

Te Ariari o te Oranga

The Assessment and Management of
People with Co-existing Mental Health
and Substance Use Problems 2010

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The content has also been influenced by the important work behind TIP 42 and draws on this in many places.

The case scenario in section 6 was initially developed for a series of three-day workshops on coexisting disorders by Takarangī Metekingi, Claire Aitken, Paul Robertson and myself and has, along with much of the content of this document, been developed further within the postgraduate programme at the National Addiction Centre (Aotearoa New Zealand).

Te Ariari o te Oranga (Dynamics of Health) was a term coined by students and tutors of Te Ngaru Learning Systems in 1996 to reflect the metaphors and experiences related to well-being, rejuvenation and recovery. Rather than pathology it is a term that expresses transition, strength and hope.

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Executive Summary

Te Ariari o te Oranga: the Assessment and Management of People with Co-existing Mental Health and Substance Use Problems 2010 presents a clinical framework to assist health professionals working with co-existing substance use and mental health problems (CEP). It is designed as a companion document to the Ministry of Health's guidance, *Service Delivery for People with Co-existing Mental Health and Addiction Problems – Integrated Solutions*.

CEP are common in both alcohol and drug and mental health settings, and are associated with a range of poor outcomes, including worse mental health and alcohol and drug outcomes, poorer psychosocial outcomes and higher rates of suicide. Current approaches to managing CEP stress the importance of comprehensive assessment and management, and of integrating alcohol and drug and mental health treatments. However, there are a number of issues, including:

- » the gold standard models appear difficult to implement with fidelity
- » engagement in treatment remains a significant challenge
- » the basic paradigms underpinning most CEP programmes appear to be based on chronic psychosis and may be less suitable for tangata whaiora with non-psychotic disorders
- » the emerging evidence base casts doubt on the effectiveness of core treatments such as cognitive behavioural therapy, motivational interviewing, assertive community treatment and integrated care for changing substance use and mental health problems.

CEP can be thought of as having generic components that are common to all people with CEP, and specific components related to an individual's particular combination of mental health and substance use problems. *Te Ariari o te Oranga* addresses the generic aspects of care for tangata whaiora with CEP and aims for an approach that is generally consistent with current approaches such as the *Treatment Improvement Protocol 42* (TIP 42). However, it recognises the limitations of these approaches by strengthening areas of weakness.

Given that current approaches do not have a strong evidence base and are therefore better thought of as expert best opinion, *Te Ariari o te Oranga* also incorporates emerging approaches where they appear clinically useful. These emerging approaches include positive psychology, self-determination and motivation, an extended model of engagement, and a structure for thinking about integrated care, starting with and driven by the needs of tangata whaiora rather than the needs of the systems within which tangata whaiora receive care.

The framework employed here consists of seven key principles.

1. **Cultural considerations:** Consider the cultural needs and values of all tangata whaiora throughout the treatment process.
2. **Well-being:** Take a well-being perspective by considering problems as barriers to well-being and seeing a state of positive well-being as the key outcome variable rather than the absence of dysfunction.
3. **Engagement:** Actively incorporate strategies to increase and maintain engagement with the clinical case manager, the management plan and the service.

4. **Motivation:** Actively incorporate strategies to enhance motivation, including, but not limited to, CEP-adapted motivational interviewing techniques.
5. **Assessment:** Screen all tangata whaiora presenting in mental health and alcohol and drug services for CEP, and where they screen positive undertake a comprehensive assessment that gives equal weight to diagnoses, individualised problems and an integrated aetiological or causal formulation.
6. **Management:** Use clinical case management to deliver and coordinate multiple interventions appropriate to the phase of treatment.
7. **Integrated care:** Integrate care by placing the needs of tangata whaiora first and delivering care driven by the integrated formulation in a single setting, and ensuring close linkages between all services and workers involved.

These are applied over five phases of treatment:

1. pre-treatment
2. early treatment
3. middle treatment
4. late treatment
5. autonomous independence.

Underpinning the seven key principles are the following key assumptions.

- » CEP are heterogeneous – there are as many different types as there are combinations of mental health problems and psychoactive substances.
- » Care should be driven by the needs of tangata whaiora rather than the needs of the system.
- » Well-being is a state linked to the processes of recovery, is a valid outcome goal, and is a construct understood by a range of systems, and therefore helps integration and is a powerful motivating factor.
- » Comprehensive or holistic understanding of the person is essential to develop care that enhances well-being.
- » Integrated care involves bringing together a full range of problem domains, not just alcohol and drug problems, driven by the needs of tangata whaiora and supported rather than dictated by service- and systems-level integration.

The document is organised into six sections. The introduction and background information (section 1) are followed by an overview of CEP (section 2) and a brief description of the CEP framework (section 3). Section 4 is the heart of the document and covers the background literature to the seven key principles. It is designed to explain the principles in depth and to assist their implementation into practice. Section 5 looks at service capacity and developing service capability to put the practice framework in a service and systems context. Finally, section 6 applies the framework to a clinical scenario.

Section 1 » Introduction

This document is designed to update the 1998 clinical guidelines *The Assessment and Management of People with Co-existing Substance Use and Mental Health Disorders* (Todd et al. 1998). Much of the content of the 1998 guidelines remains relevant, but there have been important developments in research and practice.

Co-existing substance use and mental health problems (CEP) comprise a heterogeneous assortment of problems, with as many different specific combinations as there are substances and mental health problems. Each combination has its own specific nature and needs, while sharing some important generic or common factors. This document is primarily concerned with these common factors, and aims to provide a therapeutically orientated framework to help health professionals address the generic issues. In places, specific combinations of CEP are mentioned, but it is beyond the scope of this document to provide detail on the management of all specific combinations of CEP. Further, although the framework presented in this document has relevance for subgroups of people with CEP, such as Māori, Pasifika, people in the justice system, youth, the elderly, women, and lesbian and gay people, separate specific guidelines for these groups are likely to be needed.

1.1 Background to the 2009 Update

In response to the growing awareness of the interactions between substance use and mental illness, the National Addiction Centre (Aotearoa New Zealand)¹ was commissioned by the Alcohol Advisory Council of New Zealand (ALAC), the Ministry of Health and the Mental Health Commission to develop guidelines for the assessment and management of people with substance use and mental health disorders. These were published in 1998 and disseminated widely.

The ensuing decade has seen an emerging consensus on what constitutes best practice for people with CEP and an increasing awareness among health professionals of the importance of recognising CEP and managing them appropriately. At the same time, the evidence base for these approaches has developed. Several guidelines for service development, assessment and management have been published during the past few years, most notably:

- » TIP 42 (Center for Substance Abuse Treatment 2005): (<http://download.ncadi.samhsa.gov/prevline/pdfs/bkd515.pdf>)
- » *Best Practices: Concurrent Mental Health and Substance Use Disorders* (Health Canada 2002): http://www.hc-sc.gc.ca/hl-vs/pubs/adp-apd/bp_disorder-mp_concomitants/index_e.html
- » *Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide* (Department of Health United Kingdom 2002): <http://www.rethink.org/dualdiagnosis/toolkit.html>.

The 1998 guidelines were developed from a similar evidence base to TIP 42. This document is therefore intended to update the 1998 guidelines by incorporating several promising new developments in the area, taking into consideration recent research and the limitations to the TIP 42 approach, and to extend current approaches to CEP to address those limitations.

¹ At that time it was named the National Centre for Treatment Development (Alcohol, Drugs and Addiction).

1.2 Organisation and Content of *Te Ariari o te Oranga*

This document comprises six sections. Section 1 provides an introduction to the document and section 2 an overview of CEP to place the framework in its current context. Section 3 presents the framework, the key part of the document. In section 4, each of the seven key principles is discussed in detail so that readers can fully understand the principles and how to use them, and to facilitate training and transfer of knowledge into practice. Section 5 places the principles in the context of services and systems, while the final section applies them to a case scenario.

Although this document rests on a similar body of knowledge to the 1998 guidelines and TIP 42, there are a number of key differences in content and emphasis to take into consideration.

- » These guidelines have been developed with a New Zealand context in mind, especially with respect to issues relating to Māori and Pasifika.
- » There is less emphasis on paradigms developed to treat chronic psychotic disorders.
- » There is increasing recognition that integration of care follows naturally from a holistic understanding of the person in their social context, and that many of the problems of CEP are due to the imposition of service and systems issues on the person with CEP.
- » Recent research indicates that treatment integration is associated with, at best, modest improvements in outcomes for people with CEP.
- » There is recognition that engagement and motivation are at least as influential on outcomes as specific interventions and systems of care.
- » There have been recent developments in the science of subjective well-being and positive psychology, in motivational interviewing for co-existing disorders and in thinking about underlying personality and character traits.
- » Current models of motivation, engagement and integrated care have been extended.
- » There is an emphasis on clinical application in an attempt to transfer what is known by health professionals into practice; in other words, to bridge the knowing–doing gap.

1.3 Terms and Definitions

Alcohol and drug problem / substance use problem / problematic use

Substance use may affect the course of a mental disorder without strictly meeting DSM-IV criteria² for a diagnosis of substance abuse. Examples of this include the effect of heavy use of alcohol on antidepressant medication for a major depressive illness, or the occasional use of cannabis by a tangata whaiora with schizophrenia. Problematic use, herefore, is included in the concept of co-existing problems.

In this text, the concept of problematic use is taken to mean use of a substance that may cause or exacerbate problems, including mental illness. This concept may include use that meets criteria for abuse and dependence. It should also be noted that the concept of problematic substance use and the related substance use diagnoses apply to any psychoactive substances that are consistent with these definitions, regardless of whether the substances are licit or illicit.

2 Diagnostic and Statistical Manual of Mental Disorders, fourth edition.

Clinician / practitioner / health professional

Various terms are used to describe a mental health or alcohol and drug worker. It needs to be acknowledged that within the alcohol and drug sector, the term 'practitioner' is preferred by many, while within mental health services 'clinician' is often the preferred term. 'Practitioner' may be seen as a looser term and can be applied to workers at various levels of competence and qualification, while 'clinician' is usually reserved for those who are registered health professionals. In this document the term 'health professional' is used to capture the range of clinicians and practitioners within alcohol and drug and mental health services.

Co-existing mental health and substance use problems (co-existing problems, or CEP)

There are many terms coined to capture the interaction of substance use and mental health problems. In this document the term 'co-existing substance use and mental health problems' has been used, partly due to the historical use in New Zealand of 'co-existing' and partly because 'co-existing' implies interaction more than 'co-occurring'. The word 'problems' has been preferred over 'disorders' in recognition of the fact that significant substance use and mental health symptoms may occur at levels that do not meet criteria for disorders in their own right.

Other terms used synonymously include dual diagnosis, co-occurring substance use and mental health disorders, co-existing disorders and comorbidity

Definitions of CEP vary depending on the time course. For example, general population studies often use lifetime prevalence rates, meaning that an individual may experience both a substance use problem and another mental health problem in their lives, but not necessarily at the same time. Although this has relevance for population health, from a therapeutic perspective the focus is on problems that occur at the same time and interact with each other. The latter is the definition that will be used in this document.

Cultural health professional

This term is used to describe health care professionals with the role of ensuring cultural needs are met, with the particular culture they are expert in noted in brackets. In this document, 'cultural health professional' usually refers to those working with Māori and represents the position commonly called 'Māori health worker' or 'pukenga atawhai'. The use of a more generic term such as 'cultural health professional' allows for the inclusion of experts in other cultures as well.

Mainstream

In this document, 'mainstream' is used to represent the dominant Eurocentric and medical model paradigm used within health services, especially those funded through District Health Boards. The term is particularly used to differentiate this approach from kaupapa Māori and Pacific approaches, and also some approaches (though not all) within non-governmental organisations (NGOs).

Optimal treatment and evidence-based practice

The term 'optimal treatment' is used to mean the best treatment possible within resource constraints. Decisions on what constitutes optimal treatment should, wherever possible, be consistent with evidence-based practice and the research base supporting a particular approach or practice. Services should deliver care that has a positive impact, wherever possible, and health professionals should use treatments and interventions that are supported by a weight

of good research evidence, again, wherever possible. Unfortunately there is a lack of solid research evidence for many of the approaches used for CEP. A few meta-analyses have been done, especially through the Cochrane Collaboration, but in many areas there are only a few un-replicated studies to guide the health professional, and in many others no evidence at all. Where evidence is weak or lacking, expert best opinion is valuable, but it is important to identify the strength of evidence for specific recommendations.

Self-help groups

'Self-help groups' encompasses a range of consumer-led groups. Where this term is used, it is intended to include such groups as Alcoholics Anonymous, other AOD and peer support groups, and a range of consumer-led mental health groups and organisations.

Substance abuse

The term 'substance abuse' is used strictly to mean a disorder that meets DSM-IV criteria for a diagnosis of substance abuse rather than referring loosely to problematic, hazardous or unsanctioned use of a substance. Substance abuse cannot be diagnosed according to DSM-IV without first excluding substance dependence.

Substance dependence

The term 'substance dependence' is used strictly to mean a disorder that meets DSM-IV criteria for a diagnosis of substance dependence.

Substance use disorder

In this document 'substance use disorder' is used to represent a disorder meeting criteria for one of the DSM-IV substance use disorders.

Tangata whaiora

'Tangata whaiora' is a Māori term for a person, or people, seeking health and has come to represent the users of health systems. It is used in this document to represent the person who is the subject of health care services. Other terms used synonymously include:

- » patient
- » client
- » consumer
- » service user.

'Tangata whaiora' is less widely used in the alcohol and drug and pathological gambling fields than in other mental health services.

Whānau or family

The terms 'whānau' and 'family' are commonly used synonymously. However, strictly speaking the word 'whānau' refers to a family with specific hierarchies and roles, which may differ from non-Māori family structures. In this document, 'whānau' is used to describe traditional Māori

family structures. In most parts of the text the phrase ‘whānau and family’ is used to capture both these concepts. Where ‘whānau’ is used alone it refers to more traditional Māori family structures. For example, in the clinical scenario in section 6, ‘whānau’ is used and it is intended to convey a family structure that is consistent with Māori roles and hierarchies.

Whānau ora

The concept of whānau ora is difficult to define precisely but includes the concept of the whānau as a key unit of identity and target of health interventions. Whānau ora also focuses on the wellbeing of the whānau, its ability to express important values and the capacity to carry out key functions such as manaakitanga (the capacity for caring), tohatohatia (the capacity for sharing), pupuri taonga (the capacity for guardianship), whakamana (the capacity for empowerment), and whakatakoto tikanga (the capacity to plan ahead) (Durie 1997).

There are strong similarities between whānau ora and well-being approaches, but also important differences.

Well-being, recovery and strengths

‘Well-being’ is a term that has traditionally been difficult to define in a meaningful way, but captures the positive aspects of a person’s life and can be thought of along similar lines to quality of life. There are many similarities between the concepts of well-being, strengths and recovery, not least in their empowerment of tangata whaiora to take charge of decision-making around health care and in the rejection of the over-emphasis medical- and disorder-focused models place on problems over positive attributes.

Definitions of recovery and strengths approaches vary and are often interpreted quite differently in different settings, but historically imply either living in adaptation to deficits (recovery) or focusing on enhancing existing social strengths instead of addressing deficits. A definition of recovery featuring the concept of living well in the presence or absence of mental illness is increasingly used within mental health services. Perhaps the definition closest to the concept of well-being comes from attempts to achieve a consensus definition across services, and conceives of recovery as a journey of healing and transformation enabling a person to live a meaningful life of his or her choice while striving to achieve his or her full potential (*National Consensus Statement on Mental Health Recovery*, U.S. Department of Health and Human Services, <http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/>).

However, the term ‘recovery’ also has an important role in capturing the process of change as experienced by tangata whaiora. There is concern that capture of this term by health care systems and health professionals may undermine the processes of empowerment of tangata whaiora the term signifies.

As mentioned, ‘well-being’ captures a state or outcome, albeit a dynamic and self-determined one, rather than a process. It might best be considered that well-being is the state the process of recovery arrives at. A well-being approach allows for treatment of problems as well as for enhancing positive attributes, and through the field of positive psychology is developing an emerging evidence base for effective interventions aimed at enhancing subjective well-being. Well-being also focuses clearly on an outcome rather than a process, which is arguably more useful for clinical guidance.

Finally, the concept of well-being is arguably more consistent with Māori and Pacific models of health. For these reasons, the concept of well-being is preferred in this document.

Section 2 » Overview of Co-existing Substance Use and Mental Health Problems

2.1 What are Co-existing Substance Use and Mental Health Problems?

Co-existing mental health and substance use problems (CEP), or dual diagnosis, is usually defined as the co-existence of substance use and mental health problems within one person or tangata whaiora. That services, journals and educational programmes have arisen specifically to deal with CEP may give the impression that CEP is a valid entity, and it certainly indicates that these two problem areas are difficult for services and health professionals to manage.

However, CEP is not an entity in its own right, in the way that depression or schizophrenia are. Many tangata whaiora experience problems in multiple domains of functioning and receive more than one diagnosis without those problems receiving the kind of attention CEP have. The difficulties associated with CEP occur due to the way health professionals think about the problems of tangata whaiora, negative attitudes that exist between those working in mental health and substance use services towards each other, and the way services and systems deliver care rather than any inherent split or conflict within tangata whaiora and their whānau or family.

That these factors can influence care to the extent they do is in large part due to changes in the way health care is delivered, and especially to the increasing focus on the needs of the service and the health system rather than the needs of tangata whaiora.

2.2 How Common are Co-existing Substance Use and Mental Health Problems?

CEP are common in the general population and are likely to represent a large pool of unmet need. The Epidemiological Catchment Area study, a large general population study undertaken in the United States in the late 1980s, found that 23% of the population had both a substance use problem and a mental health problem in the preceding six months (Bourbon et al. 1992). Although people with CEP are two to four times more likely to seek help from health services than those with only substance use or mental health problems (Regier et al. 1990), most do not present for help for either problem (Bourbon et al 1992). Further, approximately half of those with CEP have more than one mental health disorder (Khantzian and Treece 1985; Rounsaville et al. 1982) and approximately 25% are also likely to experience cognitive impairment (Strain 1993).

In New Zealand, Wells et al. (1989) undertook a population survey in Christchurch using methodology similar to that of the Epidemiological Catchment Area study and found significantly lower rates of CEP in the community, although, as the authors acknowledge, the lower response rate is likely to have explained some of this discrepancy. Recently *Te Rau Hinengaro: The New Zealand Mental Health Survey (the New Zealand Health Survey)* (Oakley-Browne et al. 2006), a national general population survey of mental health disorders, reported that of those with a substance use disorder in the past 12 months, 29% also suffered a mood disorder and 40% suffered an anxiety disorder. Of those with a mood disorder in the past 12 months, 12.9% also had a substance use disorder. These figures are considerably lower than those reported in the Epidemiological Catchment Area study but still represent a significant number of people.

Within therapeutic settings, rates of CEP are significantly higher. As a rule of thumb, between 30 and 50% of those in mental health settings have a co-existing substance use problem, as shown in table 2.1. Rates within addiction settings tend to be much more variable, in part due to the differing entry criteria of programmes.

Table 2.1 » Prevalence rates of substance use disorders, by psychiatric diagnosis

Psychiatric disorder	% who suffer substance use disorder
Antisocial personality disorder	80
Borderline personality disorder	50
Bipolar disorder	50
Schizophrenia	50
Depressive disorders	30
Anxiety disorders	30

Sources: Galanter and Castenada 1991; Miller, N.S. et al. 1994; Trull 2000.

There have been few published studies in New Zealand of prevalence rates of substance use disorders in people with mental health problems. A survey of 28 acute psychiatric units nationally reported that 48% of current psychiatric inpatients also had a current 'substance use issue' documented in their clinical file (Ministry of Health 1997), and Bushnell and colleagues found that 44% of a sample of people in treatment for bulimia had a lifetime diagnosis of a substance use disorder (Bushnell et al. 1994).

There is better New Zealand data on prevalence rates of CEP in substance use settings. Adamson et al. (2006) undertook a prospective study of people referred to two community alcohol and drug units in New Zealand and found that 74% of tangata whaiora had a current non-substance-related Axis I DSM-IV diagnosis. An anxiety disorder was diagnosed in 65%, a mood disorder in 53%, a specific depressive disorder in 43%, post-traumatic stress disorder (PTSD) and social phobia each in 31%, and bipolar I disorder in 11%. Only 10% of the sample was currently engaged in mental health services. These high rates of CEP are consistent with previous reports from the Wellington Salvation Army Bridge Programme (Peace and Mellsop 1989), where 95% of the sample had a current non-substance use DSM-III disorder, and from a range of residential alcohol and drug programmes in Canterbury, where 38% of tangata whaiora had a score on the BDI suggestive of probable depression (Sellman and Eggleston 1991), and from a methadone programme where more than 70% of patients had comorbid major depression or social phobia (Todd et al. 1998).

With respect to gambling, the *New Zealand Health Survey* found that 1.3% of the general population experienced problem gambling, and that those who did have gambling problems had significantly higher rates of tobacco use and problem drinking (Ministry of Health 2009). Rates of problem gambling appear to be even higher in primary health organisation settings (Sullivan et al. 2007).

Thus, it appears that CEP are extremely prevalent in therapeutic settings in New Zealand, with between a third and a half of all tangata whaiora in alcohol and drug or mental health settings likely to have current CEP. Further, many tangata whaiora with CEP may not be receiving appropriate treatment.

2.3 Implications and Impact of Co-existing Problems

Substance use and mental health problems have a negative impact on each other to worsen a range of outcomes. These include (Drake 2007):

- » increased rates of violence
- » increased rates of suicide
- » higher levels of mental health symptoms
- » increased relapses, number of hospitalisations and time spent in hospital

- » poorer general health, including increased rates of hepatitis C and HIV
- » higher rates of offending and incarceration
- » unstable housing and homelessness
- » loss of whānau or family supports
- » financial problems
- » financial costs to treating services
- » poorer subjective well-being.

This is compounded by a strong association between CEP and poor engagement with treatment, poor retention and poor compliance with treatment. Despite these negative outcomes, the presence of CEP is frequently not detected in treatment settings (Milling et al. 1993; Ananth et al. 1989).

2.4 Factors Associated with Outcome

A number of factors have been shown to predict treatment outcome in people with CEP. Factors associated with better outcomes include:

- » an initial focus on engagement and retention
- » attention to staff relationships with tangata whaiora, which is associated with improved outcomes
- » compliance with medication
- » the quality of the relationship with the staff, especially the attending specialist
- » an emphasis on medication in services and programmes
- » a greater tolerance of non-compliance with prescribed medication (in other words, working to improve compliance rather than discontinuing treatment for non-compliance)
- » the provision of aftercare that begins immediately after discharge
- » treatment components that are well integrated and consistent with each other
- » legal coercion into treatment, which is associated with improved retention.

Factors associated with better outcomes include:

- » offering a wide variety of disparate treatment activities
- » the presence of antisocial personality disorder
- » tangata whaiora having several of their problems treated in different programmes or services that do not liaise closely

(Greenberg et al. 1994; Koefed et al. 1986; Owen et al. 1996; Swindle et al. 1995).

The nature of the comorbid mental health condition also has a large impact on outcome. In other words, the natural course of mental health problems differs such that some conditions respond better to current treatments than others. Treatment approaches designed to improve the care of people with CEP are generally aimed at enhancing those factors associated with good outcomes and overcoming or minimising the impact of those factors associated with poor outcomes.

In addition, a number of other barriers to optimal care have been identified in New Zealand.

2.5 Barriers to Optimal Care – New Zealand Research

The 1998 Guidelines were driven by a series of focus groups with a variety of stakeholders, including tangata whaiora, mental health clinicians, and alcohol and drug practitioners, which identified a range of barriers to optimal care. These are summarised in table 2.2.

Table 2.2 » Summary of barriers to optimal care for people with co-existing substance use and mental health problems	
Systems	
1. <i>Lack of regional planning</i>	Individual services are established without a vision for how they might be integrated. Gaps between services are plugged with new services in 'piecemeal' fashion, creating more gaps. There is insufficient involvement of health professionals, consumers and families in service development.
2. <i>Fragmentation of services and inconsistency of care</i>	There is a lack of strategic planning for integrating services, leading to fragmentation of mental health services. Patients are referred from service to service, making integrated treatment difficult to achieve. Patients receive several assessments before they receive any significant treatment.
3. <i>Contracts encourage a narrow focus</i>	Services are often funded for a limited number of sessions (to undertake specific tasks). Limited sessions restrict the interventions that can be offered to people with complex conditions.
4. <i>Lack of resources</i>	There are heavy patient loads, lack of access to training and waiting lists for treatment. There is little time to undertake effective interventions of proven efficacy (e.g. family interventions).
5. <i>Problems in rural areas</i>	Large distances between services and lack of access to tertiary specialist services place more pressure on families/whānau, police and general health care workers. Health workers are required to have a broad range of skills but often lack the necessary specialised skills.
Clinical	
1. <i>Lack of clinical skills</i>	A minority of health professionals are able to plan effective interventions for people with co-existing disorders. There are very few health professionals with the broad range of skills necessary to carry out effective interventions. Health professionals are often expected to work in generic fashion without formal training in key skills such as assessment and case management.
2. <i>Lack of knowledge</i>	There is a general lack of knowledge about the nature and interactions of co-existing disorders, especially the nature of addiction, among mental health workers.
3. <i>Inadequate family involvement</i>	Families are often not included in assessment and treatment planning processes, and their concerns are often overlooked. Tangata whaiora confidentiality is often misused restricting family involvement inappropriately.
4. <i>Cultural issues</i>	The specific skills and knowledge needed to work effectively with Māori are lacking among health professionals in mainstream services. Professional training seldom deals with the specific needs of Māori. Health professionals fail to recognise the limits of their expertise when dealing with cultural issues.

<p>5. <i>Lack of assertive follow-up</i> Patients are too easily allowed to discontinue and drop out of treatment.</p>
<p>Attitudes</p>
<p>1. <i>Judgemental attitudes</i> There are implicit beliefs that substance use problems are a matter of choice and therefore of personal or moral deficit.</p>
<p>2. <i>Rejection of a disease model</i> There is antipathy towards the use of a disease or medical model from certain professional groups, which may lead health professionals to reject biologically based interventions. Rejection of a disease model is often due more to professional rivalry and a lack of knowledge of its uses, strengths and weaknesses than the limitations of the model.</p>
<p>3. <i>Territoriality</i> Rivalry between professional groups and regions makes the interface between services less permeable.</p>
<p>4. <i>Insistence on abstinence and confrontation</i> Patients are often put under pressure to stop using alcohol and drugs completely, with little serious consideration given to the health benefits that could be obtained from reduced levels of use.</p>
<p>5. <i>'Addiction is not the business of mental health services'</i> Tangata whaiora are often turned away from mental health services regardless of the other mental health problems they may suffer.</p>

Source: Todd et al. 2002

Recently, further work was undertaken by Ian MacEwan for Matua Raki (National Addiction Treatment Workforce Development Programme) (MacEwan 2007). This involved 165 interviews with chief executives and mental health managers from all 21 District Health Boards, mental health staff, alcohol and drug staff, funders and planners, team leaders, Māori dual diagnosis workers and tangata whaiora to canvass views on integrated practice and to explore ways in which partnerships between alcohol and drug and mental health services could be improved.

A number of common themes emerged.

- » Mental health clinicians did not appear to be motivated to think about alcohol and drug issues.
- » Alcohol and drug practitioners lacked the clinical skills to assess for common mental health problems.
- » Good integrated practice only occurred when individuals knew each other well.
- » Most – though not all – health professionals shared a vision of an integrated service for people with CEP.
- » Collaboration was hindered by mistrust, attitudes of leadership and management, and high staff turnover.
- » Responses to CEP varied markedly between regions.
- » Health professionals lacked confidence dealing with tangata whaiora with 'other sector' issues and tended to focus on what they were competent at, referring the 'other sector' issues to other services or ignoring them.
- » Differences in language and philosophies between mental health and alcohol and drug services encourages intolerance, a sense of belittlement and a lack of confidence between sectors.

Many of these themes were similar to those identified by Todd and colleagues (2002) above and indicate that despite considerable efforts to address barriers to care in the intervening years, many problems have persisted. It should be noted that they are common across both Māori and non-Māori services.

Arguably, the most enduring and problematic barrier to progress is the attitude of mental health and alcohol and drug sectors towards each other. MacEwan (2007) provided a number of quotes which exemplifies the problem well:

- » The alcohol and drug counsellors in the local NGO wouldn't recognise a mental health problem if it slapped them in the face. Waste of time and money. Any real work is done by my nurses. (District Health Board Mental Health Manager)
- » Alcohol and drug is talking therapy. They are untrained. Real medicine is by mental health. (Mental Health and Alcohol and Drug Service Manager)
- » Dual diagnosis patients are the worst attenders to services, therefore you wouldn't want to put more resources into this group. (Worker from Funding and Planning)
- » We had a regional strategic document on managing co-existing disorders two years ago but it didn't involve alcohol and drug Services. (District Health Board Clinical Director)
- » Dual diagnosis services are in place although not impressive because no-one knows what they do. (Professional Nurse Advisor)
- » Mental health simply stabilises situations. We have to do the change work. Mental health services wouldn't know where to start. (Alcohol and Drug Team Leader)
- » Mental health [services] will never work with families. They are terrified of them. (Alcohol and Drug Team Leader)
- » Alcohol and drug [services] won't include the family. They will only work 1:1 with their whaiora. Home visits? That's a joke right? (DHB Mental Health Manager)
- » I am here to treat her depression. If she uses cannabis, what am I supposed to do? Depression is my business. (Mental Health Nurse, talking about tangata whaiora)
- » Alcohol and drug is not an issue for us. It is an adult problem. (District Health Board Child and Family Psychiatrist)

Thus negative attitudes between AOD and mental health services and tangata whaiora engaged in these services appear to be common. They are likely to be significant and enduring barriers to developing effective integrated approaches to CEP, and service development needs to take them into account. Perhaps the most significant aspect of these attitudes is that not only do they express antipathy between AOD and mental health workers, but they also appear to place a higher emphasis on the views of professionals than on the needs of tangata whaiora.

2.6 Responses to Co-existing Problem: Components and Characteristics of Effective Approaches

Following increasing awareness during the 1980s that people with CEP suffer from having different problems addressed by different services within fragmented treatment systems, integrating mental health and alcohol and drug treatments has been seen as an essential component of care.

2.6.1 Serial, Parallel and Integrated Treatment Models

One of the earlier ways of categorising the relationship between mental health and substance use treatments and services was to consider serial, parallel and integrated service arrangements. The serial model describes the situation where one problem is treated before the others are addressed. The parallel model involves the treatment of two problems at the same time but in separate and distinct services, with the implication that it is the role of the tangata whaiora to

make treatment coherent. In the integrated treatment model, all problems are addressed in a single service, in which both mental health and alcohol and drug interventions are delivered by the same health professionals. The integrated treatment model is widely considered superior for people with CEP.

It should be noted that these models describe service arrangements rather than the specific care delivered to the tangata whaiora. Within an integrated service problems are still often addressed sequentially. Further, from the perspective of the tangata whaiora, care may still have a high degree of integration and consistency when delivered by health professionals from different services as long as similar treatment paradigms are used, and the health professionals deliver care from a single setting and liaise closely with each other regarding the needs of the tangata whaiora.

There is also evidence that for some combinations of mental health problems and substance use serial approaches may be preferable. For example, those with antisocial personality disorder and substance use problems may do better when the substance use problem is addressed first (Conrod and Stewart 2005). Similarly, there is preliminary evidence that social phobia and substance use disorders may do worse with integrated treatment approaches (Tiet and Mausbach 2007).

2.6.2 Key Components of Effective Programmes

Some evidence indicates that programmes that include more of the following core components do better than programmes that have fewer (Carey 1996; Drake et al. 2003; Mueser et al. 2003):

- » integration of services – the provision of services for mental health problems and substance use problems at the same time, in the same service by the same health professionals
- » staged interventions – conceptualising treatment as a series of stages that relate to the progress of tangata whaiora through treatment over time, while understanding that tangata whaiora may be at different stages for different problems and will cycle backwards and forwards between stages over time
- » models such as Osher and Kofoed's Engagement-Persuasion Model (Osher and Kofoed 1989) and Minkoff's Integrated Theoretical Framework (Minkoff 1991; Minkoff 1994) – the Engagement-Persuasion Model conceptualises treatment moving through stages of engagement with the treating health professional and team (persuasion of the need to change, active treatment and relapse prevention); the Integrated Theoretical Framework is similar but incorporates the need to ensure initial safety and stabilisation, and considers treatment to comprise the stages of acute stabilisation, engagement, prolonged stabilisation and rehabilitation/recovery
- » assertiveness – the use of assertive interventions, such as assertive community outreach, to encourage engagement and compliance rather than waiting for tangata whaiora to present or attend
- » motivational interventions – motivational interviewing as a way of enhancing the desire and ability of tangata whaiora to change their behaviour
- » multiple psychotherapeutic modalities – offering individual, group, whānau or family and social interventions, as needed
- » a long-term perspective – a long-term perspective acknowledges that benefits accrue over the long term, that people with CEP may take longer to improve than those without CEP, and that the end of interventions should not be determined by external, non-therapeutic constraints such as service policy, funding or contracts

- » comprehensiveness – treatment that does not simply focus on the present feature, such as substance use, but addresses a wide range of problems, including housing, finances, coping skills, relationships and employment
- » reduction of negative consequences – the key aim is to reduce the harmful effects of CEP in a non-judgemental and non-confrontational way
- » cultural sensitivity and competence – cultural sensitivity and competence are essential to ensure access to and engagement in treatment.

These core components form the basis of most integrated treatment models and underpin the best practice guidelines that have been produced in many countries over the past decade. Integrated treatments, therefore, aim to combine evidence-based mental health interventions and evidence-based substance use interventions in an integrated way that enhances engagement and motivation.

2.7 Responses to Co-existing Problems: Best Practice Guidelines

Over the past decade several documents have been produced by national bodies that aim to incorporate current research and expert opinion to produce CEP treatment guidelines for health professionals and programmes. All draw on a similar body of knowledge, are based on integrated treatment models and provide a rich source of detailed information about CEP. The most detailed and up to date at this point is the *Treatment Improvement Protocol Number 42 (TIP 42)* produced in 2005 by the Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States (Center for Substance Abuse Treatment 2005). All health professionals, managers, funders and policy makers are advised to familiarise themselves with TIP 42.

Also worth looking at are the Canadian best practice guidelines *Best Practices: Concurrent Mental Health and Substance Use Disorders* (Health Canada 2002) and the *Dual Diagnosis Good Practice Guide* from the United Kingdom (Department of Health United Kingdom 2002).

These are available from the following websites:

- » TIP 42: <http://download.ncadi.samhsa.gov/prevline/pdfs/bkd515.pdf>
- » *Best Practices: Concurrent Mental Health and Substance Use Disorders*: http://www.hc-sc.gc.ca/hl-vs/pubs/adp-apd/bp_disorder-mp_concomitants/index_e.html
- » *Dual Diagnosis Good Practice Guide*: <http://www.rethink.org/dualdiagnosis/toolkit.html>.

2.8 Responses to Co-existing Problems: New Zealand

New Zealand has developed a range of responses to the problem of CEP. Some regions have established dual diagnosis teams to bridge mental health and alcohol and drug services, others have placed a single dual diagnosis health professional working from alcohol and drug services within mental health services, and other regions have encouraged mental health and alcohol and drug services to enhance their own CEP capability and to liaise more closely with each other. A common thread has been the recognition that CEP are common and that single, stand-alone CEP specialist units are unlikely to have the capacity to meet the need. CEP responses have therefore generally encouraged all services to increase their ability to detect and manage CEP.

The Waitemata Dual Diagnosis team under the guidance of Dr Francis Agnew pioneered clinical approaches to CEP in New Zealand in the mid-1990s within Auckland's Regional Alcohol and

Drug Services, and in 1998 the guidelines for the *Assessment and Management of People with Co-existing Substance Use and Mental Health Disorders* was produced by the National Centre for Treatment Development (now the National Addiction Centre). There have been a range of national training initiatives, including support for the development of postgraduate programmes on CEP through Auckland, Massey and Otago Universities, and a series of short courses and workshops, notably the Ariari o te Oranga project, run for the Ministry of Health by Paraire Huata and Claire Aitken through the Moana House Training Institute. Government funding and scholarships supporting postgraduate training in CEP have encouraged health professionals to undertake further training.

Despite these initiatives, change has been slow, especially within mental health services. Two major reasons for this are the persistence of negative attitudes between mental health and alcohol and drug services and a reluctance to support these clinical developments with the necessary changes at a systems level. The Ministry of Health has recently begun to address the latter.

2.9 Limitations of Current Approaches

Current approaches to CEP appear to have significant benefits over past approaches. However, there are a number of caveats and limitations.

First, the integrated treatment approaches outlined above are supported by expert opinion but there is limited evidence to support their effectiveness. A number of early studies indicated that integrated treatment approaches improved a number of important variables, especially those related to engagement and retention in treatment, but a recent Cochrane Database Review (Cleary et al. 2008) examining controlled trials of psychosocial substance use interventions compared to standard care for people with serious mental illness and failed to find any benefit from integrated treatment approaches in terms of retention or outcome.

For non-integrated treatments there was no significant benefit in terms of retention in treatment, substance use outcome or mental state from combined motivational interviewing (MI) approaches + cognitive-behavioural therapy (CBT). CBT was associated with better retention in treatment and MI with an increased rate of abstinence from alcohol, but not other drugs. Skills training showed no benefit on any outcome measure. However, the complexity of studying interventions with multiple components meant comparisons between trials were difficult, and more studies are required to clarify these findings.

Tiet and Mausbach (2007) have also recently reviewed both psychosocial and medication treatments for CEP involving depression, anxiety, schizophrenia, bipolar disorder and 'severe mental illness'. They concluded that effective treatments for mental health problems improved mental health components in CEP, effective substance use interventions improved substance misuse components of CEP, but few interventions that combined both effective mental health and effective substance use treatments improved both mental health and substance use problems. Further, there was, at best, weak evidence to support integrated treatment approaches over standard 'treatment as usual' approaches.

Drake and colleagues (Drake et al. 2008) reviewed psychosocial interventions for co-occurring substance use and severe mental health disorders. Following are some of their key findings.

- » Group counselling involving education, peer support and a focus on the concurrent management of mental health and substance use problems was consistently shown to improve substance use and other outcomes.
- » Residential CEP programmes showed consistent positive effects on substance use problems but less consistent benefits for mental health symptoms. Effects were stronger for longer-term (over 12 months) programmes than shorter-term (less than six months) programmes.

- » Contingency management approaches appear to improve substance use outcomes and engagement.
- » Legal interventions to mandate treatment have not been thoroughly studied but appear to increase participation in treatment and a range of other outcomes.
- » Case management using assertive outreach and integrated treatment approaches consistently improves engagement, overall quality of life and decreased hospital use. Specific improvements in mental health and substance use were variable, however, and probably dependent on the specific interventions included within the case management approach.
- » There is weak and inconsistent evidence to support individual counselling involving MI or CBT interventions in terms of changing either substance use or mental health problems. It should be noted, however, that MI has been shown to enhance engagement in treatment and is therefore useful from this perspective.
- » Family interventions and intensive outpatient rehabilitation have been inadequately studied.

Thus, the evidence suggests that integrated treatment approaches may offer little benefit over standard non-integrated approaches. Further, some of the key components of integrated treatment, especially MI and CBT, may not be effective in tangata whaiora with CEP. On the other hand, there is good evidence to support group treatments, contingency management strategies, longer-term residential treatment, legal interventions and case management using assertive outreach techniques. It must be noted, however, that this evidence is based on a relatively small number of studies that do not necessarily address the heterogeneity of CEP.

Second, although current CEP approaches do attempt to address engagement, retention in treatment and treatment compliance, there is probably much more that could be done to improve these factors. As determinants of outcome, these factors are likely to be at least as important and influential as the specific interventions offered. Third, although current CEP approaches are comprehensive and address a wide range of problems, they remain predominantly problem, deficit or pathology focused. This is potentially demoralising and disengaging for tangata whaiora.

Finally, integrated treatment relies on collaboration across health and social service sectors. The attitudes of health professionals and managers between these sectors present a formidable barrier to the implementation of integrated and comprehensive approaches to CEP.

2.10 Emerging Approaches

Several emerging approaches to CEP offer promise, though they are not yet widely incorporated in most CEP treatment programmes.

2.10.1 Kaupapa Māori Approaches

Many of the principles behind kaupapa Māori services are consistent with the intent of these guidelines, especially with respect to their holistic focus on well-being, as in whānau ora approaches. As such, they are able to deliver integrated care. Increasingly, such services are being established that also includes specific expertise in both AOD and mental health; for example, the Auckland District Health Board's Māori Mental Health Services. Also emerging are bicultural or multicultural programmes that are consistent with kaupapa Māori principles while welcoming and being effective for non-Māori, such as the residential programme run by Moana House in Dunedin.

2.10.2 Motivational Interviewing for Co-existing Disorders

MI is an integral part of CEP treatment. Recent developments in MI include adaptations specific to non-psychotic CEP, an increased emphasis on placing the problems of tangata whaiora in the context of their hopes and values, and structured initial interviews aimed specifically at enhancing engagement in treatment (Zuckoff 2007).

2.10.3 Subjective Well-being and Positive Psychology

Well-being can often be a poorly defined concept. The emerging positive psychology movement defines areas of subjective well-being in ways that are useful in therapeutic settings, uses CBT approaches to enhance subjective well-being, and attempts to provide an evidence base for such strategies. This area offers considerable promise in a range of health settings, including CEP, and will be discussed further in subsequent sections.

2.10.4 Mindfulness, and Acceptance and Commitment Therapy

Two interventions for which evidence is emerging for some mental health problems are mindfulness (Breslin et al. 2002; Hoppes 2006) strategies and acceptance and commitment therapy. Both offer promise in terms of coping with difficult emotional and cognitive states.

2.10.5 Temperament, Character and Personality Traits

Personality disorders, especially antisocial and borderline personality disorders, are commonly associated with CEP and are often seen as a third dimension of CEP. However, temperament, character and personality traits are emerging as key underlying substrates and determinants of substance use and mental health problems, which may have important implications for treatment, and especially for engagement and the therapeutic relationship.

Many substance users tend to be impulsive and novelty seeking, less avoidant of harmful situations, relatively low in self-efficacy and less cooperative than non-substance users. Other mental health disorders tend to be associated with different patterns of temperament and character. For example, those with social phobia tend to be highly harm avoidant and highly responsive to the reactions of other people. Health professionals are also likely to vary in the type of temperament, character and personality traits they feel comfortable working with and engage well with. Indeed, many alcohol and drug practitioners say that it was the challenge of working with such interesting personality types that attracted them to the field. Health professionals working in other areas of mental health may be less comfortable working with such tangata whaiora. The quality of the therapeutic relationship is well known to affect engagement, retention and compliance with treatment, but there has been little attention given to the match between tangata whaiora and health professionals' temperament, character and personality traits.

There is also evidence that character traits such as low self-directedness and self-efficacy may be important predictors of tangata whaiora who do poorly in treatment for eating disorders or depression (Bulik et al. 2000; Smith et al. 2005), and that improvements in self-directedness and self-efficacy correlate with overall treatment response. Strategies to improve self-directedness, cooperativeness and other personality traits need to be developed and tested. It is therefore likely that temperament, character and personality traits have an important impact on treatment outcome for people with CEP. Further research is awaited.

Section 3 » Summary of the Assessment and Management of Tangata Whaiora with Co-existing Substance Use and Mental Health Problems

This section summarises the detail presented in subsequent sections and is designed to provide guidance on the structure of treatment and the seven key principles for managing tangata whaiora with CEP. These seven principles have been developed from an extensive literature review and from clinical practice with tangata whaiora with CEP. Wherever possible they take into account the existing evidence base, but for many aspects of care the evidence is either equivocal or lacking. In these circumstances, expert best opinion has been given significant weight, as has clinical experience. Some principles, especially those around cultural considerations and well-being, have very little evidence to support them in the area of CEP other than clinical experience but appear to be so useful they have been incorporated.

3.1 The Seven Key Principles

1. **Cultural considerations:** Consider the cultural needs and values of all tangata whaiora throughout the treatment process.
2. **Well-being:** Take a well-being perspective by considering problems as barriers to well-being and seeing a state of positive well-being as the key outcome variable rather than the absence of dysfunction.
3. **Engagement:** Actively incorporate strategies to increase and maintain engagement with the clinical case manager, the management plan and the service.
4. **Motivation:** Actively incorporate strategies to enhance motivation, including, but not limited to, CEP-adapted motivational interviewing techniques.
5. **Assessment:** Screen all tangata whaiora presenting in mental health and alcohol and drug services for CEP, and if they screen positive, undertake a comprehensive assessment that gives equal weight to diagnoses, individualised problems and an integrated aetiological or causal formulation.
6. **Management:** Use clinical case management to deliver and coordinate multiple interventions appropriate to the phase of treatment.
7. **Integrated care:** Integrate care by placing the needs of tangata whaiora first, and deliver care driven by the integrated formulation in a single setting and ensure close linkages between all services and workers involved.

The following points should be noted when considering these principles.

- » Many of the problems faced by tangata whaiora with CEP are inherent within the health system itself and are simply exposed by the complexities of CEP.
- » Managing CEP involves a range of strategies, some of which are common to most people with CEP (generic) and some of which are specific to the particular combination of mental health problem and substance used (specific).
- » The seven principles discussed here are simply those of good care for any tangata whaiora with complex problems, regardless of whether or not they have CEP.

- » The way the key principles are applied varies depending on where tangata whaiora are in their journey to well-being or recovery. It is therefore useful to think in terms of phases or stages of treatment, each defined by the key goals and strategies implemented during that phase. There are a number of different ways of conceptualising phases of treatment. For example, Osher and Kofoed (1989) define the initial phase by the need to engage tangata whaiora and the second phase by the need to persuade them to change. However, in some circumstances other priorities take precedence during these phases. Consequently, this document uses the following broad phases, within which key goals can be chosen as necessary:
 - » pre-treatment
 - » early treatment
 - » middle treatment
 - » late treatment
 - » autonomous independence.
- » Although there are multiple and varying goals through each phase of treatment, there are specific key goals that are particularly important. These key goals are outlined in table 3.1.

Table 3.1 » Overview of the key goals over the five phases of treatment	
Pre-treatment	<ul style="list-style-type: none"> » Determine appropriate service » Ascertain specific needs regarding initial contact » Cultural needs » Identify further sources of information needed
Early treatment	<ul style="list-style-type: none"> » Assessment – including screening for CEP, risk, focus on integration Safety » Stabilisation » Engagement and motivation
Middle treatment	<ul style="list-style-type: none"> » Active treatment of mental health and alcohol and drug problems » Increase focus on steps to enhance well-being » Maintain engagement and motivation – transfer motivation to more internalised types
Late treatment	<ul style="list-style-type: none"> » Maintain gains and prevent relapse » Restore well-being » Increase self-management and autonomy, and begin transfer of engagement to whānau, family and social supports
Autonomous independence for tangata whaiora and whānau	<ul style="list-style-type: none"> » Self-motivation » Self-responsibility » Independence from specialist services

- » The early phase of treatment differs depending on whether or not tangata whaiora are engaged in a mental health or alcohol and drug services. When not engaged in another service, the early phase of treatment will need to focus on issues of safety, stabilising both substance use and mental health problems and completing a comprehensive assessment, as well as on issues of engagement. When tangata whaiora are already being managed in a mental health or alcohol and drug service and are being referred to the other for shared care, issues of safety and much of the comprehensive assessment should already have been completed. In this case, the initial interviews may focus primarily on enhancing engagement and motivation.

3.2 The CEP Framework

The CEP framework therefore involves applying the seven key principles in each phase of treatment, as shown in table 3.2

Table 3.2 » The CEP framework							
	Cultural	Well-being	Engagement	Motivation	Assessment	Management	Integration
Pre							
Early							
Middle			Incorporation of seven key principles into goals and strategies during each phase of treatment				
Late							
Autonomy							

Within each phase of treatment, key tasks can be derived from the seven key principles. Many of the tasks identified will be during early phases of treatment, but will not necessarily be central at those earlier points. They are mentioned here during the phases in which they are central to treatment.

3.2.1 Pre-treatment

- » Liaise with the referer, if necessary, to establish the most appropriate initial service for tangata whaiora to enter. This minimises the subsequent need for transfers of care across services.
- » Establish the tangata whaiora's ethnicity and ethno-cultural needs during the initial steps of the treatment process.
- » Ensure appropriate processes of engagement (e.g. mihi, availability of drink and food for Māori).
- » Consider using an initial motivationally based engagement intervention to enhance engagement and motivation.
- » Involve whānau, family or other supports wherever possible from the earliest point of contact.
- » Use peer support workers or an engagement case manager to support tangata whaiora entering the service.
- » Liaise with other agencies to ensure the referral process is autonomy-supportive or to organise mandated care if necessary.

3.2.2 Early Treatment

- » Involve key supports, whānau or family.
- » Use culturally appropriate processes (e.g. the use of mihi, karakia and waiata, and demonstrate manaakitanga for Māori, when appropriate).
- » Use screening tools where necessary to identify important domains of concern (e.g. WHO-assist in mental health services or the Psycheck in AOD services).
- » Assess and manage safety issues and the need for stabilisation at first contact.
- » Appoint a case manager as soon as possible.
- » Enhance motivation through techniques consistent with the spirit of motivational interviewing and establishing an autonomy-supportive environment around tangata whaiora and their whānau or family.

- » Consider using pictorial ways of communicating, such as cognitive mapping.
- » Complete a comprehensive assessment as soon as possible.
- » Negotiate a shared formulation and management plan as a basis for integrating care.
- » Stabilise acute crises such as acute mental health issues, substance use (e.g. detox) or social crises.
- » Establish core values – the person’s concept of what well-being means for them – as soon as practical.
- » Involve the multi-disciplinary team.
- » Identify key people outside the multi-disciplinary team who are involved and establish a collaborative network. Consider setting up a collaborative online innovative network (COIN) where complex and potentially difficult linkages are anticipated.
- » Embark on active treatment of substance use and mental health problems: prioritise issues of safety and stabilisation, factors that impair the therapeutic relationship (hostility, anxiety, emotional dysregulation), and the most easily achieved goals to foster confidence and hope.
- » Continue to involve peer support to assist engagement.

3.2.3 Middle Treatment

- » Actively treat substance use and mental health problems.
- » Monitor and adjust medication.
- » Strengthen the therapeutic relationship.
- » Monitor the quality of the therapeutic relationship and address therapeutic ruptures.
- » Include a wide range of psychosocial and psychotherapeutic strategies, where relevant.
- » Maintain engagement and motivation.
- » Increasingly focus on steps to identify and enhance pathways to well-being.
- » Continue to involve peer support.
- » Actively manage linkages and collaborative networks.
- » Address issues of cultural identity and re-culturation.
- » Address issues within whānau or family and include strategies to enhance the capacity of the whānau or family to fulfil its key roles.

3.2.4 Late Treatment

- » Establish ongoing monitoring and enhancement of participation in treatment and adherence to treatment strategies.
- » Focus on relapse prevention.
- » Enhance occupational and social skills.
- » Increase the emphasis on strategies and pathways to well-being.
- » Increase self-management of CEP problems.

3.2.5 Autonomous Independence

- » Ensure engagement with supports in the community.
- » Clarify future access to specialist services.
- » Discharge from specialist services.

3.3 Team and Service Capability

Finally, there are also team and service development tasks that occur outside the therapeutic process. These include:

- » team alignment – agreeing on a common purpose, and the processes for putting it into practice
- » developing interpersonal functioning and team emotional intelligence
- » developing individual and team capability to deal with CEP
- » enhancing team skills and processes for cultural capabilities.

It should be repeated that CEP present in a wide variety of ways. The framework and its application above is hopefully a useful guide to working with tangata whaiora with CEP, but it cannot be prescriptive given this heterogeneity and should be applied in a flexible way to suit specific needs.

Section 4 » The Seven Key Principles

4.1 Principle 1 » Cultural Considerations

Culture can have a profound impact on the presentation and treatment of CEP in many ways. Tangata whaiora can come from a wide variety of cultures and sub-cultures that can influence treatment, and health professionals cannot be expected to have a knowledge and skill in all of them. However, it is expected that all health professionals will have a working understanding of the cultural needs of Māori given that they are the indigenous population of New Zealand, that the conditions for the establishment of New Zealand as a country as detailed in Te Tiriti o Waitangi has been interpreted as guaranteeing access to culturally appropriate health care, and that Māori continue to have negative experiences within the health system as a result of their ethnicity (Jansen et al. 2008). For this reason, this section will outline a broad framework for considering cultural issues in practices and will then discuss this framework in more detail as it applies to Māori. Specific guidelines for other cultures are beyond the scope of this document.

4.1.1 Overview of the Impact of Ethnicity and Culture on CEP

Cultural groupings of particular relevance in the New Zealand health context include those based on ethnicity, sexual orientation and health service usage. Just under two-thirds of New Zealanders identify as being of European descent, with New Zealand Māori comprising 14% of the population, Pacific peoples 7% and Asian peoples 9% in 2006 (Statistics New Zealand 2006). These broad groupings encompass more specific groups, each with significant cultural differences. Indeed, the differences within these groupings may often be larger than the differences between groupings. For example, the individual iwi and hapū that comprise 'Māori' may differ in important ways in terms of beliefs and processes of encounter. Pacific peoples include people of Samoan, Cook Island, Tongan, Niuean, Fijian, Tokelauan and Tuvaluan descent. Similarly, people of Asian and European descent include a wide range of different cultures.

With respect to sexual orientation, people of lesbian, gay, bisexual, transgender, takataapui and fafaine (LGBTTF) sexual orientation and identity probably comprise between 1 and 5% of the population, going by a range of international studies and depending on the definitions used. In New Zealand just under 3% of those under the age of 21 identified as lesbian, gay or bisexual in the Christchurch Health and Development Study (Fergusson et al. 1999).

There are also sub-cultural differences between tangata whaiora engaged with alcohol and drug services and those engaged with mental health services, which may have an impact on the care they receive and which will be discussed further below. Tangata whaiora may identify as belonging to more than one cultural group, and even in terms of ethnicity young people are increasingly identifying with more than one ethnic group. Complicating this further is the fact that the degree to which tangata whaiora identify with a minority culture is variable, as is the specific manner in which they experience and express this affiliation.

Being a member of a minority culture or sub-culture may be associated with a range of health disparities, including:

- » increased rates of mental illness (especially depression and anxiety), substance use and other health problems (e.g. Māori have higher rates of substance use disorders, mood and anxiety disorders than Pākehā and to a lesser extent so do Pacific peoples; Oakley-Browne et al. 2006), and presumably these higher prevalence rates of single disorders will flow through to increased rates of CEP
- » differing expressions of emotional distress and mental health problems
- » reduced access to and utilisation of health services
- » different patterns of diagnosis compared to those applied to members of the dominant culture
- » different attitudes to and acceptance of emotional problems and suicide
- » different definitions of health and well-being, and different outcome measures.

In addition, non-dominant cultures frequently have broader definitions of ill health and well-being, which include such things as spiritual connectedness, access to a secure cultural identity, rates of conviction and incarceration, access to education, and whānau or family capacities as crucial measures of well-being.

The increased rates of substance use disorders, as well as mood and anxiety disorders, among ethnic minorities suggest they are likely to be over-represented in those with CEP.

Mechanisms of disparities

There are many potential mechanisms underpinning these disparities in health status. Factors likely to increase the prevalence of mental health and substance use problems include:

- » acculturative stress (Berry 1997)
- » socio-economic disadvantage
- » overt and covert discrimination
- » reduction in resilience and protective factors, such as:
 - » weakening of traditional whānau or family structures
 - » lack of cultural identity (Marie et al. 2008)
- » factors that reduce or delay access to appropriate treatment, such as:
 - » mistrust of mainstream services
 - » undermining of traditional treatments
 - » coping styles that mean people are less likely to present for help (e.g. stoical coping styles)
 - » stigma of mental illness (especially in Asian communities)
 - » effective treatments not offered to minority cultures
 - » lack of culturally competent health professionals, and especially of health professionals of a similar ethnic or cultural background

- » lack of well-researched conceptual frameworks that have proven effectiveness (Westerman 2004)
- » covert and sometimes unconscious bias from mainstream health professionals
- » at a service level, culturally appropriate practice is often difficult to incorporate in policy and procedure frameworks (e.g. identification of ethnicity at time of referral, incorporation of family, and appropriate community supports; Westerman 2004).

Of note, the *New Zealand Health Survey* (Oakley-Browne et al. 2006) showed that social disadvantage did not explain away the discrepancies in prevalence rates of mental disorder and that non-dominant ethnicities, especially Pacific peoples, access treatment less often. Many of the mechanisms mentioned require responses at a socio-economic and public health level, but a number may also be addressed at the level of health service delivery and clinical practice.

4.1.2 Key Knowledge and Skills for Health Professionals Working with People of Other Cultures

As mentioned, the inequities in health care for Māori and people of minority cultures require a broad approach if they are to be corrected. From a clinical perspective, the key issue is to facilitate access to appropriate treatments by acknowledging differing definitions of health, as well as differing psychologies and value systems as they relate to mental health, by supporting choice of treatment approaches and by presenting health care in a culturally acceptable manner.

Key factors on the part of the health professional include:

1. cultural self-awareness:
 - a. a sound understanding of their own culture and how it differs from other cultures they contact
 - b. how their culture relates to other cultures in New Zealand and the impact their culture has on other cultures
 - c. attitudes to other cultures
 - d. overt and covert discrimination
 - e. institutional discrimination within their own culture and how this is supported by their actions
2. expression of respect for people and their right of self-determination: the right of other cultures to determine priorities and appropriate treatment approaches for themselves and not have other cultural approaches imposed upon them
3. knowledge of other cultures:
 - a. Treaty of Waitangi and Treaty principles
 - b. current issues affecting other cultures and the relationship between them and the dominant culture
 - c. historical issues that have an impact on cultural interactions, especially with the dominant culture
 - d. models of health and illness
 - e. key values, beliefs and practices
 - f. whānau or family and social structures

- g. different expressions of distress
 - h. processes of engagement and communication
 - i. culturally specific interventions
4. appreciation of diversity within cultures
 5. access for the health professional to cultural advice, support and guidance
 6. the provision of a welcoming environment within which to meet
 7. the ability to participate in key processes specific to other cultures, especially in terms of meeting, engaging and communicating
 8. the ability to access external supports such as cultural advisors, translators and healers, and to be able to incorporate these into practice where possible
 9. appreciation of systemic barriers to care experienced by Māori
 10. the ability and willingness to put the above knowledge and skills into practice.

The expectation is that health professionals should develop competence in issues relating to ethnicity and culture; in other words, they should attain the skills required to work effectively with people of other cultures. However, the first step is one of cultural sensitivity, or the attitude that the ethnicity and culture of others is important and worthy of attention (Hunt 2008).

4.1.3 Practical Implications

From a practical perspective, the application of these key factors in clinical practice may involve the following steps.

1. Establish cultural needs prior to the initial formal face to face meeting using culturally skilled staff:
 - » determine the locus of decision-making and who needs to be involved to allow the person and whānau or family to make decisions (e.g. whānau, kaumātua), and make sure of their involvement
 - » do not assume it is always appropriate to involve others: ask.
2. Inform yourself about specific needs before the first appointment.
3. Obtain advice about appropriate processes, models of health and key issues likely to affect treatment as early in the process as possible.
4. Know who to contact for support, translation and cultural advice from within the particular ethnocultural community.
5. Ensure a welcoming environment through:
 - » staff greetings
 - » posters
 - » a waiting room space for whānau or family
 - » drink and food being available, if appropriate
 - » information about services and processes being available in relevant languages, as far as possible.
6. Use culturally appropriate processes, as far as possible.
7. Ensure language needs are met – te reo Māori, translator or interpreter.

8. Do not make assumptions about knowledge or stereotypes – in other words, do not assume that a person conforms to your impression of what it is to be from that culture.
9. Be careful about expressing knowledge – it is possible you have more knowledge about a culture than someone of that culture, which may lead to them feeling ashamed.
10. Acknowledge when you do not know or do not have resources: if you don't know, ask.

Given the varying degrees of development of mainstream services, health professionals are not always able to implement all of the above. While not ideal, such situations may be coped with by maintaining respect for others, supporting self-determination, acknowledging the deficits and seeking support and advice from the whānau or family or community involved.

4.1.4 Working with Māori

The special relationship between Māori and the Crown, as laid down in Te Tiriti o Waitangi and its implementation, give Māori specific rights, which include self-determination and equitable access to appropriate health care. Thus, for Māori equitable access to culturally appropriate health care is a right, not simply a matter of good clinical practice. In many regions Māori have access to kaupapa Māori services where their cultural needs are intrinsic to the health care delivered. However, for a variety of reasons many Māori present to mainstream services, which are still obliged to provide a culturally appropriate context for care.

All health professionals need to be acutely aware of their responsibilities towards Māori and of both current and historical interactions between their own culture, mainstream culture and Māori. Historical grievances are likely to remain current for many Māori, and many of the socio-economic and health disparities that exist between Māori and Pākehā result from discrimination which, while arguably less overt today than in the past, still exists in many covert ways within individuals and institutions.

One of the ways in which covert discrimination may still occur is in the failure to recognise the nature of the differences that can exist between Māori and non-Māori as people, based, in part, on a tendency to understand others by how they differ from us rather than how they live on their own terms. Some important issues when working with Māori include the following.

There is no single way of being Māori.

- » The concept of a 'Māori people' emerged in contrast to the presence of European colonisation and exists often in the context of the relationship with Pākehā. For many, identity arises from genealogical links within whānau or family, hapū and iwi, their ancestors and the whenua/land. People of Kai Tahu would see themselves as different from Ngāti Porou, for example, rather than as one people called 'Māori'. While there are undoubtedly similarities between the values, beliefs and practices of many hapū and iwi, there are also considerable differences.
- » The Māori and Pākehā worlds co-exist and influence each other. People differ in the extent to which they blend Māori and Pākehā values, beliefs and practices. In identifying characteristics that might be considered Māori (bearing in mind the considerable diversity this entails) it should not be assumed that tangata whaiora and their whānau or family express them fully.
- » It is, therefore, important to appreciate and respect the diverse ways in which a person may experience and express their identity.

Spirituality

Many Māori see all things as being created and influenced by a higher power, or powers, and through this all things are connected. Thus, the influence of the spiritual is at the heart of all thoughts, actions and relationships and underpins the expression of values and protocols. Mainstream concepts of health seldom include a spiritual dimension, or if they do, incorporate it in a way that is disconnected from other aspects of health. For Māori, spirituality may imbue all aspects of their lives, including well-being and illness, and is therefore an essential component of health care. Associated with this is the use of karakia and waiata, which should be supported by health professionals, especially during the initial engagement process.

Respect

Given that all things are influenced by the spiritual and are therefore connected, all things are to be respected. This is seen in a reverence for the world in general, for life in particular and especially for people, to an extent not always familiar to Pākehā.

Language (Te Reo Māori)

Te Reo Māori is an essential component of identity and considered a taonga (treasure). It is important to note that meaning changes when concepts are translated from te reo to English. Care must be taken by those not fluent in te reo not to assume that the meanings of words are understood fully when translated into English, especially when they have entered common English usage. For example the word 'whānau' is often used interchangeably with the word 'family' and assumed to mean the same thing, despite significant differences between the structure of and roles within whānau and families. Similarly, the word 'wairua' is often understood by non-Māori to mean 'spirit' or 'spirituality' in a Western sense, though it has a considerable range of meanings and connotations not captured in the Western concept of spirituality. It is important, therefore, to understand the limitations of understanding Māori concepts in languages other than te reo Māori, to facilitate the use of te reo in clinical practice whenever possible by supporting health professionals with speakers of te reo, and to demonstrate respect for Māori by supporting the use of te reo in clinical practice whenever appropriate, and by learning to pronounce Māori words correctly.

Ways of thinking

Māori often see themselves as thinking differently to Pākehā (Milne 2005). This may involve differences in values, priorities and constructs to understand the world, and is beyond the role of this document to describe. For further information, refer to the work of Mason Durie (Durie 2001) and Hirini Moko Mead (Mead 2003).

Key values and beliefs

In attempting to understand the values, beliefs and actions of many Māori there are a number of important concepts that differ significantly from those values and beliefs considered part of Western thought. Given the comments above about the inaccuracies and risks of translating te reo into English, the following descriptions should be seen as approximations and their inaccuracy needs to be acknowledged. It should also be noted that definitions and usage may differ between and within iwi.

- » **Wairua** has been mentioned above under the term ‘spirituality’. It has different meanings and usages, sometimes being used to capture the spiritual essence in all things and sometimes more specifically describing something akin to the soul or the spirit of a person.
- » **Whakapapa** expresses the origins and descent of all things. Genealogy may be traced back to the origins of the universe, and as such all things are connected. With respect to relationships between people, identity is established through genealogical links, and exploring these is a key part of the processes of encountering others.
- » **Tapu** indicates the presence of a sacredness sourced from the mana of the gods (ngā atua). Everything has tapu. Tapu is powerful and potentially dangerous if not dealt with appropriately, often by restrictions on who can deal with something that is tapu and how it is dealt with. Shirres (1997) describes two forms of tapu, intrinsic tapu and the extensions of intrinsic tapu. Intrinsic tapu is a sacred potential passed from the gods to a person or object when it comes into being. The influence of this intrinsic tapu extends beyond the person or object to other people or things they come in contact with. Thus the tapu of one object comes into contact with tapu of another. All things are connected, and so the extensions of intrinsic tapu must be managed for example by protocol, ritual and karakia. Transgressions of tapu may lead to severe consequences.
- » **Noa** refers to a state in which a person or object has been made safe by the removal of restrictions relating to tapu.
- » **Mana** is closely linked to tapu, being derived from the influence of the spiritual powers. Tapu is a sacred potential, whereas mana is a more fulfilled potential or authority to act within the world. That authority, derived from spiritual powers, comes from a number of sources; for example, mana atua (directly from the spiritual powers), mana whenua (from the mana of the whenua (land) a person occupies) and mana tangata (from others, including ancestors, a person is connected with and from actions of the individual in their life). As with tapu, mana is an essential aspect of a person’s being and an important determinant of their well-being, and mana can increase or decrease depending on a number of circumstances and actions of the person, or from others around them. When in contact with mainstream health services, a person’s mana may be enhanced or (more frequently in mainstream services) diminished by the actions of the health professional and the service to the point that the effects of treatment on mana may be more important than the effects on any presenting problems or disorders. A cure that involves a marked reduction in mana may be seen by many as worsening well-being. Health professionals, therefore, need to be careful in how they approach and respect protocols around mana and tapu.
- » **Tikanga** refers to ideas, principles and practices underpinning how things should be done, usually established over generations and based in a traditional knowledge base that has powerful spiritual links. These principles are applied in both large formal gatherings, such as the protocols surrounding a powhiri, and in the day-to-day life of individuals and whānau. Tikanga and the way it is applied in practice through kawa (protocols) may vary considerably among hapū and iwi. The inability to practise tikanga correctly may lead to significant misfortune for the individual or group, something health professionals need to bear in mind when working with Māori.
- » **Utu** refers to recompense or reciprocity and includes a sense of balance. It is often used to denote a response to an inappropriate action but may also include the obligation to return or pay back favours or the settling of indebtedness. An inability to balance wrongs or return favours may diminish the mana of a person, whānau or iwi.

- » **Whanaungatanga** refers to the making and maintaining of connections and relationships between people, which is an important part of identity for Māori. Many Māori place a very high value on whanaungatanga. Traditionally capturing blood relationships within an extended whānau, the concept is now sometimes extended to include friendships and other relationships. Implicit in the concept are several other values, including whakapapa, a strong spiritual component, the need for reciprocity in relationships, and manaakitanga to sustain and honour relationships. Establishing and maintaining connections in this way is, therefore, an important part of meeting people and needs to be considered in the clinical process.
- » **Manaakitanga** refers to the process and practice of caring and nurturing, and in particular, of acting in a way that maintains and enhances the mana of others. It is an obligation upon those acting as 'hosts' to deliver the very best of hospitality, and the ability of a whānau or group to do this is an expression of their mana. It also includes the role of guardianship over land and taonga. The ability to fulfil these obligations is a mark of respect for others and is crucial in maintaining relationships. Failure to demonstrate manaakitanga disrespects guests, reduces the mana of the hosts and may damage relationships. Within clinical practice, manaakitanga may be demonstrated by respecting the values and beliefs of tangata whaiora and allowing their expression through the practices of tikanga.
- » **Tino rangatiratanga** states the importance of self-determination. In other words, the importance of Māori having the right to define for themselves what it means to be Māori and to have control and guardianship over their taonga and resources.

Identity and collective culture

Māori culture is traditionally a collectivist culture, where actions are determined primarily by the needs of the group and identity is derived from relationships between people within the key unit, usually the whānau or hapū. This differs from many – though certainly not all – European cultures, which are individualist cultures where identity rests within the individual and actions are determined by the needs of the individual. This has important implications not only for identity but also for values. Individualist cultures value highly such attributes as personal pride, independence and influence. The same attributes may be seen as negative in collectivist cultures, where personal pride and independence may be seen to undermine contributions to the group.

Processes of engagement and communication

For many Māori, the formalities of meeting people follow protocols that acknowledge many of the key values mentioned above. The use of appropriate processes is, therefore, an essential ingredient in engaging and respecting Māori and a failure to do so may diminish the mana of tangata whaiora. Health professionals should therefore be aware of the importance of offering appropriate processes for meeting and greeting tangata whaiora and whānau and support the use of these processes. At the very least they should be comfortable allowing others with cultural expertise in this area to determine what processes should be used in a particular situation and should be able to take part by understanding the process and knowing how and when to introduce themselves appropriately. The use of te reo should also be supported and facilitated. Note that when deciding on the appropriate processes to use, priority should be given to the tikanga of tangata whenua.

Whānau and family structure

As noted, the word 'whānau' has entered common usage within New Zealand English and is often assumed to mean 'family'. The word 'whānau', however, captures the particular structures and roles of Māori families. Whānau would usually include extended family, more so than Western

concepts of family, and the roles within whānau may differ significantly from those within Western families. For example, parenting may be more the responsibility of grandparents in whānau, and birth order may also have a more prominent role in determining roles and responsibilities. Particular relationships, such as tuakana/teina relationships between older and younger siblings, also bring specific responsibilities and obligations that differ from those in many Western families. It should be noted that modern whānau structures can be quite variable. Health professionals should be aware of the differences between whānau and families and ensure that key people that influence decisions for the whānau are able to be involved in the clinical process.

Models of health and health care

There are several models of Māori health and well-being, the most well known being Te Whare Tapa Whā, which conceptualises well-being as arising from interactions between four dimensions: the spirit (wairua), the family and social environment (whānau), the physical (tinana), and the emotional and cognitive (hinengaro). Other models include:

- » Te Wheke, which adds several other dimensions
- » Ngā Pou Mana, developed to inform social policy
- » Te Pae Māhutonga, which considers health promotion in terms of public health issues
- » Pōwhiri Poutama, which places healing in the context of spiritual connections and relationships.

Many of these models include a differing emphasis on certain Māori concepts that determine health, but they all share a number of crucial factors that are different from many mainstream models of health. The focus is on the positive attributes that give rise to well-being, not just healing deficits. The well-being of the whānau, its role as a source of identity and its ability to function to its fullest capacity are essential aspects of well-being. Spirituality, or wairuatanga, is implicit in many of the concepts and is arguably the most important domain. All dimensions are interconnecting, relying on and supporting each other, giving rise to a holistic understanding of well-being. The concept of balance is implicit.

From the perspective of CEP, many Māori will struggle to see the relevance of separating mental health and addiction in the first place, and Māori approaches to healing will naturally integrate care. Te Whare Tapa Whā has gained considerable popularity in helping non-Māori understand Māori concepts of well-being. This may be partly due to its superficial similarity with the bio-psychosocial model of mental health, but there is a risk that non-Māori health professionals simply use the Māori words but not the concepts. In other words, they may use the terms wairua, whānau, tinana and hinengaro while still maintaining the Western concepts of biological, psychological, social and spiritual. Care must be taken to understand the different implications and ways of thinking behind the two approaches and the different values held within each.

Differing expressions of distress

Māori may present in much the same way as non-Māori, but may also present with more physical and spiritual expressions of distress. There are also several states specific to Māori which may appear on the surface to be similar to mental health problems experienced by non-Māori. The well-known capacity to experience the presence of others, especially ancestors, in the present may appear to mimic psychosis. Mate Māori, which arises on a spiritual plane through transgressions of ritual or through curses, may present with a range of physical or emotional symptoms that mimic Western mental health problems. Whakama, or shame, may present with physical symptoms consistent with depression and anxiety but requires a different approach to healing. Health professionals trained to work in mainstream services need to be aware of these

presentations to the extent that they can seek expert advice to clarify the problem and intervene in appropriate ways.

Culturally specific interventions

Māori make use of a number of traditional approaches to healing. The most important is healing that occurs primarily on a spiritual level, though other approaches such as massage (mirimiri), and a range of natural remedies are also widely used. There is no reason why these approaches cannot be combined with Western approaches to healing if tangata whaiora wish this and the use of comprehensive models of health can facilitate this process. Western medicine has a history of neither accepting the importance or usefulness of traditional healing approaches nor supporting the conditions in which they can be safely used. It is therefore common for tangata whaiora to be secretive about using these approaches while engaged with services delivering Western health care.

Practical implications

The complex and diverse ways in which Māori may experience and express their cultural identity makes things difficult for non-Māori health professionals. However, it is important that health professionals seek to increase their understanding of Māori health paradigms and values, but it is also essential that they have access to others with specialist cultural expertise. Understanding requires dialogue, and dialogue requires a shared language. In learning more about Māori world views, great care must be taken not to perpetuate issues of colonisation through applying Western interpretations to Māori concepts. Do not assume that wairua means spirituality – the concept of spirituality might be a way to start to understand some of the meanings of wairua, but they are not the same.

In clinical practice, cultural health professionals need to be involved prior to the first face-to-face contact to determine the wishes of tangata whaiora and whānau in terms of processes of engagement and to lead these processes. Cultural health professionals also need to be involved in the assessment process to identify any cultural issues that may be important to ensure that the assessment and treatment processes remain culturally appropriate and to facilitate the cultural aspects of treatment, including the involvement of culturally specific healers such as tohunga.

Where this cultural expertise is not available to services, strenuous efforts should be made to obtain it. Addressing cultural issues ‘down the track’ when they come up in treatment is inadequate. For a start, if the initial processes of engagement are not culturally appropriate it may never be safe for tangata whaiora to bring these issues up in treatment. Also, harm may be done in areas the health professional has little awareness of, and these may exceed any benefits that other aspects of treatment have.

Two documents outline the practical skills necessary to work with Māori. *Let's Get Real*, [http://www.moh.govt.nz/moh.nsf/pagesmh/8294/\\$File/letsgetreal-sep08.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/8294/$File/letsgetreal-sep08.pdf) describes a framework of knowledge, skills and attitudes for working with people with AOD and mental health problems and includes a section on working with Māori. Matua Raḷi has developed a dual competency framework for working with Māori, which is available from them via http://www.matuaraki.org.nz/index.php?option=com_content&view=article&id=2:kaiwhakatere-mori-addiction-treatment-leadership-network&catid=9:Maori&Itemid=5.

4.1.5 Specific Issues for People of Other Cultures

Pacific peoples

As Pacific societies with collectivist approaches to identity, Pacific cultures have similarities with Māori cultures. However, each Pacific culture is unique and there are important differences between them that affect clinical practice. Respect for people, extended family structures with clearly defined roles, the importance of land, language and a concept of tapu are all important parts of many Pacific cultures and, indeed, most indigenous cultures in general. Spirituality imbues most aspects of life, with the influence of Christianity predominant in some more than others.

Clinically, key issues involve engagement and communication processes, the identification of key decision makers within the extended family (which may vary depending on the specific culture), acknowledgement of particular sibling relationships (including, for example, the 'sacred' sister–brother relationship of Samoan culture), cultural controls on the use of alcohol and other substances, and the impact of immigration to New Zealand, especially in terms of acculturation across generations.

Seitapu, a clinical and cultural competency framework for working with Pacific peoples with mental health and addiction problems, has been produced and contains some useful information for health professionals on the description of cultural differences (Pulotu-Endemann et al. 2007). It is available for download at <http://www.leva.co.nz/page/9-Publications>.

As with working with Māori, working with Pacific peoples involves treating them with respect, acquiring a basic understanding of their culture, and making use of cultural health professional advice on the use of language, processes and interventions, wherever possible.

Asian peoples

As with other ethnicities, there are many different cultures represented by the term 'Asian peoples'. Of the major cultures in New Zealand, those of Asian origin are arguably the least understood and catered for by health systems. Access to health care is a significant problem, in part due to language barriers, a fear of discrimination from health services to which faults and weaknesses may be exposed, and a sense of shame at having a mental health or substance use problem. Suicidal thinking may be extremely shameful to some and therefore may remain hidden. For others, suicide may be an honourable solution to the shame brought upon families by mental health problems.

Many Asian cultures are collectivist in that identity derives from the family more than the individual, and key values involve contribution to the family and social group more than the enhancement of individual status. Social isolation is a major issue, especially for those cultures less common in New Zealand, as is the family dislocation that often accompanies immigration, where some family members move to New Zealand to establish employment and a home while others remain in their country of origin.

Communication styles involving direct questioning about intimate health issues and direct instruction about strategies to improve health may seem inappropriate to Asian people, as may the gender, age or apparent status of the health professional. Alternatively, for some, empowerment and client choice may be seen as a sign of lack of authority in a health professional.

With regard to the symptoms of mental distress, Asian people frequently present with physical symptoms as opposed to emotional symptoms, and hallucinatory experiences may be normal within certain cultures. Issues of traumatisation may sometimes be significant, especially in refugees.

As with other cultures, advice from those with expertise should be sought wherever possible.

Lesbian, gay, bisexual, transgender, takataapui and fafāfine (LGBTTF) issues (I. MacEwan, personal communication)

In addition to issues they may experience as a result of ethnicity, LGBTTF people experience significant issues related to their sexual and gender orientation. Important considerations include:

- » significant histories of trauma from discrimination
- » an expectation that they will be stigmatised by non-LGBTTF people
- » an expectation that mainstream health services will not understand and may stigmatise them, and so the provision of a welcoming environment is important
- » high levels of social isolation, shame, anxiety, depression and substance use
- » frequent disruption of relationships with whānau or family of origin as a result of sexual and gender orientation, which means connections with social networks within the LGBTTF community may be more important to involve than whānau or family of origin
- » health professionals should be able to supply LGBTTF tangata whaiora with contacts for community support groups and counselling services
- » incomplete 'coming out' – coming out may be thought of as occurring in stages (Cass 1983–1984):
 1. identity confusion: 'Who am I?'
 2. identity comparison: 'Where do I belong?'
 3. identity tolerance: 'I am probably gay/lesbian'
 4. identity acceptance: 'I am gay/lesbian'
 5. identity pride: 'I am proud of who I am'
 6. identity synthesis: 'I am happy with who I am'.

Pākehā cultures

It needs to be acknowledged that Pākehā culture is also diverse. Many Pākehā identify as 'New Zealanders' and see Pākehā culture as being homogeneous and coherent. However, others maintain a connection with cultures of origin. Even within those of British descent there are significant historical tensions and enmities that may persist. These have received little attention within mainstream health services, but quite possibly have an impact on a person's sense of identity and their general well-being.

Key Points

- » Being a member of a minority culture or sub-culture may be associated with a range of health disparities. Key knowledge and skills for working with other cultures include:
 - » the health practitioner's self-awareness of their own identity, values and biases
 - » expression of respect for people and their right to self-determination
 - » knowledge of other cultures
 - » appreciation of diversity within cultures
 - » access for the clinician to cultural advice, support and guidance
 - » the provision of a welcoming environment within which to meet
 - » the ability to participate in key processes specific to other cultures, especially in terms of meeting, engaging and communicating
 - » the ability to access external supports such as cultural advisors, translators and healers, and to be able to incorporate these into practice where possible
 - » the ability and willingness to put the above knowledge and skills into practice.

- » Application in practice involves:
 - » pre-contact from culturally skilled staff to ascertain the needs of tangata whaiora
 - » determining the locus of decision-making and who needs to be involved
 - » not assuming that it is always appropriate to involve others: ask
 - » informing yourself about the specific needs before the first appointment
 - » obtaining advice about appropriate processes, models of health and key issues likely to have an impact on treatment as early in the process as possible
 - » knowing who to contact for support, translation and community
 - » ensuring a welcoming environment
 - » using culturally appropriate processes as far as possible
 - » ensuring language needs are met – te reo Māori, translator, etc.
 - » not making assumptions about knowledge or stereotypes – in other words, not assuming that a person conforms to your impression of what it is to be from that culture
 - » being careful about expressing knowledge – it is possible you have more knowledge about a culture than someone of that culture and may cause them to feel ashamed
 - » acknowledging when you do not know or lack resources: if you do not know, ask.

4.1.6 Further Reading

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4.2 Principle 2 » Well-being

4.2.1 Overview of Well-being

A well-being perspective involves care that aims not just to alleviate problems but also to enhance positive attributes. It is an increasingly influential part of mental health and substance use treatments and is ultimately what tangata whaiora seek. It is also a key part of recovery and strengths models. Mental health and alcohol and drug services traditionally attempt to enhance well-being by minimising the disorder, deficits and dysfunction. It is arguably what these systems do best, and the treatment of dysfunction is an important part of being well, but strategies to strengthen and enhance positive aspects of well-being also have the potential to improve health and have been neglected within mainstream services. There are a number of reasons for this, but difficulties developing consistent and measurable definitions of well-being, and systems needs that increasingly drive treatment at the expense of the needs of tangata whaiora, are major factors.

Promoting well-being through enhancing positive attributes has been part of health treatment for some time, as seen in the rehabilitative approaches (especially those involving recovery paradigms), in the public health arena, and in many alternative therapies (the latter, with their reluctance to seek scientific validation of theories and practice, are part of the reason why well-being approaches have been slow to influence mainstream health care). Further, indigenous approaches to health care, such as whānau ora, have traditionally focused on establishing and enhancing well-being as a primary goal. Recent cognitive behavioural approaches, including those of Positive Psychology, have started to define well-being in measurable ways and provide empirical evidence for its dimensions and for strategies to enhance it.

Including a well-being perspective in the treatment of tangata whaiora with CEP is important for several reasons.

- » Well-being is a valid health outcome in its own right.
- » Well-being approaches may enhance recovery and reduce relapse from problems such as major depression.
- » A well-being perspective is an important strategy for enhancing engagement and motivation. Tangata whaiora may be motivated by treatment that aims to reduce dysfunction, but may ultimately be demoralised by such an approach. A vision of realistic well-being adds another dimension to motivation: the carrot as well as the stick.
- » Thinking of enhancement of the well-being of tangata whaiora as the ultimate reason for health care, and of disorder and dysfunction as barriers to well-being, places tangata whaiora at the centre of care and helps integrate care.

There are, however, a number of underlying beliefs about well-being that restrict its use in many mainstream health settings. Two particular myths need to be highlighted.

- » **Myth 1:** *Illness and well-being are mutually exclusive* – in other words, steps to enhance well-being need to wait until the pathology is treated.
- » **Myth 2:** *If illness or dysfunction is alleviated, well-being will naturally emerge* – in other words, treatment of dysfunction will produce well-being, and if it does not, well-being will just happen.

On the contrary, there are many tangata whaiora with chronic disabilities who achieve a high degree of well-being in their lives, regardless of their persisting problems, and tangata whaiora who have complete remission of mental health symptoms, such as major depression, often experience lower levels of well-being than those who have not been depressed (Fava et al. 1998b; Fava and Ruini 2003). The implication of this is that well-being-enhancing strategies can be initiated early in treatment and may be necessary to help tangata whaiora recover a reasonable quality of life.

Definitions of Well-being

Although people often have a sense of what well-being is and can recognise when others experience a high degree of well-being, there is no widely accepted and consistent definition. The World Health Organization equates health with well-being and notes that 'health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (World Health Organization 1947). Well-being involves 'perceived self-efficacy, autonomy, competence, intergenerational dependence, and self-actualization of one's intellectual and emotional potential' (World Health Organization 2001).

Other definitions include a range of factors such as good social functioning, the ability of a person to fulfil their potential, spiritual well-being, and the context of a health-promoting environment. There is also a sense in a number of definitions that well-being involves some kind of conscious active pursuit. These definitions stress that well-being is not a neutral state but includes a sense of positive attributes, but they have seldom gone as far as defining the particular attributes in detail, or developing ways of measuring them, or researching strategies to increase them. Recent developments in the application of cognitive behavioural approaches to well-being, especially the Positive Psychology 'movement' and related approaches, have begun to take a much more evidence-based approach to well-being in terms of defining, rating and developing strategies to enhance well-being. These will be discussed further below.

Cultural Differences in Well-being

A key issue in defining well-being is that Western definitions focus on the well-being of the individual, while many indigenous definitions of well-being include an emphasis on larger groupings, such as the whānau or family. These have been mentioned previously and will be again below. As discussed, there has been considerable work done in New Zealand on the determinants of well-being and health in Māori and in developing measures of well-being that are relevant to Māori.

The concepts of well-being mentioned above see it as an individual phenomenon but recognise the differences between individualist and collectivist cultures. Individualist cultures, such as the United States, place a high priority on individual autonomy and individual goals, which take priority over group goals. These attitudes govern behaviour. Collectivist cultures such as Māori, Pacific and many Asian cultures are those in which a social unit such as the whānau or family is seen as the autonomous group, and group goals and norms rather than personal attitudes determine behaviour. Cultural differences such as these are important in evaluating well-being for individuals, because positive attributes in individualist cultures such as independence, personal achievement, and influence and self-competence may be negative traits in collectivist cultures, being seen as diminishing a person's contribution and attachment to the group (Triandis 2000). However, this still judges well-being from an individual perspective when it may be more appropriate to also consider the well-being of the group as a whole.

Māori models of well-being, for example, tend to focus more on the capacity of the whānau to carry out its key functions and therefore to attain optimal health and well-being (Durie 2001a; Durie 2005; Kingi and Durie 2000). Thus, definitions of well-being in collectivist cultures need to consider not only individual well-being as it is determined in that culture, but also the well-being of the collective whānau or family, and of the larger group, be it hapū or iwi.

Well-being versus Recovery

As mentioned, there is a considerable overlap in the concepts of well-being and recovery despite a lack of clear and widely accepted definitions. But there are differences. Recovery often implies the concept of recovery from a state of dysfunction, whereas well-being does not necessarily have this connotation. Further, the concept of recovery often involves a continued struggle to live a good life in spite of ongoing pressures to relapse, which must be managed. This is especially so for addiction models of recovery. There are also differences in how the concept of recovery is used in addiction and mental health settings, and even within addiction settings. For example, a 12-step concept of recovery implies abstinence, while other addiction models do not necessarily do so. Recent consensus statements attempt to overcome this (US Department of Health and Human Services 2004). As a concept, well-being does not have these connotations and therefore a consistent definition across addiction and mental health settings may be more easily found, helping to overcome some of the key differences between addiction and mental health paradigms.

Further, the concept of well-being may be more useful than the concept of recovery across systems and across cultures. Most people working within associated systems, such as corrections and education, will have a similar understanding of well-being, facilitating integration of care across those systems. Although Māori concepts of well-being may differ in important ways from Western concepts, well-being arguably captures the state of healthy functioning in each better than does the concept of recovery.

Hence this document uses the concept of well-being rather than recovery, recognising that most of the goals of recovery are included in the concept of well-being but that well-being is probably broader. Using the concept of well-being, however, does not preclude the concurrent use of recovery paradigms but rather embraces them.

4.2.2 Evidence-based Approaches to Well-being: The Science of Well-being

As discussed, scientific approaches to well-being seek to base interventions to enhance well-being on research into the determinants of well-being and then to research these interventions to test their effectiveness. These approaches have much in common but will be discussed separately given their slight differences. They include:

- » Positive Psychology
- » Psychological Well-Being (Ryff) and Well-Being Therapy (Fava): Well-being Therapy (WBT) has been mainly researched in the context of people with depression and is based on Ryff's model of psychological well-being which, while similar to that of Positive Psychology, does differ and will therefore be discussed separately
- » Feeling Good – Voyages to Well-being (Cloninger): Cloninger's approach to well-being is derived from his well-researched theories on the substrates and development of temperament and character and the process of self-actualisation. Given that the research behind Cloninger's model of personality and character is extensive, this model will be mentioned briefly, though the evidence behind his model of well-being is less extensive at this point.

4.2.3 Positive Psychology

Positive Psychology has been described as ‘the science of positive subjective experience, individual traits and institutions that can improve quality of life and make life worth living’ (Seligman 2002). It is based in cognitive behavioural therapy and draws together numerous strands of research on happiness and subjective well-being into a common body of knowledge that is clinically useful.

Positive Psychology approaches well-being from an individualised, Western perspective. Subjective well-being is defined as a person’s internal evaluation of their life in terms of satisfaction with their life overall, as well as specific aspects of it, the experience of positive emotional states such as joy, and the relative absence of negative emotional states such as anxiety or depression (Diener et al. 1997). Online self-completed rating scales based on these concepts can be accessed at <http://www.authentichappiness.sas.upenn.edu/Default.aspx>

Happiness is closely aligned with subjective well-being, though subjective well-being includes negative states as well as positive states. Happiness appears to have a significant inherited component. People have been shown to have a set point or degree of happiness which they tend towards and maintain. This set point is affected by life circumstances, which are often beyond the direct control of individuals, and also by actions and activities that are under voluntary control. This can be expressed as follows:

Happiness (or subjective well-being) = set-point + life circumstances + volitional activity
(Lyubomirsky et al. 2005)

Seligman (Seligman 2002; Seligman et al. 2002) proposes that the positive aspects of subjective well-being, or happiness, can be broken down into three main areas or pathways, making research easier.

- » **Pleasurable experiences:** positive emotions about the past, present and future, including pleasurable hedonistic experiences. These tend to increase happiness and well-being temporarily, but often not in a sustained way.
- » **Engaging experiences:** these include involvement in positive work, leisure and relationship activities. Especially important are ‘flow’ experiences: challenging activities that require concentration and skill. Typical features of flow experiences are a degree of intensity where the sense of self and time are diminished. In other words, a person is absorbed in the activity to the point where they are less aware of themselves, and time passes quickly. Examples might include playing a game of squash, working hard at a challenging task, or being involved in an absorbing conversation. They may often be experienced as gratifying rather than pleasurable.
- » **Meaningful experiences:** these include activities that lend meaning to a person’s life. They often involve doing things for the benefit of others in a way that produces satisfaction. Examples might include religious activities and contributions to family and community.

Research suggests that a range of factors are associated with well-being, some more strongly than others. Peterson (2006) has classified these factors in terms of the strength of their association with subjective well-being (table 4.1). Moderate correlations in this table represent robust and significant correlations.

Table 4.1 » Positive correlations with happiness and life satisfaction

Zero to small	Moderate	Large
Age	Number of friends	Gratitude
Gender	Being married	Optimism
Education	Religiousness	Being employed
Social class	Level of leisure activity	Frequency of sexual intercourse
Income	Physical health	% time experiencing positive affect
Having children	Conscientiousness	Happiness of identical twins
Ethnicity (majority v minority)	Extraversion	Self-esteem
Intelligence	Neuroticism (negative correlation)	
Physical attractiveness	Internal locus of control	

Source: Peterson 2006, p. 92

The domains of subjective well-being include the following (Peterson 2006; Seligman 2002):

1. positive experiences (mentioned above)
2. positive thinking and optimism
3. character strengths
4. values
5. interests, abilities and accomplishments
6. positive relationships
7. enabling institutions.

Rating scales and interventions designed to enhance well-being therefore target these domains, and through public health and the development of resilience the ability to cope with negative life circumstances.

1. *Positive experiences*

As mentioned above, positive experiences include the following:

- » pleasurable experiences
- » engaging experiences
- » meaningful experiences.

There are a number of simple but useful self-rating scales – such as the Fordyce Happiness Questionnaire, the Authentic Happiness Inventory and the Meaning in Life Questionnaire – that can be completed online. They compare results against population norms available at the Authentic Happiness website (free to register): <http://www.authentichappiness.sas.upenn.edu/#>

As mentioned, pleasurable experiences are associated with temporary increases in well-being, while engaging/flow experiences and meaningful experiences are associated with more sustained improvements in well-being (Seligman 2002). Engaging experiences may be most effective when they involve the identification of key or signature character strengths and then becoming involved with activities that utilise these. Meaningful activities are often congruent with people's key values. Character strengths and values are discussed below.

2. Positive thinking and optimism

Optimism has been found to be associated with a range of positive outcomes. For example, higher levels of optimism in young adulthood are associated with increased levels of psychological and physical well-being 35 years later (Peterson et al. 1988). Seligman defines optimism as a personal style of explaining the causes of things that happen, in which a person sees setbacks as temporary, limited in extent and not necessarily being due to personal failings. They are therefore able to be overcome and not necessarily likely to recur. On the contrary, pessimists see setbacks as permanent in that such events are always likely to happen to them, pervasive in that they signal failings in many areas of their life, and being due to internal personal deficits rather than external circumstances (Seligman 1998). In other words, pessimists tend to catastrophise and generalise negative thoughts, explanations and expectancies while optimists 'catastrophise' and generalise positive ones. For the pessimist, failing at something small may seem like a disaster and mean they are poor at everything; for the optimist, succeeding will be tremendous and confirm they are good at many things.

Optimism may be learned and enhanced. Seligman (1998) has pioneered a cognitive behavioural approach to enhancing optimism using an ABCDE model:

- » A = adversity – note a negative event
- » B = belief – explore assumptions made about that event
- » C = consequences – note the emotional and behavioural responses to the belief
- » D = disputation – find evidence to challenge the belief
- » E = energisation – increased energy from successful disputation or challenge.

Of note, hope is an important component of optimism.

3. Character strengths

Peterson and Seligman (2004) describe six virtues and 24 character strengths that appear to be widely accepted and valued across many cultures, and have developed a self-rated 240-item questionnaire to rate respondents' strengths, the VIA Signature Strengths Questionnaire, a version of which may be completed on the Authentic Happiness website (free to register): <http://www.authentichappiness.sas.upenn.edu/#> Simply using identified strengths more frequently does not appear to enhance subjective well-being but using key strengths in new ways as described in the 'Using Strengths in New Ways' exercise (below) has been shown to lead to sustained improvements in subjective well-being.

Exercise » Using Strengths in New Ways

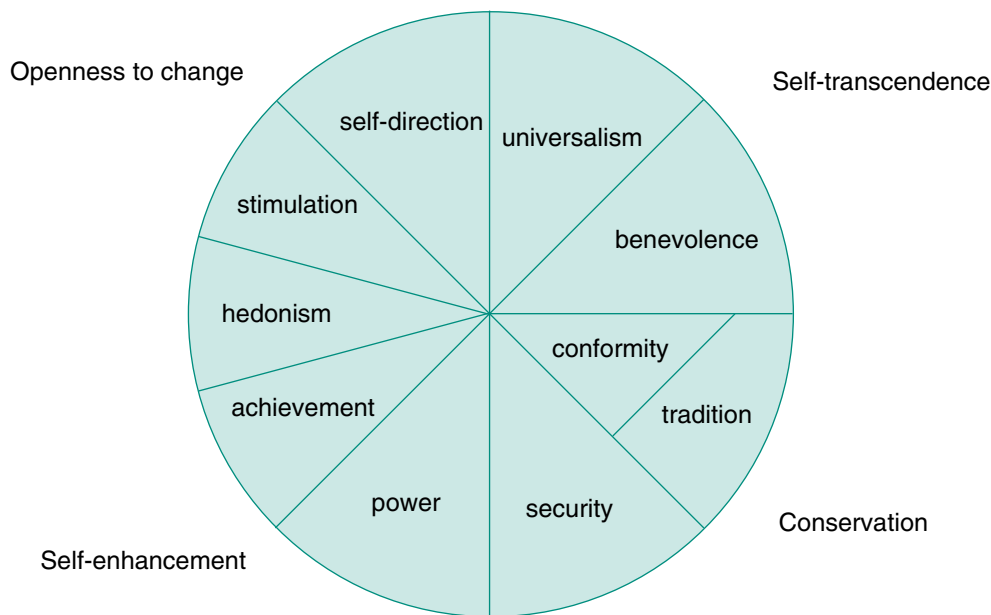
Identify your five highest strengths (VIA Signature Strengths Questionnaire). Use one of these in new way every day for one week. Significant increases in subjective well-being can be sustained for at least six weeks (Seligman and Steen 2005).

4. Values

Values can be thought of as beliefs shaped by social and cognitive mechanisms that guide a person's motivations and decisions. While there are distinct cultural differences in the prioritisation of values, there appear to be universal values common to most cultures which occur along the following dimensions: open to change versus conservation, and self-transcendence versus self-enhancement (Schwartz and Bardi 2001; Schwartz 2007; Schwartz and Boehnke

2004). Figure 4.1 outlines these values. If a person endorses a value they are more likely to endorse those near to it in the diagram (Peterson 2006).

Figure 4.1 » Schwartz's universal values



Source: Peterson 2006, p. 182

Values have been linked to well-being in three ways (Sagiv et al. 2004).

- a. Some values may be more associated with well-being than others. Intrinsic values appear to be associated with higher levels of well-being than extrinsic values. Intrinsic values can be thought of as those values based on self-evaluation that lead to independent satisfaction, such as autonomy, relatedness and competence. Extrinsic values can be thought of as those values that exist in relationship to others and are in part determined by the evaluation of others, such as financial success, attractiveness and popularity. (It should be noted, however, that well-being in collectivist cultures may be more determined by values that are extrinsic to the individual, as discussed above).
- b. The attainment of goals based on intrinsic values rather than extrinsic values is associated with higher levels of well-being. Reaching goals leads to enhanced well-being. Goals are more likely to be reached when they are based on a person's intrinsic values rather than extrinsic values.
- c. Congruence between personal values and those in the surrounding environment is associated with higher levels of well-being.

Congruence between a person's values and their behaviours is also an important aspect of well-being. In other words, acting in accordance with one's values is associated with higher levels of well-being.

With respect to interventions, there is evidence that reflection on one's values may be associated with reduced levels of stress, both emotionally and physically (Creswell et al. 2005), and therefore possibly with improved resilience and coping.

5. *Interests, abilities and accomplishments*

Activities that allow expression of a person's abilities and foster accomplishments may play an important role in enhancing well-being. There are two important themes.

- » Excelling in something is highly dependent on the context. It is therefore possible to encourage excellence by fostering an environment that supports this.
- » Plurality of talents – almost everyone has something they are both interested in and able at.

This includes the concept of multiple intelligences (Gardner 1983), in which people are proposed to have abilities or intelligences in a range of characteristics, including cognitive, emotional and social domains.

6. *Positive relationships*

Well-being is heightened by positive interpersonal acts such as:

- » expressions of gratitude
- » kindness
- » altruism
- » forgiveness and reconciliation.

There is also a strong relationship between the number of close relationships a person has and their level of well-being.

Positive relationships can be enhanced through a range of activities such as 'The Gratitude Visit' exercise described below.

Exercise » The Gratitude Visit

Within one week write and then deliver a letter of gratitude in person to someone who has been especially kind to you but had never been properly thanked. Significant improvements in happiness are possible, but the exercise probably needs to be repeated to be sustained (Seligman and Steen 2005).

7. *Enabling institutions*

'Institutions' in this context usually refer to socio-cultural constructs such as liberty, equal rights, and the whānau or family. Characteristics of institutions that enable well-being include (Peterson 2006):

- » a common purpose and a shared vision
- » safety
- » fairness
- » humanity – mutual care and concern
- » dignity – the treatment of all in the organisation as individuals.

It is also possible to consider institutions such as the health system and organisations such as the workplace from the perspective of how they enable tangata whaiora and health professionals to express the domains of well-being listed above. In other words, does the workplace encourage and model positive experiences, optimism, the expression of character strengths, well-being-

enhancing values, positive relationships and the undertaking of interesting and fulfilling activities? It is often a sobering experience to evaluate our own places of work in terms of how they enable the well-being of both staff and tangata whaiora.

Positive Psychotherapy

There are several 'packages' of intervention that involve some or all of the above. One such intervention, Positive Psychotherapy, has been developed by Seligman and colleagues and has been shown in a small study to be more effective than 'treatment as usual' psychotherapy and 'treatment as usual' plus antidepressant medication, in terms of symptomatic improvement, improvement in global functioning and rates of remission (Seligman et al. 2002).

Resilience in children and adolescents

Positive Psychology is also the basis of a programme to develop resilience in children and adolescents, the Penn Resiliency Programme <http://www.ppc.sas.upenn.edu/prpsum.htm> (Reivich and Shatte 2002). This programme has been extensively studied using randomised controlled trials and appears to confer long-lasting protection against symptoms of anxiety and depression, and also possibly against disruptive behaviours.

4.2.4 Psychological Well-being (Ryff) and Well-being Therapy (Fava)

Ryff (Ryff and Keyes 1995) has proposed a slightly different structure for what she calls 'personal well-being', arguing that it derives from the following dimensions:

- » self-acceptance
- » positive relations with others
- » autonomy
- » environmental mastery
- » purpose in life
- » personal growth.

Ryff's model has a less convincing evidence base than that of Seligman and Peterson but has led to interventions by Fava and colleagues that have proven effective in clinical settings.

Well-Being Therapy is based on Ryff's model of well-being and uses cognitive behavioural therapy (CBT) approaches applied to positive rather than negative mood states. As described by Fava and colleagues (Fava et al. 1998a; Fava and Ruini 2003) it involves:

- » eight 30–50-minute sessions
- » initial sessions focusing on the use of a mood diary to capture and explore the circumstances surrounding positive mood states
- » subsequent sessions identifying thoughts and beliefs associated with the interruption of states of positive well-being and the challenging of these automatic thoughts
- » final sessions educating about Ryff's dimensions of well-being.

Although research into the effectiveness of Well-Being Therapy is in its early stages, it has been shown to be more effective than CBT in improving the residual symptoms following treatment of depression (Fava et al. 1998b). It has also been shown when combined with CBT to be more effective in reducing rates of relapse in depression than CBT alone (Fava et al. 2004).

4.2.5 Feeling Good: Voyages to Well-being (Cloninger)

Cloninger (2006) proposes that well-being occurs with mature levels of self-awareness, which arise in step-wise fashion and correspond to stages of spiritual development. His theory is linked to his model of character and temperament and draws on spirituality and neurobiology, as well as areas of Positive Psychology, to explain well-being. A psychotherapeutic programme designed to develop self-awareness, drawing on a number of strategies (including some of those mentioned above), has been developed, but outcome studies have yet to be published and it does not appear to be in the public domain.

4.2.6 Clinical Applications for Tangata Whaiora with CEP

In practice, a well-being approach can have a potent impact on engagement and motivation as well as outcome, and can be integrated into standard care from the beginning. Most of the clinical work directly enhancing well-being will occur during the middle and late phases of treatment. It is useful to think of well-being as involving three main aspects.

1. **Helping to establish the goals of treatment:** Goals for treatment are often set early in the process and traditionally involve targeting specific problems that can be improved. A well-being approach would see these problems as barriers to well-being and set primary goals of developing a vision of what well-being might mean for tangata whaiora, setting aspects of this vision as the ultimate goals of treatment, and addressing problems and diagnoses as ways of removing barriers to the well-being goals.
2. **Enhancing engagement, motivation and integration:** This is achieved by taking an interest not just in the problems tangata whaiora face but also in their hopes and aspirations for the future. By linking treatment to the attainment of positive goals and outcomes, tangata whaiora are more likely to feel understood as people, and to therefore engage in treatment, and may be more easily motivated by the inclusion of positive states to be sought as well as negative states to be eradicated.
3. **Active treatment:** The aim is:
 - a. to improve recovery from problems such as depression
 - b. to build resilience
 - c. to enhance overall quality of life.

Specific cognitive approaches to well-being, such as Positive Psychology approaches and Fava's Well-Being Therapy, can be incorporated into case management, CBT for mental health problems and general counselling. This can occur anywhere in mid or late treatment, can be undertaken directly by the case manager or another health professional, and can also be partly self-directed by those able to use and access websites such as the Authentic Happiness website mentioned above.

Hope and optimism may also be enhanced by strategies such as deliberately planning early management tasks in a stepped way that allows quick but meaningful success.

Key Points

- » Well-being approaches to health involve the enhancement of positive attributes, not just the alleviation of dysfunction.
- » Well-being has much in common with recovery and strengths approaches but is not defined in terms of a response to dysfunction.
- » Well-being is a valid health outcome in its own right.
 - » Well-being approaches may enhance recovery and reduce relapse from problems such as major depression.
 - » A well-being perspective is an important strategy for enhancing engagement and motivation: the carrot as well as the stick.
 - » Thinking of the well-being of tangata whaiora as the ultimate reason for health care, and of disorder and dysfunction as barriers to well-being, places tangata whaiora at the centre of care and helps integrate care.
- » There are a number of underlying beliefs about well-being that restrict its use in many mainstream health settings. Two particular myths need to be highlighted.
 - » Myth 1: Illness and wellbeing are mutually exclusive.
 - » Myth 2: If illness or dysfunction is alleviated wellbeing will naturally emerge.
- » There are important cultural differences in well-being. Western approaches focus on individual subjective well-being, where self-confidence and competence are paramount, while many other cultures place a higher priority on group membership and functioning.
- » The science of well-being involves approaches that are drawn from evidence-based domains and apply research-based interventions. These include:
 - » Positive Psychology
 - » Personal Well-being and Well-Being Therapy (Ryff, Fava)
 - » Feeling Good – Voyages to Well-being (Cloninger).
- » Domains of Positive Psychology include:
 - » positive experiences
 - » positive thinking and optimism
 - » character strengths
 - » values
 - » interests, abilities and accomplishments
 - » positive relationships
 - » enabling institutions.

4.2.7 Further Reading

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4.3 Principle 3 » Engagement

Failure to engage with treatment is a major factor in the poor outcomes often experienced by people with CEP and arguably has more impact on outcome than the specific interventions used. Although much of the research literature has focused on improving outcome through the use of various treatment strategies, much less has examined the improvements that can occur through improving engagement. Note that in many treatment studies of interventions for CEP, more people failed to engage than did poorly with the interventions tested. Further, in mental health settings 40–60% of tangata whaiora are non-adherent with medication, and the presence of substance misuse is a major factor in this (Patel and David 2007).

Integrated treatment approaches for tangata whaiora with CEP have included an emphasis on the need to foster engagement early in treatment. The engagement-persuasion model (Osher and Kofoed 1989) of the stages of treatment was one of the first to explicitly focus on initial engagement in people with CEP. The core task in the engagement phased is to develop a working therapeutic relationship with the patient and to engage the patient in treatment. This may be a slow and prolonged task but is essential and cannot be circumvented.

As the name of the model suggests, engagement in treatment is the first phase of treatment. In other words, tangata whaiora must be convinced that the health professional and treatment agency have something desirable to offer them. Enticements to engagement include:

- » helping the patient avoid legal penalties
- » obtaining food or accommodation
- » maximising benefit entitlements and budgeting advice
- » socialisation and recreation
- » relief from distressing symptoms.

Engagement can also be aided by:

- » assertive outreach
- » liaison with whānau or family members
- » coercion (Mental Health Act, criminal justice order, court direction).

Key developments since Osher and Kofoed's model include the MI-based engagement intervention (Zuckoff 2007; Zuckoff et al. 2007), Simpson and Joe's model of addiction engagement and treatment process (Simpson and Joe 2004), and developments in the understanding and management of treatment compliance within the mental health field. which are outlined below. There have been few studies specifically looking at the mechanisms of, or interventions for, engagement in tangata whaiora with CEP.

4.3.1 The Nature of Engagement

The term 'engagement' is used in a variety of ways within health care systems. Much of the focus in the CEP literature has been on initial or early engagement occurring within the first few sessions of treatment, but engagement influences outcome throughout the course of treatment. Thus the concept needs to be considered throughout the course of treatment and to encompass initial engagement, compliance or adherence throughout the middle and later phases of treatment, and retention in treatment over the longer term.

Engagement can best be thought of as the degree to which tangata whaiora actively participate in treatment throughout its course, and has three key components (Cunningham et al. 2009):

- » motivation and readiness to change
- » quality of the relationship with key health professionals
- » behaviour in treatment – participation, collaboration and effort.

In its broader therapeutic context, engagement also encompasses several different relationships:

- » relationship with the key health professional
- » relationship with the service
- » relationship with the assessment, goals of treatment and management plan.

Engagement is therefore a complex phenomenon and is influenced by a wide range of determinants.

4.3.2 Determinants of and Factors that Enhance Engagement

A number of factors have been found to determine engagement with treatment and have therefore been the targets of attempts to improve engagement. However, most of the variation in engagement and the quality of the therapeutic relationship remains unexplained. There have been few comprehensive models of engagement in treatment produced for tangata whaiora with substance use or mental health problems, let alone CEP. Within the addiction field, Simpson, Joe and colleagues have produced the TCU (Texas Christian University) Treatment Model (Simpson 2004; Simpson 2002). This model of the treatment process for addiction has a heavy emphasis on evidence-based processes of engagement and retention, has been tested empirically and provides a useful base from which to consider the mechanisms of engagement.

Simpson and colleagues' model of treatment engagement and process from the TCU Treatment Model

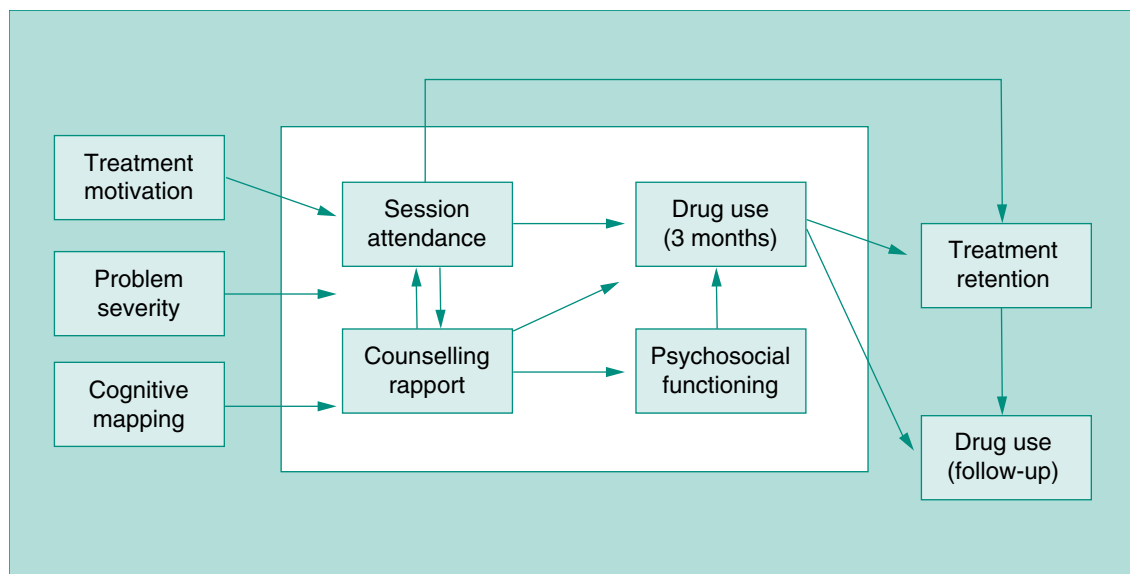
The model (see figure 4.2) captures key evidence-based components of treatment engagement and recovery and the relationships between them as part of an overall model of treatment process. Each component has been shown to affect engagement and recovery (Simpson and Joe 2004) in both community and residential addiction settings, mainly with tangata whaiora experiencing opioid or cocaine dependence.

Each of the arrows shown in figure 4.2 represents statistically significant impacts of one factor on another through different phases of treatment. Early engagement involves session attendance and the development of rapport with the counsellor (measured at two months after treatment entry), which is affected by treatment motivation and readiness for treatment, problem severity at intake and cognitive mapping strategies. Early recovery involves changes to drug use and psychosocial functioning. All these factors affect retention later in treatment which, along with earlier changes in drug use, affect drug use outcomes at follow-up 12 months after treatment entry. The relationship between session attendance and treatment retention, and drug use at three months and drug use at 12-month follow-up, were both very strong, while all the other relationships were moderately strong.

In this model, cognitive mapping strategies were used prior to treatment intake to enhance engagement. These strategies involve the use of pictorial elements such as flow charts, which are similar to genograms or mind maps and have been shown to be effective in enhancing communication with tangata whaiora and engagement in treatment (Dansereau et al. 2002; Dansereau et al. 1993).

With respect to the phases of treatment, pre-intake factors of treatment motivation, problem severity and cognitive mapping can be equated to the pre-treatment phase in this framework, early engagement to the early treatment phase, early recovery to the middle treatment phase, and retention to the late treatment phase.

Figure 4.2 » Simpson and colleagues' model of treatment engagement and process



Source: Simpson and Joe 2004

The factors in the pre-treatment and early treatment phases all measure in part engagement in treatment, as does retention. Drug use at three months and psychosocial functioning are outcomes rather than processes that may be related to engagement, though stopping drug use by three months does appear to affect retention. Simpson and colleagues have subsequently included a number of other treatment processes in terms of their impact on recovery or outcome, some of which also affect engagement. There is also increasing evidence to support other factors affecting engagement. Thus this model may be usefully adapted as a model of engagement alone (below).

Pre-treatment factors

- » **Motivation to change and readiness for treatment:** Motivation and readiness are widely recognised as important predictors of initial engagement (Simoneau and Bergeron 2003) and for retention throughout treatment. (This is discussed in more detail in section 4.4 on motivation.) However, it should be noted here that interventions such as motivational interviewing (MI), which are designed to increase motivation and thereby reduce substance use, may in fact be more effective with respect to engagement. In addition, the transformation of motivation from more external or extrinsic forms to more internalised forms may be a crucial aspect of engagement and motivation throughout the course of treatment.
- » **Cognitive mapping:** As discussed, Simpson and colleagues have demonstrated the effectiveness of cognitive mapping strategies prior to programme intake for enhancing early engagement (Simpson and Joe 2004).

- » **Problem nature and severity:** Similarly, severity of substance use or mental health problems such as depression may have an impact on engagement (Joe et al. 1999; Simpson and Joe 2004). The presence of anxious avoidance and intrusive memories and thoughts related to a history of trauma, social phobia and post-traumatic stress disorder may also undermine engagement (Conrod and Stewart 2005).
- » **Peer support:** Several models of peer support exist, ranging from peer-led interventions to the use of skilled peer support workers to facilitate engagement with treatment services. The available evidence does not indicate that peer support offers much over standard care in terms of treatment outcome (Davidson et al. 2006), but it may be very useful early in treatment for engaging tangata whaiora in treatment, especially for those who have previously been difficult to engage (Sells et al. 2006).
- » **Legal pressure and coercion:** Legal pressure and court-mandated treatment have been associated with increased early engagement in treatment (Joe et al. 1999), especially for those more mindful of the consequences of not complying (Young and Belenko 2002). It should be noted, however, that coercion may reduce any intrinsic motivation for change that is already present and is therefore likely to be most effective with those tangata whaiora who have low levels of intrinsic motivation. It is also likely that to be successful in the longer term, any coercion needs to be followed by strategies that enhance the transformation of extrinsic into more intrinsic forms of motivation (see section on motivation).

Attendance and treatment

Simpson and colleagues' model names programme attendance as a key factor in reduced drug use and retention in treatment. They acknowledge that attendance, while an independent predictor of engagement, may well represent factors associated with treatment effects rather than simply attendance in itself. Thus attendance tends to be a 'black box', which captures a range of factors, from the effects of simply attending treatment to the impact of various specific interventions. It may also be a marker of motivation and engagement as much as a contributor (Simpson and Joe 2004).

There are both specific and generic treatment factors that should be considered (many of these are discussed in section 4.6 on management). Two generic interventions that hold significant promise and have been shown to enhance motivation are mindfulness or mentalisation (see section 4.4 on motivation) strategies and flow activities (see section 4.4 on motivation and section 4.2 on well-being).

Of interest is the gaining of competence and skills in dealing with substance use and mental health problems, and the effect of competence on motivation. High levels of competence and motivation are often necessary to engage in and complete treatment, but there is evidence that they may oppose each other: progressing towards treatment goals increases competence, but at the same time the increased competence reduces motivation (Simoneau and Bergeron 2003).

Therapeutic relationship

The therapeutic relationship can be thought of as comprising a number of components, the most important of which is the therapeutic alliance (the bond dedicated to therapeutic work that forms between health professional and tangata whaiora). The quality of the therapeutic relationship (or counselling rapport, in Simpson and colleagues' model) has been consistently found to predict not only engagement and retention in treatment and compliance with medication (Meier et al. 2005; Strauss and Johnson 2006), but also a range of other outcomes such as manic symptoms in bipolar disorder (Strauss and Johnson 2006a), treatment outcome for alcohol use disorders

(Connors et al. 1997) and a range of other mental health problems including psychosis (Martin et al. 2000). A strong therapeutic relationship may be most effective in tangata whaiora with low self-efficacy (Ilgen et al. 2006). These findings appear consistent across a wide range of treatment types (Lingiardi et al. 2005). The impact of the therapeutic relationship and treatment alliance, especially in the first few sessions, is one of the strongest predictors of both retention and outcome (Meier et al. 2005) and accounts for approximately 25% of the variance in outcome (Crits-Christoph and Gallop 2006).

Health professional factors are probably more important than tangata whaiora factors in the therapeutic relationship (Baldwin et al. 2007), though the evidence is conflicting. Regardless, health professional factors play an important part in the therapeutic relationship. As such, if engagement is problematic, the health professional should look initially at their own feelings and actions rather than labelling tangata whaiora resistant (Baldwin et al. 2007). Thus health professionals need to be particularly aware of their own feelings towards tangata whaiora in such circumstances (Crits-Christoph and Gallop 2006).

A wide range of factors have been shown to influence the development of the therapeutic relationship, and within this the treatment alliance. These have been reviewed by Ackerman and Hilsenroth (Ackerman and Hilsenroth 2003) and include the following.

- » **The health professional's personal attributes:** The ability of the health professional to convey a sense of being trustworthy, interested, warm, confident and experienced, and to display empathy, appears to be crucial in the establishment of a therapeutic relationship. In addition, the ability to express oneself clearly, and to have a confident and dominant interactive style and an accurate understanding of the problems faced by tangata whaiora, are also important. There is controversy about whether training and experience affect the therapeutic relationship. Overall they do appear to, but are perhaps less important than the interpersonal skills of the health professional.
- » **The health professional's technique:** Taking a collaborative approach, and the use of strategies to actively explore the problems of tangata whaiora, especially in relation to key presenting symptoms and the key relationship themes and conflicts experienced by tangata whaiora, are associated with a better therapeutic relationship. Accurate reflection and interpretation of the experiences of tangata whaiora has also been shown to have a positive impact on the therapeutic relationship (Ilgen et al. 2006; Ackerman and Hilsenroth 2003).
- » **Tangata whaiora factors:** Motivation for treatment, symptom severity and attendance are the key tangata whaiora factors that predict a strong therapeutic relationship (Broome et al. 1999), along with the characteristics of their interpersonal interactions and attachment styles (Ross et al. 2008). Probably linked with motivation, confidence that treatment will be effective also has a significant impact (Kolden et al. 1997).

With respect to symptom severity, severity of substance use appears to be associated with a poor therapeutic relationship, while severity of depression may be associated with a stronger therapeutic relationship (Joe et al. 1998). High levels of hostility is a significant factor impairing treatment readiness and engagement, and a significant predictor of treatment drop-out (Knight 2005; Knight et al. 2006; Howells and Day 2006), especially in offenders and those with personality disorder, but also in others. Similarly, high levels of anxiety and emotional dysregulation are major barriers to the development of an effective therapeutic relationship.

Demographic characteristics such as age and gender have not consistently been shown to have a significant impact on the therapeutic relationship. Ethnicity may be important, with some studies showing increased drop-out for those of ethnic minorities with a strong sense of cultural identity who are not matched to health professionals of a similar ethnicity. Similarities of personality and cognitive style between tangata whaiora and health professional are

associated with improved engagement and retention, except for those with submissive personality styles, who seem to do better with more dominant health professionals. Having similar values appears less important, in part because dissimilar values tend to converge over the course of treatment (Beutler et al. 1997). The ability to delay gratification and being higher in occupational functioning have also been associated with a better therapeutic relationship (Kolden et al. 1997).

- » **Therapeutic rupture:** ‘Therapeutic rupture’ refers to a breakdown in the therapeutic relationship. It is common for therapeutic relationships to fluctuate in their strength and effectiveness, and there is evidence that therapeutic ruptures that are repaired effectively may be associated with better treatment outcomes than stable, strong therapeutic relationships where rupture is not experienced (Strauss et al. 2006). It is essential, therefore, that health professionals be aware of the signs of therapeutic rupture, which include withdrawal and avoidance tactics, confrontation and disagreement between tangata whaiora and the health professional regarding goals of treatment, and anger or hostility towards the health professional (Castonguay and Constantino 2004). In such circumstances, the health professional should discuss these issues directly and concentrate on displaying the same attributes that are mentioned above with respect to the development of a good therapeutic relationship.

Retention – middle to late engagement

Retention captures engagement during the middle and later phases of treatment and includes issues such as medication compliance. Early engagement is a major predictor of engagement later in treatment, and most of the factors associated with the initial phases of engagement, especially the therapeutic relationship, appear to influence retention throughout treatment (Joe et al. 1998). Very few client predictors of retention have been identified, and those that have (such as optimism and confidence in the effectiveness of treatment, the absence of aggressive personality characteristics and the ability to delay gratification) are well known (Kolden et al. 1997). As with early engagement, mandated or court-directed treatment can enhance retention in treatment programmes for offenders, especially for those who are more aware of the consequences if they drop out of treatment (Young and Belenko 2002). Matching offenders to programmes that address their particular needs, especially in terms of substance misuse, antisocial personality style, anger control problems and sexual offending, has also been shown to reduce treatment drop-out (Howells and Day 2006).

Retention and engagement in the middle to late stages of treatment also involve the issue of compliance with medication. Perhaps 50% of tangata whaiora do not take their medication as prescribed. Factors associated with non-compliance with medication and appointments include:

- » younger age, male gender and lower socio-economic status
- » loss of autonomy
- » lack of information
- » lack of involvement in the decision process
- » beliefs about illness
- » cognitive impairment
- » complexity of the medication regime
- » attitudes to medication
- » side-effects

- » stigma of taking medication
- » cost
- » poor therapeutic relationship
- » symptoms of illness (depression, grandiosity, paranoia) and lack of insight
- » lack of psychosocial treatment options and an excessive focus on medication (Mitchell and Selmes 2007; Patel and David 2007; Kreyenbuhl et al. 2009).

Of these factors, the quality of the therapeutic relationship is one of the most important. A strong relationship helps overcome many of these reasons for non-compliance, especially those relating to the loss of autonomy and the sense of pressure tangata whaiora may feel with the more assertive case management and follow-up approaches (Stanhope et al. 2009).

External factors

Factors normally considered outside the immediate treatment environment may have a powerful influence over engagement. As discussed in section 4.4 on motivation, an autonomy-supportive environment is likely to enhance motivation and especially the transition from extrinsic to more intrinsic types of motivation, which are associated with improved engagement.

- » **Programme variables:** The nature of the service within which treatment is delivered has an important effect on engagement. For a start, services vary in the degree to which they enable well-being and support autonomy. Service policies around contingencies for performance may range from tolerant to punitive. While a balance must be found between tolerance and safety, the more restrictive programmes are likely to struggle to maintain motivation and enhance well-being beyond the specific substance and mental-health related goals. Higher rates of agreement between staff on treatment goals and approaches have been shown to be associated with higher rates of engagement, as have high levels of agreement between the staff and tangata whaiora on treatment goals and the approaches to meet these (Melnick et al. 2006). Finally, programmes with more social and public health services incorporated improve engagement (Broome et al. 1999), especially if they specialise in treating specific disorders such as personality disorders (Crawford et al. 2009).
- » **Community engagement and flow activities:** The influence of community engagement in influencing treatment engagement is an under-studied area. It is mentioned here because of the strong anecdotal support from tangata whaiora, and because it is an important part of the process of recovery and enhancement of well-being, usually in the later stages. In short, when tangata whaiora actively engage with the wider community and come to feel a valuable part of it, they are likely to become much more engaged in the process of healing. One strategy that is likely to be highly effective is the undertaking of activities that create flow experiences (mentioned in other sections on motivation and well-being), both within a particular treatment programme and out in the wider community.
- » **Family:** Although family relationships are often damaged by the presence of substance use and mental illness, the characteristic pattern for those with substance abuse is for them to remain closely tied to their families, and they are more enmeshed with them than tangata whaiora with serious mental illnesses such as schizophrenia, and also those without mental health or substance use problems. How enmeshed those with CEP are is unclear, but the message is that health professionals should not assume disconnection. Where close ties to the family remain, the family, along with peers, may be potent factors in helping the engagement process (Stanton 1997).
- » **Peers:** This is discussed above under pre-treatment factors.
- » **Justice system:** This is discussed above under pre-treatment factors.

Subgroups

The evidence on engagement in specific subgroups is limited. Tangata whaiora with CEP show poorer adherence to substance abuse treatment and compliance with mental health treatment and may need a longer duration of care to make the same gains as those without CEP (De Marce et al. 2008). Coercion is often used, especially for those with limited insight or with personality disorders: this may increase attendance but may also undermine the relationship with key health professionals and the service for those with CEP (Stanhope et al. 2009).

As with adults, adolescents with greater readiness and willingness to enter treatment to address substance use problems, and who had greater involvement with deviant family and friends, have better engagement, suggesting that a desire to improve deviant networks is an important goal for young people (Broome et al. 2001). Retention in residential programmes by adolescents on probation has been associated with higher motivation at intake, lower substance use severity, having peers at low risk for substance use, and actively being involved in a religion (Barrett et al. 1988; Orlando et al. 2003). Many of these factors appear similar to those for adults, but each is affected by developmental issues. Adolescents may be more prone to assert their independence and need for autonomy, their cognitive development differs (such that while they may be able to appreciate the pros and cons of a decision they are likely to weigh the outcomes with less emphasis on consequences), and they may be less willing to accept their problems being defined as health issues (Bolton Oetzel and Scherer 2003).

Tangata whaiora with personality disorders may be more difficult to engage in treatment, especially those with cluster A disorders who have great difficulty forming a therapeutic relationship. Those with cluster B personality disorders other than antisocial personality disorder may form effective therapeutic relationships, but health professionals tend to rate them more negatively than they do those with other personality disorders (Lingiardi et al. 2005). Treatment within specialist personality disorder services can enhance engagement, though most of these services tend not to work with antisocial personality disorder (Crawford et al. 2009). Specific interventions such as Dialectical Behaviour Therapy for borderline personality disorder (Lynch et al. 2007) and Dual Focus Schema Therapy for antisocial personality disorder have consistently shown to be superior to treatment as usual for engagement and retention in treatment (Ball 2007).

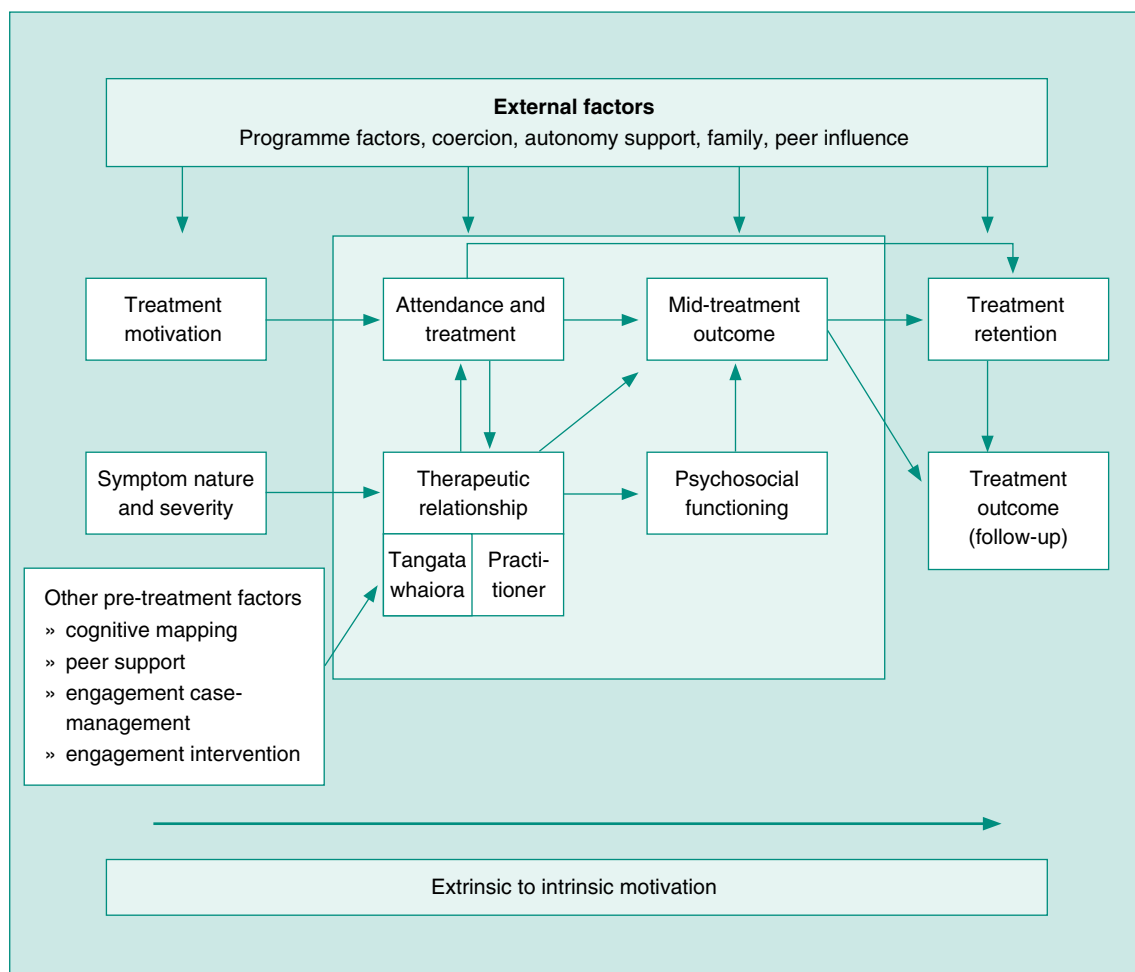
Those with antisocial personality disorder tend to receive treatment in correctional settings or in opioid substitution programmes, and the literature relating to offenders is probably relevant to all with antisocial traits and disorders. Opioid-dependent patients with antisocial personality disorder appear to do just as well as those without antisocial personality disorder when provided with individual psychotherapy, contingency management techniques and higher intensity psychosocial treatments. Dual Focus Schema Therapy has been developed with some success by Ball and colleagues to address both substance use and the dysfunctional interpersonal patterns of a full range of personality disorder, including antisocial behaviour (Ball 2007). Perceived levels of coercion are associated with significantly increased retention in those offered court-mandated treatment instead of prison (Young and Belenko 2002). Finally, high levels of hostility and anger are powerful factors that undermine the development of the therapeutic relationship and engagement in general, especially for those unable to access and recognise hostile emotional states and unwilling to discuss them with others. Even for those motivated to change their hostile behaviours, the inability to recognise these states impairs progress in treatment (Howells and Day 2006).

4.3.3 Revised Model of Engagement

As noted, the model of Simpson and colleagues (above) actually a model of the therapeutic process rather than engagement alone. Simpson and colleagues model can therefore be revised by the incorporation of these additional determinants and by retaining a focus on

engagement rather than treatment process. In revising the model, the strength of associations in the original model cannot be assumed and further research is required to validate the revised model. It is designed as a clinical tool to help health professionals think about key factors influencing engagement and to predict strategies to enhance engagement. Also, a number of the determinants of engagement, such as strategies that empower tangata whaiora within treatment, are well known to health professionals, though they may not always be applied. It is important that such factors are not only known about but are put into practice. The point of such a model is therefore not simply to inform health professionals about what is good practice, but to encourage health professionals to actually follow it. Finally, the intent of a strategy is important in terms of the way it is put into practice. Empowering tangata whaiora is often done because it is seen as the right thing to do. It should also be done because it enhances engagement, and it should be done in a way and at a time in the treatment process that it actually does enhance engagement.

Figure 4.3 » Revised model of treatment engagement



4.3.4 Strategies for Influencing Engagement

A wide range of strategies have been shown to be effective in enhancing engagement in either substance use treatment settings or mental health settings, but only a few have specifically researched strategies applied to tangata whaiora with CEP. Many of the studies that have investigated engagement in these populations included subjects with co-existing problems, however, and in light of the importance of engagement in CEP it is reasonable to make suggestions based on the evidence that does exist.

Several areas are particularly important throughout treatment, including:

- » enhancement of engagement and possibly motivation through MI
- » the therapeutic relationship
- » transfer of motivation and regulation to more internal types.

Where pre-treatment ends and early treatment starts is an arbitrary judgement. Optimally, the first contact with services would be the starting point of treatment, involving the health professionals who will be involved in ongoing treatment, and would therefore be considered part of the early treatment phase. However, some services use separate teams or health professionals for triage or screening purposes before passing tangata whaiora over to the service or team that will be involved in treatment itself. In such cases, these triage or screening health professionals may be considered part of the pre-treatment phase. It is important that these teams or health professionals act to enhance engagement rather than purely as gate keepers that limit entry to services.

Pre-treatment

External strategies

External strategies often have an impact throughout the course of treatment but many need to be in place before tangata whaiora contact the service. They include:

- » ensuring the availability of ethnically and culturally appropriate processes as far as possible (see section 4.1 on cultural considerations)
- » awareness by service leaders of how the service may enable well-being (see section 4.2 on well-being) and support autonomy (see section 4.4 on motivation) for both tangata whaiora and staff
- » ensuring high rates of agreement between staff on treatment goals and approaches, and between staff and tangata whaiora, particularly around interactions incorporating the spirit of MI and autonomy-supportive strategies (Melnick et al. 2006)
- » service policies regarding contingencies and the consequences of good performance, which allow some choice and support autonomy as far as practical, thereby encouraging the transition from external to internal types of motivation over the course of treatment
- » coercion or assertive persuasion, including court-mandated treatment, the use of the Mental Health Act, assertive community treatment approaches, and family and peer pressure, which may be used to help those with low levels of internal motivation enter treatment but should be discouraged or used sparingly in those already showing more internalised types of motivation (Stanhope et al. 2009) (this includes supporting family and whānau to make their wishes and expectations for tangata whaiora clear, but in a manner that is autonomy-supportive)
- » minimising the time between referral and the first appointment with tangata whaiora, and therefore waiting times
- » minimising discontinuities of care, especially in terms of changes of setting and the health professionals involved
- » ensuring a welcoming environment for tangata whaiora by providing:
 - » a welcoming environment that enables participation from tangata whaiora
 - » warm, reassuring and approachable reception staff
 - » a pleasant décor

- » tea and coffee and food, where appropriate
- » posters indicating your orientation towards tangata whaiora and recognition of non-dominant cultures.

Where close ties to the family remain, the family, along with peers, may be potent factors in helping the engagement process (Stanton 1997).

Treatment motivation

In most cases, enhancing motivation occurs during the early treatment phase. However, when services use stand-alone triage or screening teams that see tangata whaiora prior to referral for treatment, or when there is a specific pre-treatment induction process, there is an opportunity to enhance motivation for treatment. Strategies include:

- » assessing readiness for treatment using tools such as the TCU Motivation Scale (Simpson and Joe 1993)
- » using the ‘senior professor’ role – the use of the most experienced and senior staff member to undertake induction or orientation, which has been associated with a significant increase in engagement (De Leon 2000)
- » using interview strategies consistent with the spirit of MI that demonstrate empathy and enhance autonomy
- » using the Engagement Intervention (Zuckoff et al. 2007) (outlined in section 4.3.5 below), which incorporates these strategies and others into a specific single session shown to significantly increase engagement rates in non-psychotic CEP.

Symptom nature and severity

Although issues such as substance use and mental health severity, mood, hostility and anxiety are pre-treatment factors that have an impact on engagement, addressing these would usually be considered part of the treatment process and will be discussed under that phase of treatment, although they may be addressed as part of pre-treatment or induction strategies.

Other pre-treatment strategies

Other strategies include:

- » cognitive mapping – as mentioned above, using cognitive mapping techniques to visually enhance understanding of the need for treatment
- » peer support – particularly focusing on supporting engagement with treatment
- » early identification of those likely to drop out of treatment through assessment of motivation to change and readiness for treatment (De Leon 2001), and other factors associated with poor early engagement noted above.

Early treatment

Strategies to enhance early treatment focus on specific treatment, the therapeutic relationship and external factors. It is useful to separate these when thinking of strategies to enhance engagement, even though doing so is arbitrary in that the therapeutic relationship, for example, plays a key role in engagement and the process of treatment but also contributes to change towards specific treatment goals. Similarly, specific treatments such as medication designed to

target specific treatment goals and outcomes may also enhance engagement and the therapeutic relationship.

External strategies

These should be aimed at:

- » ensuring the external strategies for service provision described in 'Pre-treatment Strategies' (above) are maintained throughout treatment
- » involving families and appropriate peer groups using Community Reinforcement and Family Therapy (CRAFT) approaches (Bellack 2007; Miller, et al. 1999), though care should be taken not to engage tangata whaiora with flow activities in the community (see section 4.2 on well-being).

Motivation

Engagement needs to be actively supported, especially early in treatment, through enhancement of motivation to change. Strategies to achieve this include:

- » MI – specific motivational interviewing sessions aimed at enhancing motivation and readiness for change
- » health professionals working consistently within the spirit of MI, which involves:
 - » collaboration – the health professional takes a supportive rather than a persuasive stance
 - » evocation – the source of change lies within tangata whaiora and the role of the health professional is to draw it out
 - » autonomy – the responsibility for change is left with tangata whaiora, rather than the health professional directing it
- » supporting the transfer of motivation from external to more internal types through the provision of an autonomy-supportive environment, competence at dealing with substance use and mental health issues, and the development of supportive relationships.

Specific treatments

These can be thought of as strategies to directly lead to change in tangata whaiora. They will include the main treatments targeting the key goals and outcomes identified in the assessment and formulation, but also specific treatments that can target factors that directly enhance the therapeutic relationship. Following are some guidelines.

- » Use culturally appropriate processes and offer opportunities for the development of cultural identity and connection.
- » Reduce the intensity of key presenting symptoms, especially those that impeded engagement early in treatment. These may include:
 - » hostility and anger
 - » depression
 - » anxiety
 - » emotional dysregulation
 - » anxious avoidance and intrusive memories in those with histories of trauma, social phobia and post-traumatic stress.

- » Adapt interventions to take into account the impact of cognitive impairment.
- » Provide assistance with addressing basic needs such as housing, which enhances engagement and retention (Padgett et al. 2008).
- » Ensure programme rules are not excessively strict, such that motivation and engagement are undermined.
- » Strive for effective understanding of patients' problems (i.e. competence in assessment, formulation of problems and strengths, and negotiating a shared understanding with tangata whaiora).
- » Demonstrate the effectiveness of treatment early through assistance with social issues such as housing, finances, families, child care and transport to appointments.
- » Take a well-being perspective towards the goals of treatment.
- » Use physical health problems as motivators for change (O'Toole et al. 2006).
- » Explore attitudes and thoughts relating to past treatment experiences.
- » Increase hope through staging early treatment goals and tasks to encourage successful experiences and self-directedness.
- » Use specific strategies to enhance optimism (see section 4.2 on well-being).
- » Use specific strategies to improve session attendance, including:
 - » using multiple evidence-based interventions
 - » scheduling the session to occur as soon as possible after first contact (within a week, if possible)
 - » phone and letter reminders of appointments, especially if they review or mention the tangata whaiora's expectations of the coming session and explain what will happen, and are made two to three days prior to the appointment
 - » addressing presenting problems (directly discuss and problem-solve obstacles to attendance)
 - » obtaining verbal commitment from tangata whaiora to attend
 - » home-based visits
 - » contracts that require commitment to a certain number of sessions
 - » orientation pamphlets or CD-based information
 - » an emphasis on the strengths of tangata whaiora in sessions
 - » rewards such as food coupons, transport costs, food and drink

(Lefforge et al. 2007).

Therapeutic relationship

Following are some guidelines for managing the therapeutic relationship.

- » Therapeutic relationship skills are trainable. Given its importance, specific training is important to enhance skills in the development, maintenance and repair of the therapeutic relationship (De Leon 2001).
- » A significant part of the health professional's supervision should directly focus on issues relating to the therapeutic relationship with tangata whaiora.
- » Self-monitor your own processes and attend to counter-transference issues.

- » Be consistent with the spirit of MI (see above) to develop and maintain the therapeutic relationship.
- » Obtain direct feedback from tangata whaiora on their progress in treatment, the quality of the therapeutic alliance, their type and level of motivation and the quality of their social supports. Specifically work to enhance these areas in tangata whaiora deemed not be making good progress (Whipple et al. 2003).
- » The *Working Alliance Instrument* is available in long (25-question) and short (12-question: WAI-12) versions https://www.niatx.net/PDF/PIPractice/FormsTemplates/Working_Alliance_Surveys.pdf and contains both health professional and tangata whaiora self-reports on the treatment alliance. Tangata whaiora reports are predictive of the therapeutic alliance and treatment outcome, and are a simple and useful way of monitoring this (Summers and Barber 2003).
- » Attend to high levels of hostility and anger in tangata whaiora early in treatment. These are major factors that undermine the development of the therapeutic relationship (Howells and Day 2006).
- » Be clear about boundaries with tangata whaiora with cluster B personality traits.
- » Anticipate a reluctance to engage, especially in tangata whaiora with cluster A personality traits.
- » Minimise confrontation of tangata whaiora with cluster C personality traits.
- » Undertake specific training to improve skills for developing and maintaining the therapeutic relationship and for dealing with therapeutic rupture.
- » Develop an accurate case conceptualisation or formulation as a means of enhancing engagement: developing an accurate and truly comprehensive assessment and formulation supports the development of the therapeutic relationship.
- » Provide education on the rationale and benefits of treatment (Liese and Beck 1997).
- » Be aware of the likelihood that tangata whaiora have experienced multiple broken or ruptured relationships in the past, including with past therapists, and that this is likely to affect the therapeutic relationship.
- » Focus on developing conditions of psychological safety for tangata whaiora.

Engagement and Psychological Safety – Alan Zuckoff (Zuckoff 2007)

Zuckoff and colleagues propose that the key to initial engagement is the establishment of psychological safety within the therapeutic relationship. They make the following points.

- » The client is influenced by ambivalence and shame about the problems they are seeking help for, by negative past treatment experiences, and by an ambivalent view of the therapist as both dangerously powerful and potentially helpful. This often makes treatment feel unsafe for tangata whaiora. The view of the therapist as both dangerous and safe needs to be tolerated until the view of the health professional as safe predominates.
- » Psychological safety is established gradually. Tangata whaiora will test the safety of the developing therapeutic relationship by slowly revealing increasingly important personal information and reacting to the health professional's responses.
- » The health professional contributes to this process by:
 - » consistently inviting tangata whaiora to talk about themselves openly
 - » expressing empathy through non-judgemental and accurate reflection and summarising

- » emphasising that the tangata whaiora is in control of what is discussed, especially when anxiety (resistance) arises
- » maintaining an affirming approach to the tangata whaiora, especially when the tangata whaiora is expressing a more critical view of themselves.
- » The client initially focuses on safety rather than their own problems by emphasising 'good' behaviours and justifying 'bad' behaviours. They test the safety of the therapeutic relationship and gradually reveal increasingly risky information.
- » Resistance can increase if they are pushed to reveal more information than they feel safe to.
- » As psychological safety is established, the focus shifts from maintaining safety to self-understanding, and they become more able to discuss behaviour change.

Therapeutic alliance ruptures

Following are some guidelines relating to therapeutic alliance ruptures.

- » A rupture or breakdown in the therapeutic relationship should not be assumed to indicate that treatment is unlikely to be effective, but rather as an opportunity to enhance the relationship between health professional and tangata whaiora.
- » Directly address the issues underlying the breakdown of the therapeutic relationship and acknowledge that in many cases it is the behaviour of the health professional that has led to this.
- » Most of the strategies that successfully develop a therapeutic relationship are useful for repairing a rupture.
- » Specific strategies include:
 - » listening skills – paraphrasing the tangata whaiora's criticisms and feelings of anger, frustration or disappointment; asking gentle probing questions to learn more about negative feelings; and finding truth in criticisms even when they may seem unreasonable and unfair
 - » self-expression skills – if appropriate, express your feelings using tactful language, especially respect for tangata whaiora, even if they seem hostile (Castonguay and Constantino 2004).

Middle and late treatment

Strategies in the middle to late phases of treatment focus on maintaining engagement with the service, and especially with the treatment plan or retention in treatment, and the gradual transfer of engagement and attachments to supports in the community.

Psychosocial functioning and mid-treatment outcome

Psychosocial functioning includes such experiences as self-esteem, decision-making, depressed mood, hostility and risk-taking. These factors may affect engagement but in this context are best considered part of recovery and therefore outcomes, given that issues such as hostility will likely need to be addressed to reach this point in the treatment process. However, unresolved problems that make engagement tenuous may usefully be addressed in this phase in those tentatively engaged.

Retention

- » The use of a specific after-care therapist can improve retention after the completion of residential treatment for CEP (DeMarce et al. 2008), is likely to enhance retention and commitment to recovery, and improves substance use outcomes up to 12 months after completion of a residential treatment programme.
- » The use of simple reward strategies such as vouchers, financial rewards or adult equivalents of star charts using certificates may also help retention, especially for those with higher levels of psychiatric severity (Lefforge et al. 2007), though consideration needs to be given to the use of external rewards and the possibility that they may reduce internal motivation (see section 4.4 on motivation), unless tangata whaiora have control over choosing what the rewards are.

External strategies

- » As noted above, external coercion may increase attendance and retention but can undermine the quality of the therapeutic relationship and the relationship of tangata whaiora with the service, and may undermine the more effective internal forms of motivation (Stanhope et al. 2009).
- » Providing autonomy-supportive environments can help overcome this (see section 4.4 on motivation) by encouraging movement from external to more internal forms of motivation.
- » Community engagement and flow activities are under-studied strategies. They are mentioned here because of the strong anecdotal support from tangata whaiora and because they are an important part of the process of recovery and enhancement of well-being, usually in the later stages. Encouraging flow experiences (mentioned in other sections on motivation and well-being), both within a particular treatment programme and in the wider community, may be particularly useful.
- » Providing autonomy-supportive environments can help overcome this (see section 4.4 on motivation) by encouraging movement from external to more internal forms of motivation.

4.3.5 The Engagement Intervention – Alan Zuckoff (Zuckoff et al. 2007)

Zuckoff and colleagues have developed a specific interview incorporating motivational interviewing principles and strategies designed to enhance engagement when tangata whaiora transition from one service (such as an inpatient unit) to another (such as a community team). The engagement intervention has been shown to increase engagement and treatment completion for people with substance use problems and non-psychotic disorders (Daley et al. 1998; Grote et al. 2007; Swanson et al. 1999). This intervention is also likely to help engagement when tangata whaiora are referred to health professionals from another service in a shared care arrangement. The stages of the interview are summarised as follows.

1. Anticipate and explore:
 - i. the client's anxiety – the client is often initially anxious that they will be judged negatively and that they will be directed to change: their current patterns of behaviour frequently bring them benefits on one level but costs on another, including being inconsistent with their values and goals

- ii. the client's relationship with themselves – they are often unhappy with aspects of their life and themselves, and are engaged in avoidance behaviour for self-protection
 - iii. what the client wants from the health professional – they want the health professional to have understanding, genuine caring and competence and to know their own limitations.
2. Create a state of psychological safety (see Engagement and Psychological Safety (Zuckoff 2007) above).
3. Elicit the client's story.
4. Summarise to show you have heard, to crystallise the client's dilemma and to highlight their concerns and wishes.
5. Explore problems and treatment:
 - i. history – psychiatric treatment history, especially in terms of the coping strategies used, impressions of past treatment, and positive and negative experiences
 - ii. hopes – hopes and fears for treatment, for the therapist and for improvements in problems.
6. Identify personal values and life goals.
7. Identify goals:
 - i. where the client wants to go
 - ii. what the client wants to achieve.
8. Identify values:
 - i. who the client wants to be
 - ii. how the client wants to live.
9. Use the Values Care Sort exercise (see appendix 1).
10. Develop a change plan.

Key Points

- » Lack of engagement is a major cause of poor outcomes.
- » Engagement should be a key focus of treatment.
- » Engagement can occur with a clinician, a service or a management plan.
- » The therapeutic alliance is an important factor in engagement, and change in key clinicians is an important factor in disengagement.

Clinician strategies to enhance engagement include:

- » minimal changes in key clinicians
- » the use of culturally appropriate engagement processes
- » the use of visual feedback tools such as cognitive mapping
- » peer support and engagement of support workers
- » a counselling style focusing on empathy, empowerment, respect and fostering self-determination (the counselling style of MI is recommended as a means of achieving this)
- » a well-being perspective that acknowledges the tangata whaiora's hopes and aspirations, and that enhances positive aspects of their life
- » external motivators such as legal coercion or assertive community follow-up
- » exploring thoughts and attitudes related to past treatment experiences
- » strategies to reduce hostility, anxiety and avoidance in social phobia and to cope with intrusive thoughts and memories in post-traumatic stress disorder
- » early demonstrations of the effectiveness of treatment through the use of ancillary services
- » contingency management techniques and community reinforcement for those in more externalised types of motivation
- » competence, especially in interviewing skills and assessment and formulation skills – coming to and communicating an effective shared understanding
- » enhancing hope and optimism
- » considering the impact of character, temperament and personality variables on the therapeutic relationship
- » taking into account cognitive difficulties
- » enhancing the ability of the service to enable participation
- » considering the use of an engagement intervention, especially when tangata whaiora are transitioning from one service to another, or a second service is being added.

4.3.6 Further Reading

Center for Substance Abuse Treatment (2005). *TIP 42. Advice to the counselor: forming a therapeutic alliance*. Rockville, MD, Substance Abuse and Mental Health Services Administration.

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4.4 Principle 4 » Motivation

Motivation to change and readiness for treatment are important factors related to engagement in and outcome of treatment for both substance use and mental health problems (Simpson and Joe 1993; Simpson and Joe 2004; De Leon et al. 1997) and have become core components of interventions targeting CEP (Center for Substance Abuse Treatment 2005). Within the area of alcohol and drug misuse and CEP, motivational interviewing (MI) (Miller and Rollnick 2002) is the key intervention for enhancing motivation, and the Transtheoretical Model of Change (Prochaska and DiClemente 1998) has been the predominant model describing the process and stages of motivation to change.

The evidence regarding MI's usefulness for increasing motivation and improving outcome for those with CEP suggests that it is not particularly effective in changing substance use or mental health symptoms for those with serious mental health problems (Drake et al. 2008; Cleary et al. 2008; Carroll et al. 2006), especially chronic psychoses. It may be that adaptations of MI to take into consideration the nature of serious mental illness may lead to more effective outcomes, and some of these are mentioned below. There is evidence, however, that MI may be useful for enhancing engagement in treatment (Cleary et al. 2008), and so it is recommended at this point in time.

The Transtheoretical Model of Change (outlined below) has been criticised on the grounds that the stages described are arbitrary and not actually discrete changes, that the majority of people do not neatly follow the path the model suggests, that the model focuses primarily on conscious decision-making and thus overlooks other highly important underpinnings of motivation (West 2005), and that interventions based on stages of change are no more effective than those that are not based on a concept of stages of change (Riemsma et al. 2003). On the other hand, it has been very useful in providing tools for health professionals to think about motivation and to organise the ways they try to enhance it.

There has been considerable research into the nature and determinants of motivation, especially in the area of organisations and education. As a model of motivation and change, the Transtheoretical Model of Change is limited in that it does not capture a range of factors that have been shown to play a considerable role in determining motivation. The nature of internal drives, negative emotional states, self-regulation, values and desires and specific goals appear to be important and need to be considered in clinical settings when attempting to influence the motivation of tangata whaiora.

4.4.1 The Nature of Motivation

Motivation can be thought of as an internal, or intra-psychic, cognitive and emotional state that gives energy and direction to behaviour, especially that which is goal directed. The nature of motivation and its effectiveness in driving behaviour vary depending on the perceived locus

of causation – in other words, whether the source is perceived to be extrinsic or outside the individual or within the individual – and on the source of motivation.

Self-Determination Theory

Self-Determination Theory (SDT) (Ryan and Deci 2000) divides motivation into three broad types, which can be further subdivided depending on how externally or internally behaviour is regulated, or how self-regulated and self-determined a behaviour is; that is, the degree of autonomy or self-control the individual perceives over the behaviour. The three broad types are described below.

1. **Amotivation:** a state in which behaviour is performed without the direction of any intention or will, or is not performed at all. The behaviour has no meaning or importance to the individual, the individual does not feel competent to undertake the behaviour, or they do not believe the behaviour will lead to the desired outcome.
2. **Extrinsic motivation:** motivation that arises to varying degrees as a result of external pressures such as rewards, pressures or coercion. These states occur over a continuum of autonomy, and there are four types of extrinsic motivation:
 - i. external regulation– doing something solely to satisfy or avoid external pressures (e.g. being admitted to hospital under the Mental Health Act but being fully resistant to this)
 - ii. introjected regulation – partial internalising of extrinsic motives and pressures, so that the pressures to change are not fully accepted by the individual as their own (e.g. choosing to make changes to drinking behaviour or to take medication because of pressure from family or whānau or friends)
 - iii. identified regulation – the behaviour is consciously embraced as important to the individual and feels as if it is quite self-determined, even though it is not necessarily consistent or aligned with other values the individual holds (e.g. attending and working effectively in psycho-therapy for depression because the individual wants to relieve the feelings of low mood)
 - iv. integrated regulation – behaviours that are integrated into the self, seen as important and valuable, and aligned with the individual's other values, although they are still undertaken to achieve a particular separate outcome rather than for their own sake (e.g. giving up cannabis use because the individual recognises it is harmful to their education, and therefore undermines highly valued personal educational goals).
3. **Intrinsic motivation:** motivation to undertake an activity purely for the interest or enjoyment the activity creates. Intrinsic motivation is thought to be mainly associated with three broad activities:
 - i. knowledge – activities undertaken for the satisfaction of acquiring knowledge or understanding
 - ii. accomplishment – activities undertaken for the sense of achievement or accomplishment they lead to
 - iii. stimulation – activities undertaken for the sensations of pleasure they lead to (e.g. attending treatment sessions for substance use and mental health problems because they are enjoyable, and the increased self-understanding gained is satisfying in its own right).

This model is shown in table 4.2.

The model of motivation can also be considered as occurring on three levels:

1. global – the general motivational orientation an individual has towards the environment
2. contextual – the level of motivation for a specific area of activity (e.g. learning, sport, treatment)
3. situational – the motivational level an individual has for their current experience (Vallerand 2000).

Table 4.2 » Types of motivation and the continuum of autonomy					
Non-autonomous				Autonomous	
Amotivation	Extrinsic motivation				Intrinsic motivation
	External regulation	Introjected regulation	Identified regulation	Integrated regulation	Intrinsic regulation

Source: Ryan and Deci 2000

The importance of this model is the considerable evidence from a range of contexts that more autonomous motivation is associated with:

- » greater motivation for treatment
- » treatment being more valued
- » less ambivalence about treatment
- » higher levels of self-efficacy and self-esteem
- » better engagement in treatment
- » better treatment outcomes
- » a greater ability to overcome barriers to change.

Intrinsic regulation is the motivational style most strongly associated with change, but it is not necessary for change to occur. Identified regulation and integrated regulation may also provide sufficient motivation to lead to effective change (Ryan and Deci 2000; Pelletier et al. 1997; Ryan and Deci 2008).

As with other theories of motivation (including MI), SDT assumes that people naturally desire growth and desire to move towards intrinsic motivation. While acknowledging intra-psychic mechanisms, SDT also includes social conditions as major factors affecting motivation type. Three key psychological needs are thought to support the development of more intrinsic forms of motivation:

- » competence – the level of mastery one perceives over a task
- » autonomy – the degree to which the individual feels in control of their actions
- » relatedness – the degree to which the individual feels a sense of connectedness with others.

In other words, motivation is likely to move towards more internal forms when treatment occurs in

a context that enhances competence, autonomy and relatedness.

Tangata whaiora may experience a range of different types of motivation, and there is evidence that external motivation (such as legal mandates to enter treatment) can be associated with good outcomes. It is likely, however, that externally motivated entry into treatment is successful in the long term only in as much as it leads to the development of more internal motivation and self-determination over the course of treatment.

It is also important to note that the presence of external motivation has been shown to reduce internal motivation. The implication of this is that while external motivation is important for initiating treatment in people with low levels of motivation, internal types of motivation should be encouraged wherever possible, external motivating factors should be minimised, and, when necessary, strategies should be implemented to encourage the transfer of motivation from external to internal during the course of treatment.

The Transtheoretical Model of Change

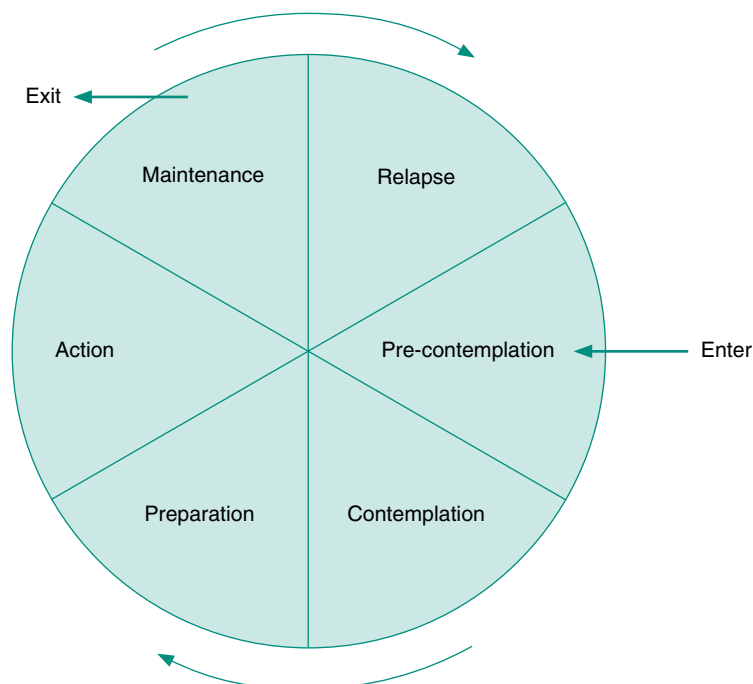
The Transtheoretical Model of Change offers a way of conceptualising the tangata whaiora's readiness to change and the process of change through a number of stages, while the techniques of motivational interviewing provide the tools for helping tangata whaiora move through the stages of readiness to change.

Motivation to change is a state, not a trait, and develops through several stages:

1. **pre-contemplation** – the individual has no intention of changing behaviour in the near future (six months or so), generally appearing unmotivated and resistant to change
2. **contemplation** – individuals state their intent to change in the near future but are ambivalent about change
3. **preparation** – individuals intend to actively change, usually within the next month or so, and preparation is therefore a transition from contemplation to action rather than a stable state
4. **action** – the individual is making changes, or has done so recently
5. **maintenance, relapse and recycling** – individuals maintain the gains made and prevent relapse.

These stages of change are often presented as a wheel or cycle, as in figure 4.2.

Figure 4.4 » Stages of change in the Transtheoretical Model of Change



Source: Prochaska and DiClemente 1998

4.4.2 Determinants of Motivation

A number of factors have been proposed to explain motivation, each of which has some merit.

Incentives and rewards

Motivation to act can occur because of the promise of rewards, or because of habituation to previous rewards. Many of the rewards for behaviour are external to the individual. These include approval from others, money, status and so on.

Although rewards may increase motivation for individuals who are primarily externally motivated, they have been shown to reduce internal regulation and intrinsic motivation and should therefore be used cautiously. It appears that rewards based on the outcome are perceived to be less autonomous and intrinsically motivating than rewards based on engagement in the activity; in other words, rewarding participation rather than results is associated with the development of intrinsic regulation and motivation (Selart et al. 2008).

Drive theories

Basic drives, such as those for food, water and sex, powerfully motivate behaviour, especially when they are not being fulfilled. It is likely, however, that when satisfied they are less influential over behaviour, allowing other motivators to direct behaviour.

Positive and negative emotional states

Action may be motivated by the wish to experience positive mental states or to avoid negative states. People vary in their innate tendency to be influenced by approach behaviours (to seek out positive experiences) or by avoidance behaviours (to avoid negative experiences). Reinforcement of positive state-seeking appears to involve stimulation of the brain reward pathways, where

psychoactive substances stimulate the neurological pathways that positively reinforce the satisfaction of basic needs and drives, such as drinking when thirsty or eating when hungry. People are also motivated to avoid negative emotional states such as substance withdrawal and frequently do so with drug use. Non-drug-related stressors such as interpersonal conflict, anxiety or depressed mood may trigger these avoidance strategies and lead to substance use, even at relatively low levels of stress (Baker et al. 2004).

An excessive avoidance of negative states can come to dominate a person's life and is associated with a range of mental health problems. Progress in psychological treatments appears to be associated with the reduction of motivation to avoid such states, firstly through a process of clarification (coming to understand and re-evaluate the motivation to avoid negative experiences) and then by a process of mastery-coping (learning new coping strategies) (Holtforth et al. 2006).

Desires

People are motivated by the things they desire. Reiss (2004), in researching the common intrinsic desires of a large number of people, established the following list of 16 core desires that directly motivate people.

Table 4.3 » Reiss's 16 motives		
Motive name	Desire	Intrinsic feeling
Power	Influence and mastery	Efficacy
Curiosity	Thinking/knowledge	Wonder
Independence	Autonomy	Freedom
Status	Social standing and importance	Self-importance
Social contact	Friends and peer relationships	Fun
Vengeance	Strike back	Vindication
Honour	Obey a traditional moral code	Loyalty
Idealism	Social justice	Compassion
Exercise	Exercise muscles	Vitality
Romance	Sex, courting	Lust
Family	Raise own children	Love
Order	Organise, ritual	Stability, predictability
Eating	Eat	Satiation (avoidance of hunger)
Acceptance	Approval	Self-confidence
Tranquillity	Avoid anxiety and fear	Safe, relaxed
Saving	Collect, value of frugality	Ownership
Order	Predictability	

Source: Reiss 2004

The majority of people embrace these desires but prioritise them differently and aim to achieve them in moderation. The most important desires for explaining an individual's motivation and behaviour are those that are either unusually strong or unusually weak. It should be noted that these 16 desires are closely related to people's core values. It is likely that desires and values are different expressions of a common underlying construct and that people tend to desire what they value, or perhaps value what they desire.

The importance of these desires is that they link values to motivation. While people experience specific 'contextual' motivations around treatment, these are usually tied to their

desires and values, and these desires and values are important motivating factors in treatment (as mentioned in previous sections).

Goals

Goals drive behaviour and action, and the way in which they are established can have an impact on motivation. When working with tangata whaiora, treatment goals are crucial for negotiating a shared understanding of the purpose and content of treatment and in directing attention and effort. The way in which goals are established also has an impact on motivation for and commitment to treatment.

Following are some of the characteristics of goals that have an impact on motivation.

Autonomy: As discussed above, goals that are driven by intrinsic motivation drive behaviour more powerfully than less internally derived goals, and where external goals are important initially, the extent to which the locus of motivation moves from extrinsic to intrinsic over the course of treatment has a significant bearing on effectiveness and sustaining of motivation over time. Encouraging tangata whaiora to have considerable choice and input into goal-setting is an important aspect of enhancing effective motivation. This does not mean that tangata whaiora should determine all goals entirely on their own. Guidance is often required to help them identify important therapeutic goals, and some goals may not be appropriate to the particular setting. The key is that tangata whaiora perceive that they have had considerable autonomy and control over the selection of therapeutic goals.

- » **Goal conflict:** Conflict in the goals set – either between the health professional and tangata whaiora, or between the treatment goals of tangata whaiora and their more general life goals – has the capacity to undermine motivation and readiness for treatment.
- » **Approach versus avoidant goals:** As mentioned above, avoidance motivation (i.e. motivation to avoid negative affective states) is associated with a range of mental health problems, while a decrease in avoidance motivation over the course of psychological interventions is associated with good treatment outcome. In other words, in cases where a person is strongly motivated by the avoidance of negative states, treatment outcome is likely to be better where the goals of treatment change from being motivated by avoidance of negative states to the achievement of positive emotional states and wellbeing over the course of treatment.
- » **Short-term versus distant goals:** While distant or long-term goals are important in shaping the direction of treatment, it is the short-term goals that generate motivation more effectively, especially when they are readily achievable and thereby increase hope and self-efficacy.
- » **Some types of goals may be more achievable than others:** While goals need to be personally relevant, aim to reduce psychopathology and enhance well-being, if all things are equal the health professional may be guided by the knowledge that some categories of goals are easier to achieve than others. In tangata whaiora with mood and anxiety disorders, certain goals appear to be more achievable than others, though which ones depends on the severity of impairment and the motivation for psychological treatment (Berking et al. 2005).

The most easily achieved goals for those with low motivation for treatment are:

- » regeneration or personal growth
- » reduction in panic attacks
- » stress reduction
- » increased assertiveness

- » work and education goals
- » increased energy and drive.

The least easily achieved goals for those with low motivation for treatment are:

- » reduction in sleep problems
- » reduction in pain
- » reduction in other anxieties and anxieties in specific situations
- » reduction in negative moods.

The most easily achieved goals for those with severe impairment are:

- » reduction in panic attacks
- » reduction in other fears and anxieties
- » increased assertiveness
- » increased self-confidence.

The least easily achieved goals for those with severe impairment are:

- » reduction in sleep problems
- » reduction in pain
- » reflecting on self and the future
- » reduction in depressive symptoms.

The implication of this is that where motivation is low it may be useful to initially target goals that are easily achieved to foster a sense of self-efficacy and hope in treatment.

External contexts

The socio-environmental context plays an important role in facilitating or inhibiting motivation and the integration of motivation from extrinsic to more intrinsic forms. Environments that encourage the three basic needs of competence, autonomy and relatedness (see section 4.4.1 above) also facilitate the integration of motivation.

Most widely studied and most important is the impact of autonomy-support environments. Three components of autonomy-support environments appear to be essential to their effectiveness:

- » conveying your recognition to the tangata whaiora of the negative aspects of the task being undertaken (e.g. that it might be difficult or boring)
- » a clear rationale given for the reason for the task
- » providing as much choice as possible and as appropriate, given the context.

Guidance in terms of choices may be offered in a non-controlling way where necessary. Clearly there are limits on the type of choices that can be made, and guidance may be offered in helping tangata whaiora evaluate the choices at hand. The key is that tangata whaiora perceive they have the ability to choose. In fact, early in the treatment process any choice (within reason) may be better than the one the health professional considers the best choice, given that more effective choices may be made later once motivation has developed.

Not all choice options are equal. Simply being offered a choice between two limited options may still be perceived as controlling. To enhance intrinsic motivation, choices need to not only allow an individual to choose between a range of options, but also to have control over the initiation of the option and over when and how it is undertaken (Patall et al. 2008). Too much choice can also undermine motivation. Offering between three and five options appears to be optimal. Providing choices enhances internal motivation, but providing external rewards for completion of chosen actions is often perceived as controlling and neutralises this unless the individual is allowed to choose what the reward will be.

Although autonomy-support is highly relevant in the context of the relationship between tangata whaiora and the therapist/health professional, it is also relevant in terms of the relationship with family and whānau, peers, the services within which treatment occurs, and a broader social context. External pressures to enter or comply with treatment may be useful for initiating treatment, but the more they can offer choice the more effective the pressure is likely to be in the medium to long term. Again, it is sometimes better to offer guidance, support and choice about treatment and then wait for tangata whaiora to develop more internalised motivation than to force treatment through high levels of external pressure.

This is also relevant in terms of the use of rewards. Offering rewards, contingencies and assertive encouragement may be useful for tangata whaiora with low levels of autonomy and internal motivation, but it is likely to be undermining when moderate levels of internal motivation exist.

4.4.3 Strategies for Influencing Motivation

When implementing strategies aimed at either increasing motivation or moving from more extrinsic to more intrinsic motivation, it is important to be aware of the type of motivation experienced by tangata whaiora and to adapt interventions accordingly. For example, external positive rewards may enhance motivation and move it towards more intrinsic forms when tangata whaiora experience extrinsic motivation, but they may undermine intrinsic motivation when it is present.

There are a number of approaches that can foster motivation and facilitate the movement from external to more internal forms of motivation. Many of these relate to the way determinants of motivation are applied, and include:

- » motivational interviewing (MI)
- » the use of rewards and contingencies
- » facilitative or enabling environments
- » mindfulness and flow
- » goal-setting
- » aligning treatment goals to values and desires
- » the way the message is delivered.

Motivational interviewing (Miller and Rollnick 2002; Zuckoff 2007; Zuckoff et al. 2007)

MI is a key tool or strategy to enhance motivation and facilitate the movement of motivation from external to internal. As mentioned, the effectiveness of MI in increasing the amount of motivation to change substance use or mental health problems in people with severe CEP is questionable, although adaptations mentioned below may show more success. There is evidence, however, that MI may enhance motivation to engage in treatment, and it appears that the spirit of MI as a general approach to working with tangata whaiora fits very well with the concepts of autonomy

support in SDT. In other words, being consistent with the spirit of MI when interacting with tangata whaiora appears to be an effective means of establishing an autonomy-support style of relationship and addressing the needs of relatedness described in SDT.

MI is based on the belief that people tend to move naturally towards a state of well-being. When facing a decision, they consider alternative choices and may then get stuck in ambivalence when there are conflicting options or when they do not believe they can achieve the desired choice. Pressure to make a decision or to act on it triggers resistance. MI involves strategies aimed at reducing resistance to change and helping people decide for themselves to move towards change through a variety of micro skills.

Central to MI are three key points that capture the spirit of motivational interviewing:

- » autonomy – respecting the fact that the tangata whaiora is responsible for their own change and is in control of such decisions
- » collaboration – meeting the client's and health professional's aspirations
- » evocation – drawing out the client's concerns, wishes, hopes, strengths, goals, values and intentions.

Four general motivational principles of MI

There are four general principles of MI which are to:

1. express empathy:

- » the key therapist task is to listen reflectively
- » ambivalence is normal
- » acceptance facilitates change; pressure to change elicits resistance
- » an atmosphere of safety promotes self-disclosure

2. develop discrepancy:

- » the key therapist task is to evoke awareness of the gap between where the client is and where they want to be (goals), and between who they are and who they want to be (values)
- » create a discrepancy between present behaviour and important goals
- » the client should present the arguments for change

3. roll with resistance:

- » the key therapist task is to avoid provoking resistance, and when it emerges to reduce it
- » avoid arguing for change
- » avoid confronting resistance
- » the presence of resistance is a signal to respond differently
- » new perspectives are invited but not imposed

4. support self-efficacy:

- » belief in the possibility of change is an important motivator

- » the patient is responsible for choosing and carrying out personal change
- » there is hope in the range of alternative approaches available.

In addition, there are a set of techniques or microskills which help implement the general principles and maintain consistency with the spirit of MI. These microskills can be summarised by the mnemonic 'OARS' and include the use of:

- O = open-ended questions
- A = affirmation
- R = reflective listening
- S = summaries.

Specific adaptations of MI for CEP will be discussed further below.

Use of rewards and contingencies

Rewarding desired behaviour such as attending sessions or compliance with medication is useful, especially for the initial engagement of tangata whaiora with low levels of more internalised motivation. However, as mentioned, external rewards may be seen as controlling and may undermine both the benefits of autonomy-support environments and the presence of more internalised levels of motivation. Rewards where tangata whaiora are allowed to choose what the reward will be may overcome this.

Facilitative or enabling environments

Environments that support autonomy provide the opportunity for developing competence (be it in the area of skills development or knowledge and understanding) and fostering relatedness. Most important is the autonomy-support environment, which can be fostered in many contexts including therapeutic and broader service contexts and involves the provision of support and guidance rather than control, in which the tangata whaiora is given choice and control over treatment.

Mindfulness and flow

Mindfulness and flow experiences (mentioned in section 4.2 on well-being) appear closely related and encourage similar mental states, although they are accessed through different mechanisms (Bishop et al. 2004). Flow experiences are those that involve the undertaking of challenging activities in which the person becomes absorbed, such that their sense of self and time are diminished, and are associated with increased levels of subjective well-being. Examples of activities that can induce flow include work, learning, sporting activities and hobbies. Mindfulness is useful for helping disengage from and therefore control negative affect and dysfunctional cognitions (Levesque et al. 2008).

In addition, there is emerging evidence that both the practice of mindfulness and engagement in flow activities increase self-regulation and autonomy (Brown et al. 2007; Levesque et al. 2008; Levesque and Brown 2007).

Goal-setting

Fostering autonomy by allowing tangata whaiora a choice of relevant treatment goals, avoiding conflict between treatment goals and life goals, encouraging approach goals (those that lead to positive experiences) in preference to avoidance goals (those related to avoiding negative

experiences), and focusing initially on short-term goals (especially those that are more achievable for tangata whaiora, see above) all facilitate the internalisation of motivation and regulation.

Aligning treatment goals to values and desires

Integrated regulation is a state of motivation where the reasons for change are felt to be controlled by the individual and are aligned with their broader key values. For those in less extrinsic states of motivation, identifying key life values and related desires – and ensuring that the reasons for seeking treatment are consistent with and attached to these – is likely to facilitate a shift in type of motivation to a more intrinsic type.

4.4.4 Motivation in CEP

How the presence of both a substance use and a mental health problem affects motivation is unclear. It is highly likely that different mental health problems affect motivation in different ways. In some, such as schizophrenia and depression and bipolar disorder, changes in motivation are core parts of the disorder; in others they are less so.

Motivation in non-psychotic CEP

It is possible that non-psychotic CEP involving problems such as depression, anxiety and eating disorders is more amenable to influence than psychotic CEP. MI approaches have been shown to reduce bingeing and purging in bulimia (Treasure et al. 1999), higher levels of autonomous motivation predict better outcome for morbid obesity (Williams et al. 1996), and levels of autonomous motivation after three sessions of psychotherapy are a strong predictor of outcome for treatment of depression, more so than the quality of the therapeutic relationship (Zuroff et al. 2007). However, meta-analyses and broad reviews (Cleary et al. 2008; Tiet and Mausbach 2007) have failed to show persuasive evidence of benefit for both substance use and mental health outcomes. Given that there is evidence for MI enhancing engagement in treatment for CEP and for moving motivation type towards more internal forms of regulation, there is good reason to support MI approaches and to recommend other strategies designed to increase autonomous motivation.

Motivational interviewing for co-existing disorders – Alan Zuckoff (Zuckoff 2007)

In addition to noting the importance of psychological safety when engaging tangata whaiora, Zuckoff points to the importance of differentiating readiness for change from readiness for treatment, and notes important reasons tangata whaiora with CEP may have for not wanting to change or accept treatment. While readiness to change has a large impact on readiness to engage in treatment, tangata whaiora may want to attend treatment but still not want to change.

This may be due to the positive effects of substance use. Substance use may relieve other mental health symptoms, can reduce stress, is a familiar source of pleasure and is a focal activity for many social connections which may be disrupted if substance use stops. Substance use can also provide a stable sense of self as a drug user and as a part of the culture the substance use is associated with.

A reluctance to change substance use behaviour may also result from concern about the negative aspects of stopping substance use. This can include a worsening of mental health symptoms, boredom and frustration, guilt and shame about previous behaviours, expectations of failure at stopping the substance use, and threats to self-esteem, which may be related to the loss of identity that can occur when the tangata whaiora is no longer a drug user.

A reluctance to accept treatment may also arise due to practical barriers, such as difficulties with finance and transport to appointments, or other obligations or appointments that clash with those related to treatment; or it may result from symptoms of mental health problems (such as impaired cognition or lack of energy), or negative expectancies about whether treatment will be effective or even necessary, or that it may be too difficult. Stigmatisation and past negative treatment experiences of the tangata whaiora or their social contacts, and personal attitudes and beliefs about seeking help, can also impede acceptance of treatment.

Zuckoff discusses a number of considerations and adaptations to MI for tangata whaiora with CEP and emphasises two: the increased rate and severity of cognitive limitations and an intolerance of intense emotions and changes to the OARS microskills each necessitates:

1. cognitive limitations (diminished information processing, memory, attention and concentration), which necessitate:
 - » simplifying language and sentence structure
 - » offering prompts/multiple choices
 - » linking past statements with current statements
 - » reflecting, summarising and repeating frequently
 - » providing written summaries/reminders
2. intolerance of intense emotions, which necessitates:
 - » deflecting from upsetting content areas
 - » limiting reflection of psychotic process – shift focus to concrete meanings
 - » limiting reflection of hopelessness – shift focus and reframe.

Motivation in severe mental illness and schizophrenia

Impaired motivation may be a core feature of schizophrenia and may add considerably to the cognitive dysfunction that accompanies the disorder. Motivation appears to mediate the relationship between cognitive deficits and psychosocial functioning (Nakagami et al. 2008). It appears that tangata whaiora with schizophrenia experience the same levels of motivation associated with skill and knowledge acquisition as those without schizophrenia, and higher levels of motivation associated with avoidance goals such as those related to anxiety (Barcham et al. 2008). However, impairments in working memory mean that mental representations of future rewards – the targets of motivation towards which motivation is directed – are not retained once those rewards are no longer present in the immediate environment (Gold et al. 2008). In other words, when appropriate goals and rewards are present and in mind, such as when they are discussed during a treatment session, tangata whaiora with schizophrenia appear to be just as motivated to achieve those goals as others. Once the context changes and the session ends, however, the goals are forgotten quickly and motivation diminishes accordingly. Therefore, the key issue appears not to be an inability to be motivated but rather a failure to sustain motivation long enough for it to have an enduring effect on behaviour.

There are currently no definitive strategies for addressing these deficits, although there are a number of promising lines of development, including appropriately designed computer learning packages; errorless learning approaches, where learning is stepped to avoid repeated mistakes that can undermine skill acquisition (Barcham et al. 2008); and the use of autonomy-support approaches, for which there is some empirical evidence for their ability to enhance intrinsic motivation and lead to changes in social behaviour (Wu 2001).

With respect to MI approaches, as mentioned above their effectiveness for people with severe mental illness, including schizophrenia, appears limited. There have been attempts to adapt MI to suit those with severe mental illness.

Motivational interviewing and CEP

Motivation and the change process are specific to a particular behaviour, and so it is necessary to be clear about the particular behaviour being targeted. People may be motivated to change one behaviour without necessarily being motivated to change another. People with CEP have multiple problems, which may fluctuate in their intensity and at times may seem more important to the tangata whaiora than the behaviour being targeted in MI, thus hindering the change process. It is important, therefore, to rate the readiness to change and the readiness for treatment for each major problem area, even though the health professional may not target them with MI initially.

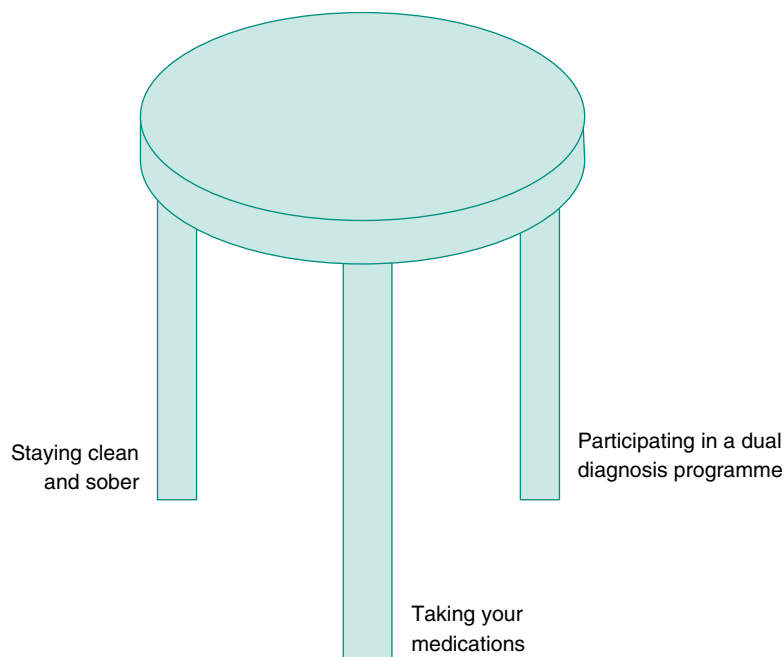
Motivational interviewing modifications for dual diagnosis – Martino and colleagues (Martino et al. 2002; Martino et al. 2006)

Martino and colleagues suggest a number of adaptations to MI which have been found to be helpful in working with tangata whaiora with CEP. They include the following.

- » Target both substance use problems and mental health problems with MI.
- » Use simple and concise language and simple, open-ended questions.
- » Use repetition, simple verbal and visual materials and breaks within sessions.
- » Employ frequent use of reflection and affirmation.
- » Give patients enough time to respond to reflections.
- » Avoid focusing on negative life events and despairing statements.
- » Use summaries to logically organise patients' statements.
- » Be prepared to guide the conversation more actively to promote the logical organisation of information.
- » Provide basic written information on interactions between mental health and substance use problems.
- » Use a simplified decisional balance matrix or grid (see below).
- » Use metaphors (e.g. hot and cold symptoms, a three-legged stool, see below).

The hot and cold symptoms metaphor is a simple technique whereby positive symptoms are called hot symptoms and negative symptoms are called cold symptoms. The three-legged stool metaphor (figure 4.5) illustrates the idea that many people with CEP find that their ability to make productive changes rests on three principles: staying clean and sober, taking medication as prescribed, and attending therapeutic sessions targeting CEP.

Figure 4.5 » Three-legged stool metaphor



Source: Martino et al. 2002

Simplified decisional balance matrix or grid

A common MI tool for substance use is the decisional balance matrix, in which the therapist draws a 2 x 2 decisional balance matrix for a target behaviour (e.g. drinking alcohol). The grid comprises columns for positive and negative aspects and rows for changing and continuing behaviours, and the therapist uses the grid to explore underlying attitudes and ambivalence. In tangata whaiora with CEP, the two rows often end up with content that is simply the opposite of each other and becomes redundant and perhaps confusing. Martino and colleagues recommend simplifying the grid to focus on the positives and negatives of changing behaviour as shown in table 4.4.

Table 4.4 » Decisional balance grid adapted for CEP		
	Positive aspects	Negative aspects
Changing behaviour		
Continuing behaviour	X	X

Source: Martino et al. 2002

Martino and colleagues also note that tangata whaiora with significant psychoses may find it difficult to use MI and that the therapist needs to be prepared to move from an MI model to a more appropriate approach, such as supporting pharmacotherapy or crisis interventions approaches, especially if risk issues become apparent (Martino et al. 2002).

4.4.5 Values and Motivation

As discussed, values can play an important role in the development of motivation and in MI itself, and they overlap significantly with the core motivational desires. Exploring key values held by the tangata whaiora and the ways in which they live up to those values are important and can provide

a potent source of motivation. The Values Card Sort (see appendix 1) is an exercise often used in MI and may be useful early in the engagement process to help generate motivation. It should be noted, however, that the values used in the Values Card Sort tend to be characteristic of European cultures and may not capture key values from other cultures.

Another strategy for clarifying values is *Lundgren's Bulls Eye Strategy*, the adaptation of which is explained at http://www.thehappinesstrap.com/upimages/Long_Bull%27s_Eye_Worksheet.pdf

4.4.6 Well-being and Motivation

A well-being perspective is an important component of motivation. MI aims to target specific problematic behaviours, but people are also highly motivated by their vision of what well-being entails and by their hopes and dreams for the future. Helping to develop a vision of well-being and maintaining it as an important goal of treatment may enhance motivation considerably.

Key Points
<ul style="list-style-type: none"> » Motivation can be thought of as occurring on a continuum from external to internal, and as including the following types along a continuum of internal regulation and autonomy: <ul style="list-style-type: none"> » amotivation » extrinsic motivation <ul style="list-style-type: none"> • external regulation • introjected regulation • identified regulation • integrated regulation » intrinsic regulation or motivation.
<ul style="list-style-type: none"> » Motivation can be enhanced by a range of internal and external factors, including: <ul style="list-style-type: none"> » motivational interviewing strategies » ensuring an autonomy-supportive environment » mindfulness and flow activities.
<ul style="list-style-type: none"> » Motivational interviewing approaches: <ul style="list-style-type: none"> » are often included in expert best opinion guidelines for CEP » may be effective for increasing engagement and developing the therapeutic relationship » have not been shown to be effective for improving motivation or outcome in tangata whaiora with severe CEP.
<ul style="list-style-type: none"> » Adaptations of MI for non-psychotic CEP and psychotic disorders may enhance the effectiveness of MI for these tangata whaiora.
<ul style="list-style-type: none"> » A well-being perspective can enhance motivation significantly by establishing and maintaining a vision of an achievable good life or, perhaps, a better life towards which tangata whaiora can strive.
<ul style="list-style-type: none"> » Values play an important part in well-being and are a core part of MI approaches, particularly in terms of making overt the core values by which tangata whaiora wish to lead their lives and helping them act in ways congruent with their values.
<ul style="list-style-type: none"> » The Values Card Sort is an effective and engaging way of helping make the cores values of tangata whaiora explicit (see appendix 1).

4.4.7 Further Reading

Martino, S., Carroll, K., Kostas, D., Perkins, J., Rounsaville, B. (2002). "Dual diagnosis motivational interviewing for substance-abusing patients with psychotic disorders." *Journal of Substance Abuse Treatment* 23(4): 297-308.

Miller, W. R. and Rollnick, S. (2002). *Motivational interviewing: preparing people for change*. New York, Guilford Press.

Ryan, R. M., Deci, E. L. (2000). "Self-determination theory and the facilitation of intrinsic motivation, social development and well-being." *American Psychologist* 55(1): 68-78.

4.5 Principle 5 » Assessment

4.5.1 Introduction

The assessment process aims to:

- » engage tangata whaiora and increase motivation to take the steps necessary to achieve enhanced well-being
- » acquire sufficient appropriate information to form an expert opinion on the problems experienced by tangata whaiora, such that effective strategies to enhance well-being may be suggested.

Engagement is an essential part of the assessment process and has been discussed under a separate section. This section will, therefore, focus on obtaining information, formulating an opinion and developing a management plan. There are three main types or levels of assessment: screening, brief assessment and comprehensive assessment.

Screening

Screening involves a brief series of questions designed to roughly ascertain whether a problem is likely to be present and whether further assessment is necessary. Ideally, it is brief and quick so that it can be applied to a large number of tangata whaiora.

Brief assessment

A brief assessment involves a series of more specific and personalised questions, taking perhaps 10 to 30 minutes, to clarify whether a problem exists and to identify its general nature. Where problems are mild, few or easily remedied, a brief assessment followed by a brief intervention may be all the intervention needed for that specific problem. Brief assessments are more commonly used for alcohol problems, where they are linked to brief interventions for abuse and mild to moderate dependence, where tangata whaiora do not experience multiple areas of dysfunction, and where simple education and advice are sufficient to reduce use to non-problematic levels. Their usefulness for non-alcohol substance use problems and in people with co-existing mental health problems is unclear.

Comprehensive assessment

A comprehensive assessment aims to formulate a broad understanding of all significant problems experienced by tangata whaiora and their whānau or family in their socio-cultural context.

4.5.2 Well-being and Assessment

The importance of including a well-being perspective has been discussed in section 4.2 on well-being. From the perspective of assessment, both alcohol and drug and mental health assessments within mainstream services have often focused on the identification of problems, disorders and poor functioning to the point of ignoring well-being. Yet ultimately, tangata whaiora present for help because they feel they are not well and wish to have a greater degree of well-being.

The improvement of negative states is a means to improving well-being and must remain a key aspect of health care, especially given that much of the research about and expertise in mainstream health services involves the treatment of dysfunction. However, it is equally important to acknowledge that the point of treatment is to enhance well-being and to make this explicit in the assessment and treatment process as depicted in figure 4.6.

Health professionals need to incorporate a well-being perspective in the assessment process, and this may involve several strategies, including:

- » acknowledgement that well-being is personal and may involve dimensions often not considered in traditional health assessments (e.g. cultural considerations, spiritual issues)
- » acknowledgement that the successful reduction of dysfunction may in fact worsen overall well-being if it has a negative impact on some dimensions of it (e.g. the process of treating psychosis may occur in a way that reduces the mana of tangata whaiora and whānau or family, such that psychosis may improve but overall well-being is reduced)
- » explicit and early recognition in the assessment process that a person's vision of their own well-being is central and that problems and disorders are seen as barriers to well-being, so that treatment is a matter of minimising barriers such that well-being can then be enhanced
- » helping tangata whaiora clarify, when necessary, what realistic well-being would be for them
- » fostering hope that enhanced well-being is achievable
- » identifying personal strengths and capabilities as well as social resources that can be fostered to enhance well-being
- » staging management plans to ensure early success and thereby increase optimism that enhanced well-being is achievable.

Figure 4.6 » Pathways and barriers to well-being



4.5.3 Screening

The purpose of screening is to determine whether certain problems might be present and therefore whether further assessment is indicated. Although the best method of screening for substance use or mental health problems is through direct questioning, this is often neglected. Where health professionals lack the skills to undertake screening, specific screening instruments may be useful.

A number of screening instruments have been developed for both alcohol and drug and mental health problems. These have been reviewed in TIP 42 (Center for Substance Abuse Treatment 2005), which outlines them in appendix G and provides in-depth descriptions in appendix H, and by the Victorian Dual Diagnosis Initiative (Croton 2007: http://www.dualdiagnosis.org.au/home/index.php?option=com_docman&task=cat_view&gid=29&Itemid=27). It is unclear which particular instruments will be most suitable in a New Zealand context, and it is recommended that further research be done in terms of their suitability, especially with respect to ease of use and implementation.

Three important issues regarding the use of screening instruments must be considered before they are implemented.

- » Screening is not a substitute for assessment. It may identify people who are likely to have substance use that affects CEP, but it does not provide formal diagnoses and does not explore the relationship between substance use and mental health problems.
- » Positive screens for mental health and AOD problems must be acted on. They should be followed up by a more in-depth assessment.
- » Screening must not be allowed to interfere with engagement and needs to be built in to the assessment process. Appropriate discussion about the results and implications of the screening with tangata whaiora can help overcome this.

Requirements of a screening instrument

To be useful in a local context, screening instruments need to:

- » be in the public domain
- » be validated
- » identify almost all those likely to have the problems being screened for
- » be brief and easy to score, and appropriate to our context and culture.

Most have not been systematically tested in New Zealand, and it may be that specific instruments to suit our local context need to be developed.

As mentioned, screening tools should be used as part of a normal therapeutic interview to aid identification of problems in services where health professionals lack the skills to do so, and positive screens need to be followed by a competent assessment of the issues rather than being used as an alternative to competent assessment.

Screening to identify substance use problems

It is important to consider precisely what needs to be screened for with respect to substance use and the time frame being examined. When it comes to CEP, screening instruments for substance use are most likely to be used by mental health services. Screening instruments for substance use within mental health settings need to consider the following.

- » Substance use at levels below that required to make a diagnosis of dependence may be significant. A screening instrument therefore needs to enquire about quantity and frequency of use, and to identify patterns of use in people who do not have dependence, as well as identifying when substance dependence may be present.
- » Screening needs to consider substance use over a reasonable period of time, such as the preceding month or months, rather than weeks. Use fluctuates and tangata whaiora may reduce use prior to entry into services. Instruments that only enquire about use over the preceding few weeks may miss a significant number of positive 'cases'.
- » Screening instruments should cover all relevant substances likely to interact with mental health problems. Commonly used instruments such as the CAGE and the Alcohol Use Disorders Identification Test AUDIT may be very effective for detecting likely alcohol problems but they do not cover other drugs.

Two screening instruments in particular appear to meet most of these criteria, but in doing so are slightly longer to administer and may therefore be more difficult to implement within services.

The Simple Screening Instrument for Substance Abuse (SSI-SA)

http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs16_138738.pdf

The SSI-SA is a widely used and well-validated screen for alcohol and drug problems occurring in the past six months. There are both self-administered and interviewer versions. The SSI-SA enquires about frequency and quantity of substance use and symptoms of abuse and dependence over the preceding six months and has been validated in a range of settings, including justice settings, though not in a New Zealand context.

The WHO-ASSIST V3.0

http://www.who.int/substance_abuse/activities/assist_v3_english.pdf

The WHO-ASSIST enquires about lifetime and past-three-month substance use and symptoms of abuse and dependence, including nicotine. It is designed to be administered by a health professional.

Mention should also be made of the Leeds Dependence Questionnaire (LDQ), which is one of the few instruments validated in New Zealand. However, the LDQ provides a measure of substance dependence rather than substance use patterns and asks about these symptoms in the past week, limiting its usefulness in a CEP context.

The Substance and Choices Scale (SACS)

<http://www.sacsinfo.com>

The SACS (Christie et al. 2007) was developed in New Zealand for use with young people. It includes a section asking specifically about substance use including nicotine (a range of substances in the clinical version, alcohol and cannabis use only plus open questions about other substances in the community version) and about some consequences of substance use over the past month. The SACS is also linked to a brief intervention for substance use.

Screening to identify gambling problems

There are several screening instruments available for gambling problems. One instrument developed and validated in New Zealand is the Early Intervention Gambling Health Test, or 'Eight' (Sullivan 1999), which can be downloaded from the web
<http://docs.rnzcgp.org.nz/info/8%20Gambling%20Screen.pdf>

Screening to identify mental health problems

Mental health screening instruments are most likely to be used in alcohol and drug services. The wide range of mental health problems that may present in these settings means that instruments that screen for a wide range of mental health problems are likely to be quite long and therefore need to make some compromises to be useful. Some such instruments therefore tend to identify people with substance use problems without indicating diagnoses. Thus it is imperative that positive screens be followed up by assessments that are able to generate diagnoses, given that these are essential in accessing support from mental health services. It is also important that where a referral to other mental health services is necessary for a more in-depth assessment, the mental health services become familiar with the screening tool used.

The Mini International Neuropsychiatric Interview (MINI)

https://www.medical-outcomes.com/HTMLFiles/MINI/MINI_Registration.htm

The MINI exists in several forms. The basic MINI takes approximately 15 minutes to administer and screens for 20 past or present mental health disorders, including substance use disorders. It has been well validated and is widely used. There is also a MINI Screen, which is a much briefer two-page questionnaire for screening current symptoms for the purposes of research or when time is limited; and a MINI Plus, which is more extensive than the MINI and can identify whether mental health symptoms were related to periods of intoxication or abstinence, and includes a version for tracking and monitoring symptoms over time.

The MINI appears to be an excellent screening tool for both mental health and substance use disorders but may take too long for many services to use. The MINI Screen is much more usable but only screens for current (past-month) symptoms and therefore is unlikely to detect relapsing and partially resolved disorders. One useful strategy may be to screen initially with the MINI Screen, and administer the MINI to those who screen positive where a skilled and more comprehensive assessment is not immediately available.

Mental Health Screening Form-III (MHFS-III)

http://pathwayscourses.samhsa.gov/bully/pdfs_bully/bully_supps_pg40.pdf

The MHFS-III was designed for use as a screen for mental health problems in people presenting in substance use treatment settings and covers a range of lifetime mental health problems through a series of yes/no questions. It can be self-administered by those with reasonable literacy skills.

PsyCheck

http://www.turningpoint.org.au/library/psycheck/lib_psycheck.htm

The PsyCheck has been developed recently in Australia and is soon to be implemented in alcohol and drug services. Although it does not identify mental health diagnoses, it screens for symptoms likely to indicate diagnoses, especially anxiety, depression and psychosis, and can also screen for suicide risk. It can be either self-administered or health professional-administered.

The Kessler Psychological Distress Scale (K10)

www.ergpa.com.au/cms/resources/K10.doc

The K10 has been widely used internationally but enquires mainly about symptoms of depression and anxiety and is a measure of general distress.

Overall, the MHFS-III has some benefit over the PsyCheck as it generates diagnoses, which the PsyCheck does not. However the PsyCheck indicates specific interventions that may be used. The MINI screen is limited to current problems while the longer MINI may take too long to be useful in many services. Services should therefore trial various screening instruments and choose one that best meets their needs.

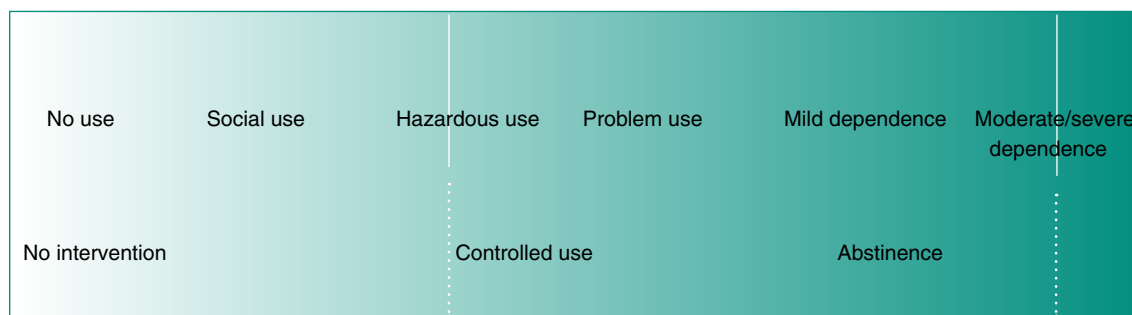
4.5.4 Brief Assessment

A brief assessment is a common tool for assessing whether alcohol or drug problems are mild or moderate to severe in non-specialist alcohol and drug settings. Mild problems may then be followed by a brief intervention to reduce use to safe levels. Moderate to severe problems usually require a comprehensive assessment and management plan.

In general, the presence of a co-occurring mental health problem is an indication for a comprehensive assessment even if the substance use problems are mild, given the need to explore the interaction between the mental health and substance use problems and the likelihood of multiple areas of dysfunction. However, where both mental health and substance use problems are mild, a brief assessment and subsequent brief intervention may be useful. This is especially the case in primary health care settings.

A brief assessment for substance use problems attempts to place the severity of the substance use problem along a continuum of no use, through social or harmless use, through to severe dependence. Such a continuum is useful in that different levels of intervention can be broadly applied to the degree of use problems, and assessment strategies have been developed to identify the level of intervention needed, at least for alcohol use.

Figure 4.7 » The continuum of substance use problems



The continuum

Hazardous use

This is use that, while not causing current problems, is at a level likely to cause problems in the future. Safe levels of alcohol consumption, above which harm is likely to occur, have been defined by the Alcohol Advisory Council of New Zealand (ALAC) as follows:

- » males – 21 standard drinks per week, no more than 6 standard drinks on any one occasion, and at least one alcohol-free day per week
- » females – 14 standard drinks per week, no more than 4 standard drinks on any one occasion, and at least one alcohol-free day per week.

These levels should be reduced in a range of circumstances, such as the young, the elderly, when there is a history of dependence on other substances, when driving, or when operating machinery. There is no safe level of alcohol during pregnancy. It should also be noted that even this level of drinking may be harmful and some recommend significantly lower levels.

Problem use

This is use that is currently causing problems but does not meet DSM-IV criteria for a diagnosis of dependence. This category would include substance abuse as defined by DSM-IV. Please note that the term 'abuse' is not infrequently used in a pejorative way to indicate any use of an

illicit substance. For precision, it is advisable to use the term only when referring to the DSM-IV definition.

Substance dependence

The construct of substance dependence is a diagnostic category defined by DSM-IV. DSM-IV does not provide specific criteria for defining whether dependence is mild, moderate or severe, but many health professionals still find such a sub-classification useful despite the fact that the cut-off point between mild and moderate–severe can be somewhat arbitrary:

- » mild/moderate dependence – three or four criteria are met and there is only a mild negative impact on the person’s life
- » moderate/severe dependence – five to seven criteria are met and there is significant negative impact on the person’s life.

The importance of using the mild or moderate-severe sub-classification highlights one of the weaknesses of the DSM-IV construct: it does not relate to outcome and treatment approaches particularly well. People who meet criteria for mild to moderate dependence can frequently learn to control their drinking or substance use again without further problems, while people with severe dependence seldom can. The concept of moderate to severe dependence is therefore widely used, and is akin to what is commonly meant by the term addiction.

Drugs other than alcohol

For many other drugs there is less evidence to support the concept of harmless social use and it is unclear when hazardous use begins. Obviously this is a fairly arbitrary cut-off. However, the concept of problem use, dependence and the differentiation between mild and moderate-severe dependence remains very useful. There is some evidence emerging to support structured brief interventions for cannabis misuse, though these ‘brief’ interventions are quite different from those used for alcohol, especially in terms of their brevity – most involve four to six one-hour sessions.

Brief intervention for alcohol problems

For tangata whaiora identified as having problematic drinking not requiring a comprehensive assessment (i.e. less than moderate to severe dependence and no significant co-occurring mental health problems), a brief intervention may be successful in reducing alcohol use to safe levels. This brief intervention would usually include the following components:

- » feedback on level of drinking compared to safe drinking guidelines
- » responsibility lies with the tangata whaiora
- » advice to reduce drinking to safe levels
- » a menu of strategies for reducing drinking, for example:
 - » planning ahead to reduce the amount consumed
 - » drinking low-alcohol drinks
 - » alternating alcoholic and non-alcoholic drinks
 - » pacing drinking
- » supporting the ability of tangata whaiora to change
- » setting clear goals
- » follow-up to monitor progress.

4.5.5 Comprehensive Assessment

A comprehensive assessment serves several purposes rather than simply the collection of information. It frequently occurs at the first contact between tangata whaiora and health professional, and the collection of information therefore needs to happen at the same time as other processes (such as cultural considerations, engagement and motivation) are attended to. This subsection will focus primarily on the content of the comprehensive assessment. Section 6 applies the seven key principles to a clinical scenario and will integrate the content of the assessment with these other processes in more detail.

Experienced health professionals tailor their interview to suit their own style of working, but while the assessment may differ in terms of the sequence of information presented, the content is usually similar. An outline of this content demonstrating one approach to comprehensive assessment is presented in appendix 2. Many will seek to obtain as much of this information as possible at the first meeting, but it is also important to acknowledge that assessment is a dynamic process, with information often being elaborated over time.

The information sought from a comprehensive assessment also varies depending on whether the tangata whaiora is already engaged in other services. For example, where tangata whaiora are referred from a mental health service to an alcohol and drug service, significant amounts of information may already be available. In such circumstances, it is wise to review this information because it may be interpreted differently, especially in terms of the interaction between mental health and substance use problems.

Aims of a comprehensive assessment

A comprehensive assessment aims to answer the following questions:

1. Who are this tangata whaiora and whānau as people?
2. What is well-being to them? In other words, what are their realistic hopes and aspirations?
3. What are the barriers to their achieving their desired state of well-being?
4. What pathways can enhance their current state of well-being?
5. What are the key factors that underpin these barriers and sustain these pathways?
6. What strategies can be suggested to minimise the barriers, enhance current pathways and establish new pathways to well-being?
7. Who do we need to involve to implement these strategies?
8. How do we help tangata whaiora and their whānau or family to implement these strategies?

Key features of a comprehensive assessment

Following are the crucial features of a comprehensive assessment.

1. **Comprehensiveness:** All significant problems, areas of poor functioning, disorders, physical health needs, strengths and aspects of well-being are screened for, and a detailed history is taken for those that may be present and pertinent. A 'significant other' is involved in a parallel assessment interview. Biological, psychological, social and spiritual factors are given equivalent weight.

2. **Equivalent weight is given to the three main approaches to conceptualising a person's problems**, each offering an important perspective on a person's situation and predicting strategies to enhance well-being.
- a. *Nomothetic or diagnostic*: those aspects of the person that can be categorised into diagnoses, which have important predictive value in terms of treatment and outcome. In other words, we are all individuals, but we are perhaps more similar than we are different. These common factors can also define us and comprise the nomothetic factors. For example, humans have two arms, two legs and a head. These are nomothetic characteristics that, in part, define us as humans. Most people with major depression experience lowered spirits, loss of interest and sleep disturbance. These common features define the category of depression and are useful in that they predict various treatments and outcomes.
 - b. *Ideographic or individualised*: those aspects of a person that are unique and define them as individuals. For example, a person with depression may have symptoms common to all others with depression (nomothetic characteristics), but will also have features individual to them – the specific nature of their relationship with their partner, their financial situation, their current job and work history. This includes not only individual problems and areas of poor functioning but also personal strengths and positive resources.
 - c. *Aetiological/causal formulation*: a longitudinal, causal explanation of the key reasons why the person presents as they do. This usually takes the form of a narrative or documentary-type view of the person's situation and considers issues of predisposition or vulnerability, triggers for their current problems, factors that maintain their current situation and factors that afford protection and resilience.
3. **Integration**: Integration involves consideration of how the various problems and causal mechanisms interact with each other. In the area of CEP, integration has often meant understanding how mental health problems and substance misuse interact. Though important, there are many other ways in which problems, strengths and other causal and maintaining factors may interact to lead to, and maintain, a tangata whaiora's life situation.

Within the comprehensive assessment, integration occurs through the following.

- a. *Interactions between mental health and substance use problems*:
 - i. Identification of primary and secondary mental health symptoms within the history: indications that mental health symptoms may be secondary to substance use include the absence of a positive whānau or family history of mental health problems, the amelioration of mental health symptoms during periods of abstinence from the substance, and the use of the particular substance prior to the onset of symptoms of the mental health problem. It is important to note that many mental health problems have prodromal symptoms or vulnerabilities that themselves can increase the likelihood of subsequent substance use. Thus, when considering the onset of mental health symptoms it needs to be judged by the onset of these prodromal or vulnerability symptoms, not the point when DSM-IV criteria for a diagnosis are met. The importance of the primary:secondary distinction is that when mental health symptoms are thought to be secondary to substance use, treatment may differ compared to when two primary conditions co-exist.

- ii. Identification of the interactions between persisting primary substance use and mental health problems: this is based on the history of the course of each in relation to the other problem over time. The intensity of mental health symptoms during periods of heavy substance use or no substance use is an important guide. Timelines for mental health and substance use problems may be useful in identifying these relationships.
- b. *Interactions between all relevant factors identified:* The key area where this is achieved is in the aetiological formulation, where the interaction of a wide range of vulnerability factors, triggers, maintaining factors and strengths may be considered from a range of perspectives and brought together into an integrated understanding of the situation the tangata whaiora faces.

Components of a comprehensive assessment

The structure of a comprehensive assessment can be thought of as having five key components:

1. data:
 - a. history – what the tangata whaiora tells you
 - b. mental state examination – what you observe of the tangata whaiora during the interview
 - c. other sources of information – other information available at the time of the assessment
 - d. summary
2. opinion:
 - » a. diagnostic statement
 - » b. problem-oriented statement, including strengths
 - » c. aetiological formulation
3. management:
 - » a. management goals
 - » b. management plan
4. prognosis (initial prediction of outcome)
5. feedback and negotiation.

The structure of a comprehensive assessment

It is important to have a structure for a comprehensive assessment to ensure all relevant areas are covered. There are many ways of structuring a comprehensive assessment, and structures are not intended to be rigorously adhered to or imposed on the story tangata whaiora present, but they are useful mental templates for health professionals to fit information into to help organise and generate an effective opinion. Outlined below is the structure of one approach to a comprehensive assessment. An example of a detailed structure, with key areas of enquiry and structures for mental state examination, opinion, management and prognosis for the comprehensive assessment, is outlined in appendix 2.

1. Data/information

The information gathered should include:

- » general information about who the tangata whaiora is, their life circumstances, hopes for the future and what well-being might mean for them
- » cultural identity, linkages, beliefs and behaviours
- » the tangata whaiora's view of presenting problem(s) and expectations of help
- » a history of the key presenting problems from their onset, a cross-sectional description of current functioning related to these problems, and the symptoms experienced such that DSM-IV diagnoses can be made
- » screening for other important mental health problems and alcohol and drug use, with full histories where screens are positive – this should include screening for pathological gambling, mood disorders, key anxiety disorders (such as social phobia and post-traumatic stress disorder), other past traumas, psychosis, antisocial personality disorder and other relevant problems
- » exploration of the interactions between substance use and mental health problems – this includes identifying mental health symptoms likely to be secondary to substance use and ascertaining the relationship between substance use and mental health symptoms (It is important not to expect that certain interactions should occur, and while there is good evidence that depressive symptoms may often, but not always, be secondary to alcohol use, and psychotic symptoms secondary to stimulant and hallucinogen use, the evidence for many other interactions is equivocal despite 'clinical lore')
- » assessment of current risk of self-harm, suicidality, homicidality and other areas of risk, both past and current
- » a history of any current medical or physical health problems, including those commonly associated with relevant substances and mental health problems, current prescribed medications, risk factors for blood-borne viruses such as hepatitis B and C and HIV, and brain injury
- » legal and forensic history, including a history of convictions, incarcerations, pending charges and illegal activities not charged or convicted for (any relationship between offending, substance use and mental health problems should be explored)
- » whānau or family structure and functioning, and the roles of tangata whaiora within this, as well as a history of substance use and mental health problems within the extended whānau or family
- » personal and developmental history, including early development and problems likely to have an impact on functioning, such as anxiety, conduct disorder, attention deficit with hyperactivity disorder, specific learning difficulties, educational and social abilities when young; plus symptoms of personality disorders should be screened for
- » current psychosocial functioning, including work, relationships, accommodation, finances, social networks, ongoing stresses, coping skills and problem-solving skills
- » spirituality:
 - » beliefs
 - » experiences
 - » practices

- » motivation and stage of change for each major problem
- » mental status examination
- » corroboration from significant others
- » physical examination.

2. Opinion

The opinion involves what the assessor makes of the data collected from the tangata whaiora. As mentioned above, there are three important ways of conceptualising a person's problems: the categorical or diagnostic (nomothetic), the individual (ideographic) and the aetiological (causal). The opinion is organised to emphasise these three complementary approaches in its structure. It is essential that these approaches be considered, as each is valuable in its own right but incomplete.

As an example, consider a tangata whaiora with alcohol dependence and bipolar depression. The diagnostic approach is most effective in predicting medication and prognosis but will not represent the fact that the tangata whaiora experiences paranoid delusions and poses a risk of harm to his or her parents. An ideographic approach will be able to make a statement about dangerousness but will not give an indication of likely course or response to medication. The aetiological or causal approach will provide an explanation of how these problems arose over time and will help identify key factors that maintain the problems, which then become the focus of significant parts of treatment.

a. **Diagnostic (nomothetic) statement:** Generally, DSM-IV is used to make the diagnostic statement in New Zealand. There are other similar diagnostic systems, especially the WHO system ICD-10:

- » Axis 1 Alcohol and drug and major mental health diagnoses
- » Axis 2 Personality disorder
 - Intellectual handicap
- » Axis 3 Physical conditions.

Axes 4 and 5 may be used, but Axis 4 tends to duplicate information in the individualised statement and aetiological formulation below, though in less detail.

b. **Individualised (ideographic problem-oriented statement or problem list):** This includes potential current issues (physical health, suicidality, dangerousness, mental health, work, whānau or family, relationship, accommodation, financial, legal, any other) and individual strengths.

c. **Aetiological or causal formulation:** The aetiological or causal formulation attempts to answer a key clinical question: 'Why is this person presenting in this way, at this time?' Specifically, the formulation seeks to identify the reasons why a person has developed, and is continuing to have, the problems they are presenting with and what strengths and protective factors reduce the impact of the causal factors and may be used to ameliorate these problems. Identifying the interaction of various key factors is critical to developing a good formulation. The main aim is to identify the factors that can be addressed in the treatment plan to reduce the impact of problems on the person.

By bringing together a range of perspectives and explanatory models, the aetiological or causal formulation acts as a key strategy for developing an integrated understanding of the situation that tangata whaiora experience, and therefore for integrating care. Unlike the diagnosis and

problem-oriented statement, it takes a longitudinal or developmental perspective, encouraging the incorporation of genetic vulnerability, early life experiences and environmental factors into the explanation of the problems experienced by tangata whaiora. It is based on the facts presented by tangata whaiora and the health professional's knowledge of factors that contribute to the development and maintenance of the problems that tangata whaiora experience. It needs to be evidence based, where possible, but will also involve a degree of speculation.

One of the key aspects of this part of the opinion is that it involves a change in clinical reasoning and thinking strategies. Up until this point in the assessment the main strategy has been one of collecting and sorting information based on pattern recognition. Through knowledge and experience, health professionals come to internalise patterns of information that indicate a particular diagnosis or problem. This allows them to hypothesise about the presence of particular disorders and related difficulties based on relatively subtle clues provided early on in the tangata whaiora's history. This approach has one significant weakness, however: we tend to recognise what we know and not recognise what we are unfamiliar with. This may be adequate with common and straightforward conditions such as alcohol abuse or mild depression, but the nature of alcohol and drug dependence and co-existing disorders is such that more complex frameworks are needed to account for the wide range of factors influencing the development of people's problems.

There are a number of tools that can be used to synthesise the various causative factors into a coherent understanding of the person's situation. One such tool is the '4x4 grid'. This grid (see table 4.5) considers the biological, psychological, social and spiritual aetiological factors that predispose, precipitate, perpetuate and protect tangata whaiora and their current situation.

Table 4.5 » The 4x4 grid				
	Predisposing	Precipitating	Perpetuating	Protecting
Bio				
Psycho				
Social				
Spiritual				

Note that the four Ps in the column headings (predisposing, precipitating, perpetuating and protecting) are often thought of by other names, such as vulnerabilities (predisposing), triggers (precipitating), maintaining factors (perpetuating) and strengths (protecting). In effect, the bio, psycho, social and spiritual axes down the left-hand side are simply convenient prompts for remembering a range of important factors, such as genes, neurotransmitters, attributions, social networks, drug-using peer groups, values, frameworks for living, and so on. The key to the grid is that it encourages the health professional not to forget important factors – to be comprehensive – and then to consider how those factors interact.

All of the four Ps are important, but some are more important than others depending on the nature of the tangata whaiora's problems and/or the timing of presentation. In acute problems of recent onset, precipitants or triggers are often important. In chronic conditions, these precipitants may have occurred many years earlier and may no longer be active or may have become maintaining or perpetuating factors. In these chronic conditions it is often the perpetuating factors that become the main focus for intervention, along with the protective factors that have helped the tangata whaiora adapt to life with their problems.

To use the 4x4 grid approach, the health professional enters known aetiological factors into the grid. Most tangata whaiora will have factors in many areas of the grid, and some factors will

be entered in several different boxes. Don't get too concerned about whether something is a psychological or a social factor: this is not a 'right or wrong' thing, just a tool to help clarify the range of issues that might be contributing to a person's situation.

The choice of factors will depend on the health professional's perspective and the explanatory paradigms they choose to use, such as cognitive-behavioural, biomedical, psychodynamic, psychosocial and so on. There is considerable evidence about factors associated with substance use problems from genetic, neurobiological, cognitive-behavioural, social, spiritual and whānau or family perspectives, and so these are the most useful approaches to draw on.

There is a danger in just using the grid to generate a list of factors, however. The aim is to use it as a part of the process to produce an integrated statement about a person's presenting problems, which identifies key causal factors and their interaction. One structure for organising the explanatory statement uses three paragraphs which consider the interaction between key factors, as follows:

- » predisposing and precipitating factors
- » perpetuating and protecting (maintaining and strengths) factors
- » a comment on the pattern of the problems over time if, as in most cases, the problems are chronic and self-sustaining (i.e. the effects of the illness reinforce perpetuating factors, which cause the illness to persist; for example, chronic alcohol dependence worsens marital relationships, which then reinforce the ongoing use of alcohol as a coping mechanism, while coping and problem-solving skills atrophy due in part to a reliance on alcohol to cope with stress).

By allowing the use of a wide range of perspectives and paradigms, the aetiological formulation becomes a key point in developing an integrated understanding of the situation that tangata whaiora experience. Because management goals should be closely linked to the formulation, this integrated understanding becomes a key mechanism for integrating care.

The initial opinion formulated in the mind of the health professional needs to be fed back to tangata whaiora, whānau or family, and a shared understanding reached as a basis for negotiating shared management goals and plan.

3. Management

a. Management goals

Management goals should flow naturally from the formulation and lead on to a specific management plan. If a good opinion or formulation has been constructed, the key management goals should be obvious.

(i) Phases of treatment

Consistent with the approach that a long-term perspective is necessary for recovery from CEP, recovery is seen as progressing through a series of stages or phases. Management goals will vary with the phase of treatment a tangata whaiora is in. Many ways of conceptualising phases or stages of treatment have been proposed, including the use of Prochaska and DiClemente's Stages of Change Model (Prochaska and DiClemente 1998), discussed previously, and Osher and Kofoed's Engagement-Persuasion model (Osher and Kofoed 1989), which divides treatment into four phases based on the key task at each point: engagement, persuasion, active treatment and relapse prevention. These two models are often used together and are the predominant models in the area of CEP.

It should be noted that the Engagement-Persuasion model was initially intended for people already being treated within mental health services and referred for specialist substance use treatment. In such circumstances, a comprehensive assessment is already likely to have been performed, mental health symptoms stabilised and risk minimised. The substance use health professional can then take the time to concentrate first on engaging tangata whaiora and then persuading them of the need to change through motivational interventions – phases that can be prolonged – before actively addressing their substance use. Interventions such as a specific engagement interview (as outlined in a previous section) may also be useful.

However, for tangata whaiora not already engaged with a service, the initial phase of treatment will need to focus equally on ensuring safety, stabilising acute mental health, substance use and lifestyle crises, and completing a comprehensive assessment, as well as increasing engagement and motivation. Stabilisation is therefore a common initial phase of treatment in these circumstances. Engagement and motivation will be two key goals in this phase but will not necessarily take precedence over the others mentioned.

The following outline includes many of the key points of phases of treatment and recovery.

Early treatment – safety, stabilisation assessment and engagement

This involves:

- » the initial interview, during which it is important to:
 - » attend to cultural considerations
 - » assess and ensure safety, including cultural safety and physical health needs
 - » begin comprehensive assessment and treatment
 - » attend to issues of engagement and motivation
 - » involve and engage whānau or family
 - » negotiate an initial shared understanding/opinion and strategies for management of the early treatment phase
- » safety, including:
 - » self-harm and suicide risk
 - » violence and risk to others
 - » medical and physical health risks
 - » cultural safety
 - » ability to care for self
- » stabilisation, which involves:
 - » the short-term management of acute crises and severe dysfunction
 - » treatment of acute mental health crises, detoxification and initial stabilisation of substance use, and management of acute lifestyle crises such as relationship issues and homelessness (some tangata whaiora may attribute lack of stability to various aspects of their life, including the spiritual dimension, being out of balance, and so the health professional needs to be aware of this possibility and have the means of assessing and dealing with such presentation)

- » assessment and initiation of a management plan
- » engagement and enhancement of motivation.

Middle treatment

This involves:

- » active treatment of mental health and substance use problems
- » increasing the focus on steps to enhance well-being
- » maintaining engagement and motivation.

Late treatment

This involves:

- » maintaining minimised substance use and mental health symptoms, including:
 - » ongoing relapse prevention, coping skills, social skills, treatment adherence (if necessary)
 - » maintaining engagement and motivation
- » restoration of well-being, rehabilitation and recovery through:
 - » supported transition to effective community functioning
 - » ongoing work on relapse prevention, coping skills, social skills, treatment adherence
 - » enhancement of well-being, the development of supportive social networks, improved whānau or family functioning, employment
- » increasing self-management.

Autonomous well-being

This involves:

- » self-motivation
- » responsibility for managing well-being lying solely with the tangata whaiora and their whānau or family
- » no longer requiring formal support of substance use and mental health services.

(i) Harm minimisation versus abstinence

Another crucial issue when setting substance use goals is whether to aim for abstinence from substances or to minimise harm through reduced use and safer use. These are not necessarily mutually exclusive. Rather, abstinence can be conceptualised as the ultimate outcome of a harm minimisation approach. Expert opinion strongly supports a harm minimisation approach. Where tangata whaiora wish to abstain, this is a reasonable goal. However, many are unable to do so initially, and an insistence on abstinence may markedly increase the risk of treatment discontinuation.

(ii) Insistence on abstinence before mental health symptoms are treated

A period of short-term abstinence may be very useful to help distinguish secondary from persisting or primary mental health problems, and to allow for a clearer picture of the nature of the tangata whaiora's problems. However, there are two myths that need to be avoided. First, it is often suggested that accurate problem identification and diagnoses cannot be made while tangata whaiora are using substances and/or are frequently intoxicated. However, a good history will usually be able to give a sufficiently clear picture for treatment to progress without having to wait for abstinence to be achieved. Second, insistence on abstinence before mental health problems are treated frequently just delays or denies effective mental health treatment. It is increasingly evident that when mental health problems (such as mood problems) co-exist with substance use problems, the substance use may not have a significant impact on mood treatments. In such cases, treatment for mood problems should proceed regardless of patterns of substance use, and health professionals should be careful not to unnecessarily delay or withhold treatment because of the presence of substance use.

b. Management plan

It is useful for the management plan to take a long-term perspective. The information and opinion/formulation upon which the management plan is based may change over time as more information becomes available. It is important, therefore, that early management strategies that will be undertaken in the near future are outlined in detail. Although strategies that will not be employed in the early phases of treatment do not need to be described in detail, it is important for the management plan to be reviewed regularly, to take into consideration the changing circumstances of tangata whaiora, including their own goals for treatment and their response to treatment.

Attention must be given not only to the details of the individualised treatment plan, but also to the context in which treatment is delivered. In other words, it is essential to concentrate on the components of basic clinical management, especially developing a therapeutic alliance that facilitates the engagement of tangata whaiora in the treatment process and assertively addresses episodes of poor treatment compliance, such as missed appointments and non-compliance with medication.

To ensure the management goals are addressed in a comprehensive manner for each phase of treatment, it can be useful to structure management for each phase of treatment. One example of a structure that can be applied in each phase includes the following headings:

- (1) Setting
- (2) Further information
- (3) Treatment of medical conditions
- (4) Psychopharmacology
- (5) Psychological interventions
- (6) Whānau or family and social interventions
- (7) Spiritual interventions
- (8) Education/work/occupation

(9) Education of tangata whaiora and significant others

(10) Self-help groups.

Each of these headings is discussed below.

(1) Setting

Tangata whaiora should be treated in the least restrictive setting that is safe and practical. Providing a safe environment must be the first consideration in all cases. Consider the following.

- » Home-based outreach, outpatient treatment, day programmes, residential treatment programmes and kaupapa Māori programmes are all options.
- » High-intensity treatment can be provided in both inpatient and outpatient settings.
- » Initial detoxification may be needed, and can be carried out in the home of tangata whaiora, in a social detoxification centre or in a medical detoxification facility, depending on the anticipated severity of the withdrawal syndrome and the degree of social support available in the community. A history of delirium tremens is a strong indicator for medical detoxification, given that it can be life threatening.
- » Decisions about setting need to include consideration of psychiatric conditions as well. Again, outpatient, day programme and residential options exist, as well as inpatient.
- » The Mental Health Act, Alcoholism and Drug Addiction Act and justice directives may be useful, where appropriate.

(2) Further information

Consider:

- » gathering a collaborative history from significant others
- » approaching employers, teachers, etc.
- » information from the GP, other involved health professionals and agencies
- » past clinical files
- » consulting to expand the psychological elements of formulation or assistance with treatment development
- » referral for further testing of cognitive problems.

(3) Treatment of medical conditions

Consider:

- » physical examination from a GP
- » routine blood tests – full blood count, electrolytes, liver and renal function
- » thyroid function tests if there are mood problems
- » HIV, HCV and HBV screening, if there are risk factors
- » treatment of any existing medical conditions
- » sexual health screening.

(4) Psychopharmacology

Consider:

- » medication for detoxification
- » disulphiram (antabuse) or naltrexone for alcohol dependence
- » methadone or buprenorphine, if available, for opioid dependence
- » nicotine replacement therapy, varenacline or bupropion for nicotine dependence
- » medication for mental health diagnoses.

(5) Psychological interventions

Consider:

- » psychological treatments, especially CBT for psychiatric conditions such as addiction, anxiety disorders, including post-traumatic stress disorder, depression; Interpersonal and Social Rhythm Therapy for bipolar disorder etc.; specific skills building (coping, problem solving, social skills)
- » motivational approaches
- » twelve-step facilitation
- » relapse prevention for substance use and mental health problems
- » coping skills, social skills training.

(6) Whānau or family and social interventions

Consider:

- » whānau or family education about the assessment and management plan for tangata whaiora, and about strategies the whānau or family can use to support treatment and recovery
- » whānau or family therapy
- » further treatment for significant others and whānau or family members' own problems, if needed
- » peer support groups
- » social activity groups
- » Multi Systemic Therapy, Social Behavioural Network Therapy
- » occupational therapy for assessment and rehabilitation of work skills, and daily living skills
- » various community support agencies.

(7) Spiritual interventions

Consider:

- » acknowledging the spiritual dimensions that influence other aspects of the management plan
- » referring to a spiritual specialist for specific interventions (minister, tohunga).

(8) Education/work/occupation

Consider:

- » further education, work and occupational skills, work opportunities
- » involvement of specialist work placement and advisory groups (e.g. Workbridge).

(9) Education of tangata whaiora and significant others

Consider:

- » meeting with the significant other/s, whānau or family for education about the tangata whaiora's problems
- » scheduling ongoing meetings regarding progress.

(10) Self-help groups

Consider:

- » Alcoholics Anonymous, Narcotics Anonymous for substance use problems; Gamblers Anonymous and other groups for behavioural addictions (where appropriate)
- » Alanon for whānau or family members
- » psychiatric consumer groups for mental health problems
- » other community-based groups that might contribute to the individual's ability to make and sustain change.

4. Prognosis or prediction of future outcome

A prognosis is an essential but often overlooked part of treatment. It is the point at which the health professional makes a reasoned prediction about what will happen to a tangata whaiora if they take various courses of action. As such, the prognosis is one of the most important factors that motivate tangata whaiora to change and to accept treatment.

It is also an important part of the initial feedback and answers one of the more pressing questions tangata whaiora or significant others have: 'What is going to happen to me/my friend/my partner?' The ability to make an informed and useful prognosis is therefore an essential skill for all health professionals to have. It provides tangata whaiora and the whānau or family with an indication of the probable course of the problems, gives a clear indication of the factors that can influence the outcome, both positively and negatively, and gives an indication of the things the tangata whaiora can do themselves to influence the course of their problems.

In clinical practice it is useful to consider prognosis in terms of three steps.

Step 1: Consider the natural history or course of the tangata whaiora's disorder: in other words, what is the natural course of the disorder or problem in most people? For example, severe alcohol dependence can be considered to have a chronic course, with episodes of abstinence and relapse. Perhaps one-third of sufferers manage to achieve sustained abstinence and a much smaller percentage achieve sustained controlled drinking over a 10-year period. It is associated with high levels of physical, psychological and social problems and may shorten the tangata whaiora's life expectancy.

Step 2: Consider individual factors that are likely to be a positive influence on the natural course.

Step 3: Consider individual factors that are likely to be a negative influence on the natural course.

In effect, the prognosis is usually restating those factors identified in the aetiological formulation, while considering the likely impact of the management plan on these factors over a specific time period such as the next six months, 12 months or five years.

5. Feedback and negotiation

The final part of the comprehensive assessment involves the health professional feeding back to tangata whaiora their understanding of the tangata whaiora's vision of well-being, their opinion about both the problems experienced that form barriers to well-being and the strengths and protective factors, and their suggested strategies for enhancing well-being – the management plan. Negotiating a shared and agreed understanding of the above is an essential part of the process and forms the basis upon which management can proceed.

Key Points	
»	A well-being perspective is an important starting point for assessment, in which problems are seen as barriers to well-being and a vision of the well-being of tangata whaiora acts as the desired outcome.
»	Levels of assessment include screening, brief assessment and comprehensive assessment.
»	Screening tools may be useful, but in general direct questioning from a skilled interviewer is preferable.
»	Comprehensive assessment involves data collection, opinion, the management goals and plan, prognosis or prediction of outcome, and feedback.
»	The opinion formed by the clinician is the core feature of the comprehensive assessment and includes: <ul style="list-style-type: none"> » diagnoses » individualised statements of problems and strengths » aetiological or causal formulation.
»	The aetiological or causal formulation is a key point of integration, allowing the synthesis of a wide range of problems from different perspectives into a coherent and holistic understanding of the situation faced by tangata whaiora.
»	Management goals and the management plan flow naturally from a good opinion and should be predictable given the opinion.

4.5.6 Further Reading

Kina Families and Addiction Trust provide excellent training and resources focusing on family-inclusive practice relevant to people with substance use problems and CEP:
<http://www.kinatrust.org.nz/>

4.6 Principle 6 » Management

4.6.1 Overview of Management Approaches

Management involves implementing the management plan derived during the comprehensive assessment. It is useful to think of management involving two levels or components:

1. generic strategies common to most tangata whaiora with CEP
2. specific strategies directed at the particular combination of mental health and substance use problems being addressed.

There is limited evidence to support many of the treatment strategies widely used for CEP. This is especially true for specific strategies targeting particular combinations of substance use and

mental health problems, where few interventions appear to help both the substance use and mental health problems at the same time. Many of these interventions have not been adequately researched. However, several commonly recommended interventions, such as MI and CBT approaches for substance use problems, have been researched and have been shown to be of questionable effectiveness for the key problems people with CEP experience (Tiet and Mausbach 2007; Drake et al. 2008; Cleary et al. 2008).

Interventions for which there does appear to be some support include:

- » group counselling
- » long-term residential CEP programmes
- » contingency management approaches.

Although other interventions should not be rejected out of hand, given the limited research base, health professionals should give strong consideration to those that are supported by evidence. Health professionals are strongly advised to become familiar with the strength of evidence for interventions they are considering using, and the reviews cited above are a good starting point.

Generic strategies include:

- » clinical case management to coordinate care and deliver interventions
- » inclusion of cultural considerations
- » establishment and maintenance of engagement
- » strategies to maintain safety
- » techniques to stabilise acute substance use, mental health and lifestyle problems
- » strategies to enhance and maintain motivation
- » strategies to enhance well-being
- » integration of care
- » individual counselling, such as MI and CBT, despite limited evidence for their effectiveness in CEP
- » group counselling
- » whānau or family interventions, despite limited evidence of their effectiveness in CEP
- » contingency management
- » facilitation of legal mandate and court direction to receive treatment.

Specific strategies include:

- » evidence-based strategies that are particularly suited to the specific combination of substance and mental health problem/s (e.g. the preferential choice of medications that also have a positive impact on substance use for mental health problems, such as clozapine or possibly quetiapine in chronic psychosis)
- » where evidence is lacking to guide treatments for specific combinations of problems, the use of evidence-based treatments for the specific substance added to evidence-based treatments for the specific mental health problem, adapted to take into consideration the interaction between the two (e.g. the use of cognitive-behavioural approaches which avoid exposure techniques for anxiety problems, and the specific targeting of intrusive thoughts in CBT for post-traumatic stress problems in substance users – see below).

4.6.2 Clinical Case Management

Having one health professional take responsibility for overseeing and coordinating the management plan is an essential ingredient of comprehensive and integrated care and may be one of the most important factors in determining the effectiveness of interventions with tangata whaiora with CEP (Dumaine 2003).

Models of case management

There are a number of different models of case management, including:

- » brokerage, where the main task of the case manager is to assess needs, refer to other services as necessary and coordinate treatment
- » clinical case management, where the case manager coordinates care but also delivers specific interventions
- » assertive community treatment (ACT), involving case management by a multi-disciplinary team, which delivers assertive outreach in the community and comprehensive interventions are delivered by the team rather than using external referrals
- » intensive case management (ICM), where individual case managers provide intensive assertive outreach interventions several times a week for tangata whaiora who are difficult to engage (Mueser et al. 1998).

The brokerage model of case management suffers in that care is often not well integrated and specific interventions may not be delivered often enough or easily. ACT and ICM tend to be resource-intensive, with case managers having small case loads of 10–15 people. There is also little evidence that ACT or ICM is associated with better outcomes than standard clinical case management (Cleary et al. 2008; Drake et al. 2008). Further, some of the key characteristics of ACT and ICM, such as assertive outreach, are able to be incorporated in standard clinical case management approaches. As such, clinical case management is probably the preferred initial model in most circumstances, especially in services that are not heavily resourced.

Principles of clinical case management

- » The clinical case manager should be integrated into a multi-disciplinary team and should be part of a team of case managers who have knowledge of each other's cases.
- » The clinical case manager should be the single coordinating point for all care.
- » The clinical case manager should follow tangata whaiora over time and continue to be the coordinating point of contact for all psychiatric and addiction services. The 'case' should be held over time, even when tangata whaiora drop out of treatment for a period of time. When a case manager leaves a service, his/her cases should be taken over by another member of the case management team.
- » The clinical case manager needs a comprehensive range of skills to allow them to attend to a wide range of problems and to be able to undertake a range of interventions. These should include comprehensive assessment and management planning, motivational interventions, relapse prevention, psychiatric monitoring, and education of the tangata whaiora and whānau or family members.
- » They also need to have sufficient understanding of all other interventions that may be used, and the ability to recognise their own limits and be able to refer on when these are reached.

- » Clinical case management should be assertive. Tangata whaiora who fail to attend appointments should be phoned or visited at home and a great deal of effort needs to be put into engaging the tangata whaiora and keeping them in treatment. When a tangata whaiora refuses treatment and cannot be compelled to receive it, every effort should be made to support the whānau or family and social network, providing strategies for helping the tangata whaiora indirectly.
- » The clinical case manager should be mobile and community based.
- » The clinical case manager's workload should be such that they have the time to manage tangata whaiora effectively. This may require a smaller case load, given the intensity and wide range of interventions tangata whaiora with CEP need.

Key tasks and skills of the clinical case manager

The key tasks of the case manager are:

- » undertaking a comprehensive assessment
- » maintaining and fostering engagement and the therapeutic alliance
- » enhancing motivation, treatment compliance and assertively following up missed appointments
- » coordinating care and linking with other health professionals and services involved
- » monitoring mental state, drug use, medication response and side-effects, and assessing risk
- » crisis management – there should be 24-hour access to health professionals who have ready access to information about the tangata whaiora and who are able to see the tangata whaiora in the community if necessary
- » delivering specific interventions such as relapse prevention, CBT, group interventions, contingency management, and assessment of well-being and strategies to enhance this
- » liaising with, educating and supporting whānau or family members and significant others
- » training and liaising with other health professionals and services involved, such as employment agencies, social welfare services, Māori health workers and addiction specialists
- » ensuring continuity of formulation, continuity of care and continuity of key health professionals as much as possible and assisting transitions in these when changes in these are required
- » preparing the tangata whaiora for entry into self-help groups
- » facilitating self-management.

Case management of substance use and antisocial personality disorders

Antisocial personality disorder (ASPD) frequently co-occurs with substance use disorders and several mental health disorders (such as mood disorders), is highly prevalent in justice settings, and presents a considerable challenge to health professionals. Research into the treatment for ASPD with comorbid problematic substance use is limited but there are a number of findings of interest.

- » Motivation to change strongly influences substance use outcomes. Tangata whaiora with ASPD who are also motivated to change do as well as those without ASPD in substance use treatment (Conrod and Stewart 2005; Conrod and Stewart 2006).

- » Motivation is strongly associated with the quality of the therapeutic relationship, which develops slowly in those with ASPD (Conrod and Stewart 2005; Conrod and Stewart 2006).
- » Longer-term treatments that facilitate the development of a strong therapeutic relationship are therefore recommended when ASPD is accompanied by low motivation (Conrod and Stewart 2005; Conrod and Stewart 2006). Residential therapeutic communities are recommended in these circumstances (Hesse and Pedersen 2006).
- » The more severe the ASPD, the more likely it is that coping skills approaches rather than interactional or interpersonal approaches will be useful.
- » A case manager who meets with and begins engagement prior to the beginning of treatment may enhance retention in treatment (Havens et al. 2007).
- » Use of court mandates to motivate treatment is associated with lower rates of drop-out than voluntary treatment (Daughters et al. 2008).
- » Contingency management with clear positive and negative behavioural reinforcements, within a treatment programme that utilises a clear and consistent approach with little flexibility, may be the most effective treatment approach (Reid and Gacono 2000).
- » Dual Focus Schema Therapy, in which underlying cognitive schema associated with both substance use and antisocial behaviours are addressed simultaneously, may be effective (Ball 2007; Ball et al. 2005).

In addition, some basic common-sense principles are useful.

- » Treat other co-existing mental health problems – symptoms of ASPD may emerge in adulthood in the context of other mental health problems, and treatment may reduce the impact of the antisocial symptoms.
- » Attend to boundary issues – boundaries serve an important function in the management of tangata whaiora. They help establish a therapeutic environment that is safe for tangata whaiora, the health professional and relevant others, and help the tangata whaiora gain control of ‘out-of-control’ behaviours and emotions. Examples of boundaries include limits on the expression within treatment of certain behaviours (such as aggression), rules on contact with the therapist outside regular appointments, and the timing and setting of appointments. Here are some guidelines.
 - » Make boundaries and limits explicit from the start.
 - » Have clear consequences for transgressions of these boundaries.
 - » Clarify what confidentiality means and when it may be breached (e.g. a duty to inform if there is direct risk to others).
 - » Clarify which other professionals and whānau or family members the therapist will need to be free to communicate with.
 - » Be reliable and consistent applying boundaries.
 - » Do not shift the boundaries once established.
 - » Validate the feelings of tangata whaiora.
 - » Encourage the tangata whaiora to take responsibility for their actions while being aware that they may not do so easily.
 - » Gently point out behaviours and thinking of personality dysfunction (e.g. blaming of others for the tangata whaiora’s problems or believing that he/she is always right).

- » Be reliable – on time, supportive, consistent.
- » The therapist should have individual supervision in which they can discuss the case.
- » Manage transference and counter-transference – health professionals need to be mindful to issues of transference and counter-transference. These terms can loosely be defined as the assumptions and prejudices, usually originating in past relationships, that tangata whaiora hold about the health professional (transference) and those that the health professional holds about tangata whaiora (counter-transference).
- » Acquire a high level of skill at assessing and managing risk.

4.6.3 Treatment Strategies

Treatment strategies can be considered for each phase of treatment against the key goals of that phase. An example is outlined below.

Pre-treatment

Key goals

During the time between a referral being received and the initial interview it is important to:

- » determine which is the best service to see the tangata whaiora
- » ascertain the specific needs of tangata whaiora with respect to the process of initial contact and the best people to be involved in this
- » determine specific cultural needs and how these will be catered for
- » clarify and obtain any further information that might be useful, prior to the initial interview.

Key treatment strategies

- » Obtain any past clinical records.
- » Involve appropriate cultural expertise when indicated.
- » Contact tangata whaiora and whānau or family to ascertain cultural needs, especially those relating to people to include in initial contact and the desired processes of initial engagement.
- » Consider contacting referral to clarify the most appropriate service.

Early treatment – safety, stabilisation, assessment and engagement

Key goals

- » The key goals of the initial interview are to:
 - » assess and ensure safety, including cultural safety
 - » attend to cultural considerations
 - » begin comprehensive assessment and treatment
 - » attend to issues of engagement and motivation
 - » involve and engage whānau or family

- » negotiate an initial shared understanding/opinion and strategies for managing the early treatment phase.
- » Safety involves considering:
 - » self-harm and suicide risk
 - » violence and risk to others
 - » medical risks (e.g. metabolic disturbances such as low serum potassium associated with eating disorders, thyroid dysfunction that might underlie mood disorders, vitamin deficiencies and liver impairment in tangata whaiora using alcohol heavily, possible drug overdoses, drug withdrawal seizures and delirium, and blood-borne infections such as HIV and Hepatitis B and C)
 - » cultural safety – this applies to all tangata whaiora, but especially to those whose identity lies outside the mainstream (e.g. in relation to ethnicity or sexual orientation); attention to cultural safety ensures that a person does not feel demeaned or invalidated by the processes of assessment and treatment
 - » ability to care for self and dependants safely, especially children.
- » Stabilisation involves:
 - » the short-term management of acute crises and severe dysfunction
 - » treatment of acute mental health crises; detoxification and initial stabilisation of substance use; and management of acute lifestyle crises such as relationship issues, homelessness etc. (some tangata whaiora may attribute lack of stability to various aspects of their life, including the spiritual dimension, being out of balance, and so the health professional needs to be aware of this possibility and have the means of assessing and dealing with such presentation)
- » assessment and initiation of a management plan
- » engagement and enhancement of motivation enhancement.

Key treatment strategies

- » Issues of safety take precedence over all others. While empowering and non-confrontational approaches are important in interactions with tangata whaiora, they should not take priority over ensuring safety. Following are some guidelines.
 - » Safety and risk must not only be assessed but must be managed.
 - » Every service should have a protocol for managing risk.
 - » Safety issues require continual monitoring throughout treatment.
 - » The initial assessment should screen for and, where relevant, fully assess risk, and implement plans to manage risk and maintain safety.
 - » Consideration must be given to the possibility that some interventions, while affording short-term protection, may increase medium- to long-term risk and therefore would be inadvisable. For example, prolonged admission in a controlling environment, such as in a tangata whaiora psychiatric unit, may increase the subsequent risk of self-harm of tangata whaiora with borderline personality traits or dependent personality traits.

- » Few, if any, tangata whaiora with CEP are at no risk. The management of safety issues should balance the benefits of an intervention against its disadvantages. There is usually some degree of risk in any intervention, and it is therefore important that health professionals are skilled in assessment and management of risk and have access to experienced senior health professionals.
- » Following are some guidelines for detoxification.
 - » Withdrawal from psychoactive substances can be associated with physical trauma, worsening of mental health problems, physical harm and/or death.
 - » Services should be able to assess the risk and manage important complications of substance withdrawal, including delirium tremens, seizures and Wernicke-Korsakoff's syndrome. These are often medical emergencies.
 - » Services should have clear protocols for managing substance withdrawal themselves, while also having the ability to obtain support from specialist services or transfer care to specialist services.
 - » A useful resource is the *NSW Detoxification Clinical Practice Guidelines*: http://www.health.nsw.gov.au/publichealth/dpb/publications/pdf/detoxification_clinicalpractice_guidelines.pdf
 - » Simple tools such as the Clinical Institute Withdrawal Assessment for Alcohol – Revised (CIWA-A) can be useful for determining the severity of alcohol withdrawal, and scoring can be linked to interventions such as medication prescribing – see the *New South Wales Detoxification Clinical Practice Guidelines* (above) for details.

(1) Setting

Tangata whaiora should be treated in the least restrictive setting that is safe and practical. Providing a safe environment must be the first consideration in all cases. The setting tangata whaiora present to should take responsibility for initiating comprehensive and integrated care and should be the initial sole coordinating point for ongoing treatment. When services are required from other agencies, these should be brought into the initial setting whenever possible and integrated into the initial management plan. Where it is decided that the needs of tangata whaiora will be better met by another service in a different setting, it is important to transition care effectively and maintain continuity of the opinion/formulation and management plan. Precipitous changes of opinion and management should be avoided, especially any changes in diagnosis.

Consider:

- » home-based outreach, outpatient treatment, day programmes, residential treatment programmes, kaupapa Māori programmes
- » high-intensity treatment – this can be provided in both inpatient and outpatient settings
- » initial detoxification – this may be needed, and can be carried out in the home of tangata whaiora, in a social detoxification centre, or a medical detoxification facility depending on the anticipated severity of the withdrawal syndrome and the degree of social support available in the community (a history of delirium tremens is a strong indicator for medical detoxification, given that it can be life threatening)
- » decisions about setting – these need to include consideration of psychiatric conditions as well, and, again, outpatient, day programme and residential options exist, as well as inpatient

- » the use of the Mental Health Act, Alcoholism and Drug Addiction Act and Justice directives to enforce treatment, where appropriate and necessary.

Note that the Mental Health Act cannot be used solely on the grounds of alcohol and drug problems or personality disorder, but can be used for mental health symptoms that may arise in part from the effects of alcohol and other drugs. An example of this is psychotic symptoms that prove to be secondary to cannabis use, or suicidal depression that proves to be secondary to alcohol use. The Mental Health Act should therefore be considered if significant risk of self-harm is apparent. Common sense and concern for the best interests of the tangata whaiora and their whānau or family should guide the health professional.

The Alcoholism and Drug Addiction Act was introduced over 30 years ago and is limited in its usefulness, especially for tangata whaiora with CEP. In most instances where tangata whaiora safety is compromised, the health professional is advised to consider the use of the Mental Health Act. The Alcoholism and Drug Addiction Act does have a role in cases where mental health symptoms are not considered to pose a danger to self or others, but alcohol or other drugs are being used in a way that seriously endangers physical health and in a way that is potentially fatal.

Justice settings provide an opportunity to offer treatment to the many tangata whaiora who experience CEP. Motivation is a key issue influencing the effectiveness of CEP interventions in the offender, but mandated treatment does appear effective in many and motivation is often developed after mandated treatment begins. Much work is necessary before screening, assessment and treatment is able to be effectively delivered in these settings.

(2) Further information

Consider:

- » gathering a collaborative history from:
 - significant others
 - employers, teachers etc.
 - GP and other involved health professionals and agencies
- » reviewing past clinical files
- » consulting to expand the psychological elements of the formulation or for assistance with treatment development
- » referral for further testing of cognitive problems, and especially the impact of brain injury.

Information given about recent drug use may be corroborated with a urinary drug screen. A baseline cannabinoid:creatinine ratio may be useful if cannabis has been recently used. It is important, however, to balance the need for confirmation with risk to the therapeutic relationship from intrusive tests, such as urine drug screens. Developing a trusting, empathic and non-judgemental therapeutic relationship markedly increases the chances that the history from tangata whaiora will be accurate.

(3) Treatment of medical conditions

Consider:

- » physical examination from a GP
- » routine blood tests – full blood count, electrolytes, liver and renal function

- » thyroid function tests if there are mood problems
- » HIV, HCV and HBV screening if there are risk factors
- » treatment of any existing medical conditions
- » sexual health screening.

It is reasonable that services that do not have access to medical staff of their own request the medical review to be carried out by the tangata whaiora's GP. Many tangata whaiora do not have regular GPs or are reticent to mention such problems to their GP. It is therefore essential that there is close liaison with a GP who can assist the tangata whaiora in this regard to ensure the medical review actually happens.

(4) Psychopharmacology

Early treatment involves the use of medication for stabilisation and the initiation of longer-term treatments. The principles of prescribing medication to tangata whaiora with CEP are the same as those for other tangata whaiora. However, in addition special attention needs to be given to using the lowest effective dose and minimising side-effects, given the problems of treatment compliance in this group of tangata whaiora and the possibility they may be especially susceptible to tardive dyskinesia from antipsychotic medication.

Consider:

- » continuing medication already prescribed for physical problems
- » medication for detoxification – this may include reducing doses of an opioid such as methadone or buprenorphine for opioid withdrawal (usually in a controlled setting) or benzodiazepines for alcohol withdrawal and benzodiazepine withdrawal (again, usually in a controlled setting for benzodiazepine withdrawal)
- » disulphiram (antabuse) or naltrexone for alcohol dependence (note that naltrexone may be useful for reducing craving, an important predictor of failure to complete treatment, in residential settings where tangata whaiora are not exposed to alcohol)
- » methadone or buprenorphine, if available, for opioid dependence
- » nicotine replacement therapy; varenicline or bupropion for nicotine dependence
- » initiation of medication for mental health diagnoses – research into specific medications for mental health disorders in tangata whaiora with substance use problems is at an early stage, but there are some findings that, while still needing replication, are worth considering
- » chronic psychosis (schizophrenia, schizoaffective disorder):
 - Risperidone appears to be associated with increased rates of abstinence in tangata whaiora undergoing substance use treatment when compared with olanzapine, ziprasidone and traditional antipsychotics. This may be related to compliance with psychological treatments, partly due to an interaction between nicotine withdrawal and the metabolism of olanzapine and typical antipsychotics, with nicotine inducing the P4501A2 (CYP1A) cytochrome, which is involved in the metabolism of these drugs but not risperidone or ziprasidone. It is possible that during substance use treatment, reduced nicotine use may increase the activity of P4501A2 and therefore reduce the metabolism of these antipsychotics, increasing side-effects, including sedation (Rubio et al. 2006; Stuyt et al. 2006).

- Clozapine also appears to reduce substance use in tangata whaiora with schizophrenia (Brunette et al. 2006) and appears more potent in this regard than risperidone (Green et al. 2003) though the side effect profile of clozapine means that risperidone is preferable at least initially.
- » cannabis use and major depression – fluoxetine has been associated with a reduction in cannabis use in depressed alcoholics (Cornelius et al. 1999) and with lower rates of treatment completion compared to nortriptyline in people with major depression using cannabis; it is possible that there is an aversive relationship between cannabis use and fluoxetine, which leads some to stop cannabis and others to stop fluoxetine, although this finding requires further research and it is unclear whether it is specific to fluoxetine or includes other SSRI antidepressants
- » bipolar disorder and substance misuse – sodium valproate may be more effective than lithium carbonate for tangata whaiora with substance use problems, possibly because sodium valproate is associated with fewer side-effects and therefore better compliance in this population (Weiss et al. 1998), and sodium valproate may also be more effective than lithium for rapid cycling bipolar disorder, which is more common in those who misuse substances (Brady et al. 1995).

(5) Psychological interventions

During the early treatment phase, psychological interventions will usually focus on:

- » developing engagement and motivation through establishing a therapeutic relationship
- » the use of motivational interviewing techniques adapted to take into account mental health symptoms
- » specific coping strategies for acute crises, such as anxiety reduction techniques and cognitive strategies, to cope with any substance withdrawal symptoms
- » the exploration of what well-being entails for tangata whaiora – their life goals, hopes and aspirations for the future.

(6) Whānau or family and social interventions

Where reasonable whānau or family relationships exist, family involvement and the involvement of the tangata whaiora's main social supports are essential from the earliest stages of treatment. This is especially so for Māori and tangata whaiora from cultures where whānau or family and collective responsibility are of central importance. It should also be noted that in many cases the definition of whānau or family may differ from the usual Western conceptualisation. Education about the nature of the problems, the approach to treatment and the early signs of relapse is an important prelude to involving the whānau or family in the treatment process.

The tangata whaiora's social networks may be involved in monitoring treatment compliance, especially attendance at appointments and the taking of any prescribed medication and the monitoring of progress and relapse. A social milieu that is not supportive of treatment can seriously undermine the tangata whaiora's cooperation with treatment.

Where the relationships with whānau or family and friends are problematic or deficient, specific interventions may be warranted. Consideration should be given, once the tangata whaiora is stable, to specific whānau or family interventions, and to training in social skills to assist the tangata whaiora to establish new support networks.

Consider:

- » whānau or family education about the assessment and management plan for tangata whaiora, and about strategies the whānau or family can use to support treatment and recovery
- » stabilisation of whānau or family crises
- » involvement of whānau or family in monitoring symptoms, progress and treatment compliance.

(7) Spiritual interventions

Consider:

- » acknowledging the spiritual dimensions that influence other aspects of the management plan
- » taking care, especially with Māori and Pacific peoples, to respect spiritual needs and to involve spiritual and cultural health professional advice from the earliest stages of treatment to support treatment and avoid spiritual transgressions
- » referral to a spiritual therapist for specific interventions (minister, tohunga) early in treatment.

(8) Education/work/occupation

Consider liaising with the employer to support the maintenance of employment if tangata whaiora are unable to continue working while unwell.

(9) Education of tangata whaiora and significant others

Consider:

- » psychoeducation, which can begin gently from the earliest point of treatment and should take advantage of any enhanced motivation for change that acute illness may present
- » meeting with the significant other, whānau or family for education about the tangata whaiora's problems, and consider scheduling ongoing meetings regarding progress
- » education for Māori clients focused on assisting them to reconnect or connect with the resources of te ao Māori (e.g. through learning te reo).

(10) Self-help groups

Consider consumer support groups such as AA, mental health support groups.

Middle treatment

Key goals

The key goals for middle treatment are:

- » active treatment of mental health and substance use problems
- » increasing the focus on steps to enhance well-being
- » maintaining engagement and motivation.

Key treatment strategies

(1) Setting

This may take place in either community or residential settings. Consider:

- » clinical case management
- » continued use of the Mental Health Act if needed, community based if possible
- » continued use of the Alcoholism and Drug Addiction Act, if needed
- » treatment within Justice settings or in residential or community settings mandated by Justice services.

(2) Further information

Consider:

- » a collaborative history regarding progress of the management plan
- » urinary drug screens to provide feedback on progress.

(3) Treatment of medical conditions

Consider:

- » continuing treatment of pre-existing medical conditions
- » monitoring and enhancement of general physical well-being.

(4) Psychopharmacology

Consider:

- » initiation of medications, as for the early treatment phase, if not already started
- » monitoring of dose, adherence and response
- » augmentation or change of medication if ineffective.

(5) Psychological interventions

Many psychological interventions aimed at actively treating the core substance use and mental health problems will be initiated in the middle phase of treatment. When selecting which treatment to offer tangata whaiora, the health professional should be guided by what is known to be effective, what the tangata whaiora feels comfortable with and what the therapist is competent at providing. The health professional should also consider which of the acceptable treatment approaches for a particular problem integrate well conceptually with those approaches used for other problems.

Consider:

- » culturally specific interventions, including the strengthening of cultural identity, knowledge and application of key cultural values
- » psychological treatments, especially CBT (see box below) for psychiatric conditions such as addiction, anxiety disorders (including post-traumatic stress disorder), depression; Interpersonal and Social Rhythm Therapy for bipolar disorder; and specific skills building (coping, problem-solving, social skills) (Frank 2007; Frank et al. 2005)
- » motivational approaches
- » twelve-step facilitation

- » relapse prevention for substance use and mental health problems
- » coping skills, social skills training.

Cognitive Behavioural Therapy (CBT) for CEP

Conrod and Stewart (2005; 2006) have reviewed dual-focused CBT in some depth. Combined CBT for substance use and mental health problems (dual-focused CBT) appears effective, especially in mood disorders. However, specific CBT strategies differ for different problems, and applying a generic approach to all problems is unlikely to be particularly successful. The relationship between substance use and the specific symptoms of mental health problems needs to be understood for CBT to be effective.

The reviews by Conrod and Stewart make the following points about specific strategies.

Substance use and anxiety disorders

- » Dual-focused CBT for anxiety problems is particularly difficult.
- » Many people with substance use and anxiety problems do not engage in treatment or drop out of treatment early.
- » Tangata whaiora with substance use and anxiety problems experience marked avoidance of anxiety-provoking situations and often rely on substance use to manage their anxiety. Withdrawal symptoms may worsen arousal, and the loss of the anxiolytic effects of substance use further entrenches avoidant strategies, which may include avoiding treatment. Strategies to cope with arousal and to overcome avoidance should be a key focus of early treatment.
- » CBT treatments using exposure-based approaches provoke further anxiety and can conflict with messages from substance use treatments to avoid high-risk situations. Exposure-based approaches should therefore be avoided if possible, or used late in treatment if needed.
- » With post-traumatic stress disorder, sedative substances, including alcohol, are the most commonly used, aimed at reducing increased arousal. Intrusive thoughts and memories appear to be the strongest predictor of relapse to substance use. Thus, strategies to cope with hyperarousal should be undertaken early in treatment, and intrusive thoughts, memories and emotions should be a focus of treatment overall.
- » There have been few studies on CBT for social phobia with substance use. One of the few studies showed that outcomes for social phobia were no different, and for substance use were actually worse, with dual-focused CBT and integrated care. Serial treatment may be a better option, and treatment may need to go more slowly than usual over a longer time period. For tangata whaiora who use sedative drugs to cope with social anxiety, the focus of treatment should be on social avoidance.
- » CBT approaches can be effective for personality disorders with substance use problems.

Substance use and borderline personality disorder

Dialectical Behaviour Therapy (DBT), with an added substance use module, has been shown to be effective for addressing substance use problems in those with borderline personality disorder while maintaining the benefits of DBT for borderline symptoms (Linehan et al. 1999; Verheul et al. 2003). Another proven treatment for borderline personality disorder, Mentalization-based Treatment (MBT), remains effective in the presence of significant substance use (Bateman and Fonagy 2008).

CBT targeting specific personality risk factors

Personality traits appear to be associated with specific patterns of substance use in adolescents. Specifically, sensation seeking is more associated with mood enhancement and in females with alcohol dependence, while anxiety sensitivity and hopelessness are more associated with the use of substances to cope with negative emotions, anxiety sensitivity is associated with sedative drug misuse, and hopelessness is associated with depression and opioid misuse. CBT strategies targeting these personality traits have recently been developed and appear promising in prevention for adolescents as well as having potential for treatment in adults.

(6) Whānau or family and social interventions

Consider:

- » whānau or family education about the assessment and management plan for tangata whaiora, and about strategies the whānau or family can use to support treatment and recovery
- » whānau or family therapy
- » further treatment for significant others and whānau or family members' own problems, if appropriate
- » peer support groups
- » social activity groups
- » Multi Systemic Therapy, Social Behavioural Network Therapy
- » occupational therapy for assessment and rehabilitation of work skills; daily living skills
- » various community support agencies.

(7) Spiritual interventions

As for early treatment.

(8) Education/work/occupation

Consider:

- » further education, work and occupational skills; work opportunities
- » involvement of specialist work placement and advisory groups (e.g. Workbridge).

(9) Education of tangata whaiora and significant others

Consider ongoing education relevant to the important tasks of treatment and strategies for significant others to support the application of psychological treatments and compliance with medication.

(10) Self-help groups

Consider:

- » Alcoholics Anonymous and Narcotics Anonymous for substance use problems; Gamblers Anonymous and other groups for behavioural addictions, where appropriate
- » Alanon for whānau or family members
- » psychiatric consumer groups for mental health problems
- » other community-based groups that might contribute to the individuals' ability to make and sustain change.

Late treatment

Key Goals

The key goals for late treatment are:

- » maintenance of minimised substance use and mental health symptoms, including:
 - » ongoing relapse prevention, coping skills, social skills, treatment adherence (if necessary)
 - » maintaining engagement and motivation
- » restoration of well-being, rehabilitation and recovery, including:
 - » supported transition to effective community functioning
 - » ongoing work on relapse prevention, coping skills, social skills, treatment adherence
 - » enhancement of well-being, the development of supportive social networks, improved whānau or family functioning, employment
- » increasing self-management, including supporting tangata whaiora to apply the strategies above increasingly independently.

Key treatment strategies

(1) Setting

This point in treatment should usually be undertaken with tangata whaiora who are in a stable, independent home environment, or who are transitioning to this in the very near future. Case management should continue but will be increasingly supportive rather than therapeutic

Consider:

- » reviewing the collaborative history regarding the progress of the management plan
- » Performing urinary drug screens to provide feedback on progress.

(2) Further information

As above.

(3) Treatment of medical conditions

Consider:

- » continuing treatment of pre-existing medical conditions
- » monitoring and enhancement of general physical well-being.

(4) Psychopharmacology

Consider:

- » medication will generally be established and stable at this point in treatment
- » ongoing monitoring of treatment adherence, while increasingly giving responsibility for managing medication to tangata whaiora and their whānau or family.

(5) Psychological interventions

Consider:

- » the focus shifts from direct psychological interventions to supporting tangata whaiora to apply them in their day-to-day lives
- » reinforcement of previously learnt coping skills and other strategies.

(6) Whānau or family and social interventions

Consider:

- » increasing education about the specific strategies used in treatment and transition of the case manager's supportive role to significant others and whānau or family
- » encouraging the establishment of non-substance using and pro-social peer relationships.

(7) Spiritual interventions

As above.

(8) Education/work/occupation

Consider the tangata whaiora engaging in work, ongoing learning and leisure activities.

(9) Education of tangata whaiora and significant others

As above, and related to whānau or family and social interventions above.

(10) Self-help groups

Consider:

- » Alcoholics Anonymous and Narcotics Anonymous for substance use problems; Gamblers Anonymous and other groups for behavioural addictions (where appropriate)
- » Alanon for whānau or family members
- » psychiatric consumer groups for mental health problems
- » other community-based groups that might contribute to the individual's ability to make and sustain change.

Autonomous well-being

This involves:

- » self-motivation
- » placing the responsibility for managing well-being solely with tangata whaiora and whānau or family
- » no longer requiring the formal support of substance use and mental health services.

Key treatment strategies

- » Ensure supports are in place and functioning well, including primary care.
- » Clarify access to services in future if problems recur, then discharge from specialist services.

4.6.4 Medication–Drug Interactions (see Appendix 3)

Interactions between prescribed medications and psychoactive substances are potentially significant. There is a lack of hard data on this topic and so it is difficult to be definitive. There are many potential interactions that are mild or infrequent, but there is also likely to be considerable personal variation in reactions. A summary of possible interactions for health professionals to be aware of is included in appendix 3.

There are several potentially severe interactions that should be avoided. These include (but are not limited to) the combination of:

- » lorazepam and alcohol, which has been associated with significant respiratory and cardiac depression (this appears to be more likely with lorazepam than other benzodiazepines)
- » amyl nitrate and sildenafil (Viagra), which has been associated with potentially fatal hypotension
- » ecstasy and ritonavir, which has been associated with fatalities
- » ecstasy and monoamine oxidase inhibitors (including moclobemide), which have been associated with fatalities
- » amphetamines and monoamine oxidase inhibitors (including moclobemide), which have been associated with a severe hypertensive crisis.

Serotonin syndrome

Serotonin syndrome is a potentially fatal over-activity of the serotonin system, usually caused by the use of serotonin-enhancing drugs or an interaction between drugs. Symptoms range from mild to fatal, and include increased heart rate, sweating, tremor and shakiness, increased blood pressure, increased body temperature, agitation, seizures and a range of serious metabolic consequences (Boyer and Shannon 2005).

A wide range of drug interactions have been associated with serotonin syndrome (see table 4.6).

Table 4.6 » Drugs associated with serotonin syndrome	
Class	Drug
Analgesics	Tramadol, fentanyl, pentazocine, pethidine
Antibiotic	Linezolid (zyvox)
Antiemetics	Ondansetron, metoclopramide, granisetron, sibutramine (reductil)
Antimigraine drugs	Sumatriptan
Antiviral agents	Ritonavir (used in the treatment of HIV/AIDS)
Some cough mixtures	Dextromethorphan
Dietary supplements and herbal remedies	St Johns wort, ginseng
Illicit drugs	MDMA (ecstasy), LSD
Monoamind Oxidase Inhibitors	Moclobemide, phenelzine and others
Mood stabilisers	Lithium, valproate
Other antidepressants	Venlafaxine, trazadone, nefazadone, isobarboxacid
SSRIs	Fluoxetine, citalopram, paroxetine, fluvoxamine, sertraline
Tricyclic antidepressants	Clomipramine, imipramine

Note: these drugs have been associated with serotonin syndrome and combinations of these drugs are more likely to lead to serotonin syndrome.

The following drug combinations have been associated with instances of severe serotonin syndrome.

Table 4.7 » Specific drug interactions associated with severe serotonin syndrome
Tramadol, venlafaxine and mirtazapine (antidepressant)
Paroxetine and buspirone
Citalopram and linezolid
SSRIs and moclobemide
SSRIs and phenelzine

It should be noted that in the case of fluoxetine, serotonin syndrome may be caused by drug interactions up to five weeks after the discontinuation of the medication.

Key Points

- » Conceptualising treatment as occurring in phases or stages, each with its own key goals, is useful. There are many different classifications of treatment phases, but they generally follow the following pattern:
 - » early treatment – safety, stabilisation, engagement, motivation assessment and initiation of key treatment strategies
 - » middle treatment – active treatment of mental health and substance use problems, maintaining engagement and motivation
 - » late treatment – maintenance of minimised substance use and mental health symptoms, ongoing relapse prevention, restoration of wellbeing, supported transition to effective community functioning
 - » autonomous wellbeing – self-motivation, responsibility of managing well-being solely with tangata whaiora and whānau/family.
- » The structure of a management plan needs to include:
 1. setting
 2. further information
 3. treatment of medical conditions
 4. psychopharmacology
 5. psychological interventions
 6. whānau/family and social interventions
 7. spiritual interventions
 8. education/work/occupation
 9. education of tangata whaiora and significant others
 10. self-help groups.
- » Evidence for specific strategies for CEP: effective treatments for reducing psychiatric symptoms tend to work in people with CEP and effective treatments for substance use tend to reduce substance use in people with CEP. Specific strategies include:
 - » group counselling approaches
 - » longer-term residential CEP programmes
 - » contingency management
 - » clinical case management
 - » specific cognitive behavioural interventions for anxiety and substance.

4.7 Principle 7 » Integrated Care

Treatment integration has become one of the central principles of treatment for CEP over the past two decades. Integration can be thought of as the bringing together of various components of a system such that the system functions as a single or whole unit. Within health systems integration can occur at a number of levels of organisation:

- » at the level of tangata whaiora (integrated care)
- » at the level of programmes and services (treatment integration)
- » at the level of health care organisations and between social service organisations (systems integration) (Minkoff 2006).

Given that the key purpose of health care systems is to enhance the well-being of tangata whaiora, whānau and families, this document takes the approach that integration of care needs to start at the level of the needs of tangata whaiora, whānau and families and to integrate these into a coherent and comprehensive understanding of a person's situation. Integration of care also needs to incorporate domains beyond mental health and alcohol, such as values, strengths, whānau ora, physical health needs, social relationships, educational and occupational needs, interactions with the justice system, spiritual needs and cultural needs. This is not to say that alcohol and drug and mental health services need to take responsibility for all these areas themselves. Rather, they need to ensure that the strategies they develop are aimed at the enhancement of overall well-being rather than the treatment of specific disorders or dysfunctions, and that these strategies are consistent with those developed by other involved parties. In other words, the interventions offered by mental health and alcohol and other drug services should be integrated with those offered by other agencies, with the overall aim of enhancing well-being.

Integration at the level of programmes, services and systems should function to support integrated care. Frequently integration occurs at the programme and system level without considering how it will affect integration at the level of tangata whaiora. When thinking starts at a systems level, the purpose often comes to be the running of an efficient system. When thinking starts at the level of services and programmes, the purpose often comes to be the integration of treatment components for the particular disorders a service feels it is responsible for treating. To integrate the care of tangata whaiora, whānau and families, thinking about integration needs to start with building an integrated system of care around the needs of tangata whaiora, with programme, service and systems integration developed subsequently, with the overall aim of supporting integrated care at the level of tangata whaiora.

Non-integrated approaches involve tangata whaiora with CEP being treated for one problem in one service first, then transferred to another service for treatment of the other problem (serial treatment) or treated simultaneously for each problem in separate services (parallel treatment). It should be noted that the process of addressing problems in a stepwise fashion (e.g. detoxification from substances before treating remaining mental health problems) is not unreasonable, but that when this involves several different services, each with different priorities and philosophies, problems can arise, including:

- » gaps and discontinuities between services, such that tangata whaiora may be declined help in any one service
- » important issues not being addressed (e.g. cultural, interaction between substance use and mental health issues)
- » high-priority actions not being focused on (e.g. lack of time for collaboration)
- » conflicting philosophies and treatment approaches between services
- » multiple changes in case conceptualisation and diagnosis between services over time

- » treatment of problems rather than people
- » confusion and subsequent poor participation by tangata whaiora in treatment
- » lack of motivation.

Treatment integration approaches were initially designed to overcome these barriers to care by integrating mental health and substance use treatments into a single coherent package of care, delivered, where possible, from a single setting.

4.7.1 Current Approaches to Integration

There have been a number of approaches to integrating mental health and substance use treatments. Initial attempts involved increasing the detection of CEP and adding alcohol and drug interventions, such as substance abuse counselling and peer support, to mental health services. This led to the development of more intensive and comprehensive programmes, the inclusion of MI techniques, and the conceptualisation of treatment as occurring in phases, depending on the person's engagement with treatment and their stage of change.

The predominant model of a comprehensive integrated treatment programme that has emerged is characterised by the following core features:

- » substance use and mental health treatment being delivered by the same health professionals within a single team, trained to treat both mental health and substance use problems and presenting a consistent and coherent approach
- » substance abuse treatments adapted to suit people with severe mental illness, including:
 - » a focus on minimising anxiety and building trust rather than on confronting denial
 - » harm reduction rather than immediate abstinence
 - » use of motivational interviewing approaches
- » use of medication, where indicated
- » a long-term staged perspective, matching key tasks to the tangata whaiora's stage of change (stages of engagement, persuasion, active treatment, relapse prevention)
- » assertive outreach
- » case management
- » a variety of treatment types offered, including:
 - » individual counselling
 - » group counselling
 - » whānau or family education and involvement
 - » twelve-step interventions
- » a broad range of life issues addressed, including;
 - » social supports
 - » coping, occupational, parenting, social skills
 - » rehabilitation

(Drake et al. 1998; Brunette et al. 2006; Center for Substance Abuse Treatment 2005).

Programmes established along these lines have been considered the gold standard of treatment integration. However, they are expensive and difficult to implement and maintain, requiring considerable support from multiple levels of a health organisation, strong and effective leadership, support for lower health professional case loads, and cultural change at a number of organisational levels (Torrey et al. 2002; Brunette et al. 2008; Timko et al. 2005).

Services may be integrated in a variety of ways, depending on local needs and circumstances. Treatment integration can be seen to occur along a continuum and can involve integration within a single or across multiple services for any of the key areas of: screening, assessment, treatment planning, treatment provision and continuing care (Minkoff 2006; Center for Substance Abuse Treatment 2007).

In describing processes for the integration of care, Minkoff's *Comprehensive Continuous Integrated System of Care (CCISC)* (Minkoff 2000) describes eight principles of integrated treatment and 12 steps for the implementation of care. The eight principles of integrated care are as follows.

1. Dual diagnosis is an expectation, not an exception.
2. All types of dual diagnosis are not the same.
3. Empathic, hopeful, integrated treatment relationships are essential.
4. Case management must be balanced with empathic detachment, expectation, contracting, consequences and contingent learning for each client in each service.
5. When psychiatric and substance use disorders co-exist, both should be considered primary, and integrated, primary, diagnosis-specific treatment is recommended.
6. Both can be treated within a disease and recovery model.
7. There is no single correct intervention.
8. Clinical outcomes should be individualised.

Minkoff (2000; 2006) also outlines 12 steps for implementing a CCISC, which include services forming a consensus on using the model, the use of CEP programme standards and health professional competencies, specific structures for integration across services and systems, system-wide training plans and strategies to improve identification of problems, and access to services.

Treatment integration does not need to be limited to the integration of substance use and mental health components. Indeed, integrated care where treatment is driven by a comprehensive and integrated understanding of tangata whaiora in their social context requires the integration of a number of other perspectives, such as cultural considerations, physical health needs and educational and occupational needs. In practice, few services in New Zealand are large enough to meet all the needs of tangata whaiora and need to involve expertise from other services. Care must be taken that integration of service components actually reduces gaps rather than simply shifts them or creates different interface problems. Effective linkages between services and between health professionals from different services remain imperative, regardless of the degree of integration. It should also be noted that while these models are client centred and stress integration at the level of the tangata whaiora/health professional interface, when implemented they often focus on the treatments provided by the service, diagnostic groups and service needs rather than the needs of tangata whaiora. This can, in fact, become a barrier to integrated care.

4.7.2 The Evidence for Current Approaches to Integration

Although treatment integration makes sense and is strongly supported by expert best opinion (Center for Substance Abuse Treatment 2005; Drake 2007), the evidence supporting its effectiveness remains mixed. Researching treatment integration approaches is difficult given the heterogeneity of CEP, the different ways treatment integration has been implemented and the focus on integrated programmes and services rather than integrated care (as defined above). Further, the design of many studies has not been optimal, especially in terms of reporting data that allow a clear picture of rates of recruitment and engagement, and of the programme's substance use goals and outcomes.

There have been a number of studies reporting advantages for integrated over non-integrated approaches in terms of substance use outcomes, mental health outcomes, psychosocial functioning or overall quality of life. Most of these come from studies of the models pioneered by Drake, Mueser and others in New Hampshire. There have also been studies that have failed to show any benefit from integrated treatment approaches, and recent reviews of treatment integration (Cleary et al. 2008; Donald et al. 2005; Tiet and Mausbach 2007) have concluded that there is little evidence that these approaches are effective in terms of improving specific outcomes, though they may be associated with better engagement and retention.

It is possible that these models are more effective than other models and that the benefits are neutralised when reviews combine them with other less successful models, or with attempts to replicate the original models that are unable to apply them with a high degree of fidelity. Important problems with the faithful implementation of the Drake and Mueser model include the need for reduced client workloads, significant financial resourcing, skilled and motivated leadership, supportive attitudes from all involved, and management and systems that are willing to change to support the new models. Even when these things are in place, between a third and a half of services attempting to introduce these integrated treatment models may not succeed (Brunette et al. 2006). In another recent review, effective treatments for reducing psychiatric symptoms tended to work in people with CEP, and effective treatments for substance use tended to reduce substance use in those with CEP (Tiet and Mausbach 2007), though seldom did combining both mental health and substance use treatments work for both. In most studies reviewed, the mental health problem or the substance use problem improved, but seldom both.

Many models of treatment integration also incorporate particular and specific interventions. It is therefore not clear whether any benefits of treatment integration that might be shown are due to the processes of integration or the specific treatments used. The lack of evidence should not be taken to mean that the processes of treatment integration do not work; rather that the research has limitations, that the key components have yet to be identified, and that models have yet to be established that are both successful and easy to implement. Integrated treatment approaches may be most useful where there is a clear and close causal relationship between substance use and psychiatric problems. Parallel treatment may be adequate for some problems, especially when there is close liaison between the services, and integrated care is achieved at the level of assessment and management planning (Donald et al. 2005).

Treatment integration approaches are therefore expensive, require support from many levels of system organisation and lack a strong evidence base, as mentioned. Though associated with improved engagement and retention, engagement remains problematic. For example, in a recent study by Bellack and colleagues, which demonstrated the superiority of an integrated community-based harm reduction approach over standard treatment for severe and persistent mental illness, of 251 eligible subjects, 56% failed to engage in treatment and only 33% of those eligible eventually completed treatment (Bellack et al. 2006).

Finally, integrating treatment may require collaboration between mental health and alcohol and drug services, which can be very difficult when attitudinal barriers exist. For a start, senior management that sees CEP as an optional extra requiring additional funding to address, rather than as part of core business, is likely to undermine attempts to integrate care. Also, negative attitudes between mental health and alcohol and drug practitioners are arguably the largest barrier to integration and may be the most difficult to overcome.

4.7.3 Steps to Integrated Care Driven by the Needs of Tangata Whaiora

Integrated care needs to start with the initial interaction between tangata whaiora and the health professional. There are a number of points in the clinical process that act to integrate care, and thinking about them as key points of integration is useful.

1. **Collecting information from multiple sources:** This includes information from tangata whaiora, whānau and family, friends and peers, employers, those with whom tangata whaiora interact within the justice system, and other agents who may carry important information. Each source may present information in different ways based in different belief systems and perspectives. These need to be brought together into a common framework.
2. **Comprehensive history – bringing together information across multiple domains:** This includes gathering a comprehensive history that builds a broad picture of the person, and includes values, hopes and aspirations, a sense of what well-being is for the person, personal strengths and attributes, relevant ethno-cultural factors, substance use, mental health, physical health, whānau and family health, psychosocial functioning, spiritual health, offending history, educational and occupational issues, and other relevant areas.
3. **Formulation – integrating different paradigms and causal explanations through aetiological formulation:** Forming an understanding of the person and the factors that contribute to their current situation is a crucial step in helping tangata whaiora. It involves a range of essential skills that separates health professionals from unskilled listeners, and in effect explains the diagnoses and problems as a narrative or story of key factors that have led to the current situation and which then become targets for intervention. In doing so, the health professional needs to incorporate a number of different paradigms and philosophies into a coherent explanation. A process for facilitating this is described under the section above on assessment.
4. **Negotiating a shared understanding with tangata whaiora:** This includes integrating the different perspectives of health professionals, tangata whaiora and significant others to establish a common, shared understanding.
5. **Negotiating the management plan:** Key targets for intervention will be indicated by the diagnoses, specific problems and strengths, and the explanatory formulation. Health professionals and tangata whaiora frequently differ in their beliefs about what interventions are useful and appropriate. The process of negotiating a management plan that is shared by both the health professional and the tangata whaiora involves integrating these differing perspectives into a common agreed approach, without which the treatment process is unlikely to be mutually participative.
6. **Multi-disciplinary team (MDT):** The members of the MDT frequently differ in their philosophies. In the process of the team working together to offer treatment, these need to be integrated into a single common approach. As mentioned in section 4.3 on engagement, when a team is able to agree on a common purpose, within which differing views are put aside for the benefit of tangata whaiora, engagement is significantly enhanced.

7. **Collaboration – integrating helping professionals from outside the MDT:** The needs of tangata whaiora frequently exceed the capability of the MDT and the service. Some MDTs are able to provide a wide range of substance use, mental health and psychosocial helping strategies, but tangata whaiora will almost always be involved with other external agencies such as justice, education, employment, housing and financial services. It is important that those external to the MDT are aligned in terms of the goals and intervention strategies being used and are kept informed of progress. Effective collaboration is an essential activity for ensuring this and is dependent on well-functioning personal relationships. As noted previously, negative and pejorative attitudes between services are a major barrier to effective collaboration and integration and need to be overcome.
8. **Leadership and managerial support:** Clinical leaders and managers need to not only support the activities required to enhance integrated care but to place a high priority on them and expect them to be undertaken.
9. **Resources – contracts, funding and monitoring:** For most services and health systems, the financial means required to improve integrated care need to be found from within current resources. This will require diversion of some current resources from activities that do not directly benefit the care of tangata whaiora. An example of this is the large amount of time spent by health professionals to record data that measures outputs and is primarily designed to ensure the efficient running of the system. Contracts and funding need to support activities aimed at integrating care. Monitoring should include measures of integration and of outcomes for tangata whaiora, as much as outputs of the system, and this may require a shift in emphasis in terms of the data collected.
10. **Systems integration:** Systems integration includes the signalling from government agencies of the importance of integration, the establishment of structures for collaboration between different agencies (e.g. justice or education agencies and mental health services), the development of competencies for the skills needed to enhance integrated care, and workforce development.

4.7.4 Specific Strategies for Enhancing Integrated Care

Within the steps to integrated care mentioned above, there are a number of strategies and skills that can enhance integration.

Always ask, ‘In what way does this decision or action benefit the person we are working with?’ Posing this crucial question increases the likelihood that care is driven by the needs of tangata whaiora rather than the needs of health professionals, the service or the system. It especially helps undermine the attitudinal problems that exist between health professionals in different service and systems.

1. **Strategies to identify pathways to well-being:** These have been discussed in section 4.2 on well-being.
2. **The use of screening tools, ecograms and timelines to explore the relationship between substance use, mental health and other problems:** Screening tools have been discussed in the section above on assessment (see section 4.5.3) and help ensure that important domains – such as substance use, mental health problems, gambling problems and cognitive impairment – are identified. The use of ecograms (a combination of a family genogram and a social ecomap) may be useful to bring together key family and social supports. Timelines that capture the date of onset and course of substance use, mental health and other relevant problems can be used to help identify the temporal relationship between these problems.

3. **Integrating different paradigms and causal explanations through aetiological formulation:** Discussed in section 4.5 on assessment, the use of tools such as the 4x4 grid may be helpful for the crucial task of integrating various paradigms and domains into a causal explanation that predicts specific interventions. This is aided by the use of compatible models and concepts wherever possible.
4. **Tools to assist feedback and negation of a shared understanding and management plan:** Feedback and the negotiation of a shared understanding and management plan can be facilitated by the use of visual tools, such as timelines and cognitive maps.
5. **Integration through the multi-disciplinary team (MDT):** There are several aspects to enhancing integrated care through the MDT, including:
 - » processes for identifying a range of problems, such as the use of screening tools
 - » enhancing MDT capability (see below) to deliver as much of the necessary care as practicable from a single setting
 - » a single coordinating point with mental health services and alcohol and drug services
 - » tangata whaiora should be able to access all addiction and mental health care through a single point – initially the health professional responsible for their care, and, when appointed, the case manager
 - » stable long-term clinical case management, as discussed previously
 - » agreed common purpose, strategies and alignment in philosophy
 - » team morale and functioning.

An important aspect of MDT functioning is the interpersonal relationships within teams. This is an area that is often overlooked, but it has a significant bearing on a team's morale and ability to work towards a common purpose. The concept of team emotional intelligence (EI) is useful in this respect (Goleman et al. 2002; Goleman 1998). Team EI involves the ability of individuals to work collaboratively as a team, to develop team self-awareness, and to be able to identify and manage relationships within the team effectively to support an agreed common purpose. It also involves open acknowledgement of the unstated or covert norms that underpin team functioning. Many MDTs within alcohol and drug and mental health services are not afforded the time to work on their collaborative functioning, do not function optimally as a result, and therefore are unable to deliver optimal integrated care. MDTs should therefore be encouraged to take the time to explore their functioning in this way, and doing so is likely to enhance their morale, their performance and the care they offer.

6. **Collaboration – integrating health professionals from outside the MDT:** When the needs of tangata whaiora exceed the capability of the MDT, input needs to be sought outside the MDT. This may involve other mental health professionals, physical health professionals or GPs, and is often the case for occupational, social support and similar needs. Integrating these people into a coherent team involves collaborative skills.

Most health professionals are familiar with the processes involved in collaboration, given that they often work with tangata whaiora to encourage them to function more collaboratively in their whānau, family or social environment. However, they do not always apply this knowledge to their own professional functioning, as evidenced by the judgemental attitudes that exist between alcohol and drug and mental health professionals.

One mechanism for enhancing collaboration are the Collaborative Online Innovative Networks (COINs). COINs involve the establishment of online networks using an email group or instant messaging to enhance communication. With respect to CEP, a COIN would involve all the key professionals involved in the care of a person and their whānau or family and would aim to utilise the synergy and innovation that can arise from groups that communicate effectively.

Key features of COINs include:

- » being established for an explicit common purpose (e.g. to support the well-being or needs of a single tangata whaiora)
- » facilitation by a single person (e.g. a clinical case manager)
- » clear ground rules for interaction (e.g. non-tolerance of negative personal comments)
- » initial face-to-face contact prior to establishment of the email group
- » encouragement of discussion of personal issues – personal relationships are the key to an effective collaborative network
- » development of trust between team members during face-to-face contact resulting from personal contact
- » regular communication and updates from a facilitator
- » support from management and clinical leadership
- » hands-off management, allowing the COIN to develop organically without external control.

7. **Resources – contracts, funding and monitoring:** Integrated care needs to be supported by adequate resources to allow the development of integration and collaboration skills within individuals and teams. It is unlikely in the current climate that significant extra resources will be made available for this. However, diversion of resources from other areas is possible.

A major component in terms of resources for health professionals is time. Increasing amounts of time are spent on documentation and compliance issues, most of which are designed to serve the needs of the system rather than tangata whaiora. In other words, documentation focuses far more on outputs (system performance) than outcomes (improvements in quality of life for tangata whaiora). Similarly, monitoring compliance and key performance indicators for the health system is heavily weighted towards outputs rather than outcomes. For there to be improvements in integrated care – and, indeed, overall care of tangata whaiora – resources need to be diverted from systems needs to the needs of tangata whaiora. For example, monitoring should focus on issues such as changes in quality of life, the quality of the therapeutic alliance, and the quality and effectiveness of certain tasks such as risk assessment, rather than time in treatment, attendance rates and whether risk assessments have been done or not.

Contracts and funding need to support integrated care. A certain percentage (say 10–15%) of funding for services should be dedicated to integration and collaboration activities, and contracts should have such activities in-built. Included in this should be time for the development of personal connections necessary for effective collaboration with and between teams.

8. **Systems integration:** integration at the level of systems involves:

- » ensuring there are mechanisms in place for collaboration and shared care between different services within a particular system, such as between services and divisions within a District Health Board
- » ensuring collaborative mechanisms between systems such as mental health and justice, both locally and nationally
- » establishing infrastructure for the development of CEP capability
- » providing leadership and support for integrated care at the levels mentioned above.

Strategies to achieve this include:

- » the signalling from government departments that integrated care is a high priority
- » the development of processes and procedures for inter-service and inter-agency collaboration – this may include formal processes for collaboration but needs to be actively supported by senior managers with clear expectations that the deliverers of health care will actively participate in these processes (e.g. the Strengthening Families process for young people and their whānau and families, where inter-agency meetings are supported at a service manager level by the insistence that professionals attend and participate)
- » the use of workforce development agencies to support the enhancement of health professionals' skills and the service capability needed to deliver integrated care, which involves processes for skill acquisition for health professionals, especially around collaboration skills and team functioning, and support for specific tools to enhance team and service capability to deliver integrated CEP care
- » the dedication of a certain percentage of funding within contracts for systems and services towards the actions needed to enhance integrated care
- » the establishment of shared documentation and information systems.

The integration of care is therefore an essential step in delivering optimal care for tangata whaiora with CEP and involves a number of complex processes. Exactly how care is integrated will vary from service to service depending on the specific nature of the service and the services capability. Enhancing the capability of services in this regard is an important process in improving care for tangata whaiora with CEP.

Key Points	
»	Integration can be thought of as the bringing together of components of a system such that it functions as a single or whole unit.
»	Integrated care needs to focus first and foremost on those parts of the health system that most directly affect the care of tangata whaiora – the practice or clinical level.
»	Integration at the programme, service and system level is important primarily to support integration of care at the practice or clinical level.
»	Integration involves more than just AOD and mental health care.
»	Treatment integration approaches targeted at the programme or service level are resource intensive and difficult to implement, and there is a lack evidence to support their effectiveness over standard non-integrated approaches.
»	There are degrees of integration which, given the lack of evidence for fully integrated approaches, are reasonable to implement where appropriate.
»	Integrated care rests on: <ul style="list-style-type: none">» putting the needs of tangata whaiora ahead of those of the system» use of a comprehensive formulation to integrate different models of care and to provide a holistic perspective» use of compatible models, where possible» enhancing the capabilities of the multi-disciplinary team to deliver integrated care» focusing on effective linkages and collaboration when the needs of tangata whaiora exceed the capability of the multi-disciplinary team» diversion of resources away from systems needs towards activities that support integrated care» funding, contracts and leadership to actively support integrated care.

Section 5 » Service Capacity and Developing Service Capability

Developing service and systems capability for dealing with CEP is discussed in depth in Ministry of Health document *Service Delivery for People with Co-existing Mental Health and Addiction Problems – Integrated Solutions*. This section briefly introduces some key concepts to link the clinical content of this document with the services and systems focus of the service document.

It is useful to classify services in terms of their capacity to provide integrated care for tangata whaiora with CEP. There are a number of ways of classifying service capability. One approach suggested by TIP 42, used in some Australian services and reinforced in a New Zealand context by MacEwan (2007), considers services as mental health or alcohol and drug only, CEP capable and CEP enhanced (figure 5.1).

Figure 5.1 » A continuum of service capability to deliver integrated care



Alcohol and drug-only services can be thought of as those that deal primarily with substance use issues and do not detect the presence of many mental health (MH) problems, while MH-only services primarily manage mental health problems and frequently do not detect the presence of substance use problems.

CEP capable services would usually have either substance use or mental health problems as their primary focus, but would readily detect the presence of the other group of problems, understand the relationship between them and be able to develop an integrated formulation and management plan. They may even be able to undertake basic interventions for the problems they do not specialise in, especially the treatment of depression or early management of alcohol and drug problems. However, they are likely to have to refer to other services for more intensive middle and late treatment interventions.

CEP enhanced services have a similar capability to CEP capable services in terms of assessment skills but are also able to deliver complex treatments for many of the substance use and mental health problems they are likely to see. Where the complexity of problems exceeds their capabilities, they are able to refer to other specialist health professionals, incorporating them into the treatment team in a seamless way. They would also have a close and seamless relationship with other agencies, such as social service agencies, with whom they regularly interface.

Fidelity scales, whereby services can rate their CEP competence, have also been produced, though these may need adapting to a New Zealand context. Those developed in Australia, such as the *Dual Diagnosis Capability in Addiction Treatment Index Toolkit* (DDCAT) <http://www.vaada.org.au/resources/items/2008/08/226803-upload-00001.pdf> are the ones most likely to meet our needs.

Most of these models assume that integrated care should aim to have all treatments delivered from within one service. However, this may not be practical – or even necessary – as long as good relationships and linkages exist between services that need to be involved in the care of a particular tangata whaiora. Table 5.1 provides an outline of CEP capability in terms of the processes of assessment and management.

Table 5.1 » CEP Capability related to assessment and management processes

	AOD or MH only	CEP capable	CEP enhanced
Screening and assessment	<ul style="list-style-type: none"> » Unaware of AOD or MH issues » Screening for other issues and then referral 	<ul style="list-style-type: none"> » Identifies the presence of CEP and the relationship between them » Comprehensive and integrated formulation 	<ul style="list-style-type: none"> » Identifies the presence of CEP and the relationship between them » Comprehensive and integrated formulation
Management planning	<ul style="list-style-type: none"> » May become aware of management needs but not able to plan integrated interventions 	<ul style="list-style-type: none"> » Plans management for AOD and MH problems driven by integrated formulation 	<ul style="list-style-type: none"> » Plans management for AOD and MH problems driven by integrated formulation
Management provision		<ul style="list-style-type: none"> » Refers to other services for provision of AOD or MH aspects of care 	<ul style="list-style-type: none"> » Delivers AOD, MH and other treatments from within own team
Continuing care		<ul style="list-style-type: none"> » Refers to other services for provision of AOD or MH aspects of care 	<ul style="list-style-type: none"> » Delivers AOD, MH and other treatments from within own team

5.1 Conceptualising Service Capability and Development

Extending the capacity of treatment systems to meet the needs of tangata whaiora with CEP involves two main approaches:

- » enhancing the capability of the individual service in the areas indicated in section 3
- » improving linkages between services, especially between alcohol and drug and other mental health services, to provide the necessary services.

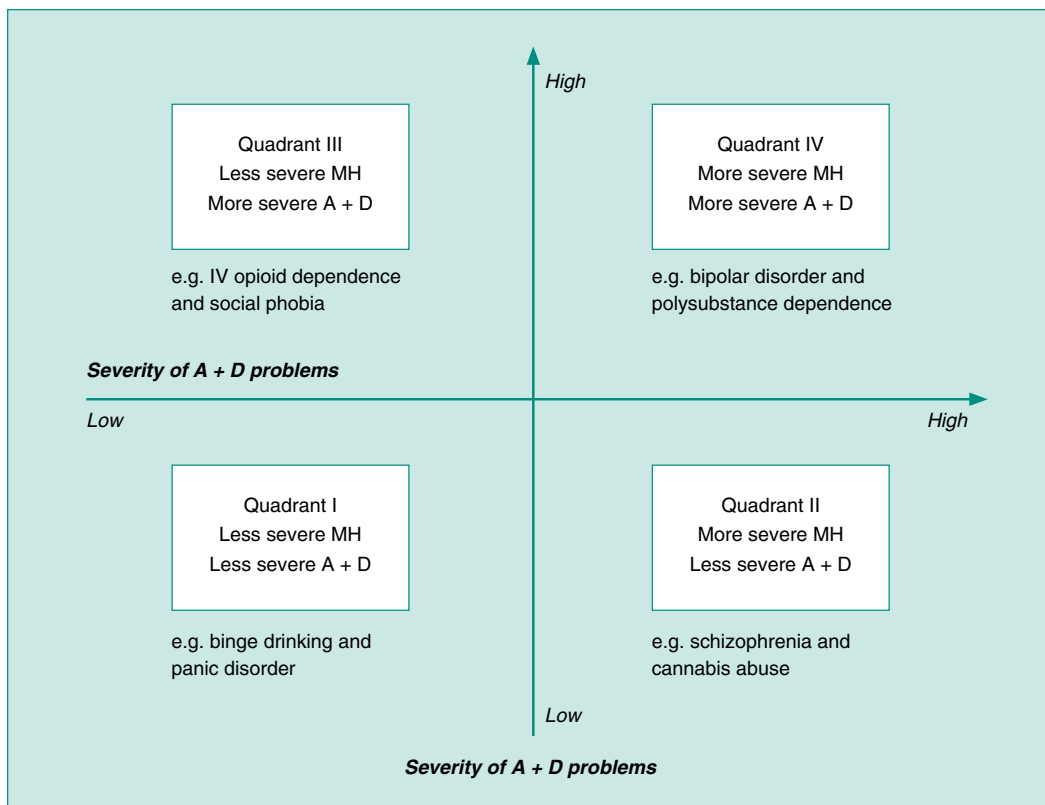
One common approach to conceptualising where tangata whaiora fit within a particular system of care is the quadrant approach (Minkoff 1994; 2006), outlined in figure 5.2 This has been used in various ways, such as for severity of problems, capability of services or the primary focus of services. There are a number of problems with this approach, however.

- » Tangata whaiora may not fit neatly into a quadrant.
- » Severity is often based on questionable assumptions about particular diagnoses, such as schizophrenia being more severe than others (anxiety disorders, for example).
- » Emphasis has often been placed on developing one particular quadrant that is perceived to be more important than the others. For example a quadrant representing severe alcohol and drug and severe mental health problems may be seen as more important than a quadrant representing mild alcohol and drug and mild mental health problems, though each quadrant may represent similar needs in terms of service development.

However, this quadrant approach has been found useful in a number of contexts and has a lot to offer if these limitations are borne in mind.

It should also be noted that primary care services are not well captured by this model. Although the management of CEP in primary care is an important issue, many of the problems with CEP arise from the systems and services interface between alcohol and drug and mental health services at a tertiary level of care, and the responses therefore need to focus on this level initially.

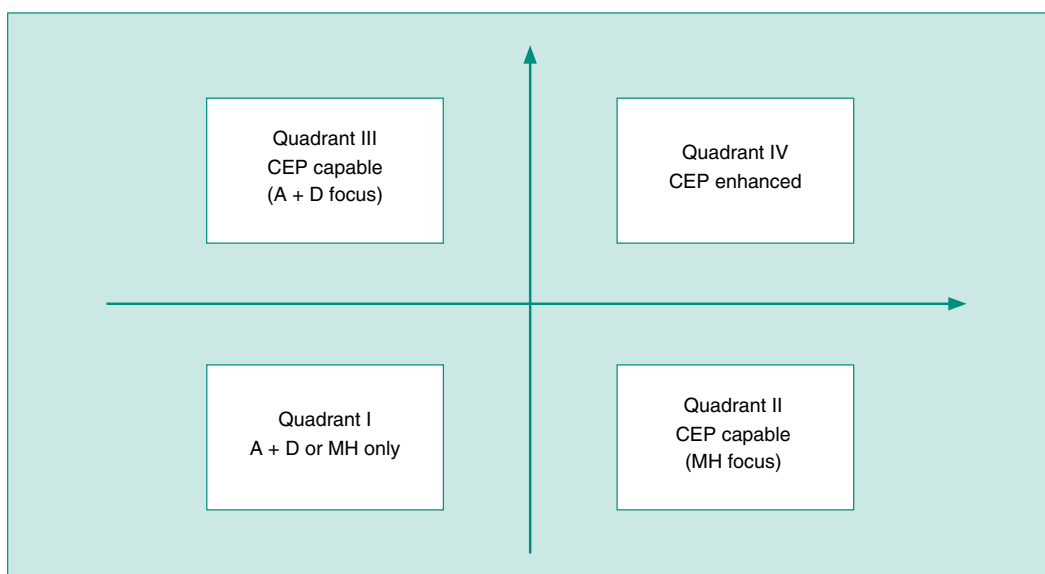
Figure 5.2 » Scope of substance use and mental health problems, classified by severity



Source: Minkoff 2000

Rather than thinking of services in terms of the severity of problems they deal with, it might be more useful to think in terms of their CEP capability, as outlined in figure 5.3 below.

Figure 5.3 » Scope of substance use and mental health problems, classified by service capability

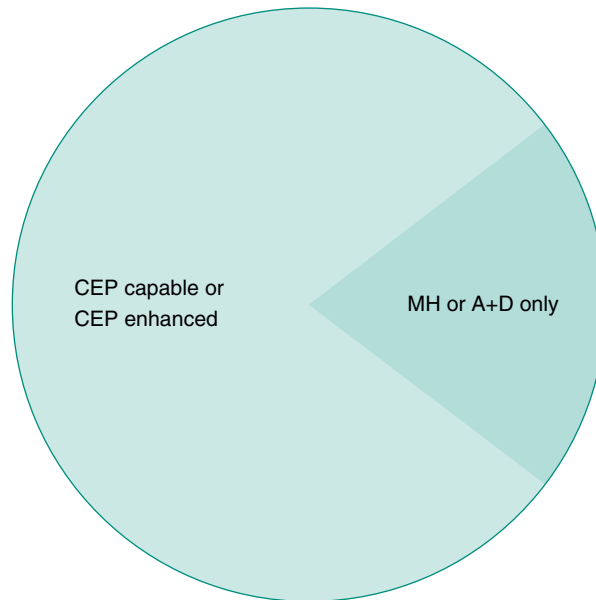


The implication of this is that it is the capability of the service to meet the needs of tangata whaiora rather than the severity of problems experienced by tangata whaiora that determines the organisation of services.

5.2 Service Need in New Zealand

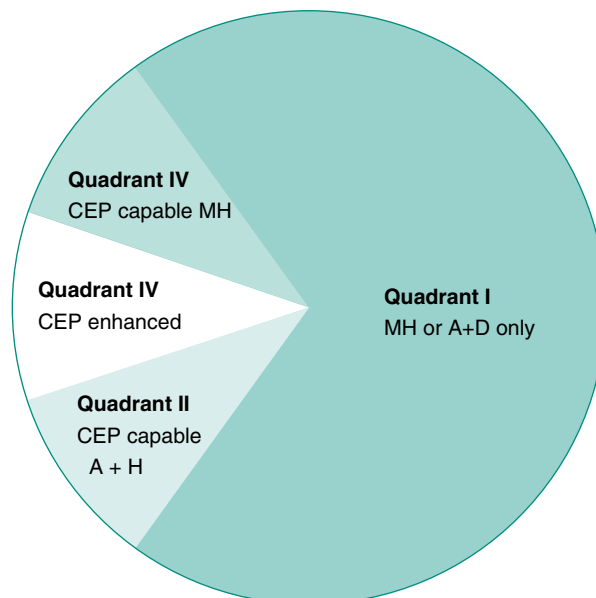
Given the high percentage of CEP within both alcohol and drug and mental health services, the need is clearly for services to develop their capability towards being CEP capable and, in some cases but not all, CEP enhanced. The need for CEP capable services is depicted in figure 5.4.

Figure 5.4 » Need for CEP capable services in New Zealand



The current situation in New Zealand is more like figure 5.5, indicating a significant need for services to increase their capability.

Figure 5.5 » Current CEP service capability in New Zealand



The prevalence rates of CEP in each region should give a clear indication of the optimal configuration of services. Each region is likely to differ in terms of the capability of services that already exist, meaning the response will also differ. However, the general principles of developing service capability to meet the needs of tangata whaiora with CEP still apply.

Section 6 » Practical Applications

6.1 Introduction

This section applies the seven key principles to the scenario of a hypothetical case scenario, Rick. Assessment and management processes are structured using the phases of treatment described previously. The key goals and strategies in each phase were summarised in section 3 and are repeated here as a reminder (figure 6.1).

Figure 6.1 » A summary of the phases of treatment and key goals, with key treatment strategies

	<pre> graph TD A[Referral from other service] --> C[Engagement interview/s] B[Not in a service] --> C </pre>
<p>Pre-treatment: Ascertain specific needs, including cultural needs</p>	<ul style="list-style-type: none"> » Involve cultural expertise when indicated. » Where appropriate, contact tangata whaiora and whānau or family to ascertain cultural needs, especially relating to people to include in initial contact and desired processes of initial engagement. » Consider contacting referral to clarify the most appropriate service.
<p>Early treatment: Safety Assessment Stabilisation Engagement</p>	<ul style="list-style-type: none"> » Involve key supports (e.g. whānau or family) if appropriate. » Assess and manage safety issues. » Develop a comprehensive and integrated assessment and management plan, including an integrated formulation, to integrate care. » Appoint a case manager. » Stabilise acute crises, substance use, physical and social problems. » Detox if appropriate. » Use culturally appropriate engagement processes and assessment. » Address spiritual needs. » Link with and involve other services, as indicated. » Enhance motivation. » Initiate or adjust medication. » Use initial coping strategies to help manage crises.

Middle treatment: Active treatment Enhance well-being Maintain engagement	» Monitor and adjust medication. » Actively treat mental health and substance use problems, including specific psychotherapies and social interventions. » Use specific whānau or family interventions. » Maintain engagement and motivation. » Use an increasing focus on steps to enhance well-being. » Use peer support groups. » Continue to manage linkages with others involved. » Establish relapse prevention. » Facilitate re-culturation and increased ability to access cultural resources.
Late treatment: Maintain gains Restore well-being Increase self-care	» Maintain ongoing monitoring of treatment adherence. » Maintain ongoing work on relapse prevention. Enhance occupational and social skills. Increase self-management of mental health and substance use problems. » Strategies to enhance well-being include:
Autonomy: Self-motivation Self-responsibility Independence	» ensure community supports in place » clarify future access to services » discharge to primary care.

The choice of scenario is designed to highlight the seven key principles of working with CEP. That Rick is of Māori descent allows in depth discussion of cultural considerations and the highlighting of issues that are often poorly dealt with in mainstream services.

In this scenario the sections in normal text outline the Rick's history and management through the various phases of treatment. The italicised text provides general comments and discussion about the scenario.

6.2 Case Scenario » Rick

Rick is a 55-year-old man of Māori descent currently working as a building subcontractor, having previously owned his own building company. He was been referred to you at the local community mental health service by his GP, having been taken there by his younger brother and a niece concerned that he had been increasingly sad and withdrawn over the last month and was expressing thoughts that life wasn't worth living. His alcohol use had also been heavy for the past six weeks. He has previously received treatment for alcohol problems. He is flatting on his own in a large city and frequently returns to his marae one and a half hours' drive away.

6.2.1 Pre-treatment

Clarification of appropriateness of mental health referral (as opposed to alcohol and drug)

Rick's GP was aware of both substance use and mood problems and, in conjunction with Rick and his whānau, chose to refer to mental health rather than alcohol and drug services.

Note: It is unclear whether the main problem is related to mood or substance use, and it would be useful to clarify this with the GP to ensure prior to first contact that the community mental health service is the most appropriate service to see him. If Rick is best seen by alcohol and drug services, this is the time to redirect the referral, because once he has been seen, engagement will have begun and transfers between services at this point may well be disruptive. However, that Rick's GP was aware of both problems and chose to refer Rick to mental health services should be given some weight. Mental health services should be able to cope with the alcohol and drug aspects of Rick's presentation.

Clarification of cultural needs and processes

Rick's GP was spoken to and said that while he was aware of the issues with alcohol, both he and Rick thought his mood and suicidal thinking were the main problems and that mental health services were the most appropriate point of referral. While mood problems may, in fact, turn out to be secondary to alcohol, this was not clear at this point and it was decided to see Rick within mental health services, respecting that there were likely to be complex reasons behind his preference that should be taken into consideration.

Rick and his whānau expressed a preference for Māori protocol and to involve his brother and niece in the interview, as well as a respected uncle. It was decided that the cultural health professional (Māori) would welcome the whānau with a mihi whakatau and karakia following the local protocols of tangata whenua. Introductions would follow and relationships between those present, their extended whānau and their connections with their marae and te ao Māori would be explored. A hot drink and food would be offered before proceeding with the assessment phase of the initial interview.

Note: Expertise in Māori health will be needed and should be available within the mental health team. If it is not, it should be available from outside the team and brought in. The cultural health professional (Māori) will need to make contact with Rick and his whānau to determine the processes Rick would prefer at the initial interview and to ensure the appropriate people are invited, including those who may advise Rick and help with the decision-making process. It should be noted that Rick has accepted a referral to mainstream mental health services. There may be many reasons why he has agreed to this rather than seeking kaupapa Māori services at this point. This does not relieve the mental health team of their responsibility to offer culturally appropriate care.

Once the appropriate processes have been determined, these need to be communicated to the mental health clinicians likely to be involved in the initial interview and arrangements for this interview made. Attention should be given to room size, the presence of a cultural health professional (Māori) at the initial interview, allowing sufficient time for the necessary processes to be carried out, and ensuring non-Māori staff are familiar with the process to be used.

6.2.2 Early Treatment: Initial Interview, Stabilisation, Assessment and Engagement

Note: If Rick was currently being seen in either an alcohol and drug or mental health service, much of his history would already be clarified and any risk issues managed. Time could then be spent at the initial interview engaging him by means of an engagement interview. However, given that Rick is not currently being cared for by either an alcohol and drug or mental health service, the initial assessment needs to include a comprehensive assessment and risk assessment. Engagement will still be an important aspect of this interview, but less time will be spent focusing on this, given the need to come to a shared understanding of his problems and to develop an effective initial management plan. Thus the initial interview flows seamlessly into the early phase of treatment, which can be thought of in this case as the phase in which alcohol use is stabilised (abstinence is the focus here, given Rick's dyscontrol and past sustained periods of abstinence), depression improved and ongoing treatment agreed upon and initiated.

Key goals

The goals for the initial interview included:

- » maintaining cultural safety, and engaging Rick and his whānau through the protocols mentioned above and through appropriate interactions during the interview

- » developing a vision of Rick's hopes and aspirations for the future for himself and his whānau and establishing, as far as possible, what a state of well-being would involve
- » completing as much of an initial comprehensive assessment, including integrated formulation, as possible to enable the development of a management plan focusing on the early phases of treatment
- » ensuring risk is assessed and managed
- » engaging Rick and his whānau in the treatment process through interviewing strategies that acknowledge Rick as a person, including his culture, that is empowering, that allows ample time for them to express their concerns and that uses summarising and reflection to express empathy.

Cultural considerations, engagement, motivation and well-being

The initial interview began with a mihi and karakia from the cultural health professional (Māori) and the process proceeded as planned (outlined above). Rick noted that his main problems were sadness and his alcohol use, which were negatively affecting his whānau, especially his grandchildren and his ability to undertake his roles within his hapū through his local marae. His vision of a good life revolves around having a lot of positive contact with his grandchildren, contributing to the continued well-being and mana of his whānau and marae, having sufficient income for basic needs, and living consistently with his values and world view, which includes a focus on whānau or family and on his tikanga. The interview process initially concentrated on: supporting his choices, where possible; reflecting an understanding of what he was saying using motivational interviewing microskills of reflection, summarising and affirmation; and acknowledging his support people by including them in the discussion and giving them ample time to express their views. The interview then moved into a more direct question and answer style to screen for other problem areas and to elaborate key domains so as to complete a comprehensive assessment.

Outline of the comprehensive assessment

Rick is the eldest of six siblings. His youngest brother, aged 35 years, lives close by and accompanied him to this interview. Currently divorced, he has five children, aged from 16 to 37 years, and 10 grandchildren. He is currently on the marae committee, is involved in a number of Māori and non-Māori organisations in his local community, including being a trustee on the school board of his daughter's high school, and is widely respected in the community for the quality and extent of his contributions. He currently works as a builder's labourer, having previously owned his own construction company. He strongly identifies his ethnicity as that of his local hapū and iwi, is heavily involved in the affairs of his local marae, is fluent in te reo Māori and is acknowledged as having a sound knowledge of his whakapapa (lines of descent) and tikanga. He was clear that his sense of well-being was strongly linked to that of his whanau and hapu and that being a grandfather was especially important to him, as was being able to contribute to the functioning of his marae.

Psychiatric history

Rick reported that he had been treated off and on for depression by his GP since his mid-thirties and had been prescribed fluoxetine 20 mg in the morning, which he was currently taking. Over the past three weeks he had avoided spending time at the marae and had missed the last two weeks of work. Since that time he admitted persistent and overwhelming sadness, loss of enjoyment in life, a sensitivity to comments from others, which he interpreted as more critical

than they were intended, and feeling continually tired, despite sleeping for approximately 10 hours each night – significantly more than his usual seven hours. He had difficulty concentrating on tasks and had noticed he was forgetting things, such as his children’s phone numbers. He acknowledged he had many such periods in the past, lasting anything from a few weeks to six months and did not feel fluoxetine had helped him much.

When asked if he had ever experienced periods of elevated mood, he had difficulty understanding what this meant but his brother quickly described Rick suffering brief periods over many years during which he experienced lots of energy, reduced sleep and increased creativity and social interaction. Rick was able to acknowledge this and noted that at these times he had a habit of making bad decisions. Examples included once buying a new sports car he could not afford and, on another occasion, selling his construction company to invest the proceeds heavily in a fur coat importation scheme in Fiji, which failed, costing him all his money. He also suspected that he was in such a state when, out of character, he indulged in a brief extramarital affair, which resulted in the ending of his marriage 15 years earlier. He felt deep shame at the end of his marriage and about stupidly selling his construction company, which he had always intended would one day support his children and grandchildren. His brother noted that these periods lasted only two or three weeks and were then usually followed by a ‘crash’ – a more prolonged period of depression. On this occasion, Rick’s depression had been preceded by several weeks of lack of sleep and long hours working on a land claim for his iwi, during which his behaviour had become slightly erratic and he had to be removed from the ‘spokesperson’ role for the group.

In the context of depression and his deep shame about these poor decisions, Rick had often thought it might save everyone trouble if he was no longer around. He had toyed with the idea of gassing himself in his car but had never got to the point where he actually intended to kill himself. His commitment to his children and grandchildren and their acceptance and support of his mood problems prevented him from ever seriously contemplating acting on these thoughts.

Rick denied ever experiencing psychotic symptoms, though did acknowledge he had experienced the presence of tupuna/ancestors, which he thought quite normal and which occurred independent of his mood state. There was no other history of mental health problems.

Alcohol and drug history

Rick had used alcohol regularly ‘off and on’ over the years and had smoked nicotine from his mid-teens until stopping with the help of nicotine replacement 10 years ago. He denied the use of other psychoactive substances.

He first used alcohol at the age of 12 years at a whānau or family gathering and began drinking regularly from the age of 15 after he left school to undertake a building apprenticeship. Throughout his 20s he would consume one to two jugs of beer after work each day with workmates, drinking more heavily throughout the weekends. His drinking escalated in his mid-30s averaging four to five jugs of beer most evenings, and during this period he started to experience cravings for alcohol, sweating and ‘shakes’ if he did not drink. He often attempted to reduce the amount he drank but could not manage to sustain this for more than a few weeks at a time. He would neglect his whānau, choosing to stay out drinking with friends and work mates rather than being at home, and this led to a deterioration in his relationship with his wife, who often complained about his intoxication. He described himself as mostly a happy drunk, not indulging in violence or arguments, and usually drinking more when his mood was good than when depressed. His GP at the time advised him that alcohol probably contributed to his depressed moods, but this did not influence the amount he consumed significantly.

He undertook three residential treatment programmes for alcohol dependence, the first in his mid-30s after his marriage break-up, the second in his mid-40s, after which he remained largely

abstinent from alcohol for seven years, and the most recent three years ago. Over the past three years he had two brief periods of a fortnight each during which he relapsed on beer and bourbon, though did not return to previous levels of consumption. During the past six weeks he had been drinking four to five days a week from around midday, though was able to stop and remain sober when he had important activities to attend to and experienced no withdrawal symptoms. He felt he was beginning to lose control of his alcohol again, though, and that it was affecting his relationship with his grandchildren, who were complaining that he was different when he was drunk. He was also concerned about the impact of alcohol on his low mood but not sufficiently to stop drinking.

Relationship between alcohol use and mood symptoms

On further questioning, Rick identified a period of elevated mood lasting approximately a week and followed immediately by his current period of depressive symptoms. This coincided with late nights spent working on the iwi's land claim. His relapse on alcohol happened during this period and he recalled starting to drink again when, after a good evening's work on the land claim, he accompanied his colleagues for a 'quick beer'. In retrospect, he felt that many of his past relapses occurred in similar circumstances when his mood was 'really good' rather than normal or depressed, and he acknowledged that an association between drinking and elevated mood was a common one for him.

Whānau or family history:

Rick's mother died of a heart attack when he was in his early 30s. Her death 'hit me harder than I thought it would' and was followed by a period of depression and increased alcohol use. His father died in his 60s of emphysema secondary to nicotine use. There was a history of heavy drinking on his father's side, his mother's father committed suicide, a maternal uncle was diagnosed with bipolar disorder, and Rick thought his mother probably suffered from depression and anxiety, though never sought treatment for this.

Other relevant history

There was no history of significant medical problems. Rick was born in a rural community close to his marae and had no early developmental problems. His whānau or family moved to the city when he was five years of age due to his father's job. His mother was a harsh disciplinarian and was frequently violent towards Rick. He was an able student, had no behavioural problems at school but withdrew from social contact at secondary school. His school work deteriorated and he began associating with peers involved in shoplifting, truancy and alcohol use, though Rick himself exhibited no conduct problems. After leaving school he undertook a building apprenticeship and eventually established his own successful construction company, which he eventually sold as mentioned. Marital problems began when his children were young, his wife complaining that he did not help at home, that he worked too hard and spent too much time drinking with his friends.

Other than one conviction for driving while intoxicated in his early 30s, he had no convictions and no history of other illegal activities.

Since his divorce he has had occasional female companions but no sustained long-term relationship. He is reported to be highly respected as an honest, affable and able person, though unreliable and having a tendency to go 'over the top' at times. He had recently irritated others of his hapū by appearing intoxicated at a hui and overestimating his status on the marae.

Stage of change/type of motivation

Rick appeared to have a reasonable understanding of his situation and to be in the preparation stage with respect to his mood problems, and in advanced contemplation or early preparation

with respect to his alcohol use. With respect to motivation type, Rick accepted that both his mood and alcohol use were causing him problems in their own right and he had some degree of awareness that these problems impacted on other areas of his life that he valued highly such as his ability to participate in and support his whānau and especially to function as he wanted as a grandfather, and also his ability to participate effectively in marae activities. His motivation type was therefore somewhere between introjected regulation and internal regulation.

Mental status examination

Rick was noted to be casually and appropriately dressed and was maintaining reasonable self-care, but was sad, tearful and slowed in his movements and speech. He had problems with distractibility and short-term memory, but there was no evidence of significant anxiety or psychotic symptoms during the interview. He was well orientated in time, place and person and had reasonable insight into his situation.

Opinion

(a) Diagnoses using DSM-IV

Axis I	Alcohol dependence (severe) with physiological dependence Bipolar affective disorder – depressed phase
Axis II	No diagnosis
Axis III	No diagnosis
Axis IV	Covered under ‘Individualised Problems and Strengths’ below.

Note: Despite a clear history of periods of mood elevation, a diagnosis of bipolar disorder had not been made previously, mainly because health professionals had not thought to ask specifically about periods of mood elevation and Rick lacked some insight into the link between these, his drinking and his depression. The presence of significant others, who are often more aware of these periods of elevation, assisted in the diagnosis being made. The importance of diagnosing bipolar disorder in this context is that it indicates specific interventions which may be quite successful in managing mood and preventing relapse onto alcohol, whereas standard treatments for depression are less likely to be successful, even for the depressive phases. It should be noted that bipolar disorder has a higher rate of comorbid substance use problems than any other major mental health problem, other than, perhaps, antisocial personality disorder, and is significantly over-represented in tangata whaiora presenting to alcohol and drug services.

(b) Individualised problems and strengths

Problems include:

- » inability to control alcohol use
- » depressed mood
- » inattention, poor short-term memory
- » shame about letting his whānau down, about his problematic behaviours at a recent hui and with the land claim process, and about past failings, such as his divorce and the squandering of his construction company, which he had intended would support his whānau in the future
- » low sense of self-efficacy
- » lack of assertiveness in relationships and being overly eager to please others.

Strengths include:

- » a sound personal identity based on his whakapapa, connections with his whānau and marae
- » a strong sense of values
- » strong support from his whānau and hapu
- » an affable, likeable personality
- » hard working
- » loved by whānau, grandchildren.

(c) Aetiological or causal formulation

Note: To integrate all these factors into a common understanding, the health professional undertaking the assessment and the cultural health professional (Māori) constructed a four by four (4x4) grid to ensure all relevant factors were included and then considered how the key factors interacted to produce an integrated formulation.

It should be noted that the 4x4 grid is simply a tool to ensure comprehensiveness. There is no right or wrong box for factors to be placed in, and some factors cover several boxes, including perpetuating and protecting factors. For example, a whānau may be a strength in that it provides support, but may also perpetuate problems through maladaptive patterns of functioning. This approach also allows the combining and integration of a number of different paradigms or models of understanding. For example, factors specific to Māori can be included, especially if Te Whare Tapa Whā is used, as well as Western constructs, though it is important to appreciate the differences and not simply use Māori words for Western concepts when doing this, as mentioned earlier in this document.

Many experienced health professionals will avoid the use of such a tool, being comfortable that they can generate a comprehensive and integrated formulation without it. However, a formulation of this nature requires a shift in thinking patterns from the pattern recognition approaches used in making diagnoses and recognising individual strengths and problems, to a more comprehensive way of thinking. Health professionals recognise patterns with which they are familiar, and inexperienced health professionals may fail to consider important factors they are less familiar with. A tool such as the 4x4 grid may help overcome this.

It is important to be flexible when using such tools. There may be occasions when the models health professionals wish to use have more dimensions than the four in the left-hand column; for example, if using the Te Wheke model. The purpose is to allow the integration of a number of different models, to be comprehensive, and to encourage links to be made between factors.

Table 6.1 » Rick's 4x4 grid

	Predisposing (vulnerabilities)	Precipitating (triggers)	Perpetuating (maintaining factors)	Protecting (strengths)
Tinana (biological)	<ul style="list-style-type: none"> » Genetic – alcohol dependence, bipolar disorder » Neurotransmitter abnormalities 	<ul style="list-style-type: none"> » Lack of sleep » Alcohol » Elevated mood 	<ul style="list-style-type: none"> » Natural course of bipolar disorder and addiction 	<ul style="list-style-type: none"> » Good general physical health
Hinengaro (psychological)	<ul style="list-style-type: none"> » Guilt and shame – divorce, mother, loss of healthy self, whānau, loss of business » Poor coping skills – stress and mood management » Lack of assertiveness and self-efficacy 	<ul style="list-style-type: none"> » Poor judgement when mood abnormal » Lack of insight when elevated » Despondency and shame from incongruence between core values and behaviours 	<ul style="list-style-type: none"> » Guilt and shame » Low self-efficacy » Hopelessness when depressed 	<ul style="list-style-type: none"> » Organisational and business skills » Social skills, affable personality » Sense of responsibility to others » Tikanga » Motivation » Empowerment from whānau, hapū, iwi functioning
Whānau (social)	<ul style="list-style-type: none"> » Childhood physical abuse » Peer drinking patterns when younger 	<ul style="list-style-type: none"> » Changes in iwi functioning » Responsibility and pressure related to land claim process » Culture of alcohol use among peers 	<ul style="list-style-type: none"> » Responsibilities and expectations within whānau, hapu and iwi 	<ul style="list-style-type: none"> » Supportive whānau and hapu; brother, niece
Wairua (spiritual)	<ul style="list-style-type: none"> » Historical inter-generational trauma 	<ul style="list-style-type: none"> » Incongruence between core values and behaviours 		<ul style="list-style-type: none"> » Wairuatanga » Tikanga » Mana » Te reo » Sense of identity and turangawai-wai » Whakapapa

Note: In Rick's formulation, Te Whare Tapa Whā has been used as well as a Western bio-psycho-socio-spiritual approach. Te Whare Tapa Wha implies close links between all dimensions, perhaps more so than Western models as they are used in practice. There are also a number of other models implicit in this grid, including a strengths or well-being approach, and the inclusion of a spiritual perspective, which is often missing from Western models.

(d) Linkages, interactions and patterns between factors

Simply listing key factors is often insufficient. The interactions between them must be understood in order to come to a good understanding of Rick's situation. In Rick's case, key interactions include:

- » mood and his perception of his problems – his depression currently tints all his psychological and social interactions, especially his sense of shame
- » mood and alcohol use – Rick relapses on alcohol, particularly when his mood is elevated and his judgement impaired (alcohol use then destabilises his bipolar disorder and maintains the subsequent depression)
- » lifestyle (stress, sleep) and mood; also stress and alcohol use
- » social interactions and both mood and alcohol use
- » a strong sense of responsibility to and connection with whānau, hapū and iwi acting as a protective factor in terms of identity and support, a vulnerability and maintaining factor in terms of the stress resulting from the obligations he feels to them, and a source of shame.

Rick: integrated formulation

Rick has a genetic vulnerability to both bipolar disorder, through his maternal uncle and possibly his maternal grandfather and mother, and to alcohol dependence, through his father's whānau or family. He formed a strong attachment to his mother, though her violence towards him and emotional unavailability, through bouts of depression, may have been associated with the development of chronic feelings of low-self worth, a tendency towards self-blame and guilt, and a lack of assertiveness, which, in turn, predisposed him to later major depressive episodes. The history of withdrawal from social contact and deterioration in academic performance at secondary school suggest that his mood disorder may have begun at this time and may have increased the likelihood of leaving school early, associating with dissocial substance-using peers, and exposure to their culture of heavy alcohol use, which further increased his risk of mood problems.

The precipitants of both mood disorder and alcohol dependence are distant. His mood disorder followed a chronic relapsing course, and manic episodes appear to have been the main triggers for his relapses on alcohol. His current mood problems were triggered by the stress of his hard work for the iwi and lack of sleep. He initially experienced elevated mood, with consequent disinhibition and poor judgement, and relapsed on alcohol as a result of this and with the encouragement of alcohol-using colleagues.

Over time his mood and substance use problems have been maintained by his lack of resilience to stress arising from a chronic sense of low self-esteem and self-efficacy, grief and shame regarding the break-up of his marriage, and the loss of his construction business worsening his sense of shame towards his whānau. His affable nature hides a lack of assertiveness which, coupled with a strong sense of responsibility towards his whānau and hapū, leads him to take on too much with respect to his roles within the iwi. His whānau and hapū do not fully appreciate the limitations his problems place on him and their continued expectations of him exacerbate the stress he experiences, as well as enhancing his sense of shame when he fails to live up to these expectations. At the same time, his connections with whānau, hapū and iwi are protective in that they provide him with support and a sense of identity, which help ameliorate the intensity of his problems. His commitment to his tikanga and his strong spiritual beliefs and practices are also important protective factors, though they are also a source of shame when he fails to live up to his own expectations in this regard.

Overall, Rick has chronic problems with mood and alcohol use, which follow a pattern of relapse and remission. There is an interaction between his mood problems and alcohol use, each worsening the course of the other, and this pattern has developed some stability over the years. Key drivers of this interaction appear to be low-self efficacy and a tendency to experience high levels of guilt and shame, and the nature of his interpersonal relationships which, while providing him with support, also place expectations on him that he is unable to cope with.

Management goals

Short-term – early goals

- » Engage Rick and his whānau in the treatment process through culturally appropriate approaches and enhance his motivation to change.
- » Ensure safety, including cultural safety.
- » Stabilisation – stabilise mood and stop alcohol use.

Medium to long-term goals

- » Improve relationships and lifestyle issues that destabilise mood, especially those that increase levels of stress and compromise sleep.
- » Address issues of guilt, shame and lack of assertiveness.
- » improve coping skills for managing mood and stress.
- » Strengthen his key support networks by increasing their understanding of his problems.
- » Enhance general well-being of Rick and his whānau.

Note: There is a risk in attempting too much at once. While several interventions can coincide, too many are likely to overwhelm Rick and confuse him, especially when it comes to psychological interventions. It is important, therefore, to take a stepped approach within each phase of treatment consistent with the particular goals being dealt with, as outlined below.

Mood instability plays a big part in recent patterns of drinking and needs to be a primary target. It is likely that alcohol use will complicate the stabilising of his mood, though it should be noted that there is little evidence that mood stabilisation cannot occur when alcohol is being used. Hence, both should be targeted aggressively from the start.

Management

The management plan negotiated at the initial interview needs to be specific in terms of the early phase of treatment. There also needs to be a less detailed indication of likely medium- to long- term goals and strategies, though these may change depending on the outcome of early treatment and further information that may come to light.

Early Treatment

(1) Setting

Rick was eager to remain with his whānau. Given that the brief current episode of drinking meant that severe withdrawal symptoms were unlikely, and the lack of significant risk of self-harm, it was decided that Rick should stay with his brother's whānau or family for a few weeks while he stopped alcohol and his mood was stabilised. They were happy to provide the necessary support and did not wish to see him in a residential setting if that could be avoided. A clinical case manager was appointed from within community mental health services with the task of coordinating care and being the primary agent of interventions, wherever possible.

Note: The precise nature of outpatient treatment will depend on the local structure of services and the capability of mental health services to manage his substance use. Optimally, the community mental health team would have the expertise to help Rick stop using alcohol while it also addressed his mood problems. However, many mental health services lack this capability and need to involve alcohol and drug services as well. Again, the nature of support for stopping drinking depends on the local structure of the alcohol and drug services. Some regions have access to residential detoxification facilities; others have community-based withdrawal support teams; and a few have both.

In Rick's case, the community mental health team was not confident in its ability to help him stop drinking or to deal with further treatment of his alcohol dependence. Local alcohol and drug services were therefore involved, according to a predetermined arrangement for shared care, and a detoxification support worker joined the community mental health multi-disciplinary team, visiting Rick with the clinical case manager or the cultural health professional (Māori), who also remained involved.

Rick was also offered the involvement of local kaupapa Māori services but declined, preferring to involve the support of his hapū, who would be able to provide culturally based interventions, including spiritual interventions. He was happy for the team's cultural health professional (Māori) to make links with and coordinate care with the hapū-based traditional health experts.

(2) Further information

Further information was sought from past clinical files relating to mental health and substance use treatments, and from his GP, who confirmed that there was no history of physical problems that would complicate treatment, including detoxification, and specifically that there was no known history of seizures. In the process of liaising with Rick's employer, the clinical case manager also clarified that there were no other significant issues that had arisen in the context of his work.

Note: Consideration could also be given to the use of rating scales for mood, such as the Beck Depression Inventory (BDI), to help monitor changes in depression.

(3) Treatment of medical/physical conditions

A physical examination was performed by Rick's GP prior to referral, with a focus on the complications of alcohol dependence. Blood tests were ordered by the community mental health team, which comprised a full blood count and routine biochemical and renal function tests, liver function tests to check for alcohol-related liver damage, and thyroid function tests, given the potential for abnormal thyroid function to present as depression and to exacerbate mood disorders. There was no indication for other tests at this point.

Note: Optimally, for tangata whaiora with complex needs the medical work-up should be available from within the community mental health team. However, many community mental health teams lack this resource, and where this is the case liaison with the GP for a physical examination will be needed. Given that the GP has an important role to play in the health care of tangata whaiora, and in their mental health care once they no longer need specialist mental health input, their involvement is advisable. It is important, in such circumstance, to liaise closely with the GP to ensure they are aware of the thinking of the mental health team and of the relevant physical complications to look for.

(4) Psychopharmacology

Rick chose to detoxify with his whānau. No medications were prescribed for this initially, other than a sedative to assist sleep and prophylactic oral thiamine and Vitamin B supplements. Given concerns about the potential misuse of benzodiazepines in someone with alcohol dependence not being treated in a controlled environment, low-dose quetiapine (which may also enhance mood slightly, while protecting against any mood elevation) was prescribed. Rick's relapse was brief and there was no evidence of Wernicke's encephalopathy (confusion, unsteady gait, abnormal eye movement), but thiamine supplementation is safe and the consequences of Wernicke's encephalopathy severe.

Rick was informed about medication options for mood and longer-term support of abstinence. These included naltrexone or disulphiram (antabuse) for alcohol dependence, and mood stabilisers for bipolar disorder. Given that mood stabilisers may not improve depressive symptoms particularly well, the option of short-term antidepressant medication to improve mood if depressive symptoms persisted after detoxification was also raised. It was decided to monitor mood changes during the first few weeks of detoxification and await the blood test results before starting medication.

(5) Psychological interventions

Initial psychological interventions involved general support, coping skills (including anxiety reduction techniques to help with the symptoms of detoxification), and a motivational approach to interactions to enhance empowerment and engagement, and to attempt to enhance motivation to change drinking behaviours. Motivation was further enhanced by helping Rick to reiterate his core values and world view through the use of the Values Card Sort and involvement of whānau in his care.

Several sessions of Social Rhythm Therapy were, initiated mainly to help Rick learn to stabilise circadian rhythms. This focused on establishing and maintaining regular times for getting out of bed, showering, going outside for the first time, meals, exercise and going to bed, finding a suitable balance of activity and rest periods, and exploring and managing factors that might disrupt daily social rhythms.

(6) Whānau or family interventions

Other than education of whānau, mentioned below, specific whānau interventions were not undertaken at this point. It was noted, however, that there was a culture of drinking within the whānau which might need to be dealt with at a later date.

Nothing specific other than issues mentioned under Psychoeducation at this point.

(7) Spiritual interventions

Rick was keen to address spiritual issues as part of treatment. The cultural health professional (Māori) ensured that Rick's brother involved the relevant people from his hapū who could offer such interventions. The community mental health team members involved in his care were also careful not to act in a way that conflicted with Rick's values and beliefs and took a lead from the cultural health professional (Māori) in terms of respecting issues of mana, tapu, tikanga and the whānau expression of manaakitanga.

(8) Education/work/occupation

Liaison with Rick's employer was undertaken to gain support for his absence due to detoxification and low mood.

(9) Education of tangata whaiora and significant others

Either Rick's brother or his sister-in-law was present at most of the follow-up appointments, which happened at their home, and they developed a good understanding of Rick's problems and how they needed to support him. Several meetings with Rick's whānau were organised at his brother's place. The case manager and cultural health professional (Māori) took this opportunity to educate them about the need to support Rick being abstinent,

what problems were attributable to his depression, and how periods of stress could spark elevated mood, which could then lead to relapse on alcohol, and how they could help him manage this stress, recognise early signs of elevated mood and support him remaining abstinent from alcohol.

(10) Self-help groups

The possibility of Rick joining a local Alcoholics Anonymous (AA) group was discussed with him. Rick had attended AA in the past but had struggled to engage, feeling uncomfortable with the group setting. It appeared that the presence of depressive symptoms at those times may have inhibited his ability to gain from the social aspects of AA. He was reluctant to consider it early in treatment. The case manager respected this decision but reserved the right to mention AA again later in treatment.

Note: AA and similar support groups can be extremely effective in helping people recover from alcohol and drug problems when abstinence is their goal. However, tangata whaiora do not always feel comfortable with the philosophies of AA, and abstinence is not always the most appropriate initial goal. Where tangata whaiora show interest in AA it should be encouraged and facilitated, but it should not be 'pushed' on reluctant participants. Health professionals should be mindful of barriers to engaging with AA in people who might find it helpful. These include shame about their mental illness, cognitive impairments and social skills deficits, social anxiety and depression, as in Rick's case. Suggesting AA again once some of these barriers have improved is worthwhile.

Integrated care

Integration of Rick's care revolved around the comprehensive assessment, which covered all relevant areas including mental health and alcohol and drug problems and the relationship between them. The aetiological or causal formulation (above) pulled together all relevant factors into an integrated understanding of Rick's situation, which then drove the management plan.

The community mental health team had previously ensured it had the capacity to assess alcohol and drug problems and their interaction with mental health problems, and to initiate management of both. They lacked specific skills in terms of detoxification and some of the addiction-specific interventions, and so had established a relationship with local alcohol and drug services, which supported collaboration and shared care. In this instance, a health professional from the alcohol and drug service who was able to manage the detoxification process worked alongside the community mental health team, and from Rick's perspective appeared as much part of the team as any of the other health professionals he dealt with.

In addition to organising treatment, monitoring treatment progress and providing basic coping skills to help Rick manage his stress and depression, the clinical case manager had the key task of ensuring treatment was integrated. This involved personal contact with all health professionals involved, especially the cultural health professional (Māori) and the alcohol and drug health professional, to ensure lines of communication were effective and that everyone involved was aware of the key goals and strategies involved in treatment.

6.2.3 Middle Treatment

Where the early treatment phase ends and the middle treatment phase begins varies from person to person and with the nature of their problems. In Rick's case it is reasonable to see the early treatment phase as being the first two to four weeks of abstinence from alcohol, during which the response of his mood to stopping drinking is being monitored and decisions about the precise mood medications to be prescribed are being made and

negotiated. The middle phase of treatment can therefore be seen as the phase in which active treatment for mood, further treatment and relapse prevention for alcohol use are undertaken.

Rick managed to detoxify from alcohol without significant problems over one to two weeks. His depression gradually improved with abstinence, but symptoms of sleep disturbance, mild persistent sadness and lack of energy remained. Blood test results also revealed a borderline elevation in gamma-glutamyltransferase (GGT), a liver enzyme that may be elevated with chronic severe drinking, but this returned to normal when checked again three weeks after he stopped drinking.

Key goals

The key goals are:

- » to maintain engagement and motivation of Rick and his whānau
- » active treatment of bipolar disorder and alcohol dependence
- » enhancement of well-being.

Note: There are a number of different interventions that are indicated during the middle phases of treatment, including several different psychological interventions. It is important not to do all at once and risk overwhelming Rick. Different psychological interventions are often intertwined in a stepped approach, following specific goals, and dealing first with factors that may prevent other interventions being successful.

In Rick's case, the most important goals in the middle phase of treatment were to maintain or enhance engagement and motivation, to achieve some further improvement of any residual depression that might limit the effectiveness of psychological interventions, while also introducing steps to stabilise his mood and the cycling between elevated and depressed moods over time.

Cultural considerations

Care should be taken to ensure cultural issues continue to be respected and that the cultural health professional (Māori) remains fully involved in Rick's care. Demonstrations of respect for the cultural aspects of treatment are likely to increase Rick's confidence in keeping the community mental health team informed of other remedies and healing strategies he is accessing.

It is also important to understand the ways in which care delivered in a mainstream setting may conflict with the cultural beliefs and values of Rick and his whānau; for example, supporting appropriate processes when meeting, which might include karakia, the provision of food and drink, acknowledging and supporting the expression of the various roles existing within the whānau, being careful to maintain the mana of Rick and his whānau and, as mentioned, supporting culturally specific interventions Rick and his whānau wish to access, such as traditional remedies (rongoā), mirimiri and those involving tohunga. Where the clinical case manager is unsure of how to act, expert advice should be sought, giving priority to the rights of tangata whenua to determine what is appropriate and necessary.

Well-being

A well-being perspective is important to maintain engagement and motivation. While much of the focus during the early and middle phases of treatment has been on identifying and treating problems and diagnoses, well-being can be incorporated simply by regularly keeping in mind and acknowledging that treatment is about overcoming barriers to well-being and by helping Rick savour positive experiences, such as time spent with his grandchildren.

Specific interventions for enhancing well-being are often simple and straightforward and can be incorporated opportunistically into other psychological interventions. Helping Rick identify his core character strengths can be done simply by accessing the websites mentioned in previous sections. Once this has been done, simple encouragement to use his strengths between sessions, especially in new ways, can be part of homework tasks, as can encouraging him to undertake expressions of gratitude and acts of kindness.

It is likely that more focused work on developing and engaging more in gratifying activities that are for the benefit of him and his whānau, rather than others, would wait until the later phases of treatment. It was also planned that CBT approaches to enhancing optimism would be interspersed with CBT for depression, as appropriate, or would follow directly on from CBT for depression.

Engagement

As mentioned, it is important to work at monitoring and maintaining engagement throughout treatment. Signs of diminishing engagement include missed appointments, forgotten medication, and negative attitudes towards the effectiveness of treatment and towards the initial formulation and diagnoses.

Note: Important factors that influence engagement in this phase of treatment include ongoing ambivalence about stopping drinking; demoralisation related to depressed mood; disruption within key support groups, or individual support people who may disagree with the treatment direction or philosophy; and medication side-effects; adjustment to having the problems identified or a continual focus on the negative aspects of the problems tangata whaiora face. The clinical case manager needs to be mindful of these possibilities and actively address them when present.

It should also be noted that while the spirit of motivational interviewing involves empowering tangata whaiora, it is common for there to be a waning of commitment to abstinence after it has initially been chosen as a treatment goal. This is often related to the process of alcohol dependence. While in some circumstances it may be reasonable to adjust the goal of abstinence towards a trial of controlled drinking, in others this should be challenged. Health professionals should be reluctant to empower decisions that are driven by the disorder and that are highly likely to undermine progress and well-being.

Rick continued to be well engaged, though at times he expressed doubts about the need to abstain completely from alcohol and to take medications for his mood. With further exploration it transpired that he was craving alcohol at times and also that a member of his whānau believed that all he needed to be well was traditional Māori interventions and not Western medicine. On further exploration and reaffirming of his vision of well-being, Rick regained his commitment to abstinence and with the support of his whānau decided to continue medication and psychological approaches for his mood disorder, which he saw as being compatible with traditional Māori approaches.

Motivation

As mentioned in the previous paragraphs, Rick's motivation waxed and waned a little, influenced, in part, by fluctuations in his depression and his sense of hope for the future. His primary source of motivation initially came from his desire to enjoy and express the love of his whānau and to contribute to their well-being as best he could. His ambivalence about drinking was quickly contained by increased contact with his whānau, especially his grandchildren, and refocusing him on his key values and world view.

As the therapeutic relationship with the community mental health clinicians developed, Rick and his whānau increasingly shared information about their Māori background and how they expressed this in their day-to-day lives. Rick's sense of responsibility to key ancestors/tupuna and to his tikanga became more important as a motivating factor.

Assessment

Issues regarding assessment during this phase include adjusting the initial opinion if and when further information comes to light, and reviewing the comprehensive assessment if progress in treatment is poor.

Management

(1) Setting

Rick initially stayed with his brother for three or four weeks and then elected to return to his own home, where he had regular support from his whānau.

(2) Further information

Further information was integrated into the initial opinion as it came to light. Rick and his whānau increasingly shared information about their Māori beliefs and practices, which were integrated into the opinion and formulation, and the management plan was adjusted accordingly.

(3) Treatment of medical/physical conditions

Continued treatment of medical and physical conditions if necessary, as described for early treatment.

(4) Psychopharmacology

After initial detoxification Rick's mood improved somewhat, but there were still significant symptoms of depression present. He was prescribed medication to stabilise his mood over the medium to long term. There were pros and cons to both lithium and valproate, but ultimately the decision was made to prescribe lithium rather than sodium valproate, given that Rick was in a depressed phase that had improved somewhat, but not completely, over three to four weeks of abstinence from alcohol. Naltrexone was considered to be an option in the future if he struggled with abstinence from alcohol, but it was decided not to offer it at this point, given that naltrexone and valproate both may impair liver function and he had been able to initiate periods of abstinence without it in the past.

Note: Lithium and valproate differ in a number of ways that affect bipolar disorder with comorbid substance use, but both are effective in many cases. A small amount of evidence indicates that sodium valproate may be better when comorbid substance use is present. It is unclear whether this is because of some impact from substance use or because substance use is associated with higher rates of rapid cycling in bipolar disorder and that valproate might be more effective for rapid cycling, regardless of the presence of substance use. Valproate also has the potential to cause and be affected by liver impairment, and this warrants consideration in tangata whaiora who use alcohol heavily, given that alcohol may cause liver damage and that naltrexone may be useful to treat the alcohol dependence but may itself impair liver function. Lithium has the potential to impair thyroid function, which can destabilise bipolar disorder, though this is manageable when detected. It may also be superior in treating the depressed phase of bipolar disorder. Ultimately the decision about which medication to prescribe initially will depend on the specific details of a person's problems, their choice given the side-effect profiles of the two drugs, and the preferences of the prescribing health professional, considering that health professional confidence in the effectiveness of prescribed medication is likely to have an impact on outcome.

Rick's depressive symptoms improved further once lithium was established but did not completely resolve. Consideration was given to prescribing a brief course of antidepressant medication to attempt to shift the mood further towards normal, but because of the risk of precipitating elevated mood or increasing the rate of cycling of bipolar disorder the treatment team decided to await the

effect of psychological interventions.

Rick went through a period of several weeks where he was reluctant to continue lithium due to some weight gain. Strategies were put in place to help cope with this, including single-day dosing of lithium at night, substituting low carbohydrate drinks for normal sugar-based drinks, eating more meals of smaller proportions throughout the day to avoid between-meal snacking, support from a dietician around meal planning, and increased daily activities and exercise.

He continued to struggle with cravings for alcohol at times, though did not relapse. Triggers for these cravings involved friends using alcohol, but also came from cues in newspapers and past memories. He was therefore prescribed naltrexone to assist with the cravings for a period of four months, which successfully reduced them and allowed him to develop skills to cope with them when they did subsequently recur.

(5) Psychological interventions

As mentioned, coping skills to manage detoxification, early craving and mood fluctuations were introduced during the early phase of treatment and a regular rhythm of daily tasks was established. Several sessions of CBT for depression were undertaken by the clinical case manager with the support of the team's clinical psychologist, targeting current depressive cognitions as well as grief issues.

Note: Many clinical case managers have some skills in CBT for anxiety and depression, but many do not. The involvement of a clinical psychologist to support CBT is a useful way of developing skills in other staff members that are essential for many tangata whaiora with mood and addiction problems. Services need to ensure they plan to develop this capacity within their teams.

Rick's mood responded further to CBT to the point that he was no longer depressed. At this point, the focus of CBT changed and work was done to improve his underlying levels of optimism and to enhance hope, which he responded well to. Although the importance of him being able to make his needs known to his whānau was discussed, encouraging Rick to assert those needs ahead of the needs of others was seen to conflict with his key values of supporting the functioning of his whānau. Work was therefore done with the whānau to enable them to take collective responsibility in meeting his needs, especially those around reduced levels of stress and reduced demands on his time when vulnerable to relapse.

Note: The issue of assertiveness is one that needs to be approached with care in tangata whaiora who are from more collectivist cultures. Although the ability to make one's needs known is important in all cultures, collectivist cultures may see excess assertion of individual needs and rights as dysfunctional and a failing. Assertiveness in this context is more likely to involve the making of one's needs known while continuing to act in the best interests of the whānau or social group, and encouraging the whānau or social group to take collective responsibility for meeting those needs.

Interspersed within CBT are specific strategies to prevent relapse to alcohol and to minimise relapses in mood.

(6) Whānau or family interventions

As mentioned in the sections above, representatives of the whānau were encouraged to be present whenever Rick was seen, especially when important treatment decisions were being made, but excluding the CBT sessions.

The issues regarding assertiveness and helping Rick to manage the stress and demands on his time were discussed with the whānau, and they were supported in taking collective responsibility for monitoring and managing these demands, acknowledging that Rick would need to let

them know when experiencing stress but also that he would be unable to refuse to fulfil his obligations to whānau and hapū. Especially important in this was for the whānau, in liaison with their local kaumātua, to manage the demands from others outside the whānau who might not fully understand Rick's situation. It was essential to find some tasks he was able to cope with that would maintain his mana within the hapū and wider group while limiting the extent of the pressures on him.

It was also important to address any problems within the whānau, especially those related to substance use, which may increase Rick's risk of relapse in the future and just as importantly undermine the well-being of the whānau. Ideally, the cultural health professional (Māori) will have the skill to do this, but if not it may involve others with the expertise and position to help the whānau enhance their own well-being.

It would also be useful to encourage the whānau and influential others to explore patterns of substance use at their marae and to consider changes if substance use is prevalent there. This needs to be done with delicacy by someone with an understanding of marae processes and with respect for the principles of self-determination of those attached to the marae.

(7) Spiritual interventions

Specific spiritual interventions had been undertaken by a tohunga during the early phase of treatment. Rick continued to reaffirm his commitment to his tikanga and core values within his whānau and in his regular visits to his local marae, all of which contained a significant spiritual component.

(8) Education/work/occupation

Rick was advised to have time off work for much of the middle phase of treatment. His employer was supportive, but the reality of the construction business is that he would have to replace Rick. He agreed, however, that when Rick was ready to return to work he would do everything possible to find him a job.

(9) Education of tangata whaiora and significant others

As above. In addition, the whānau need to be educated about what Rick needs to do in terms of taking medication, watching for side-effects and preventing relapse.

(10) Self-help groups

As above. Rick continued to be reluctant to join AA, believing that the social and spiritual support from his whānau and through his marae were adequate.

Integrated care

As above. Key tasks in terms of integrating care during the middle phases of treatment involved maintaining a focus on the integrated assessment and aetiological formulation, maintaining a well-being perspective, with all problem areas being seen as barriers to a common goal, and continuing close liaison and linkages between all involved.

Note: An important aspect of integration as treatment progresses is maintaining the close working relationship between the clinical case manager and the cultural health professional (Māori). Although integrating mental health and substance use care is crucial, integrating mainstream and Māori perspectives is equally important and, arguably, just as difficult.

6.2.4 Late Treatment

In Rick's case, late treatment can be thought of as that phase of treatment in which much of the core treatment has been established and completed, the strategies for lifestyle change have been implemented, and the key task involves continuing to support Rick as he puts these changes into practice successfully, while resuming as normal a day-to-day life as he is capable of.

This phase requires close monitoring and support from health professionals in the early part, with increasing encouragement of Rick and his whānau to assume responsibility over time. It should be anticipated that the course of Rick's problems may fluctuate and that there might need to be periods of active treatment during this phase.

Key goals

- » maintain gains while integrating them into day-to-day life
- » restore well-being
- » increase self-care.

Cultural considerations

The principles as discussed for early and middle treatment continue to apply in late treatment.

Well-being

The principles as discussed for early and middle treatment continue to apply in late treatment. As Rick maintained stability, and lifestyle changes became more habitual, attention shifted slightly to include more focus on achieving well-being. This involved further exploration of character strengths, ways in which Rick could express these in his day-to-day life, the establishment of fulfilling and well-being-enhancing activities (such as employment), and strengthening and gaining pleasure from social relationships.

The issue of the use of substances within the whānau and at Rick's marae has been discussed. Reviewing with Rick the various services and social institutions he is involved with and how they enable well-being versus dysfunction is likely to be very useful. Supporting methods to strengthen the well-being-enhancing nature of those groups and organisations, and carefully selecting which to be involved with if they are not able to change, is important.

Engagement

Key tasks involve monitoring engagement and treatment adherence, using specific interventions if these appear to be compromised, and engaging Rick with others outside the treatment team who need to be involved in the long term. This includes ensuring engagement with his GP and other support networks.

Motivation

The principles as discussed for early and middle treatment continue to apply in late treatment. Special attention should be given to ensuring Rick finds motivation for ongoing adherence to treatment in sources outside of the community mental health team and especially within himself.

Assessment

The principles as discussed for early and middle treatment continue to apply in late treatment. If treatment is proceeding well in the late phases it can be presumed that earlier assessments were useful and that the opinion formed was accurate. A review of earlier opinion and formulation may still be useful however, especially when the emphasis shifts from management of problems to enhancement of well-being and recovery.

Management

The principles as discussed for early and middle treatment continue to apply in late treatment. The key activities include monitoring progress to ensure gains are maintained, intervening quickly when problems arise with active interventions, encouraging Rick and his whānau to take increasing responsibility for monitoring and overseeing his care, and working further on relapse prevention. In preparation for autonomous independence, considerable education of others who are likely to become more involved in the longer term is needed. This includes Rick's GP.

Integrated care

The principles as discussed for early and middle treatment continue to apply in late treatment. During this phase of treatment Rick remained abstinent from alcohol but had brief periods of mood instability, particularly mild depression when feeling stressed. These periods were not sustained as he managed to take steps to reduce the stress he was under with the support, and at times direction, of his whānau.

Autonomous independence

When Rick and his whānau are managing his problems successfully, accessing necessary supports independently and he is progressing well towards a satisfying state of well-being, the community team need to withdraw from treatment. Rick and his whānau need to be clear about when and how to access their help again if needed, and encouraged to do so early rather than late.

Appendices

Appendix 1 » The Values Card Sort

The Values Card Sort exercise involves the health professional and tangata whaiora engaging in conversation about key values identified by the tangata whaiora using a set of values cards. There are a number of subtle variations of the procedure, but the following appears to work well.

Procedure

Say to the tangata whaiora, 'Each of the cards represents something that might be important to people'. Then ask the tangata whaiora to sort the cards into two piles:

- » important to me
- » not important to me.

Finally, ask the tangata whaiora to select the three to five most important cards from the most important pile. Discuss and explore:

- » What is it about this value that is important to you?
- » To what extent do you feel you are or are not living up to this value?
- » Are there any ways in which you would like to be living out these values more than you are at the moment?

Bill Miller's values cards are in the public domain and are available for download at:
<http://motivationalinterview.org/library/valuescardsort.pdf>

Appendix 2 » Outline of the Comprehensive Assessment and Management Plan

History

1. Introduction

Name, age, occupation, marital status, children, current social circumstances, key relationships.

Hopes for the future, identification of what well-being might mean to tangata whaiora.

2. Presentation

Nature of referral, including tangata whaiora's view of presenting problem(s) and expectations of help.

3. History of presenting problems

Begin with the problem the tangata whaiora believes is the most important – either alcohol and drug or a mental health problem.

4. Alcohol and drug/addiction history

(A) Alcohol and other drugs:

» substances used in life, including nicotine:

- ever used
- regularly used
- recently used or currently using
- quantity and frequency of use
- ever used intravenously

» pattern of substance use for each regularly used substance:

- current or most recent use
- age of first use
- age of first regular heavy use
- first problems from use
- heaviest three- to six-month period of use
- DSM-IV symptoms during heaviest period of use
- current patterns of use
- current DSM-IV symptoms
- longest periods of abstinence.

» person's stated or implied reasons for using

» complications of alcohol and drug use

» dependence/abuse status (i.e. DSM-IV symptoms)

- » interactions between substance use and any mental health symptoms
- » treatment history (including use of self-help groups).

DSM-IV	Alcohol	Cannabis	Nicotine	Sedatives	Stimulants	Opioids	Poly
1							
2							
3							
4							
5							
6							
7							

(B) Behavioural addictions

Pathological gambling:

- » exploration of patterns and consequences of gambling
- » attempts to control or reduce gambling
- » DSM-IV criteria for pathological gambling
- » interaction between gambling, substance use and mental health symptoms
- » previous treatments.

Other addictive behaviours.

5. Mental health history

This includes:

- » key current problems and symptoms
- » identifying likely DSM-IV diagnoses
- » determining the onset of symptoms, problems and any vulnerability factors or prodromal symptoms (e.g. history of shyness and separation problems with current anxiety problems)
- » the course of symptoms since onset and their relationship to significant life events
- » considering constructing a timeline of the course of mental health symptoms relative to substance
- » current and past diagnoses and treatments.

Screening of other mental health problems

This includes, but is not limited to, the following.

- » **Generalised anxiety:** Have you ever worried a lot about terrible things that might happen, even when it was unrealistic to worry as much as you did?
- » **Social anxiety:** Is there anything that you were ever afraid to do or felt uncomfortable doing in front of other people, like speaking, eating or writing? What were you afraid could happen when doing this?

- » Agoraphobia: Were you ever afraid of going out of the house alone, being in crowds, standing in a line or travelling on buses or trains? What were you afraid could happen?
- » Panic: Have you ever had a panic attack, when you suddenly felt frightened, anxious or extremely uncomfortable? Have you ever had one when you did not expect to at all?
- » Post-traumatic stress disorder: Have you ever experienced a very traumatic event which was extremely distressing?
- » Anorexia nervosa: Have you ever had a time when you weighed much less than other people thought you ought to weigh but you continued to feel overweight?
- » Bulimia nervosa: Have you ever had eating binges during which you ate a considerable amount of food in a short period of time and during which your eating was out of control?
- » Obsessive compulsive disorder: Have you ever been bothered by thoughts that did not make any sense and kept coming back to you even when you tried not to have them? Was there ever anything that you had to do over and over again and could not resist doing, like washing your hands again and again or checking something several times to make sure you had done it right?
- » Dysthymia: Have you ever been bothered by, or experienced, depressed mood most of the day, more days than not, for a period of several years?
- » Major depressive syndrome: Has there ever been a period of time when you were feeling depressed or down most of the day nearly every day, for at least two weeks?
- » Manic syndrome: What about ever having the opposite of depression, when you were feeling so good or high that other people thought you were not your normal self or you were so high that you got in trouble?
- » Delusions (reference and persecutory): Did it ever seem that people were talking about you or taking special notice of you? What about receiving special messages from the TV, radio or newspaper, or from the way things were arranged around you? What about anyone going out of their way to give you a hard time, or trying to hurt you?
- » Hallucinations (auditory and visual): Did you ever hear things that other people could not hear, such as noises, or the voices of people whispering or talking? Did you ever have visions or see things that other people could not see?

Exploration of self-harm, suicidality, homicidality and other areas of risk

(Past/current)

Interactions Between Substance Use and Mental Health Problems

Identify mental health symptoms likely to be secondary to substance use as suggested by:

- » amelioration of symptoms during abstinence
- » absence of whānau, or family history of the mental health problem
- » onset of mental health symptoms after onset of substance use and possibly during a heavy period of use.

Identify the relationship between substance use and mental health symptoms, including:

- » the course of mental health symptoms during abstinence from substance use
- » mental health symptoms during heavy periods of substance use
- » the effects on intoxication on symptoms.

This should be informed by current research on interactions.

Note: It is important not to expect that certain interactions should occur. While there is good evidence that depressive symptoms may often, but not always, be secondary to alcohol use and psychotic symptoms secondary to stimulant and hallucinogen use, the evidence for many other interactions is equivocal, despite 'clinical lore'.

6. Medical history

This includes:

- » current prescribed medications
- » past diagnoses/treatment, including head injuries
- » current symptoms/problems in systematic review:
 - nervous
 - endocrine
 - cardiovascular
 - respiratory
 - gastrointestinal
 - genitourinary
 - musculoskeletal
- » estimated risk of infection
- » whānau or family disorders and problems in first- and second-degree relatives – especially Hep B, Hep C, HIV.

7. Legal/forensic history

This includes:

- » convictions
- » illegal activities not convicted of
- » jail terms
- » charges pending and current legal status
- » relationship between substance use, mental health symptoms and offending.

8. Whānau or family history

This includes:

- » structure of whānau or family of origin
- » role within whānau or family

- » whānau or family disorders and problems in first- and second-degree relatives:
 - alcohol and drug
 - psychiatric
 - medical
 - legal
- » living in the whānau or family while growing up:
 - general whānau or family functioning
 - adequacy of specific relationships within whānau or family
 - occurrence of emotional/physical/sexual abuse
- » other behavioural disturbances
- » historical involvement with social agencies (e.g. Child, Young Persons and Families Service)
- » current relationships within whānau or family of origin
- » ability of whānau or family to fulfil key functions.

9. Personal/developmental history

This includes:

- » birth problems, early developmental milestones
- » significant life events in infancy, including separations from parents
- » nature and personality in infancy, early childhood
- » significant early health problems
- » schooling:
 - primary, intermediate and secondary
 - academic ability and performance, including periods of reduced performance
 - specific learning difficulties, estimate of baseline intellectual ability
 - socialisation – ability to make and sustain friendships, nature of peer affiliation
 - discipline and behavioural problems at school, attention problems
- » other behavioural disturbances, including conduct disorder
- » adult relationships
- » ability to establish and maintain friendships:
 - psychosexual development and marriage
 - key enduring friendships
 - nature of peer relationships
 - quality of social support networks
 - sexual orientation
- » occupational history

- » personality:
 - including description by tangata whaiora and whānau or family
 - personality strengths
 - screening for presence of personality disorder, especially antisocial personality disorder and any other personality disorders
 - other issues (e.g. anger control problems)
- » leisure skills:
 - interests, hobbies
- » cultural history:
 - cultural identity
 - cultural practices
 - relevant cultural beliefs
 - issues likely to affect cultural impact on CEP and treatment.

10. Current psychosocial functioning

This includes:

- » work
- » relationships
- » accommodation
- » finances
- » social networks
- » ongoing stresses
- » coping skills
- » problem-solving skills.

11. Spiritual History

This includes:

- » spiritual beliefs
- » spiritual experiences
- » spiritual practices
- » impact of spirituality on substance use and mental health issues.

12. Stage of change for each major problem

Current Mental State Examination

Note: the current mental state examination observes the mental state of tangata whaiora as it presents currently (i.e. during the current interview). For example, if delusional thinking is evident during the interview it is included, but if there is a recent history of delusional thinking over preceding days but it is not observable during the interview, it is entered in the history (above).

- » Appearance and behaviour:
 - » physical appearance
 - » clothing
 - » movements
 - » state of intoxication
 - » state of consciousness.
- » Speech:
 - » speed
 - » articulation
 - » volume
 - » relevance.
- » Affect and mood:
 - » depressed mood
 - » elation
 - » anxiety.
- » Thought process:
 - » specific thought disorder.
- » Thought content:
 - » preoccupations
 - » overvalued ideas
 - » delusions.
- » Perception:
 - » illusions
 - » hallucinations.
- » Insight/motivation and readiness to change:
 - » degree of awareness/acceptance and ability to co-operate with treatment
 - » stage of readiness to change.
- » Cognitive screening:
 - » orientation (time/place/person); year, season, month, day, date, time.
- » Registration of four unrelated objects

- » Attention and concentration; '100-7 test', spell word (e.g. world) backwards
- » Naming of objects (e.g. name watch strap, clasp) and tell time
- » General knowledge (e.g. prime minister of New Zealand, capital city of Australia, closest planet to the sun)
- » Interpretation of a proverb; concrete or abstract interpretation
- » Constructional ability (e.g. draw a clock face)
- » Short-term recall of the four unrelated objects.

Physical Examination

Opinion

1. **Diagnosis** (using first three axes of DSMIVDSM-IV multi-axial system)

Axis 1 Substance use disorders, behavioural addictions and other psychiatric disorders (including conduct disorder).

Axis 2 Personality disorder
Mental handicap.

Axis 3 Physical conditions and problems.

2. **Individualised Problem List**

Current issues:

- » physical health
- » mental health
- » work
- » whānau or family
- » relationship
- » accommodation
- » financial
- » legal
- » any other.

3. **Aetiological or Causal Formulation**

Note: The formulation is an explanatory statement. It attempts to answer a key clinical question: 'Why is this person presenting in this way at this time?'. It is a statement that links individual characteristics and issues (past and present) to diagnoses in a way that generates treatment goals and management plans. (The 4x4 grid may help in organising ideas: bio-psycho-socio-spiritual / predisposing / precipitating / perpetuating / protecting factors.)

Feedback of Shared Understanding as a Basis for Negotiation of Management Plan

Management

1. Management Goals

The key goals of management are drawn from the opinion.

2. Management Plan

Ten key areas to address are:

1. setting
2. further information required
3. treatment of medical conditions
4. psychopharmacology
5. psychological interventions
6. whānau or family and social interventions
7. spiritual interventions
8. education/work/occupation
9. education of tangata whaiora and significant others
10. self-help groups

All of the above considered for the following phases of treatment:

- » pre-treatment
- » early treatment
- » middle treatment
- » late treatment
- » autonomous independence.

Prognosis

This includes:

- » the natural course of the illness
- » positive factors that modify the course in this tangata whaiora
- » negative factors that modify the course in this tangata whaiora
- » synthesis and prediction (symptoms and general functioning).

Appendix 3 » Drug–Drug and Drug–Medication Interactions

This appendix accompanies the text in section 4.6.4 and is intended to be a guide to drug–drug and drug–medication interactions. Interactions between psychoactive substances are potentially important, though much is unknown, especially for interactions between prescribed medications and illicitly taken substances. This section highlights some key interactions to be aware of, but it is not comprehensive. Note that the absence of an interaction described here does not mean it does not exist and therefore the combination is safe.

Interactions may arise through a number of mechanisms, including synergistic effects on neurotransmitter systems, augmentation of side-effects and alterations in the metabolism of a drug. Alterations in metabolism are potentially complex and often involve the cytochrome (CYP450) system in the liver. There is a wide range of cytochromes, and where drugs taken at the same time are metabolised by the same cytochrome, metabolism may be affected by either inhibition or induction of the enzymes. The main cytochromes of relevance for CEP are CYP2D6 and CYP3A4. A table of CYP450 interactions is available at: <http://medicine.iupui.edu/clinpharm/DDIs/table.asp>

As noted, there are likely to be important interactions that are not mentioned, and many of the interactions that are mentioned are theoretical or based on a small number of case reports. There is also considerable interpersonal variation in these interactions. This section should therefore be used as a guide to possible interactions, and in most cases drugs that interact should still be prescribed, but cautiously, and the effects monitored.

There are several potentially severe and fatal interactions. The combination of the following medications and drugs is best avoided:

- » lorazepam and alcohol, which has been associated with significant respiratory and cardiac depression (this appears to be more likely with lorazepam than with other benzodiazepines)
- » amyl nitrate and sildenafil (viagra) or tadalafil (cialis), which has=ve been associated with potentially fatal hypotension
- » ecstasy and ritonavir, which has been associated with fatalities reported
- » ecstasy and monoamine oxidase inhibitors, including moclobemide, which have been associated with fatalities
- » amphetamines and monoamine oxidase inhibitors, including moclobemide, which have been associated with a severe hypertensive crisis.

Nicotine

The main effect of nicotine on other drugs is via the polycyclic aromatic hydrocarbons in tobacco smoke and their induction of certain CYP450 enzymes. This increases the metabolism and reduces serum levels of a range of drugs, though there are other mechanisms that may be involved. The dosage of such medications may need to be increased in smokers and reduced upon cessation of smoking to avoid the emergence of side-effects.

Reduced blood levels may occur with the combination of tobacco use and the following drugs:

- » alprazolam and other benzodiazepines
- » beta-blockers, especially propranolol
- » caffeine
- » chlorpromazine

- » clozapine (reduction in blood levels may be marked)
- » corticosteroids
- » haloperidol
- » heparin
- » inhaled insulin (currently unavailable; causes a significant increase in insulin levels, contraindicated in current or recent tobacco users)
- » mexiletine
- » olanzapine (mild effects, so may not need dose adjustment)
- » pentazocine
- » theophylline
- » tricyclic antidepressants (especially imipramine and nortriptyline).

In addition, it should be noted that through other mechanisms, there may be an increased risk of myocardial infarction when tobacco smokers take oral contraceptives.

Table A3.1 » Interactions between alcohol and medications

Medication class	Medication	Effects
Anaesthetic agents	Fluothane, propofol	Risk of liver damage; higher dosages needed to induce anaesthesia
Analgesics – non-opioid	Aspirin and NSAIDs	Increased risk of gastric bleeding
Antibiotics	Metronidazole and tinidazole (antabuse-type reaction), griseofulvin, quinacrine	Reduced effectiveness, nausea/vomiting, headache, seizures
Anticoagulants	Warfarin	Increased clotting time with acute alcohol use; reduced clotting time with chronic use
Antidepressants	Tricyclic antidepressants	Increased sedation, impaired motor skills
	Monoamine oxidase inhibitor	Tyramine-rich drinks (beer, red wine) may cause severe hypertension and, rarely, cardiac arrhythmias
	Serotonin-specific re-uptake inhibitors (fluoxetine, citalopram, paroxetine)	May enhance the intoxicating effects of alcohol
Antidiabetic agents	Tolbutamide	Acute intoxication increases and chronic consumption reduces tolbutamide availability
Antihistamines	Diphenhydramine (Benadryl)	Increased sedation and dizziness, especially in elderly
Antipsychotics		Enhanced side-effects, especially sedation, hypotension, impaired judgment and motor incoordination; possible increase in akathisia and dystonic reactions (small case series)
Anticonvulsants	Phenytoin	Increased phenytoin levels with acute alcohol consumption
Antiulcer drugs	Ranitidine, cimetidine	May increase alcohol levels
Cardiovascular meds	Nitroglycerin, reserpine, methyldopa, hydralazine, guanethidine	Possible increased postural hypotension

Medication class	Medication	Effects
Mood stabilisers	Lithium	Increased motor incoordination; lithium may slightly reduce intoxicating effects of alcohol in some
	Valproate	Increased sedation, especially in early phases of valproate treatment
Opioids		Increased sedation, possible respiratory depression, risk of overdose
Sedatives	All benzodiazepines	Sedation, motor incoordination
	Lorazepam	Respiratory and cardiac depression (avoid in acute intoxication)

Sources:

- » NIAAA Alcohol Alert January 1995, no. 27 PH 355 publication
- » Alcohol-drug Interactions, University Health Service (UHS) Health Promotion Office, Rochester University: <http://www.rochester.edu/uhs/healthtopics/Alcohol/interactions.html>

As noted, the interaction between lorazepam and alcohol may lead to possible cardiac and respiratory depression and should be avoided.

Where sedation and incoordination are noted, tangata whaiora should be advised not to drive and to avoid using machinery.

Advice about not combining alcohol with specific medications should be given carefully, especially where the risk or severity of complications is mild. Tangata whaiora are as likely to stop medication as alcohol, if advised not to combine them. This is especially the case in the treatment of mood problems, especially bipolar disorder, where mood stabilisers are likely to reduce alcohol consumption and the potential complications are usually mild.

Cannabis

Much of the information on cannabis interactions comes from research into the synthetic tetrahydrocannabinol (THC) analogue dronabinol. It should be noted that cannabis has a number of extra actions due to the large number of other compounds it also contains.

Table A3.2 » Interactions between cannabis and medications

Other medication	Effects
Amphetamines, cocaine, other sympathomimetics	Hypertension, tachycardia, possibly cardiotoxicity
Atropine, scopolamine, antihistamines and other anticholinergics	Tachycardia, drowsiness
Amitriptyline, amoxapine, desipramine, other tricyclic antidepressants	Addictive tachycardia, hypertension, drowsiness
Disulfiram (antabuse)	
Possible hypomania (single case)	
Benzodiazepines, alcohol, lithium, opioids, buspirone, antihistamines, other CNS depressants	Additive drowsiness and CNS depression
Theophylline	Increased theophylline metabolism, similar to the effects of smoking tobacco
Fluoxetine	Possible hypomania (single case)
Naltrexone	Intoxication enhanced by naltrexone

Note: CNS = central nervous system

There is some evidence that THC intoxication is enhanced by naltrexone (Haney et al. 2003), though other studies contradict this (Wachtel and de Wit 2000).

Prior recent exposure to nicotine may enhance some of the effects of cannabis, especially in males (Penetar et al. 2005), though it has been shown that THC ameliorates acute nicotine withdrawal and that the cognitive effects of nicotine withdrawal (memory) are greater in marijuana users (Viveros et al. 2006).

Stimulants

Stimulants are drugs that are both prescribed and used illicitly. Amphetamines are metabolised by CYP2D6 and inhibitors of this enzyme such as paroxetine and fluoxetine. The concomitant use of methylphenidate (ritalin) and monoamine oxidase inhibitors is contraindicated due to the risk of hypertensive crisis. Methylphenidate may decrease the effectiveness of medications used to treat high blood pressure and may increase levels of warfarin and tricyclic antidepressants.

Methamphetamine has many potential interactions. The following are the major interactions that can occur; in combination with:

- » selegiline – hypertensive crisis (contraindicated)
- » bupropion – increased risk of seizures
- » tramadol – seizures
- » SSRIs and venlafaxine – potential increase in amphetamine activity, potential serotonin syndrome with some (e.g. dexamphetamine)
- » linezolid (a new antibiotic) – has monoamine oxidase inhibitor actions (contraindicated)
- » sibutramine (reductil) – contraindicated due to adrenergic and serotonergic reuptake inhibition.

Other medications with stimulant actions, especially those affecting the adrenergic system, can lead to increased blood pressure and pulse rate (e.g. chlorpheniramine, phenylephrine, dextromethorphan and brompheniramine), which are often found in cough mixtures. Antacids can increase amphetamine absorption and therefore actions.

MDMA (Ecstasy)

MDMA is potentially hepatotoxic, and liver function should be monitored when prescribing other medications that are also hepatotoxic, such as naltrexone and sodium valproate. It also releases large amounts of serotonin and is mainly metabolised by CYP2D6. There is therefore a risk of serotonergic syndrome, especially in combination with drugs like fluoxetine, citalopram, paroxetine, venlafaxine bupropion and pethidine.

The most serious combinations include:

- » ecstasy and MAOIs, including moclobemide (which has been associated with fatal interactions)
- » ecstasy and ritonavir (fatalities have been reported).

Inhibition of metabolism via CYP2D6 inhibition can occur with:

- » fluoxetine
- » paroxetine
- » bupropion
- » methadone
- » haloperidol
- » quinidine
- » ritonavir (antiviral agent).

Enhanced serotonergic effects can occur with:

- » amphetamines
- » St John's wort
- » tramadol
- » venlafaxine
- » lithium
- » clomipramine

(Oesterheld et al. 2004).

Benzodiazepines and other sedatives

Benzodiazepines differ in terms of their metabolism. Most are metabolised by the CYP450 system in the liver and therefore are affected by other medications that increase or decrease the activity of that system. Medications that induce CYP450, such as St John's wort, carbamazepine, phenytoin and rifampicin, therefore decrease the action of these benzodiazepines. Medications that reduce the activity of CYP450, and therefore increase the effects of benzodiazepines, include oral contraceptives, antibiotics, antidepressants and antifungal agents. Benzodiazepines that are not metabolised by the CYP450 system, and therefore are not affected by these interactions, include lorazepam, oxazepam and temazepam.

Opioids

Pethidine

Pethidine has the potential to induce a serotonin syndrome when used together with other drugs including:

- » dextromethorphan
- » pentazocine
- » tramadol
- » tricyclic antidepressants
- » selective serotonin reuptake inhibitors (SSRIs)
- » monoamine oxidase inhibitors (MAOIs), including moclobemide.

Pethidine can increase risk of seizures in combination with the following drugs:

- » theophylline
- » tricyclic antidepressants
- » fluoroquinolones (which can potentiate the seizure potential of pethidine).

Methadone

The tendency for methadone to prolong the QT interval may be enhanced by other drugs that do the same. A list of these can be found at:

<http://www.azcert.org/medical-pros/drug-lists/printable-drug-list.cfm>

Precipitation of opioid withdrawal

This can result from:

- » buprenorphine
- » pentazocine
- » naltrexone
- » naloxone
- » tramadol.

Unpredictable interactions

These can result from combining opioids with:

- » antiretroviral drugs
- » benzodiazepines
- » cannabis
- » cyclizine
- » interferon + ribavirin
- » methylphenidate
- » opioids
- » promethazine
- » tricyclic antidepressants.

Decreased methadone effects

This can result from combining methadone with:

- » some antiretroviral drugs
- » alcohol
- » carbamazepine
- » phenytoin
- » rifampicin

- » St John's wort
- » tobacco
- » Urinary acidifiers.

Increased effects of methadone

These can be induced by combining methadone with:

- » cimetidine
- » some antiviral drugs
- » diazepam
- » dihydroergotamine
- » alcohol
- » erythromycin
- » fluconazole
- » grapefruit
- » moclobemide
- » omeprazole
- » serotonin-specific reuptake inhibitors
- » verapamil
- » cyclizine

(Leavitt 2005).

Morphine

Morphine may interact with monoamine oxidase inhibitors to cause serotonin syndrome.

Solvents and volatile substances

Solvents may sensitise the heart to adrenaline, and this has been associated with sudden cardiac death when adrenaline is co-administered. This usually only occurs in emergency medicine situations.

Other commonly prescribed medications

Naltrexone

- » Opioid antagonist, precipitates opioid withdrawal in those with physiological dependence on opioids.
- » Otherwise known significant drug interactions.

Serotonin-specific reuptake inhibitors (SSRIs) (fluoxetine and citalopram)

The use of SSRIs with monoamine oxidase inhibitors is contraindicated. SSRIs may lower the seizure threshold and should be used cautiously with other drugs that do the same. Serotonin syndrome may occur when SSRIs are used with other drugs that enhance serotonin activity, or with drugs that inhibit SSRI metabolism.

Antipsychotics (risperidone, quetiapine, olanzapine, clozapine, chlorpromazine)

Antipsychotics may be associated with an increased risk of seizures and cardiac arrhythmias especially in those with QT prolongation. This risk may be enhanced with other drugs that have similar effects, particularly amphetamines.

Bupropion (Zyban)

The use of bupropion and monoamine oxidase inhibitors is contraindicated. The metabolism of bupropion may be inhibited by paroxetine, sertraline and antiretroviral agents, increasing its blood levels. Bupropion inhibits the CYP2D6 isoenzyme and may increase blood levels of drugs metabolised by this enzyme, including most antidepressants (e.g. nortriptyline, imipramine, desipramine, paroxetine, fluoxetine, sertraline), antipsychotics (e.g. haloperidol, risperidone, thioridazine), beta-blockers (e.g. metoprolol) and antiarrhythmics, and antipsychotics. Bupropion can also lower the seizure threshold and should be used with other drugs that act similarly only with great caution. This is especially so in tangata whaiora with bulimia or anorexia nervosa due to possible increases in seizure risk in this population.

Varenicline

There are no known or predictive drug interactions of significance.

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