



CURRENT AND FUTURE TRENDS IN COMORBIDITY

**THE NEW ZEALAND COEXISTING DISORDERS
FRAMEWORK**

**CULTURAL CONSIDERATIONS, ENGAGEMENT
AND WELLNESS APPROACHES**

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Overview

- **Current Trends**
- **Limitations of Current Approaches**
- **Overview of the “New Zealand Framework”**
- **Cultural Considerations**
- **Wellbeing**
- **Engagement**



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A Brief History of Dual Diagnosis

1980s



1990s



2000s



- DSM
- Community treatment
- Population Studies (ECA)
- Increasing awareness in MH
 - prevalence
 - poor MH outcome
- Engagement-persuasion Model (Osher and Kofoed 1989)

A Brief History of Dual Diagnosis

1980s

1990s

2000s

- Increasing evidence of high prevalence and poor outcome
- Drake, Mueser, Carey
 - Integrated treatment models, MI, Assertive Community Treatment
- Minkoff - Service integration models
- 1998 NZ Asst and Mx of CED



New Hampshire Model of Integrated Treatment

(Drake)

Mental health problems and substance use treated by same clinicians in a single programme

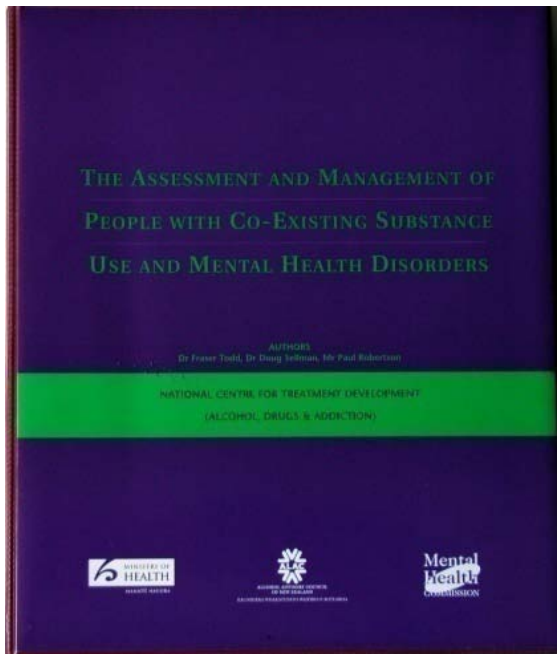
Substance abuse treatment tailored for people with severe mental health problems

- Prevent increased anxiety rather than confront
- Harm reduction rather than abstinence
- Slow pace, long term perspective
- Staged, using motivational interviewing (e.g. Engagement-persuasion)
- 12 step groups for those who chose them, rather than for all
- Pharmacotherapies supported rather than contraindicated
- A variety of life issues addressed

Assessment and Management of Co-existing Substance Use and Mental Health Disorders 1998

Five Key Principles:

1. Safety
2. Stabilization
3. Comprehensive assessment and treatment planning
4. Clinical case management
Engagement-persuasion model, MI, CBT/RP
Assertive follow-up
5. Treatment integration



A Brief History of Dual Diagnosis

1980s

1990s

2000s

- Increasing development of integrated treatment programmes in US
- 2004 UKDDx Toolkit
- 2005 TIP 42
- Increasing attention to systems, policies
- “universal” screening and assessment
- Key Research Reviews

TIP 42

Treatment Improvement Protocol for People with Co-occurring Disorders

<http://csat.samhsa.gov/publications>

Important Concepts

- Detection and awareness
 - Comprehensiveness
 - Stages of change
 - Phases of treatment
 - Long term perspective, recovery
 - Treatment Integration by analyzing and using the data on one disorder e.g. MH in light of the other e.g. A+D
- empathic counseling approaches
 - therapeutic alliance to engage
 - use of MI, assertive follow-up, culturally appropriate treatment

Levels of Service Capability

(TIP 42)



A+D only	CED Capable	CED Enhanced (Fully Integrated)	CED Capable	MH Only
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Fidelity and clinician/service rating scales



Summary of Current Trends

- Widespread identification - screening and assessment
- Comprehensive or holistic care
- Treatment integration
 - US, UK, NZ differ
 - including MI, CBT, Assertive community follow-up, case management
- Linkages between services, service capability
- National Guidelines
- Central support for implementation - policy, resources



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Limitations of Current Approaches



- Implementation
- Effectiveness
- Engagement
- Constructs used – psychosis, disorder focused



Implementation

- “New Hampshire Model” faithfully implemented in 30-50%
- Schulte et al 2008
 - 2006 - Questionnaires to all A+D and MH services
 - Low response rate
 - < 50% assessed for both A+D and MH
 - 80% used a “serial” model of treatment
- dual diagnosis teams struggle to integrate with other teams
- training but limited “action” – knowledge practice gap
- attitude barriers

Barriers to Optimal Care

(Todd, Sellman, Robertson 2002)

barriers (esp. attitudes) identified in 1997 still persist in 2007

Systems

Lack of regional
planning

Fragmentation &
inconsistency of care

Contracts encourage
narrow focus

Lack of resources

Problems in rural areas

Clinical

Lack of clinical skills

Lack of knowledge

Whanau/family
involvement

Cultural issues

Lack of assertive
follow-up

Attitudes

Judgmental attitudes

Rejection of medical or
disease model

Territoriality

Insistence on abstinence
confrontation of denial

Addiction is not the
business of MH services

Implementation: Attitudes

(MacEwan 2007)

“Dual Diagnosis patients are the worst attenders to services, therefore you wouldn’t want to put more resources into this group “ (F&P)

“We had a regional strategic document on managing CED 2 years ago but it didn’t involve A+D services” (CD, DHB)

“Dual diagnosis services are in place although not impressive because noone knows what they do” (Professional Nurse Advisor)

“I am here to treat her depression. If she uses cannabis, what am i supposed to do? Depression is my business” (MH Nurse)

“Alcohol and drug reports are all touchy feely. You don’t have an understanding of a patients mental health problems from one of their reports” (Community MH Nurse)



Effectiveness

- Recent Reviews of Treatment:

(Tiet & Mausbach 2007, Drake et al 2008, Cleary et al (Cochrane) 2007)

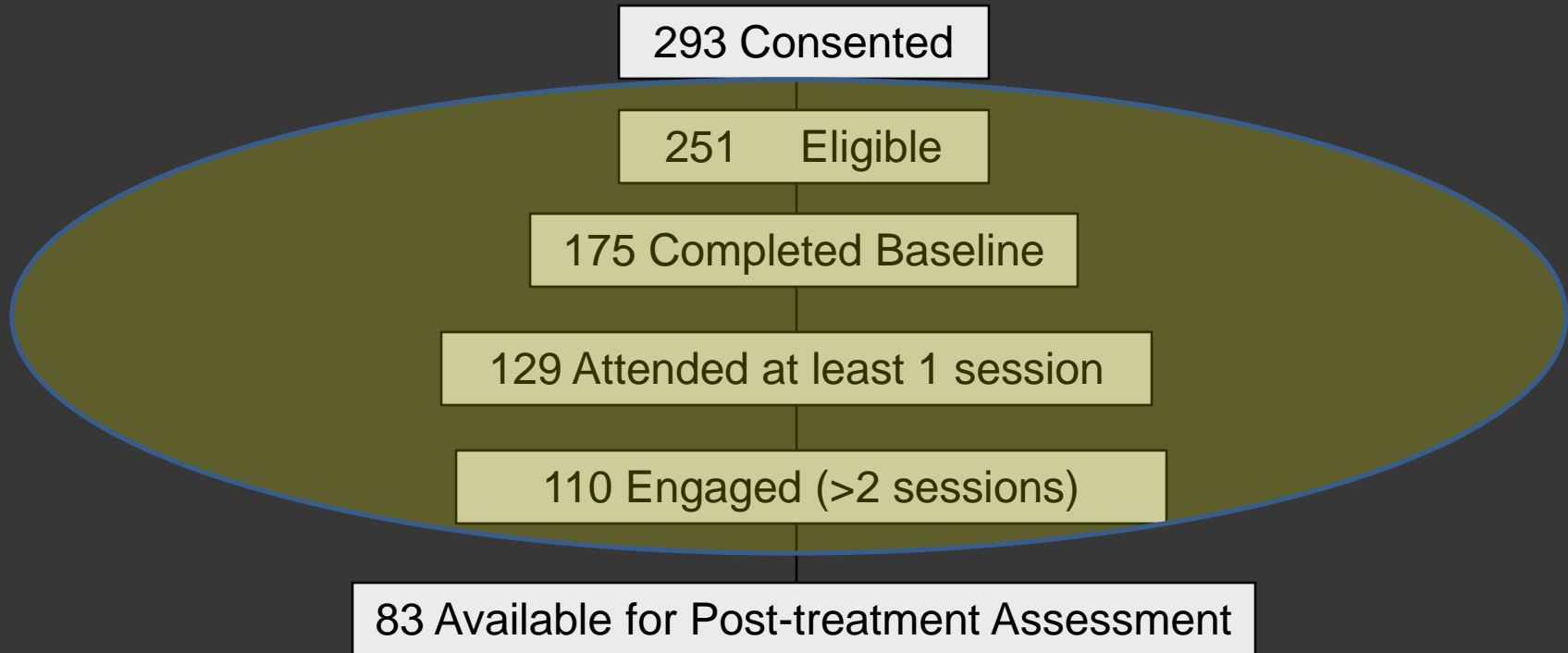
- Research difficult however >25 RCT's
- Case management, group counselling, long-term residential treatment useful components for A&D issues in CEP
- MI, CBT, Assertive Community Approaches not shown to be effective for A+D or MH problems
- TI may be better for engagement and in chronic psychosis
- Parallel and serial treatment may be as/more effective for some combinations e.g. Social phobia and alcohol

Engagement

- Culturally appropriate care very limited
- Marked health disparities remain for non-dominant cultures including mental health and substance use
- MH and A&D care remain predominantly deficit/disorder focused rather than focused on needs of tangata whaiora
- Approaches to engagement remain problematic with current strategies

BTSAS Study

Bellack et al. Archives of General Psychiatry 2006;63:426-432)



56% failed to engage

25% dropped out after engaging

33% of those eligible completed

Constructs Used

- Treatment paradigms mainly based on:
 - integration of MH + A&D
 - chronic psychotic disorders
- “Evidence-based practice”?
- Disorder and dysfunction focused
- DSM/Axis I focused – role of temperament and character
- Service focused
 - Treatment integration is about services re-organising the treatments they offer for MH and A+D



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TE ARIARI O TE ORANGA

The Assessment and Management of People with Co-existing Substance Use and Mental Health Problems 2009





Aims of the Framework

- Care driven by the needs of the client not the service
- Culture change
- TIP 42 approach... placed within a well-being context
- Strengthen areas of culture, engagement, motivation
- Strategies to guide knowledge into practice
- Incorporate emerging approaches



7 Key Principles

1. Cultural Considerations
2. Well-being
3. Engagement
4. Motivation
5. Assessment
6. Management
7. Integrated Care

Phases of Treatment and Key Goals

Pre-Treatment:	ascertain specific needs including cultural needs
Early Treatment:	safety assessment stabilisation Engagement
Middle Treatment:	active treatment well-being maintain engagement
Late Treatment:	maintain gains restore well-being increasing self-care
Autonomous Independence:	self-motivation self-responsibility Independence

NZ Co-existing Problems Framework

	1	2	3	4	5	6	7
Pre-treatment							
Early Treatment							
Middle Treatment							
Late Treatment							
Autonomous Independence							

Incorporation of 7 Key Principles into goals and strategies during each phase of treatment



Early Treatment

Key Goals	Key Strategies
safety assessment stabilisation engagement	<ol style="list-style-type: none">1. involve key supports e.g. whānau/family if appropriate2. assess and manage safety issues3. comprehensive and integrated assessment and management plan including integrated formulation to integrate care4. appoint case manager5. stabilise acute crises, substance use, physical, social problems6. detox if appropriate7. culturally appropriate engagement processes and assessment8. address spiritual needs9. link with and involve other services as indicated10. enhance motivation11. initiate or adjust medication12. initial coping strategies to help manage crises

Integrated Formulation

Diagnostic Statement

- ▣ DSMIV axes 1 - 3

Problem Orientated Statement

- ▣ Problems
- ▣ Strengths

Aetiological or Causal Formulation

- ▣ 4x4 Grid

4x4 Grid for Integrated Formulation

	Predisposing	Precipitating	Perpetuating	Protecting
Bio				
Psycho				
Social				
Spiritual				



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Importance of Cultural Considerations

- Assessment and management is only meaningful for clients if relevant to their cultural context
- Cultural issues (e.g. identity) are a major factor in the aetiology of substance use and mental health problems
- Values and therefore desired outcomes differ
- Integration of culturally specific models and interventions
- Secure cultural identity provides resilience against mental health problems (Marie et al 2008)



Cultural Considerations – The NZ Context

- Treaty of Waitangi 1840

- NZ Population (2006)

NZ Maori = 14%

Other Pacific Peoples = 7%

Asian = 9%

Caucasian = 65%

LGBT = 3% of those under 21 years

- Emerging historical tensions within British “Pakeha”?



Cultural Considerations – The NZ Context

- Marked health disparities in minority subgroups not explained by socio-economic status
- Increased rates of mental illness:
 - especially depression, anxiety, substance use disorders
- Increased rates of incarceration
 - NZ Maori = 14% of general population, but 50% of prison population



Clinician Knowledge and Skills

1. Cultural self-awareness
2. Support right of self-determination
3. Knowledge of other cultures
4. Appreciation of diversity within cultures
5. Access for the clinician to cultural advice & guidance
6. Provision of a welcoming environment
7. Ability to participate in key processes
e.g. meeting, engaging and communicating
8. Ability to access external supports
9. Willingness to put knowledge and skills into practice



Practical Implications

- Ensure access to cultural expertise for key cultures
- Prior to first appointment identify likely cultural issues and obtain advice where necessary:
 - processes of encounter, models of health, values, locus of decision-making in family*
- Include the people that need to be included
- Ensure a welcoming environment and appropriate processes
 - physical environment, drink and food, culturally appropriate processes as far as possible*
- Ensure language needs are met
- Do not make assumptions & take care expressing knowledge



Specific Strategies for NZ Maori I

Pre-contact:

identify ethnicity, tribe

acknowledge historical interactions with own culture

access cultural expert

Initial Contact

involve whanau, family

maintain mana – offer appropriate welcoming process, food and drink, acknowledge spiritual issues, te reo (language)



Specific Strategies for NZ Maori II

Early Treatment:

acknowledge key values

*- importance of whanau/family capacities, reciprocity,
reverence for people, spirituality in all things
maintenance of mana/prestige*

culturally specific idioms of distress (shame, curse,
experience of ancestors)

models of health (family, spiritual, physical, mental)

cultural interventions – identity, tohunga, whanau ora



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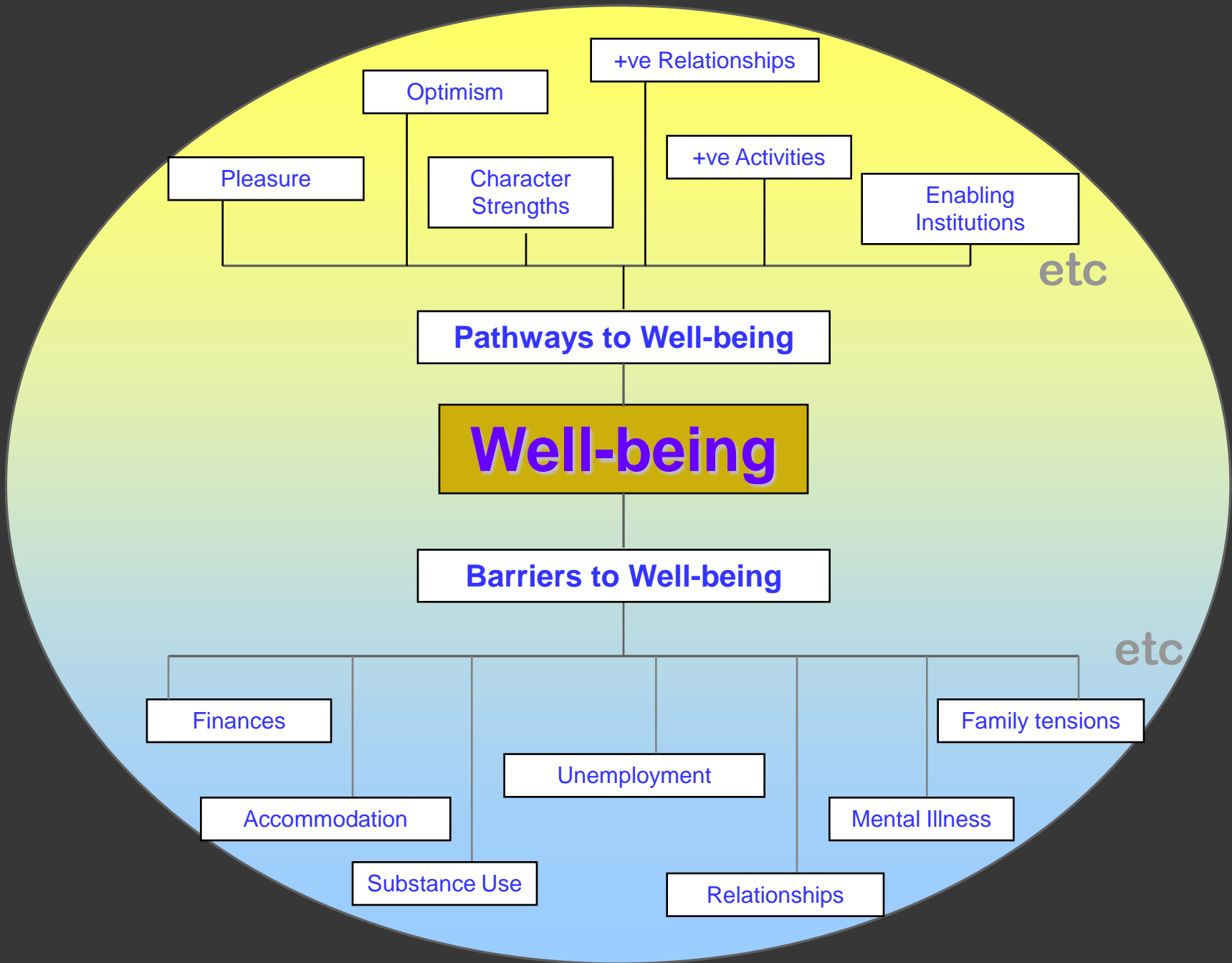
What is Well-being?

- Many vague definitions
- Personal; multiple dimensions
- Evidence based approaches to well-being
 1. Subjective Well-being
 - individual autonomy and achievement
 2. Collective Well-being
 - capacity of collective to carry out key functions



The Importance of Well-being

- A valid health outcome in its own right
- May enhance recovery and reduce relapse from problems such as major depression (Fava et al 1998, Picardi et al 2002)
- An important strategy for enhancing engagement & motivation
- Places problems in the context of the clients life, enhances the meaning of assessment and treatment



Optimism

+ve Relationships

Pleasure

Character Strengths

+ve Activities

Enabling Institutions

etc

Pathways to Well-being

Well-being

Barriers to Well-being

Finances

Family tensions

etc

Accommodation

Unemployment

Mental Illness

Substance Use

Relationships



Well-being vs. Recovery

- Multiple definitions of recovery:

AA definition often includes recovery from dysfunction

Mental health definition – recovery of a healthy lifestyle

- Recovery often seen as a process
- Well-being seen as an outcome or state
- Well-being more consistent with indigenous concepts



The Science of Well-being

Draws together numerous strands into a common body of knowledge that is clinically useful

Three threads

- Positive Psychology
- Well-being Therapy (Fava et al 2003)
- Feeling Good, Voyages to Wellbeing (Cloninger 2004)

Positive Psychology

The science of the...

- Positive subjective experience
- Positive individual traits
- Positive institutions

... that can improve quality of life and make life worth living

□ Peterson, C. A Primer in Positive Psychology

Oxford University Press 2006

□ Seligman, M. Authentic Happiness

Free Press 2004

Domains of Well-being

- Pleasure, meaning and engagement
- **Positive thinking and optimism**
- **Character Strengths**
- Values
- Interests, abilities and accomplishments
- Positive Relationships
- **Enabling institutions**

Positive Thinking – Optimism & Hope

- higher levels of optimism in young adulthood correlates = increased levels of wellbeing 35 years later

(Peterson, Seligman & Vaillant 1988)

- Catastrophizing and over-generalizing
 - Pessimism = negative generalizations and Catastrophizing
 - Optimism = positive generalizations and “Catastrophizing”

Learned Optimism – Explanatory Style



Three primary elements

1. Permanence

permanent v temporary

2. Pervasiveness

specific v universal

3. Personalization

internal v external

Positive Thinking Exercise

□ Three Good Things

- ▣ Write down three things that went well each day and their causes, each evening every day for one week. Include a causal explanation
- Significant improvements in happiness sustained for at least 6 months

Character Strengths and Virtues

(Peterson & Seligman 2004)

Six overarching virtues that contribute to happiness:

- Wisdom and Knowledge
 - Courage
 - Humanity
 - Justice
 - Temperance
 - Transcendence
-
- Common across 40 countries
 - ?teenagers
 - Character strengths inventory

<http://www.authentic happiness.sas.upenn.edu/#>

Character Strength Exercises

- Using Signature Strengths in New Ways
 - Identify 5 highest signature strengths
 - Use one of these in new ways every day for one week
 - Significant improvements in happiness scores persisted for at least 6 months

Enabling Institutions

- Common features of Enabling Institutions (Petersen 2006)
 - ▣ Purpose = shared vision, safety, fairness, humanity, care and concern, dignity

Can also consider the culture institutions by the same criteria as individuals

- ▣ Wellness orientation = positive experiences, meaning, engagement
- ▣ Character Strengths
- ▣ Ability to engender optimism and hope
- ▣ Core Values
- ▣ Interests, abilities & accomplishments = specific attitude to its role, skill base
- ▣ Positive interpersonal relationships



Well-being in the Clinical Process

Early Treatment

- *place assessment and management in the context of key values, aspirations, well-being goals
- motivation generated by desire for values congruence and enhanced well-being
- Values Card Sort
<http://motivationalinterview.org/library/valuescardsort.pdf>.
- specific strategies for optimism, hope & self-efficacy



Well-being in the Clinical Process

Middle & Late Treatment, Autonomous Independence

- key outcome goal
- use of a range of specific strategies to enhance well-being

Positive “flow” experiences, gratitude, positive relationships etc

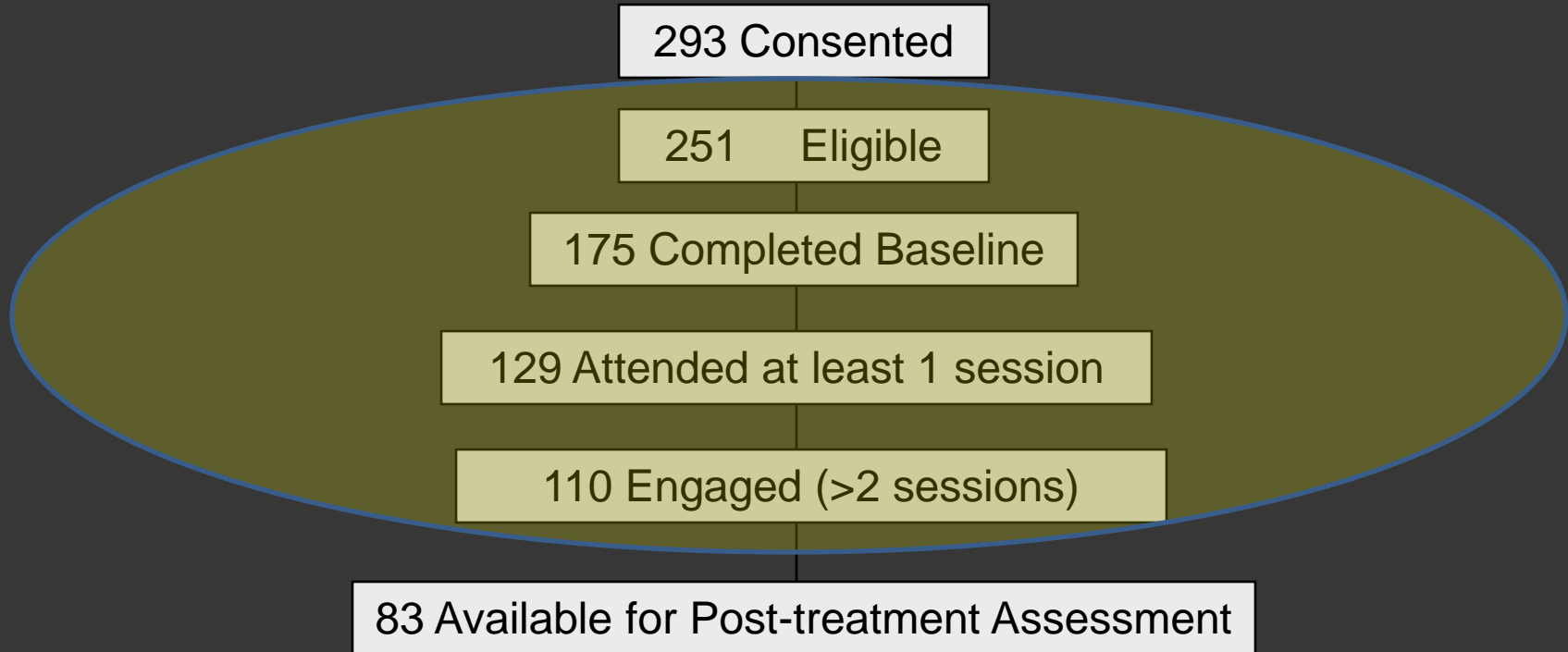


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Engagement

Lack of engagement is a major cause of poor outcome

The therapeutic alliance is a key factor in engagement...

... but not the only factor

↑ engagement = making the most of multiple factors



Engagement

of:

the client

key supports

with:

1. **key clinician**

2. service

3. **assessment and management plan**

4. key supports



Engagement

Treatment Integration and MI \neq improvement in MH or A+D

However; both shown to enhance engagement



Enhancing the Therapeutic Relationship

- Clinician style – the spirit of motivational interviewing
empowerment, respect for autonomy, self-talk change
- Specific MI techniques – the Engagement Intervention
- Engendering hope, enhancing optimism
CBT for optimism, staged management plan
- Consideration of temperament and character, fit with clinicians
e.g. low self-determination, low cooperativeness



Engagement with the Assessment and Management Plan I

- Comprehensive Assessment
 - meaningful and relevant
 - wellbeing
- Integrated formulation
- Acting on the assessment – assessment to management
- Consistency of formulation and diagnosis over time
 - who “owns” the assessment and management plan?
 - the process of changing diagnoses



Engagement with the Assessment and Management Plan II

- Special attention to specific interactions:

PTSD and substance use – trauma/abuse history,
intrusive memories

Social phobia + substance use – avoidance v exposure

The Engagement Intervention

(Zuckoff)

1. Anticipate & Explore:

- ▣ That the client is anxiously ambivalent
- ▣ The client's relationship with themselves
- ▣ What the client wants from the clinician

2. **Create a State of Psychological Safety**

3. Elicit the Clients Story

4. History and Hopes

5. **Identify Personal Values and Life Goals**

6. Develop a Change Plan

7. Explore and Plan for Barriers to Treatment Seeking

Psychological Safety

Clinician viewed as both dangerous and helpful

As safety is established, focus shifts:

Maintaining safety —————> **Self disclosure**

Clinicians role – spirit of MI

Empathy – non-judgemental and accurate reflection

Self-efficacy – client is in control of what to reveal

Affirming approach when client self-critical

Resistance if push for too much information

Empirical Evidence I

- RCT's with non-psychotic CEP
- Inpatient to outpatient
 - more than doubles attendance at first outpatient appointment
 - (Swanson et al 1999, Daley & Zuckoff 1998)
- Engagement with community treatment for IPT
 - Initiation of treatment – 96% v 68%
 - Completion of treatment - 36% v 7%
 - (Grote, Zuckoff et al 2007)



Conclusions





Current Trends

- Universal Screening and Assessment – no wrong door
- Treatment integration – MH +AD treatments
- Dual diagnosis enhanced teams (US)
- Dual diagnosis capable services with strong linkages (UK, Aus, NZ)
- Clinician and Service Capability



“Improvements” on Current Approaches

- Client first - treatment driven by the needs of the client rather than the needs of services
- Cultural approaches as integral rather than “tacked on”
- Holistic care - use of well-being approaches to engage and motivate
- Outcome determined by achievement of well-being rather than alleviation of disorder
- Strategies to enhance engagement beyond the therapeutic relationship



New Directions

- Increasing research for both generic and specific strategies
 - e.g. well-being approaches
 - impact of/interventions for cannabis on bipolar disorder
- Identification of the determinants and processes of recovery
- Temperament and character based interventions
 - e.g. self-determination/self-efficacy, cooperativeness