options and the limited number of psychologists.

Access issues where you said more resources were required were shared in the areas of:

- No inpatient withdrawal services,
- withdrawal/rehabilitation services-time delays due to not enough beds not enough rehab services and;
- It was observed, the acute hospital is too hard for withdrawal,

Gaps in services exist to the point that it was noted, as service providers you are unable to get some people any services. Gaps identified were AOD specialist at hospital, AOD services in rural and remote areas, no co-morbidity services, lack of services generally, lack of support services in remote areas, and lack of transport in remote areas.

**In education and training areas** it was noted: Training resources for education options are limited and education at the University is not being offered.

***More resources-related to 'access' above: 24.4% of you providing individual responses and 2 groups (42.3% of group participants) said the need for more resources created a major issue for you as individuals and professionals. Resources as an issue in the responses were across both government and non-government work settings and across mental health, AOD and Health and Community Services.***

The resources you said were lacking that were required were:

- Mental health services to meet expectations, to deliver more training programs according to need, Mental health working to 110% and we need more,
- Services to fill the gaps,
- A Peak for AOD in the NT,
- More rehabilitation places,
- An inpatient withdrawal service option,
- Access to more tools,
- Higher staffing levels,
- Remote area staff,
- More staff and more time,
- More money both human and financial,
- Accommodation options and;
- Money to cover remote area work and distances covered by staff.

### **‘More knowledge & information’**

***26.7 % of you providing individual comments and one group (19.2% of group participants) said lack of knowledge and information were an issue for you in your work.***

The most common areas you identified as requiring more knowledge and information were in the area of evidence based information for planning and re: best practice information for service delivery in the area of co-morbidity.

Shared areas identified were:

- The need for information on co-morbidity generally
- The need to combine/integrate AOD and mental health knowledge bases,
- The need for early Intervention and Assessment knowledge and;
- General service information.

Further individual comments related to understanding the training needs of the sectors, in mental health and Indigenous appropriate mental health. Also, noted was a desire for government to have information in order to understand real needs in remote communities and what staff are trying to provide.

### **‘More skills & training’**

***20% of you providing individual responses said the lack of skills and training was a major issue for you as individuals and workers.***

The areas you said were most important were co-morbidity specific and the need to increase skills across both sectors including skill transfer in cross sector case meetings.

Other training areas identified as causing issues were in mental health, in counselling, healing and therapeutic approaches, and in suicide intervention.

### **'Nature of work'**

***13.3% of individual commentators and two groups (38.5% of group participants) placed priority on the complexity of the nature of the work. This was provided largely by people working in mental health in both government and non-government settings, but also within the Health and Community Services area.***

The shared observations were issues related to the fact that motivation and commitment of clients is not clear and that the same people keep returning to services.

Single observations included:

- being unsure of the best approach as experts disagree,
- the idea that Indigenous people particularly don't fit separation of issues or time delays,
- lack of understanding solutions,
- The reality of no short term 'fix' and;
- the interrelatedness of alcohol and drug use on mental health and visa versa impacting on treatment.

### **'Human resource management'**

***22.2% of you providing individual responses said 'human resource management' issues were an issue for you in your work roles and as professionals.***

Shared concerns were noted for staff morale and the need for staff support, training, and feeling valued, and for remote area staffing difficulties, recruitment and retention including the amount of time this takes, and staff shortages were all highlighted.

Other comments related to workforce development requirements and small staff numbers resulting in limited capacity, shortage of already trained staff and safety issues for staff. Issues related to networking and new programs due to fear of poaching of skilled staff was also noted.

# Focus Question 3: What did you say the main challenges professionally for you are?

## **Challenges for Consumers**

**Total data set: six individual commentators and two groups (7 people in groups)**

***All comments related to challenges experienced by consumers were due to access.***

These included observations that finding a place where the two services meet is harder with two services. Consumer unhappiness with services as they are not satisfied and the trouble involved for people in getting assistance, leading to feelings they have no options.

Other challenges for consumers that were noted was the cultural inappropriateness of programs and limited housing and accommodation options.

The consumer and carer part of the consultancy would provide much more detail about the challenges consumers face on a day to day basis.

## **Challenges for Workers**

**Full data set: 13 individual commentators and six groups (33 people in groups)**

### **‘Split system’**

***15.4% of individual respondents and two groups (21.2% of group participants); all from government settings noted separation of AOD and Mental Health created challenges for staff providing direct service delivery.***

The aspects of the ‘split system’ which created the challenged were noted to be:

- the uncertainty of how to align and determine the concept of lead professional responsibility,

- The lack of agreement between services in policy and protocols related to service delivery and;
- the very different philosophical and theoretical approaches to working with people.

Observation that distinguishing mental health issues from AOD issues is often far more important to the clinician than the person seeking assistance was made.

## **‘Approach’**

***30.8% of individual respondents and one group (6% of group participants) raised the approach as the main challenge for workers.***

The challenges noted were to be related to the need for greater flexibility, holistic approaches and, the need for workers to be able to feel comfortable with the nature of the work. The fact that solutions are not readily available through existing legislation to provide treatment was also observed.

## **‘Access & more resources’**

***Access to services was raised as a major challenge by 53.8% of individual respondents and three groups (57.6% of group participants). This included access to existing services and the identification of the need for additional resources, due to the absence of services.***

The types of things you said about why access created such a large challenge for you were:

- There are no current services for some people (e.g. those that have diagnosis of PD), or those who cannot access the program due to the constraints and requirements of the assessment-in-take process,
- The lack of follow up services,
- Lack of support services available,
- Accessing existing services requires a high level of creativity,
- When people are linked in the service but cannot provide the adequate level of resource anyway,
- The long time delays and waiting lists involved in accessing existing services does not fit with the need to respond to individuals motivational levels,
- The lack of clear process for accessing detox services,

*The ...'bottom line is getting access to services for clients. This is the main problem'.*

## **'More knowledge & information'**

***Challenges identified by 23.1% of you related to recognition that a lack of knowledge or information created challenges for staff delivering services.***

The type of knowledge or information you said you did not have was knowing who the correct services or people were to refer people to for assistance and resulting inability to provide accurate service information to people. Being unsure of best practice approaches and which issue to deal with first including assessment information was another issue for workers identified.

## **'Nature of the work'**

***15.4% of individual respondents and 6% of group respondents said the nature of the work was a major challenge for staff providing direct services.***

The statements about this varied and were:

- that the person and family need support as no-one is sure what to do,
- the fact that a small window of opportunity to build rapport and earn trust and if something goes wrong-having to start again is harder,
- Plans in place then high risk situation occurs and when the plans are changed you cannot get support to address current crisis,
- Encouraging people to acknowledge behaviour is having negative impact, sometimes it is too hard for them,
- child and adolescents require parental consent and if parents using and not wanting to consent-it really impacts on the children and;
- it is difficult to break cycle of interrelated mental health and alcohol and drug use using mental health legislation, but some break is needed.

## **'Human resource management'**

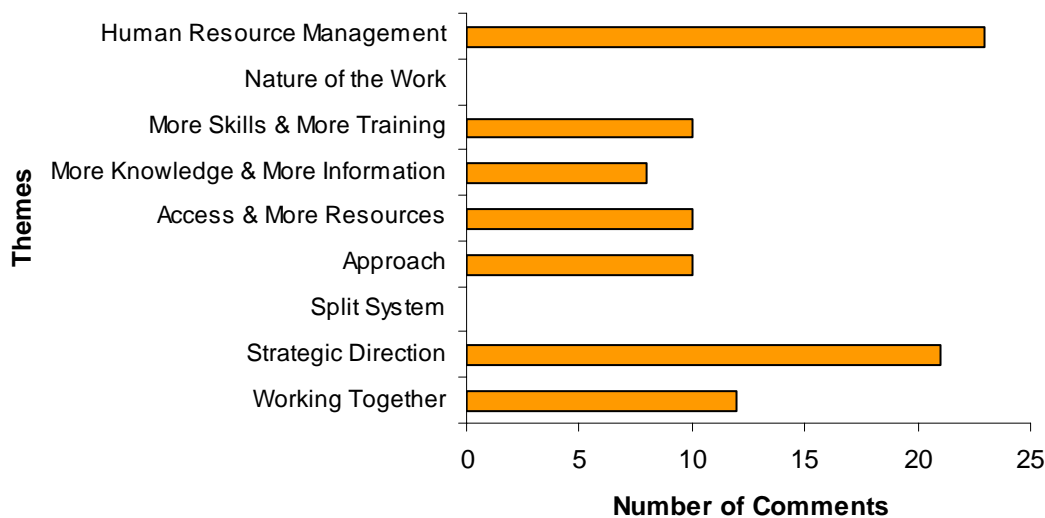
***23.1% of individual respondents and three groups (63.6% of group participants) expressed the challenges for workers due to human resource management, were all from the non-government sector.***

The human resource management issues noted to be challenges for workers were concerns for staff morale and staff support and issues related to supporting staff leadership, and dealing with the high staff turnover.

## Challenges for Managers and Leaders

Full data set: 35 individual commentators and two groups (13 people in groups)

### Q4: Comments by Frequency-Leaders



### **'Working together'**

***Aspects of the theme of 'working together' was identified by 31.4% of individual respondents and one group (38.5% of group participants) as a major challenge for leaders working across AOD and mental health.***

The main comments about what created this challenge were finding common threads and the lack of intradepartmental information sharing. This was noted to be both within programs and departments as well as across sectors, and resulting in lack of co-ordination across legislation and therapy and inability to identify the lead agency and lines of responsibility.

The other main focus in working together was the differences in philosophy and approach between mental health and AOD:

*'...AOD ideology around promotion, policy, and social compared to clinical, Bio-psychosocial models cannot argue a case for the development of clear pathway for interventions'.*

In service delivery areas the shared challenges identified were:

- the need for clinicians to integrate knowledge bases,

- the need to improve co-ordination of complex care, integrated care, shared case management and shared care planning and;
- It was observed that service creates boundaries for good reasons, but co-morbidity often falls outside these boundaries,

Entrenched vested interests were also raised. Interagency work as one of the biggest challenges and the desire to formalise partnerships was discussed.

## **‘Strategic direction’**

***60% of individual respondents identified your challenges as leaders to be related to ‘strategic direction’.***

The aspects of strategic direction you identified to be challenging was the lack of formal processes and protocols and lack of co-ordination of policy, legislation or service delivery. It was observed there should be clearer co-ordination rather than knee jerk response operating at policy level.

*‘..A small group of staff maintain service delivery.....and my impression is that it happens because they are who they are and not because structures within organisations support them’*

Observations that might explain this was the acknowledgement of a lack of time to reflect on future vision and planning due to high administrative demands.

Things that would assist you to address these challenges were provided as:

- Removing the uncertainty on how to prioritise energy when co-morbidity is not acknowledged,
- A guide for service delivery in complex care co-ordination,
- Moving forward and having resources to change organisational visions,
- Getting feedback about issues and keeping the big picture and;
- Five or ten year planning.

Several of you referred to the funding models as complicated, not flexible and competitive. It was discussed that this does not promote working together or make streamlining services or planning easy. The need to diversify funding was also raised by non-government organisation commentators.

Shared views were offered about the lack of priority to issue by government and how to raise it on the agenda, particularly when evidence of the extent of the problem in the NT is really clear:

*‘Evidence screams issues in AOD/MH yet appears treatment not readily accessible when necessary and no links to treatment’*

Improvements were noted due to increased focus and commitment to training and education but staffing issues still make this hard for leaders and managers. The challenges you face relate to:

- not recognising the impact training has on outcomes,
- the need for training to be meeting workforce needs and;
- the need to train people and getting support from government for this process.

Other things you said need to be addressed were:-

- New services need to fit with community needs,
- Need to work at an approach to integrate knowledge that is not necessarily restructuring,
- The lack of KPI to monitor progress and;
- The need to adjust to significant change and growth in non government sector organisations.

In service delivery you said we need to:

- move towards new models of intervention including screening and early intervention,
- Recognise that establishing new services is hard, and;
- Supporting staff through organisational change to promote participation and enthusiasm is hard,

## **‘Approach’**

***28.6% of individual respondents also mentioned challenges related to the need to adopt specific approaches in service delivery.***

Shared challenges for leaders around approach were the need to find common ground, formalise processes and improve care co-ordination and shared care planning.

Other challenges identified for leaders were the areas of assessment and early intervention, the need to increase flexibility in remote service delivery, the need for a holistic approach and the need to increase therapeutic skills and services.

## **‘Access & more resources’**

***28.6% of individual respondents raised leadership challenges to be related to access to services and the need for more resources.***

The most common access and resource challenge was identified to be a result of the need for services to be appropriate and acceptable to the different needs of the population.

Time was noted to be related to access and resources in terms of needing more time and resources to devote to tasks and there being not enough time for planning.

Access in terms of time delays and lack of services were also noted. The areas identified were the need for a mental health youth facility, the lack of housing and accommodation options, the lack of services in remote areas and the lack of available psychologists.

Challenges related to remoteness of communities in providing services and time delays and waiting lists associated with accessing existing services were also noted.

## **‘More knowledge & information’**

***22.9% of those providing individual responses said the lack of knowledge was a challenge to you in leadership roles.***

The type of knowledge some of you said you needed was information sharing across programs, departments and sectors including updated information on AOD and mental health and mental health services information

A challenge identified was keeping people informed about the big picture without overwhelming them

Service delivery information identified was assessment tools and client information sharing information

Information to strengthen staff skills and knowledge was identified as website resources, more practice knowledge due to limited experience in the work area, decreasing fear of mental health, so staff are comfortable and general mental health information (ie: signs and strategies for staff)

## **Balancing resources and time:**

***As leaders 17.1% of individual respondents noted specific balances as major challenges in your roles as leaders.***

Some of you identified the challenge of the need to balance two competing demands is relevant to all of us in our work and personal lives. The most common balance that created a

challenge for leaders was demand v's available resources. This translated for one commentator to include the need to have clear priorities for clinical time in mental health.

Other aspects observed were managing outsourcing and ensuring quality and ensuring service delivery flexibility v's standardised quality services.

### **'More skills & training'**

***Leadership challenges noted to be major by 28.6% of individual respondents were connected to training.***

The training issues identified were all related to improving service delivery. These were:

- the need to increase therapeutic and healing approaches and skills,
- the need to ensure the appropriateness of the training and;
- the need to ensure outcomes of the training are recognised and monitored.

Other challenges noted for leaders in the area of staff skills and training were:

- the process of keeping staff up to date across AOD and mental issues was a challenge,
- getting funding support for training,
- maintaining the training demand and ensure training priorities were reviewed,
- Working around staff shortages to ensure staff are trained and;
- the lack of existing trained staff and training availability

### **'Human resource management'**

***60% of individual respondents and two groups (100% of group participants) identified major challenges as leaders to be related to human resource management.***

The main aspects identified by you were meeting staff support needs, including through organisational change and concerns and acknowledgement about staff morale and stress related to working in the area..

Recruitment and retention, including high staff turnover and appointments of culturally appropriate staff and Workforce development including, training strategies, professional development and developing and supporting leadership were all discussed as challenges for leaders. Staff shortages and finding skilled staff were also shared challenges by more than four of you.

Other comments related to challenges in human resource management were managing remote area staff from distances and staff safety.

## **Challenges in the Area of Co morbidity**

Total data set: 12 individuals and four groups (17 people in groups)

### **'Working together'**

***25% of individual respondents and four groups (100% of group participants) addressing this focus question said working together was a major challenge in working in the area of co-morbidity.***

The challenge of working in the area was described to be a result of having little input into policy and big the picture, the desire for consultation and the lack of dialogue at strategic level. A desire and requirement for communication and networking was expressed.

*'some of the lessons being learned at the coal face are not being included in policy because no mechanism exists for feedback..'*

*'Need agreement for sharing experience, education, ideas and knowledge'  
'limited forums to share information'*

### **'Strategic direction'**

***Challenges related to the area of co-morbidity were identified to be related to 'strategic direction' by 41.7% of individual respondents and two groups (52.6% of group participants). Nearly all respondents highlighting strategic direction challenges were working in government settings.***

The challenges identified were:

- Raising profile by use of evidence-need to get smarter
- Need to include lessons on ground into policy
- Creation of dialogue at strategic level is the biggest challenge.
- Need focus so funding allocations are planned
- Agreement will allow sharing of knowledge, etc
- Need to review legislation of Adult Guardianship
- Funding and governance models not currently effective

## **‘Approach’**

***16.7% of individual responses and two groups (36.8% of group participants) noted challenges in the area related to approaches taken.***

The comments made were:

- the need to take a longer term and holistic approach,
- to be culturally appropriate (Indigenous),
- to follow best practice and evidence based practice,
- It was observed that multi-skilled backgrounds together worked well and;
- we had the ability to use existing NT strengths.

## **‘Access & more resources’**

***33.3% of individual respondents and three groups (63.2% of group participants) making comments to the focus question noted access and more resources to create a challenge in the area of co-morbidity.***

The access and resource challenges were noted to be a result of:

- No co-morbidity service,
- No Youth mental health ward,
- Government services not dealing with some clients-or do quick ‘in and out’,
- Detox and rehabilitation services for women lacking,
- Lack of training available,
- Lack of clinical supervision in mental health,
- Lack of accommodation options for people and;
- Not enough rehab treatment services.

## **‘More knowledge & information’**

***Issues around information and knowledge were identified by 16.7% of individual respondents and one group (10.5% of group participants) to be a challenge in the area of co-morbidity.***

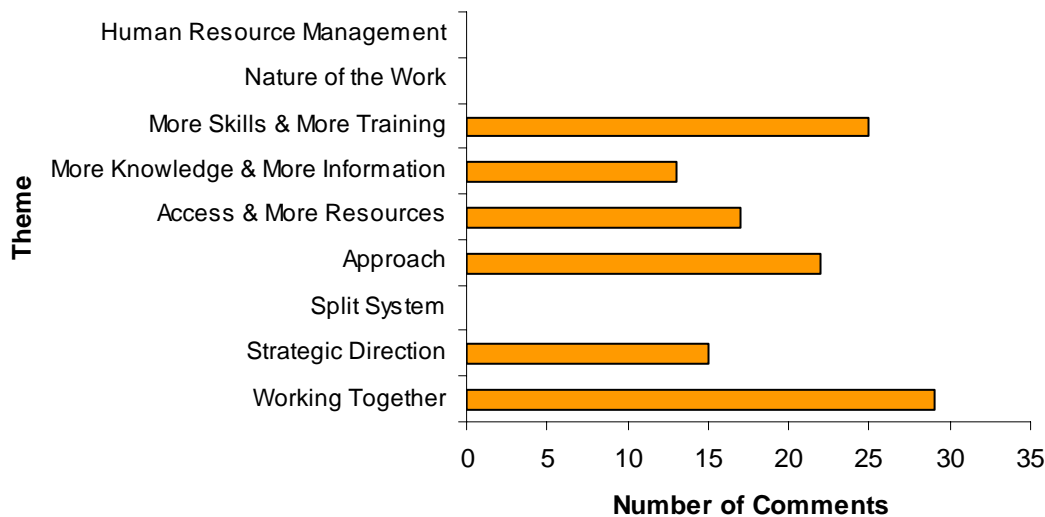
The types of information and knowledge noted to be required were:

- education- to reduce stigma,
- Commonwealth funding and strategies, as current information is confusing,
- information on services because they are always changing and;
- Sharing information with each other, this is not currently happening.

# Focus Question 4: What did you say is happening that is good/bad/or could be better?

Total data set: 42 individual commentators and six groups (33 people in groups)

## Q4: Comments by Frequency



### **'Working together'**

***What is already happening and obvious to 54.8% of individual respondents and all groups (100% of group participants) is that the positive results of working together demonstrate your belief this is what we should be doing more of.***

The most common things that are working when we work together, and what we can do more of, were noted to be networking opportunities and building relationships. More joint activities across policy, program and service planning and provision areas were shared suggestions.

*'knowledge of others skill base and trust'*

*'huge commitment evident but often this stops at the talking but I'd like to see this come to really tangible outcomes.*

*'Crucial if we want to improve, build capacity, need to talk to the other side to know what they are doing and how they are doing, so we can pull together expertise from both services'*

*'the fact we are talking about this problem is great in my opinion and we have to make sure that we get some real outcomes from this project'*

Other shared responses included the need for more interaction between government and non-government sectors and better links with Tamarind, including interagency meetings and information sharing.

Individual responses were ideas about more co-located services, more consultation. *'proper consultations, not humbug'*, joint problem solving and the idea of the further development of TOADS for sector responses.

Many responses focussed on working together for improved service delivery. The most common focus in this area was the desire and need for more complex care co-ordination, case management, shared care plan, and screening and assessment.

*'Programs in AOD and Mental Health are good at coming together and talking about clients-we need to translate this into meaningful activity and direction'*

Another shared priority identified as case conferencing and clinical meetings with mental health (from AOD) have had good outcomes-happens when case manager appointed and joint training/sharing training for AOD and mental health

*'...Good to broaden and share ideas, building links between services and sharing resources'*

Other things that were noted to work well when we worked together and people wanted to see happen more frequently was integrating services and agencies, providing support to people using Tamarind and more recognition between AOD and mental health

*'and being proactive in what we are doing and our approaches'*

Observations and ideas by individuals included:

- including homelessness in the discussion,
- the development of a multi agency referral form,
- doing more planning with clients,
- getting better at linking into other services,

- formalising the psych Registrar who has provided advice on medications and
- encouraging interdisciplinary Team approach.

**What you said was currently happening that you didn't want to be happening any more** with respect to working together was that different expectations, lack of cooperation between services and lack of cohesion in government services was not OK.

*'we get funded to do x and then we are referred to people that are too difficult for them and they don't offer back-up after 4.21'...*

**What you are doing that you don't want to do anymore.** Things about working together that you said you didn't want to be doing anymore was not supporting NGO's in services delivery and stop working in non-respectful ways.

*'beneficial for agencies and people seeking services-agencies stop dumping on each other...*

Comments made that are related to decisions outside individual agencies are that they did not want inappropriate resourcing of AOD to continue and desired more mainstreamed services.

*'strong sense of AOD promotion-but needs to be balanced by recognition of real world events e.g: increase road toll, and suicides involving AOD...'*

**What people said was happening that they wanted to happen differently** in the area of working together. 100% of individuals and groups who have responses related to this focus sub-question identified some areas about working together that is happening that they would prefer wasn't.

Some of the observations included:

- In other places AOD, mental health and police work together but we don't take advantage of that opportunity here,
- We need agreement on what responds to treatment across sectors and we need to respect and value each others perspectives,
- We don't really take time to find out what others are really doing,
- we need relationships with other organisations to make services responsive and;
- government employees are too busy and don't know who is out there (from government employee)-know on social basis, but not professional basis.

A couple of people said they want structured and planned networking and planning between stakeholders including case conferencing, meetings, etc.

## **‘Strategic direction’**

**33.3% of individual respondents and 1 group (24.2% of group participants) said some things related ‘strategic direction’ could be built on.**

The most common shared threads here were more joint activities across policy, program and service delivery, planning for future collaborations and future needs, more strategic thinking around individual programs and individual client care plans including planning relationship development and Advocacy-speaking out were supported.

*‘More sophisticated framework for responding to people with co-morbidity’*

*‘we need to keep this subject on the table and not let it slip off the governments’ radar’.*

Clear about what organisations are working towards and why we do what we do.

*‘All the people to part of that help.....when team has same focus and vision it does well’.*

Ideas provided by individuals included:

- ensuring services appropriate to need (remote) *‘not fly in fly outs’*,
- move towards programs with more flexibility (like PHaMS)
- integration of services,
- funding priority shift away from administrative,
- need to access resources to ensure up-skilling and training of staff ....*‘which includes integrated planning that brings all stakeholders together’.*

**What is happening that you don’t want to be happening anymore was observed to be competitive funding.** This observation suggested removing competitive funding would help agencies work together.

**What are we doing that you don’t want to be doing any more** in relation to strategic direction was commented to include:

- co-morbidity and Dual Diagnosis shouldn’t be specialist area and should be mainstreamed skills,
- professionals visiting for one hour and making judgements is not OK, we need to support local workers to develop skills and qualifications because they are there all the time and;
- competitive funding should not continue as it makes it too hard to work together.

**What is happening that you would like to see happening differently** in the area of strategic direction. 100% of respondents talked about the need for change in strategic direction. The shared observations were that a common approach that recognised the two areas often go 'hand in hand' and an agreement about the best approaches and shared outcomes would exist.

Other comments referred to:

- referral processes needing good relationships to happen,
- no effective framework exists for substance abuse in rural areas,
- decision making needs to be localised,
- funding has too much focus on administration and agencies need to be out there doing the work and;
- lack of planning in funding would be a thing of the past.

*'sick of being promised this and that....no consultation. and funding whisked away with no explanation...'*

### **'Approach'**

***45.2% of individual respondents and three of the six groups (60.6% of group participants) noted the approaches they have seen be used successfully and suggest we could build on these experiences. People responding covered both government and non-government work settings and all areas of service delivery focus.***

The strongest common thread for approach that has been successful and could be built on was holistic approach.

Other ideas shared by multiple participants were:

- taking a long term outcome view,
- being client driven and person centred,
- Providing non-judgemental, non-labelling approaches that value and respect the person
- Improving screening, early intervention and referral and;
- more flexibility as the basis of the approach.

Shared ideas about what models were effective and that people would like to do more of were outreach models and co-located services, co and dual case management and increasing generic healing, counselling and therapy approaches. Other ideas included focussing on the model of change, community development models-, particularly in remote areas, group work for young people, expanded family approaches and using initiative and creativity in service delivery.

Other aspects of our approach observed to be effective and therefore to be an opportunity for further development were multi-disciplinary approaches, identified as better rounded and using existing strengths NT, including our smaller size, to make things happen.

**What one person said about what was happening that you didn't want to keep happening was the lack of continuity of services.**

**What is happening that people said they wanted to be happening differently** in the area of approach were not only hard outcomes would be measured, but soft outcomes about quality of life would also be measured. Commentators also wanted more family approaches and services would target those most in need, including expansion of outreach models.

Multiple people said our approach was not correct and common ground needed to be found. Workforce development and training in remote areas and development and family approaches in service delivery needed to be supported.

### **'Access & more resources'**

***30.9% of individual responses and four groups (69.7% of group participants) said increasing access would be good.***

Ideas around specific areas were:

- Some of the ideas about access are about increasing consistency and access, which may either require rethinking how current resources are used and adapting this or the increased resources. The most common response to improve access was to continue to embrace broader approaches/guidelines-family-approaches not always meeting need, suitable and appropriate services.
- Other comments about access included consistency in existing services eg: '*1800 number works sometimes*', increase training-quality training, and increase after hours support.
- The need for better access to support services providing practical assistance, counselling Services, accessing GP's, co-morbidity services, detox in timely way were also highlighted and better resource the specialised AOD policing unit.
- The most common shared resource deficiency was More staff and time, including '*more time to reflect on practice*' and Remote mental health, on the ground,

Resource gaps highlighted were the lack of inpatient withdrawal services, housing and low cost accommodation options, nurses and rural area services for AOD.

**What you said was happening that you didn't want to happen anymore was noted to be overwhelming workloads, creating the inability to create leadership.**

**What is happening that you would like to happen differently** is that organisations would recognise the frustration and burnout of staff and realise that for remote staff, this is where people live where they work and there is no relief.

In terms of service delivery commentators said they:

- didn't want lack of access to after hours access to services,
- didn't want lack of access to continuity of services,
- wanted increased access to GP's and;
- wanted a change in the way we target services to prioritise hard to reach client populations-*'we are not doing it'*.

**What is happening that you want to be happening differently in access to services and resource allocation** produced multiple comments. These included accesses to mental health assessment shouldn't be hard and professional opinion should be valued and access to mental health services wouldn't be so hard, or based on judgement.

*'..If person has been through service and 'not done the right thing' they don't want to see people'..*

Other comments included:

- there would be appropriate rehabilitation facilities for co-morbidity,
- there would be family based services,
- there would be mental health services for anxiety, depression, high prevalence disorders, related issues that can escalate would be available,
- families would be included in services and planning of support,
- services could respond immediately when people motivated for change,
- outreach services for at risk clients would exist and;
- Services would be set up to meet the needs of the most vulnerable.

## **'More knowledge & information'**

***23.8% of individual respondents and three groups (39.3% of group participants) said building on knowledge and information would be good.***

The most common knowledge and information people identified that could be built upon was:

- awareness of each others roles,
- latest developments in both areas (AOD and mental health),
- broadening knowledge across both sectors,
- People don't seek services because of stigma, therefore more community awareness, and;
- an increase in mental health knowledge/basic mental health skills in AOD services.

Individual comments included:

- the need for increased awareness of other co-morbidities,
- information shared needs to be transferred through organisations,
- the need to be careful how we use assessments, etc,
- GP learning effective referral pathways-happens by one on one visits and;
- the need to continue to explore what has been successful in other places

**What is happening that you would like to be happening differently in the area of more knowledge and more information** were commented on as professional development relevant to needs and the mental health sector would have people with better skills in AOD. It was also noted, that general information would be readily available, either through websites or booklets and service information about the areas and how to access services would be readily available.

### **‘More skills & training’**

***Building on existing training and up-skilling was identified by 52.4% of individual respondents and 3 of the 6 groups (39.4% of group participants).***

There were three areas of shared priorities expressed in this area. The most frequently raised was the benefit of more training together

*‘..found training between non-government and government really effective in not only increasing knowledge, but networks...’doing dual diagnosis workshop....had to do 2-3 days placement in opposite sector....I think this was fantastic and more of this should happen’.*

Other ideas, shared were more quality training for staff and up-skilling based on staff needs and making training ongoing.

*‘Without training people can be very judgemental’*

The desire for more opportunities to train staff in dual diagnosis/co-morbidity transferrable skills and more professional development workplace placements-job swaps were also shared priorities expressed by participants.

The types of training AOD government and non-government said they needed more of were improving assessment skills in dual diagnosis, and basic mental health intervention-skills.

Individual responses suggested:

- information and education forums for the AOD sector are really good and should be more of them,

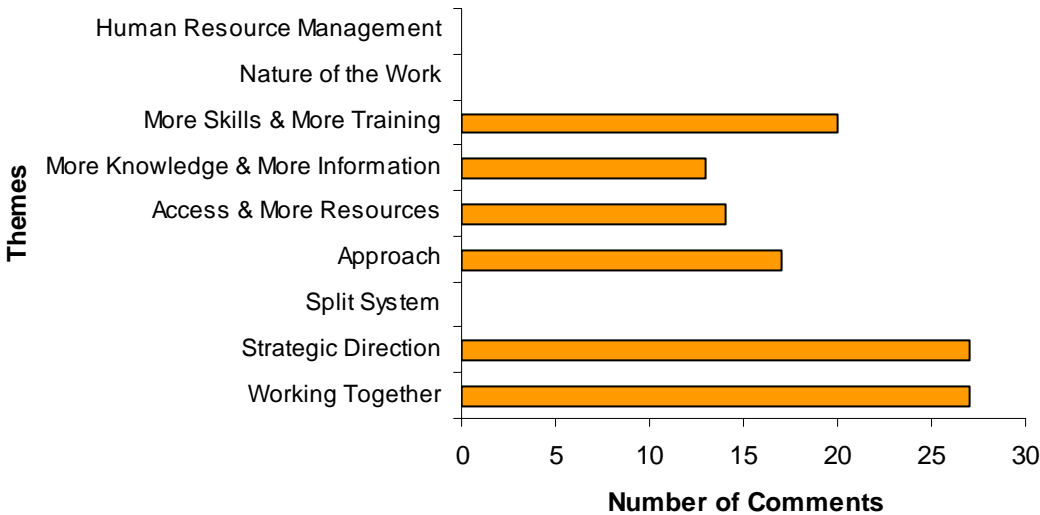
- more encouragement for staff to use both skill sets in our clinical settings,
- more focus on generic healing and therapy approaches,
- more training for practitioners and community members-how to read signs.

Ways to continue increasing skills were noted to be available through more joint clinician discussions and continued focus on staff supervision

# Focus Question 5: What did you say were the first concrete steps we should take?

Full Data Set: 43 Individual Commentators & six groups (33 people)

Q5: Comments By Frequency



## ‘Working together’

**51.2% of individual respondents and 5 groups (78.8% of group participants) identified actions that could be taken under ‘working together’ as what they thought would be the first concrete steps forward.**

The most commonly shared actions participants thought should be taken was to set avenues for interactions with concrete strategies and planned forums, including joint training and workshops for collaboration, networking and dialogue. To focus on relationships and building trust including addressing training and processes and to sit down together and redefine goals:

what we are trying to do, set common goals and standards and make plans to meet targets were all highlighted.

Other shared actions suggested were the development of a joint language, joining everything together, and two services could become one, identifying a leader to pull everyone together and developing an MOU between AOD and mental health.

Individual responses included processes for all parts of service delivery and for this to include everyone, focus on building trust for clinical supervision, placing dual diagnosis positions in each service, gaining support from corrections, increasing links with TEMHS-Tamarind, involving the whole NGO sector, partnership with each other and formalising communication pathways.

For working together in service delivery, the most common actions people said could be taken were improving referrals, processes and planning and problem solving issues around confidentiality.

Individual responses included providing a dual approach to service delivery rather than a specialist approach, for senior clinicians to exchange and share sector knowledge and approaches, for staff to be encouraged and resourced to develop networks and to share client information and to form management plans.

## **‘Strategic direction’**

***53.5% of individual respondents and four of the six groups (78.8% of group participants) identified concrete starting points related to Strategic Direction.***

The suggestions arising most frequently by participants were:

- to join mental health and AOD resources and service delivery,
- to include best practice from both areas,
- to develop an MOU,
- to redo policies to acknowledge co-morbidity,
- to engage and secure government support formalised, in meaningful way,
- to define together what we are trying to achieve by setting goals and making strategy, standards and;
- to develop a strategic plan

*‘Government (both) needs to make a clear stand’.*

For non-government organisations several participants raised the need to diversify funding. Other comments related to funding included the desire to stop categorising in funding, and to develop a better model for remote.

Individual respondents provided ideas including reducing bureaucracy by localising decision making, removing organisational policies stopping access for co-morbidity and promoting evaluation and funding systems that do not categorise

Actions and desires to increase organisational transparency re-approach training with a broader approach across the two areas and focus on prevention and promotion focus were also made by participants.

Comments included the recognition that facilities and programs for trained staff to work in were required and that it is possible to reduce duplications of services.

A service plan for rural and remote areas would be developed.

A peak AOD group would be funded to inform advice and consult and a peak Indigenous body would be funded to inform advice and consult. Community consultations would occur.

Actions that were noted as priorities in the area of strategic direction related to service delivery were to develop dual diagnosis positions in each service and to develop concrete strategies for collaboration-referrals.

Individual commentators said to create forums for senior clinicians to understand different models of care, create services that respond to both, involve greater consumer voice in service design, shared care planning would translate to action and outcomes and to explore legislative options for treatment were concrete steps that would be good to take.

For the area of workforce development, various participants suggested concrete actions.

Suggested actions included:

- was to appoint a driver and plan workforce development and implement the plan,
- to make clear career paths across both AOD and mental health and;
- to select key people to undergo cross sector teaching-training and to plan and target training where it is needed most.

## **‘Approach’**

***34.9% of individual respondents and two of the six groups (30.3% of group participants) said looking at the approach would be concrete first steps that could be taken to improve services.***

The most commonly noted approaches people said needed change or development was suggested as dual management and support, shared care planning, and joint delivery of services including in Detox.

*'provide a dual approach to service rather than a specialised service..'*

Other approaches participants shared ideas about were holistic (more focus on cause of problem, less medical focus models), use existing strengths including existing worker expertise and role models-people who have faced difficulties and overcome them, community education-involving the public and focus on client centered and driven services.

*'Greater consumer voice in service design'*

Aspects of service delivery shared by commentators included improving screening and assessment and creating management plans.

Individual comments included the need to normalise mental health and broaden the concept of dual diagnosis. Comments suggested the desire to have an open door policy and never say no and to focus on continuity of care, taking a longer term outlook. To broaden therapeutic-healing options and to include broader services- e.g: accommodations, environmental impact into the service delivery approach were supported.

### **'Access & more resources'**

***30.2% of individual respondents and one group (18.2% of group participants) said it would be good for some of the initial starting points to be related to the area of access and resources.***

The concrete steps to increase access made included:

- getting a commitment for GP for 2 hours per week,
- removing barriers to referral,
- providing services for co-morbidity,
- increasing mental health expertise in AOD work areas,
- providing AOD in hospital and Accident & Emergency
- providing screening in hospital and;
- establish better links with Top End Mental Health Service (TEMHS).

**More resources** that are first priorities were identified as more rehabilitation options/places and more staffing and funding allocation. Commentators observed the need for government support and funding, staff and money to ensure training needs are met, and staff provided with enough resources to network.

Individual's responses included more mental health nurses in AOD, more services in rural and remote areas and infrastructure required to house existing staff.

## **‘More knowledge & information’**

***25.6% of individual respondents and two groups (36.4% of group participants) said initial concrete steps could be taken in the area of more knowledge and more resources.***

The areas of priority, where respondents shared ideas were around information and information exchange, service information, work approaches, work experience, about each others areas, Successful models of care information/best practice/evidence based. Research service gaps and the development of a generic website, or resource book were also suggested.

## **‘More skills & training’**

***39.5% of individual respondents and three groups (36.4% of group participants) said making initial steps in the area of skills and training would be important.***

Suggestions most frequently raised in skills were to increase cross sector participation in case reviews, clinical supervision and cross sector placements

*‘cross sector teaching/fertilisation-having work in both sectors: key people’*

More training was a shared area of concrete action by participants. The comments identified the action of setting training goals and establishing a plan based on what is required.

Aspects of training people raised was that it had to be continuous and an increase availability of training in NT was required, including the suggestion to link with University to provide appropriate training and the need to look at scholarship options.

The most common type of training participants said was important was more co-morbidity training and screening tools. Other training identified included Indigenous specific training.