Let's get talking

A suite of talking therapy tools from Te Pou

Te Pou
o Te Whakaaro Nui

Therapy

A guide to evidence-based talking therapies

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Overview

Let's get talking: Therapy is part of the *Let's get talking* toolkit developed by Te Pou o te Whakaaro Nui to support mental health and addiction services to increase access to evidence-based talking therapies in Aotearoa New Zealand.

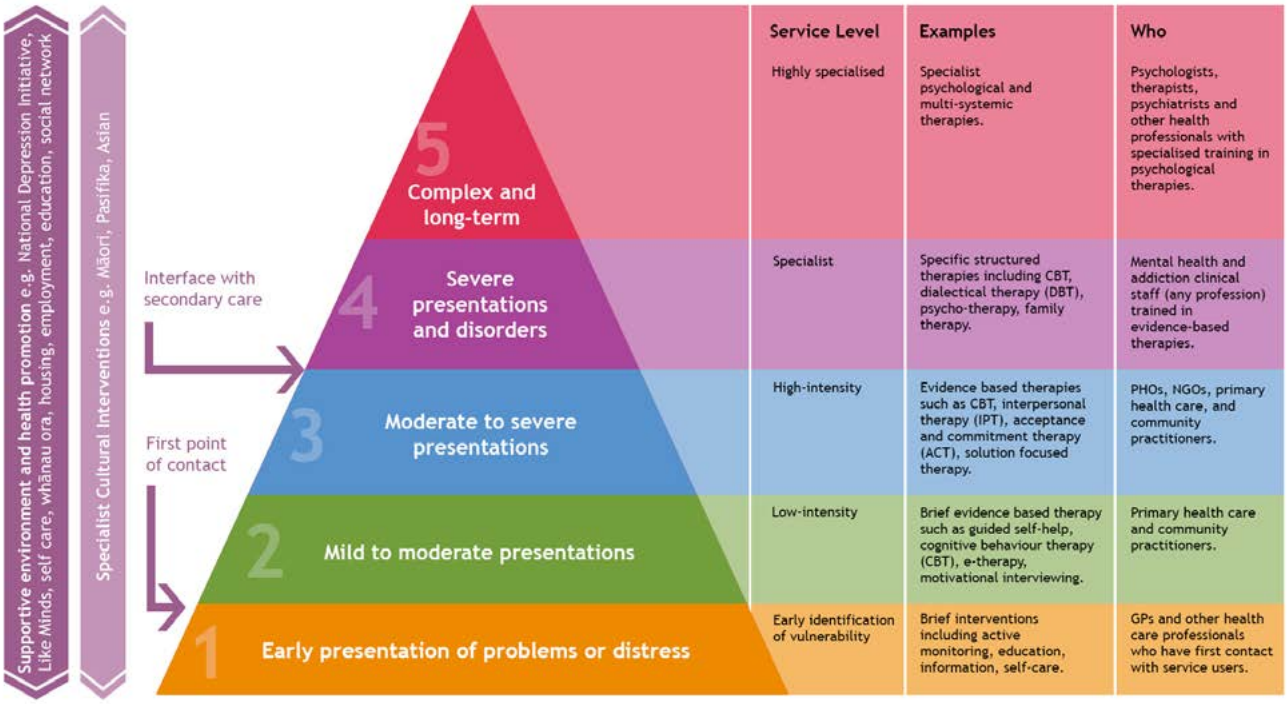
The *Let's get talking*: *Therapy* tool is designed to support best practice delivery of talking therapies using a stepped care approach. For an overview of talking therapies and stepped care refer to *Let's get talking: Introduction*, www.tepou.co.nz/initiatives/lets-get-talking-toolkit/146.

This tool provides information on the evidence base for various talking therapies in order to assist practitioners with matching a therapy(s) to a person's presenting need(s). For further information on matching to therapy, refer to *Let's get talking: Assessment*, www.tepou.co.nz/initiatives/lets-get-talking-toolkit/146.

This tool is designed for use with adult populations. For information related to infant, child and adolescent please refer to the Werry Centre for Infant, Child and Adolescent Mental Health, www.werrycentre.org.nz.

Following is a list of resources that complete the *Let's get talking* toolkit available on the Te Pou website, www.tepou.co.nz/letsgettalking.

- Introduction: A stepped care approach to talking therapies
- Planning: Develop or extend talking therapies delivery
- Skills survey: Identify strengths and areas for development in talking therapies delivery
- Assessment: How to match talking therapies to peoples' needs
- Therapy: A guide to evidence-based talking therapies
- Review: Progress and outcome measures to support talking therapies delivery
- Practice support: Competencies, training and supervision for talking therapies delivery



The stepped care approach

In New Zealand, a stepped care approach to meeting the needs of those experiencing mental health and/or addiction problems is supported (Mental Health Commission, 2012; Ministry of Health [MoH], 2012). This approach draws on a range of services including self-care, primary health care, community and specialist care to achieve the best outcomes for a person (Dowell et al., 2009; Ministry of Health, 2010; Ministry of Health, 2012; New Zealand Guidelines group, 2008; World Health Organisation [WHO], 2001).

The *Therapy* tool is divided into two parts.

Part 1: The current evidence base for various talking therapies

- A link to 'The Matrix' – a comprehensive international summary of evidence-based talking therapies for mental health and addiction issues. This was developed by the National Health Service, Scotland.
- A summary of the evidence for two additional therapies commonly used in Aotearoa New Zealand: Acceptance and Commitment Therapy (ACT); Solution-Focused Brief Therapy (SFBT).
- A summary of the evidence for use of talking therapies with cultural groups in Aotearoa New Zealand, namely, Māori, Pasifika and Asian people, and refugees, asylum seekers and new migrants.

Information contained in part 1 of the tool is relevant to all levels of stepped care and aids practitioners working in both primary and secondary care to determine the most appropriate therapy to use with a person.

Access part 1.

Part 2: Brief Interventions

- A summary of the evidence base for brief interventions.
- A guide to brief interventions which are delivered mainly at levels one and two of stepped care, in primary care, for people who may have emerging mild mental health and/or addiction problems.

Access part 2.

The reference list for parts 1 and 2 of the tool can be found at the end of the document.

View the reference list.

Part 1: The current evidence base for various talking therapies

Best practice in the delivery of talking therapies is supported through the use of evidence-based therapies. This enables practitioners and services to plan and provide the most effective therapy available for a person or population. The following are key principles which support best practice.

- **Values based practice and a recovery approach**
  Delivery of talking therapies is based on values such as respect for the individual, ethical practice, person and whānau centred care, respect for diversity and promoting equality (MoH, 2008; Te Pou, 2014a). A recovery focused approach supports a person to create a meaningful self-directed life, regardless of challenges faced, that includes building resilience, having aspirations and the achievement of these (Te Pou, 2014b).

- **Supportive and positive relationships**
  A good therapeutic relationship between the practitioner and the person is one of the best predictors of successful outcomes. This is further improved by mutually agreed upon goals and the feedback they give regarding any support and therapy they receive (Miller et al., 2006).

- **Delivering evidence-based therapies**
  Practitioners primarily aim to deliver therapy which has an evidence base for the mental health and/or addiction problem(s), and is consistent with a model of therapy practice, in order to enhance effectiveness of therapy outcomes (National Health Service Scotland, 2015; The Australian Psychological Society, 2010).

- **Training and supervision for talking therapies**
  Training and supervision is essential to ensure the safe, effective and efficient delivery of therapy
  Refer to *Let's get talking: Practice support* tool for further information, www.tepou.co.nz/initiatives/lets-get-talkingtoolkit/146.

The Matrix

The Matrix: A guide to delivering evidence-based psychological therapies in Scotland provides a summary of the international evidence for common talking therapies. It was developed by the National Health Service, Scotland (2015). Practitioners can use *The Matrix* when considering the most appropriate therapy to use with a person. Factors such as the costs of training, the sustainability of service delivery, available expertise and existing strategic plans are discussed which can aid service leaders and managers in their decision making.

The Matrix is divided into two parts.

Part 1: provides key information on the delivery of evidence-based therapies, service planning and delivery, stepped care, training and supervision.

Part 2: summarises the evidence base for common talking therapies. The evidence tables are listed under a disorder or health issue. The recommendations regarding appropriate evidence-based therapies and the grading of evidence for the talking therapy are provided. The tables do not cover all diagnoses or mental health issues, and focus on common mental health and addiction problems. It is important to note however that the absence of an established evidence base for a specific talking therapy does not show that it is ineffective; it is likely to be an emerging therapy where an evidence base has yet to be established.

Access *The Matrix*

Additional therapies

Two additional talking therapies commonly delivered in Aotearoa New Zealand are acceptance and commitment therapy (ACT) and solution-focused brief therapy (SFBT). These are not included in *The Matrix* as the evidence available does not reach the criteria for inclusion in either the Scottish Intercollegiate Guidelines Network (SIGN) or the English National Institute for Clinical Excellence (NICE), upon which *The Matrix* is based.

There are other talking therapies currently used within Aotearoa New Zealand that are not included in this tool, such as various psychotherapies, problem-solving therapy, mindfulness-based therapies and peer talk. Practitioners are advised to research the evidence base for additional therapy types they may be considering for use.

Acceptance and Commitment Therapy (ACT)

ACT helps people to increase the acceptance of the full range of their experiences and learn to control distressing thoughts, beliefs, sensations, and feelings. This enables change towards achieving wellbeing and an improved quality of life, as people identify their own values and translate them into specific goals (Forman et al., 2007).

ACT has been independently validated as an empirically supported treatment by the US Substance Abuse and Mental Health Administration (SAMHSA). The American Psychological Association, Society of Clinical Psychology (Div. 12) has indicated that ACT has strong research support for treatment of chronic pain, and modest research support for treatment of depression, mixed anxiety, obsessive compulsive disorder (OCD) and psychosis.

(With acknowledgement to Steve Humm, clinical psychologist, for kindly assisting with this information).

Acceptance and Commitment Therapy (ACT)	
Meta-analysis	Seven key meta-analyses have been conducted on ACT to date (Hayes et al., 2006; Öst, 2008; Powers & Emmelkamp, 2009; Ruiz, 2012; Öst, 2014 & A-Tjak et al., 2015). A-Tjak et al. (2015) found ACT was superior to waitlist, to psychological placebo and to the standard treatment as usual. ACT was also superior on secondary outcomes, life satisfaction/quality measures and process measures compared to control conditions.
Anxiety	Research on ACT across anxiety disorders is promising with additional research needed in all areas. *Obsessive compulsive disorder (OCD)*: Twohig et al. (2010) showed fewer sessions of therapy were required than usual ERP (exposure response prevention) treatment. One cross-cultural study (Hooper and Larsson, 2015) found reduced experiential avoidance, enhanced exposure exercises and reduced patient drop out. The usefulness of ACT has been shown with three OCD-related disorders: *skin picking, tourette syndrome and trichotillomania* (Hooper & Larsson, 2015). *Generalised anxiety disorder (GAD):* One randomised controlled trial (RCT) showed positive results (Wetherell et al., 2011). Several RCT's (Avdagic et al., 2014; Hayes-Skelton et al.,2013; Roemer et al., 2008) and open trials (Roemer & Orsillo, 2007; Roemer et al., 2008) with acceptance-based behaviour therapy (AABT) showed effectiveness equivalent to cognitive behaviour therapy (CBT). *Social anxiety:* Research has shown ACT to be as effective as CBT (Hooper and Larsson, 2015; Kocovski et al., 2013; Dalrymple et al., 2014; Craske et al., 2014). *Post traumatic stress disorder (PTSD):* Several small scale studies have indicated potential effectiveness (Hooper & Larsson, 2015). Further research is needed. *Panic disorder with/without agoraphobia:* Research showed effectiveness with those non-responsive to other treatment (Hooper & Larsson, 2015; Gloster et al., 2015). *Mixed anxiety:* A large scale RCT on ACT vs CBT showed equivalent efficacy (Arch et al., 2012).

Depression	There is evidence for the effectiveness of ACT for the treatment of depression, with a significant increase in studies undertaken in the last five years (Hooper & Larsson, 2015). RCTs have been conducted with: - adults (Zettle & Rains, 1989; Lappalainen et al., 2007) - adult women (Zettle & Hayes, 1986) - adults with depression and anxiety (Forman et al., 2007) - group-based early intervention (Bohlmeijer et al., 2011) - self-help for depression (Fledderus et al., 2011) - online ACT and behavioural activation (Calbring et al., 2013) - depression and alcoholism (Peterson & Zettle, 2009). Positive results have been found with other studies including open trials, feasibility studies and using different modes of therapy delivery (Hooper & Larsson, 2015) with adolescents (Hayes et al., 2011; Livheim et al., 2014), unemployed people and people on long-term sick leave (Folke et al., 2012), and using combinations of internet, smartphone applications and telephone counselling (Lappalainen et al., 2013; Lappalainen et al., 2014).
Psychosis	A significant case study and RCT with schizophrenia and psychosis showed improved psycho-social functioning (Hooper & Larsson, 2015). *Schizophrenia:* Bach & Hayes (2002), Gaudiano & Herbert (2006), Hooper & Larsson (2015) showed reduced hospital rates and less believability in disorder associated thoughts than treatment as usual (TAU). *Depression and psychosis*: White et al. (2011) found that at follow-up, depression scores had decreased and the ACT group showed less negative symptoms of psychosis and greater increases in mindfulness skills. *Depression and symptoms of psychosis:* Gaudiano et al. (2013) used ACT and behavioural activation, plus pharmacotherapy. Results showed large reductions in depressive and psychotic symptoms at post-treatment and at follow-up.
Opioid and cannabis use	RCTs with ACT and methadone maintenance, methadone detoxification and problematic methamphetamine use showed reduced use. Case study showed reduction in the use of cannabis when ACT was used (Hooper & Larsson, 2015). *Illicit drug use:* Studies were carried out to reduce use and increase the effectiveness of methadone maintenance (Hayes et al., 2004). ACT and intensive twelve step facilitation showed lower drug use at follow up. *Methadone reduction programme*: Stotts et al. (2012) compared ACT and counselling. Drug use was comparable but completion rates and rate of successful detoxification were higher with ACT. *Methamphetamine:* Smout et al. (2010) compared ACT to CBT. Attendance rates and self-reported drug use were similar but CBT group showed reductions in drug use.

Smoking cessation	Extensive large scale research has been undertaken on ACT for smoking cessation. Overall ACT outperformed all other treatments on 30-day abstinence measure, with rates up to twice as great for ACT (Hooper and Larsson, 2015). RCT's on: - nicotine replacement therapy (NRT) vs. ACT (Gifford et al., 2004) - ACT vs CBT (Hernández-López et al., 2009) - telephone delivered ACT + NRT vs. Quitline + NRT (Bricker et al., 2014) - bupropion vs. buproprion + ACT + Functional Analytic Psychotherapy (Gifford et al., 2011) - web-based ACT vs. Smokefee.gov (Bricker et al., 2013) - smartphone app ACT vs. Quitguide (Bricker et al., 2014).
Chronic pain	Extensive research has been undertaken on ACT for chronic pain. The American Psychological Association, Society of Clinical Psychology (Div. 12) has indicated strong research support for ACT in the treatment of chronic pain.

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Solution-Focused Brief Therapy (SFBT)

SFBT is a client-directed, interactional, competency-based, future-oriented and goal-directed approach. It focuses on a person's own perceptions and choices, recognising and validating their concerns, and supports behaviour building solutions based on what the person says, does, wants and observes.

Review[1] of publications and summary of research shows benefit from solution-focused approaches (Solution-Focused Approaches, 2015). SFBT is included in Substance Abuse Mental Health Service Administration's National Registry of Evidence-based Programs and Practices (SAMHSA NREPP). Solution-focused group therapy has been independently assessed and rated for Quality of Research and Readiness for Dissemination (SAMHSA). The application of SFBT to a range of disorders, levels of severity, service and intensity of intervention needs further research.

(With acknowledgement to Paul Hanton, clinical project lead, Te Pou for kindly assisting with this information).

Solution-Focused Brief Therapy (SFBT)	
Meta-analyses	Kim (2008) found small effects in favour of SFBT; and best for personal behaviour change. SFBT is equivalent to other therapies. A meta-analysis found that SFBT was better than no treatment and as good as other treatments. Best results for personal behaviour change, adults, residential / group settings. Recent studies show strongest effects. It is shorter than other therapies and respects service user autonomy (Stams et al., 2006). SFBT is now included in Substance Abuse Mental Health Service Administration's National Registry of Evidence-based Programs and Practices (SAMHSA NREPP).
Depression	In a meta-analysis, Gingerich (2013) found the strongest evidence of effectiveness was in the treatment of depression in adults (see also Hanton, 2008). Australian Psychological Society (APS) review found some evidence for the effectiveness of SFBT in treating depression (APS, 2010).
Anxiety	SFBT for depression and anxiety reduction, at three year follow-up, showed significant effect (Knekt et al., 2008).
Obsessive Compulsive Disorder (OCD)	For OCD, improvement using SFBT was shown over medication alone (Yang et al., 2005).
Addiction	Effectiveness of SFBT for substance use disorders and addiction was found at 16 month follow-up, with less drug offences and less total offences than controls (Lindforss & Magnusson, 1997). SFBT group therapy showed significant improvement in depression and distress (Smock et al., 2008). APS review found emerging evidence for treatment of substance use disorders (APS, 2010).
Schizophrenia	High intensity SFBT showed improvement in general functioning (Wang et al., 2014; Zhang, 2010; Liang et al., 2014). There is emerging evidence for effectiveness of SFBT for schizophrenia.

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1 More than 1,900 publications annually. Currently 3 meta-analyses; 6 systematic reviews; 194 relevant outcome studies including 68 randomised controlled trials showing benefit from solution-focused approaches with 45 showing benefit over existing treatments. Of 64 comparison studies, 53 favour SFBT. Effectiveness data is also available from over 7,000 cases with a success rate exceeding 60 per cent; requiring an average of 3 – 6.5 sessions of therapy time, www.solutionsdoc.co.uk/sft.html.

The evidence base for talking therapies for cultural groups in Aotearoa New Zealand.

This tool provides information on the evidence base for talking therapies for cultural groups in New Zealand, specifically Māori, Pasifika and Asian people, and refugees, asylum seekers and new migrants.

Examples of current evidence for each of these groups are provided. This does not discuss how to deliver therapy to these groups. Clinical diligence and consultation is recommended when considering using a therapy for a particular cultural group or individual and it is the responsibility of the practitioner and the person to work together to find the best fit. It is important also to acknowledge that not everyone from within a cultural group identifies with their culture and traditions in the same way and to the same level. Furthermore, religious practice may be integral to maintaining health and wellbeing, cultural identity and belonging (Haque & Kamil, 2012; Worthington et al. 2010; Hodge & Lietz, 2014; Mir et al., 2015). Traditional therapies may also be used within some cultural groups. Each cultural group may have unique values, opinions and needs, therefore therapy should be adapted based on an assessment of each person's individual preferences and needs. This supports delivery of talking therapies in a way that is more likely to be acceptable for service users of different cultures (Te Pou, 2010).

Talking therapy guides (www.tepou.co.nz/initiatives/talking-therapy-guides/56), developed by Te Pou, provide further information on effective engagement and adapting therapies to meet the needs of those from different cultural groups.

Māori

To date, there is little research on the effectiveness of talking therapies for Māori people. Further research is needed across all talking therapies to determine use and effectiveness. This evidence summary provides examples of research of talking therapies with Māori people.

Key points to effective engagement with Māori people, and with therapy include:

- A bi-cultural approach to therapy considers both the individual and whānau in assessment, treatment and care planning - Aro Matawai (Macfarlane et al., 2011). This includes a combination of both westernised and kaupapa Māori health models (Te Whare Tapa Whā, Te Wheke, and Meihana). Culturally competent practitioners have an understanding of Māori worldview, culture, beliefs, spirituality and a holistic view of wellbeing (Thomas, 2010).
- Culturally appropriate values are included such as whanaungatanga (relationships), whakamanawa (encouragement) and mauri (spirit) (Durie & Hermansson, 1990); and use of traditional Māori mythology (O'Connor, 2002). Emphasis is on the importance of whakapapa (genealogy) sharing and whakawhanaungatanga (developing relationships) during the engagement process (Mitchell, 2014).
- Practice is underpinned by an understanding of tikanga Māori including processes which can be incorporated into practice, for example, pōwhiri, karakia, mihimihi, whanaungatanga (Abel et al., 2012). Awareness of the diversity of cultural identity among Māori people is important and practitioners should avoid the use of cultural checklists and generalising cultural needs and wants (Hirini, 1997).
- A strengths-based approach includes processes that incorporate celebration of individual and whānau successes. It also encourages the building of relevant and effective networks in Māori communities, whakawhanaungatanga (Te Korowhiti Harris, 2014).

Previous research studies and information on effective engagement when working with Māori people is available in *He Rongoā Kei Te Kōrero. Talking Therapies for Māori:Wise practice guide for mental health and addiction services,* www.tepou.co.nz/initiatives/talkingtherapy-guides/56 (Te Pou, 2010).

Māori	
Brief Intervention	A study on the Māori cultural adaptation of a brief intervention in primary care was well received by both providers and tāngata whai ora, with improvement in service users' K10 scores. Further research with larger sample and RCT is needed (Mathieson et al., 2012). Web-based alcohol screening and brief intervention (e-SBI) reduced hazardous and harmful drinking among non-help-seeking Māori students (Kypri et al., 2012). Practices that enhance engagement with Māori people include mihimihi (introduction/greetings), pōwhiri (process of welcome/engagement) and hui (meeting) (Matua Raki, 2012).
Cognitive Behaviour Therapy (CBT)	Increased effectiveness of CBT through building rapport and developing a positive therapeutic alliance (Bennett, 2009; Bennett et al, 2008; Cargo, 2007), use of therapist self-disclosure, exploration of whakapapa, the establishment of connections and engagement with relevant whānau. A review of CBT and usefulness for Māori people by Bennett et al. 2008 discusses concepts of rational thinking, seeking objective evidence and scientific view of the world that may be ineffective with people who hold more spiritually based beliefs. A review of CBT and the relationship to the concept of whakataukī "Kāore te kūmara e kōrero mō tōna reka" (humility and understatement) within Māori society (Hirini, 1997), discusses the implicit exclusion of the spiritual dimension in the cognitive-behavioural approach as a limitation when working with Māori people.
Family-based intervention	A systematic review found the evidence for the effectiveness of family-based alcohol interventions with indigenous communities is less than optimal, although the reviewed studies did show improved outcomes (Calabria et al., 2012). Further discussion of family therapy with Māori people and whānau: - family therapy and relevance to Māori people and whānau (O'Connor et al., 2002; Durie et al., 1990) - paiheretia or relational therapy for a whānau-based intervention model (Durie, 2003) - family therapy and Māori models of health and theories of social change (Durie, 1994, 1984; Pere, 1997).
Motivational Interviewing (MI)	Takitaki mai (guide to MI, Britt et al., 2014) found MI has a greater effect for ethno-cultural groups who have experienced marginalisation and societal pressure. There is international evidence to support cross-cultural application of MI (Miller et al., 2008).
Narrative approach	Swan et al. (2012) reviews the concept of whakapapa narratives and their application to counselling practices with Māori people. They highlight the importance of whakapapa and whānau when counselling Māori people and promote whakapapa-informed counselling practices.
Psychotherapy	Wilson (2013) supports the use of existential therapy with Māori people in conjunction with the Te Whare Tapa Whā model of Māori health.

Pasifika

To date, there is little research on the effectiveness of talking therapies for Pasifika people. The evidence summary provides examples of current research.

Key points to effective engagement with Pasfika people, and with therapy include (Ihara 2011; Medical Council of NZ, 2011; MoH 2014; Te Pou, 2010):

- the understanding of Pasifika world view and connections to environment, ancestry and rituals
- importance of family and community for Pasifika people and the complex inter relationships which exist within these structures
- the role of spirituality in Pasifika people's lives
- the importance of engagement and creating and maintaining relationships and va (relational space).

Talking Therapies for Pasifika Peoples. Best and promising practice guide for mental health and addiction services www.tepou.co.nz/resources/talking-therapies-for-pasifika-peoples/152 (Te Pou, 2010) provides information on effective engagement with Pasifika people and information and expert opinion on the use of talking therapies with Pasifika people.

Pasifika	
Acceptance and Commitment Therapy (ACT)	ACT has an emerging evidence base for minority cultural groups (Hayes et al., 2011). Discussion of ACT and Pasifika concepts of 'talanoa', and 'va'. (P. Tupouniua, personal communication, 2015; Te Pou, 2010) and use of metaphor, mindfulness and clarification of values.
Motivational Interviewing (MI)	Discussion of the use of MI approach for engagement and motivation with Pasifika people (Te Pou, 2010).
Narrative therapy	Discussion of the Pasifika cultural practice of 'talanoa' (talking or having a conversation) as relevant to narrative therapy (Te Pou, 2010).
Solution-Focused Brief Therapy (SFBT)	The discussion of the concept of 'talanoa' to ask people to generate their own solutions (Te Pou, 2010), relates to solution-focused brief therapy (SFBT).
Therapy relationship	Mana Moana is an intervention currently being researched (Mila and Daniela, 2014). This reviews culturally embedded ways of dealing with distress and developing wellbeing. Arofa (giving and receiving love), va/wa (relational spaces between) and atami (how information processing informs actions) are central to the approach. Seiuli (2013a) discusses the Uputaua approach to counselling psychology using concepts of the Fonofale model and faletalimalo (meeting house). Seiuli (2013b) discusses meaalofa (the gift that connects counsellors with service users) as a therapeutic and holistic approach to enhance the effectiveness of counselling. Tutty & Goodyear-Smith (2014) examined the effectiveness of a chronic care management (CCM) programme for depression in a predominantly Pacific practice. Results showed a significant immediate improvement in PHQ-9 scores on entering the programme. However, dropout rate was high (60 per cent after the third consultation). Tutty & Goodyear-Smith recommend further research into the CCM depression programme and reasons for dropout. The need for ethnic-specific research into depression in Pacific ethnic groups is highlighted.

Asian

There is much research to support the use of cognitive behaviour therapy (CBT) with Asian populations to treat depression, anxiety and problem gambling. Most other therapies fall into the emerging evidence category or no specific evidence to date. The evidence table provides examples of current research with Asian people. Many Asian people experiencing mental health and/or addiction problems will use traditional therapies. These are not within the field of evidence-based talking therapies but are commonly used in Asian cultures (WDHB, 2013a). The therapeutic approach of mindfulness based practice is congruent with many traditional and cultural values and this modality can accommodate people with the integration of traditional practices, such as, Qi Gong, Tai Chi, Taoist philosophy and meditation.

Practitioners can complete Culturally and Linguistically Diverse (CALD) cultural competency training to enhance their knowledge and skills in working with Asian people from culturally diverse backgrounds. Visit www.eCALD.com for more information about CALD courses and resources.

Talking therapies for Asian People: Best and promising practice guide for mental health and addiction services http://www.tepou.co.nz/resources/talking-therapies-for-asian-people/149 (Te Pou, 2010) provides information on previous research studies and principles of engagement with Asian populations.

Asian	
Cognitive Behaviour Therapy (CBT)	RCT (Choi et al., 2012) provides preliminary support for the efficacy and acceptability of a culturally adapted internet CBT (iCBT) program at reducing symptoms of *depression* in Chinese Australians. Support for the effectiveness of a culturally adapted 16-week manualised individual CBT program for Japanese people with major *depressive disorder* (Fujisawa et al., 2010). Hwang et al. (2015) evaluated the effectiveness of CBT and culturally adapted CBT (CA-CBT) in treating Chinese-American adults with *depression*, with significant decreases in depressive symptoms. Results suggest that short-term treatments were not sufficient to address severe depression and that more intensive and longer treatments may be needed. There is support (Lee, 2014) for the use of a guided self-help, low intensity CBT programme, Living Life to the Full, for students of Asian descent in New Zealand, for increasing quality of life, adjustment and understanding of stress and low mood. RCT (Lam et al., 2015) investigated the efficacy of metacognitive training (MCT) in Chinese people experiencing schizophrenia spectrum disorders, with significant improvements in cognitive insight (such as increased self-reflectiveness). RCT (Li et al., 2015) showed that both CBT and supportive therapy (ST) combined with medication had benefits on psychopathology, insight and social functioning of people experiencing *schizophrenia* in China. CBT was significantly more effective than ST overall, on positive symptoms and social functioning of those experiencing schizophrenia in the long-term. RCT (Naeem et al., 2015) supports the use of a brief culturally adapted CBT for effective treatment of *psychosis* when provided in combination with treatment as usual for service users with schizophrenia in low and middle income settings. Naeem et al. (2015) recommend further research in other low and middle income countries. A community-based telephone-delivered *gambling* treatment program for Asian-Americans (Parhmi et al., 2012) found reported decrease in *gambling* behaviour and improved overall life satisfaction, gambling urges, and self-control. A review of the general problem *gambling* treatment literature and Asian problem *gambling* treatment literature showed that behavioral, cognitive, and combined cognitive behavioral treatments (CBT) appear to be the most effective in treating *gambling* problems (Paylu et al., 2013).

Taoist cognitive psychotherapy	Taoist social and wellness principles combines an analytical component with mindfulness (Wong, 2012). The Taoist philosophy needs to be congruent with the person's philosophical beliefs and basic Taoist principles are integrated into therapeutic goals (Young, 2008). Effective for treating *generalized anxiety disorder* (GAD) and in reducing type A behaviour, improving coping style and decreasing emotional problems (Yalin et al., 2002).
Family therapy	Wang & Henning (2013) explored the dynamic between Chinese people experiencing *bipolar disorder* and family functioning. Analysis showed family members are a primary resource; recovery is linked with caregiving; quality of family relationships is associated with acceptance of illness; and perception of caregiver burden motivates self-care. RCT (Chien et al., 2013) showed that a family led mutual support group for Chinese people with *schizophrenia* produces longer-term benefits to both the service users' and families' functioning, and relapse prevention for service users, compared with psycho-education and standard care.
Motivational Interviewing (MI)	Research demonstrates the efficacy of MI for addiction treatments especially in reducing alcohol and other substance abuse (Miller & Rollnick, 2002).
Solution-Focused Brief Therapy (SFBT)	A meta-analysis of nine studies of SFBT outcomes in China (Kim et al., 2015), found it was effective in reducing internalisation of problems.

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Refugees, asylum seekers and new migrants

Information in this section has been kindly contributed by Sue Lim, eCALD™ Service, Waitematā DHB.

Migrants constitute a large and growing proportion of the national population. It is important to consider not only cultural but individual differences, as well as any experience of trauma including civil war, torture, dangerous refuge flight, and loss and grief (WDHB, 2013).

Migrants come from diverse cultural, linguistic and religious backgrounds and have needs that may not be met by existing health or social services, therefore any talking therapy requires assessment and tailoring to a person's needs.

There is research to support cognitive behaviour therapy (CBT), and narrative exposure therapy (NET) for post-traumatic stress disorder (PTSD) with refugee and asylum seekers. Most other therapies fall into the emerging evidence category, or no specific evidence to date.

For further information please refer to: *Therapies for refugees, asylum seekers and new migrants: Best and promising practice guide for mental health and addiction services* www.tepou.co.nz/resources/therapies-for-refugees-asylum-seekers-and-new-migrants/167 (Te Pou, 2010). Practitioners can complete CALD cultural competency training to enhance their knowledge and skills in working with those from culturally diverse back grounds, www.eCALD.com.

Refugees, asylum seekers and new migrants	
Cognitive Behaviour Therapy (CBT)	Bisson et al. (2013), in a review of 70 studies, found support for the efficacy of individual trauma focused CBT (TFCBT), eye movement desensitization and reprocessing (EMDR), non-TFCBT and group TFCBT in the treatment of chronic *post-traumatic stress disorder* (PTSD) in adults. Other non-trauma focused psychological therapies did not reduce PTSD symptoms as significantly. Bisson et al. highlight the methodological issues evident in some of the studies. A systematic review showed that cognitive processing therapy (CPT), culturally adapted CPT, and narrative exposure therapy (NET) contribute to the reduction of *PTSD* and *depression* severity (Dossa & Hatem, 2012). Hinton (2012) illustrates the adaptation of CBT for refugees who experienced *trauma* and those from ethnic minorities with examples from culturally adapted CBT (CA-CBT). Twelve key aspects that make it a culturally sensitive treatment are discussed. Kar (2011), in a review of the literature, showed robust evidence that CBT is a safe and effective intervention for both acute and chronic *PTSD* following a range of *traumatic experiences* in adults, children, and adolescents. However due to factors such as co-morbidity, it was noted that non response to CBT for PTSD can be as high as 50 percent. There has also been effective use of internet-based CBT in PTSD. Kayrouz et al. (2015) examined the preliminary efficacy and acceptability of a culturally modified therapist-guided CBT treatment delivered via the internet for Arab Australians with symptoms of *depression and anxiety*. Significant improvement in symptoms was seen across all outcome measures. A systematic review by Palic and Elkit (2011) indicates broad suitability of CBT in the treatment of core symptoms of *PTSD* in adult refugees. Phiri (2012) and Rathod et al. (2010) tested the effectiveness of a culturally sensitive adaptation of an existing CBT manual for therapists working with those experiencing *psychosis* from African-Caribbean, Black-African/Black British, and South Asian Muslim communities. The results found significant improvement post-treatment compared to the TAU. Attrition rates were low and therapy experience and satisfaction were highly rated.

Eye Movement Desensitization and Reprocessing (EMDR)	EMDR for *PTSD* for working with people with *traumatic experiences* or pre-migration trauma. A study showed 90 per cent improvement in PTSD symptoms (Wadnerkar in Te Pou, 2010). A pilot RCT (Acarturk et al., 2015) supports the effectiveness of EMDR to reduce *PTSD* and *depression* in Syrian refugees, with lower trauma and depression scores.
Motivational Interviewing (MI)	Sorsdahl et al. (2015) investigated a blended motivational interviewing (MI) and problem-solving therapy (PST) intervention to address risky substance use amongst South Africans. Results showed a significant reduction in *substance use* at three-month follow-up. Lee et al. (2014) investigated responses to a cultural adaptation of motivational interviewing for high alcohol use amongst an immigrant Latino population in the US. Results support the acceptability and relevance of this adaptation.
Multi-modal Therapy	Drosdek et al. (2014) examined the outcomes of a one-year trauma-focused, multi-modal, and multi-component group therapy, day treatment program for *PTSD* over an average period of seven years for Iranian and Afghan service users. The findings showed treatment appeared to improve mental health on both the short and longer term.
Narrative Therapy	Discussion of culturally sensitive counselling and research frameworks (Parry and Doan cited in Morris, p.1, 2006), and the effective use of narrative therapy with migrant and refugee populations. Meta-analysis (Gwozdziewycz & Mehl-Madrona, 2013) supports the effectiveness of narrative methods among refugee populations for treating *trauma* and *PTSD*. Morkved et al. (2014) showed prolonged exposure (PE) and narrative exposure therapy (NET) can be effective in alleviating *PTSD* symptoms. Robjant & Fazel (2010), in a review of the available literature, suggest that narrative exposure therapy (NET) is an effective treatment for *PTSD* in individuals who have been traumatised by conflict and organised violence. Results in adults have demonstrated the superiority of NET in reducing PTSD symptoms compared with other therapeutic approaches. There is evidence to support CBT and NET in certain populations of refugees in reducing *trauma* related symptoms (Slobodin & de Jong, 2015).

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Part 2: Brief Interventions

Currently there is considerable variation in what activity is defined as brief intervention across mental health and addiction service providers. Brief interventions are evidence-based practices designed to motivate individuals at risk of mental health and addiction and related health problems to change their behaviour and improve their wellbeing (adapted from SAMHSA, www.integration.samhsa.gov/clinical-practice/sbirt/brief-interventions).

This document uses the term 'brief interventions' to describe the range of approaches that primary health practitioners can provide for people who have been identified through screening as potentially having emerging signs of, or mild presentation of, mental health and/or addiction problems. Brief interventions also support people with health problems and chronic conditions. The addiction treatment sector further refers to brief interventions as very short, early interventions provided by frontline staff in a range of health and social services.

Brief interventions can be categorised into three main types: brief interventions, extended brief interventions and low intensity therapy (brief therapy). Brief interventions and extended brief interventions are mainly delivered as a first response to a problem (level 1 of stepped care). Low intensity therapy can be brief intervention for mild to moderate mental health and addiction problems (level 2 of stepped care).

High intensity therapy is delivered to those with moderate problems (level 3 of stepped care) in primary care and in collaboration with secondary health specialist services. Where a person presents with more severe or complex problems they are referred to specialist secondary services for therapy at levels 4 and 5 of stepped care. At all levels consideration should be given to cultural needs and preferences as well as social determinants of health. The following table further describes the three different types of brief interventions.

Table 1: Guide to brief interventions

(Adapted from tables in Ministry of Health, 2010; and the SAMSHA, 2012).

Screening	Brief intervention		Low intensity therapy	High intensity therapy
	Brief intervention	Extended brief intervention		
• Single questions • Screening tools	• Single 5-10 min conversation • Self-managed • Feedback from screening • Advice • Information on self-help resources • Educational leaflets • Monitoring • Access to cultural resources • Access to social, financial, housing, educational, and employment services	• 1-3 sessions, 20-60 mins • Self-managed or supported • Motivational coaching • Guided self-help • Skills groups • E-therapy • Monitoring • Access to cultural resources • Access to social, financial, housing, educational, and employment services	• 4-8 sessions, of about 60 minutes long for individual therapy • Therapy, for example: » cognitive behaviour therapy » motivational interviewing » solution-focused brief therapy » problem-solving therapy » option of group therapy • Access to cultural resources • Access to social, financial, housing, educational, and employment services	• 12-20 sessions, of about 60 minutes long for individual therapy • Referral to PHO, NGO, DHB mental health and addiction specialist services • Access to cultural resources • Access to social, financial, housing, educational, and employment services

Screening	Brief intervention		Low intensity therapy	High intensity therapy
	Brief intervention	Extended brief intervention		
Workforce involved				
• GPs, practice nurses and health practitioners	• GPs, practice nurses and health practitioners, for example, NGO whānau ora workers, support workers in mental health and addiction services	• GPs, practice nurses and health practitioners, for example, NGO whānau ora workers, support workers in mental health and addiction services	• GPs, practice nurses, practitioners in PHOs and/or NGOs • Practitioners with training and supervision in therapy and in mental health and addiction	• Provided in primary and secondary services by trained mental health and addiction practitioners and specialists
Examples of current initiatives				
e-Chat screening tool www.health.govt.nz/our-work/health-workforce/new-roles-and-initiatives/established-initiatives/myhealthscreen-echat-risk-screening-tool PHQ 9 www.nzgp-webdirectory.co.nz/site/nzgp-webdirectory2/files/pdfs/forms/PHQ-9_Depression.pdf Kessler 10 www.nzgp-webdirectory.co.nz/site/nzgp-webdirectory2/files/pdfs/forms/Kessler_10.pdf GAD 7 www.nzgp-webdirectory.co.nz/site/nzgp-webdirectory2/files/pdfs/forms/GAD-7_Anxiety.pdf	Wellbeing www.mentalhealth.org.nz/home/ways-to-wellbeing/ CALM computer assisted learning www.calm.auckland.ac.nz/ Self-help skills www.get.gg/selfhelp.htm Citizen's Advice Bureau (CAB) community advice www.cab.org.nz/Pages/home.aspx Alcohol drug helpline http://alcoholdrughelp.org.nz/ Lifeline telephone help www.lifeline.org.nz/Suicide-Intervention_2022.aspx Online support for young people https://thelowdown.co.nz/	Mental health information www.healthnavigator.org.nz/healthy-living/mental-health/ Depression website www.depression.org.nz Beating the blues www.beatingtheblues.co.nz/patients.html Anxiety management www.healthnavigator.org.nz/health-a-z/a/anxiety/ Alcohol management www.healthnavigator.org.nz/health-a-z/a/alcohol-problem-drinking/	BPAC depression electronic decision support tool www.bpac.org.nz/BPJ/2009/adultdep/management.aspx CBT strategies Guides to talking therapies www.tepou.co.nz/initiatives/talking-therapy-guides/56 ABC alcohol program http://www.matuaraki.org.nz/uploads/files/resource-assets/alcohol-ABC-for-general-practices-and-maternal-and-child-health-services-project.pdf	ProCARE Psychological Service (PPS) www.psychologynz.co.nz/ Comprehensive care www.comprehensivecare.co.nz/services-and-programmes/addictions/ ACC www.acc.co.nz/making-a-claim/what-support-can-i-get/registered-counsellors/index.htm

For further information on brief interventions refer to:

Brief interventions in primary care (SAMHSA)**:** key components to brief intervention. www.integration.samhsa.gov/Brief_Intervention_in_PC,_pdf.pdf

Brief intervention guide: addressing risk and harm related to alcohol, tobacco, other drugs and gambling (Matua Raki, 2012). www.matuaraki.org.nz/resources/brief-interventionguide-addressing-risk-and-harm-relating-to-alcohol-tobacco-and-other-drugs-and-gambling/394

Te Pou's *Let's get talking* toolkit: consists of seven tools to support planning and delivery of talking therapies using a stepped care approach. Tools 1 (*Introduction*), 4 (*Assessment*) and 7 (*Practice support*) contain further information regarding brief interventions. Tool 4 *Assessment* provides information on the matching of therapy to a person's level of need using a stepped care approach. www.tepou.co.nz/initiatives/lets-get-talking-toolkit/146

Te Pou's talking therapy guides: a suite of guides for working with different population groups. www.tepou.co.nz/initiatives/talking-therapy-guides/56

The evidence base for brief interventions

Brief intervention is a relatively new area of service delivery and the evidence base is being established. There is emerging evidence for the effectiveness of brief interventions for addressing common mental health issues such as depression or anxiety, and some evidence for the effectiveness of extended brief interventions, such as, guided self-help or psycho-education approaches. There is an established body of evidence illustrating the effectiveness of low intensity therapy (a brief series of therapy sessions) to address mild to moderate depression and anxiety within primary health settings (refer to table 2).

There is substantial evidence for the use of brief interventions in reducing problematic alcohol consumption. The evidence for effectiveness with problematic substance use, while promising, is still accumulating.

Currently there are not many studies of the effectiveness of brief interventions with Māori and Pasifika people in New Zealand.

Table 2: Summary of evidence for brief interventions

Brief interventions	
Problematic alcohol use	A trial of New Zealand students found that a screen for hazardous drinking, accompanied by a 15 minute brief intervention (BI) delivered online resulted in 26 per cent reduction in alcohol use, with 24 per cent of the study group experiencing fewer related problems six weeks later. Intervention effects were found to endure after 6 and 12 months (Kypri et al., 2010). Brief intervention was found to be effective in the short-term across different settings and with different populations. Systematic reviews and meta-analyses have consistently demonstrated that brief alcohol intervention in primary care reduced alcohol consumption at 6 and 12 months (Ballesteros et al., 2004; Bertholet et el., 2005; Moyer et al., 2002; O'Donnell et al., 2013). This Cochrane Review included 24 controlled trials in primary care settings, from various countries. After one year or more, those who received the brief intervention drank less alcohol than people in the control group (Kaner et al., 2009).
Problematic substance use	A randomised controlled trial indicated brief intervention can reduce cocaine and heroin use (Bernstein et al., 2005). Motivational interviewing coupled with a self-help booklet given to people who took amphetamine regularly resulted in reduced levels of drug use (Baker et al., 2005). Adults treated using solution-focused brief therapy (SBFT) showed improvement in substance use problems (Smock et al., 2008). Brief interventions have shown some promising results for people screened for cocaine, heroin, and amphetamines in various health and social service settings beyond emergency departments (Cunningham et al. 2009). The World Health Organization (2008) sponsored a multi-national study demonstrating that screening and brief interventions resulted in short-term reductions in a variety of illicit drug use, including marijuana, cocaine, amphetamines and opioids.

Depression	Review of recent evidence by the National Institute for Clinical Excellence (NICE, 2010) advises watchful waiting for those showing signs of vulnerability to mild depression (as recovery can occur without treatment). Further assessment is normally arranged within two weeks. If symptoms have not improved then treat as mild depression using guided self-help programmes based on CBT, computerised CBT, and exercise (NICE, 2010). For mild to moderate depression, NICE (2011) recommends delivering psychological therapies specifically focused on depression (such as problem solving therapy, brief CBT and counselling) for six to eight sessions over 10 to 12 weeks. A meta-analytic review (Van Daele et al., 2012) of psycho-education techniques to reduce stress found a small but consistent effect on depression and anxiety symptoms. The techniques included education and provision of simple coping strategies. The positive effects noted were not maintained, or worsened, over a six month period. A New Zealand developed ultra-brief intervention is currently undergoing a random clinically controlled trial. This three contact intervention can be delivered by a trained health practitioner to address early presentation of mental health issues (Collings et al., 2011). There is limited evidence supporting the use of ultra-brief interventions for early signs of depression in primary health, using cognitive behavioural and interpersonal principles. A review of qualitative studies concluded guided self-help interventions for mild depression showed promise, however lack of robust quantitative studies mean a firm evidence base is yet to be established (Khan et al., 2007). A systematic review of CBT-based guided self-help interventions for depression reported support for effectiveness among media-recruited individuals, but more limited effect with people referred through routine clinical practice. The effectiveness of guided self-help for people experiencing depression is not yet conclusive (Coull & Morris, 2011). Behavioural activation as a brief intervention has been shown as effective in the treatment of depression in three meta-analyses, one randomised controlled trial and one follow up study (Sturmey, 2009). Systematic reviews and meta-analyses have shown low but significant effects for reducing depression using a range of brief therapies such as cognitive behaviour therapy, counselling and problem solving therapy within primary health. However these improved clinical outcomes for service users are not maintained in the long-term (Bower et al., 2011; Cape et al., 2010; Cuijpers et al., 2008).

Anxiety	Review of recent evidence by NICE (2011) advises identification and assessment, education about general anxiety disorder (GAD) and active monitoring for all known and suspected presentations of GAD. For people diagnosed with GAD that have not improved after education and active monitoring in primary health, NICE (2011) recommend individualised non-facilitated self-help, individual guided self-help and psycho-educational groups. Interventions such as psycho-education, including bibliotherapy, have been shown to reduce symptoms of anxiety (Donker et al., 2009). A systematic review (Coull & Morris, 2011) of CBT-based guided self-help interventions for anxiety reported support for effectiveness among media-recruited individuals, but more limited effect with people referred through routine clinical practice. The effectiveness of guided self-help for people experiencing anxiety is not yet conclusive. Brief CBT for anxiety demonstrated comparable results to longer and more formal therapy typically delivered in specialist services. However positive results were not maintained in the long-term with improved outcomes reverting to baseline after 12 months (Bower et al., 2011; Cape et al., 2010; Cuijpers et al., 2008).

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