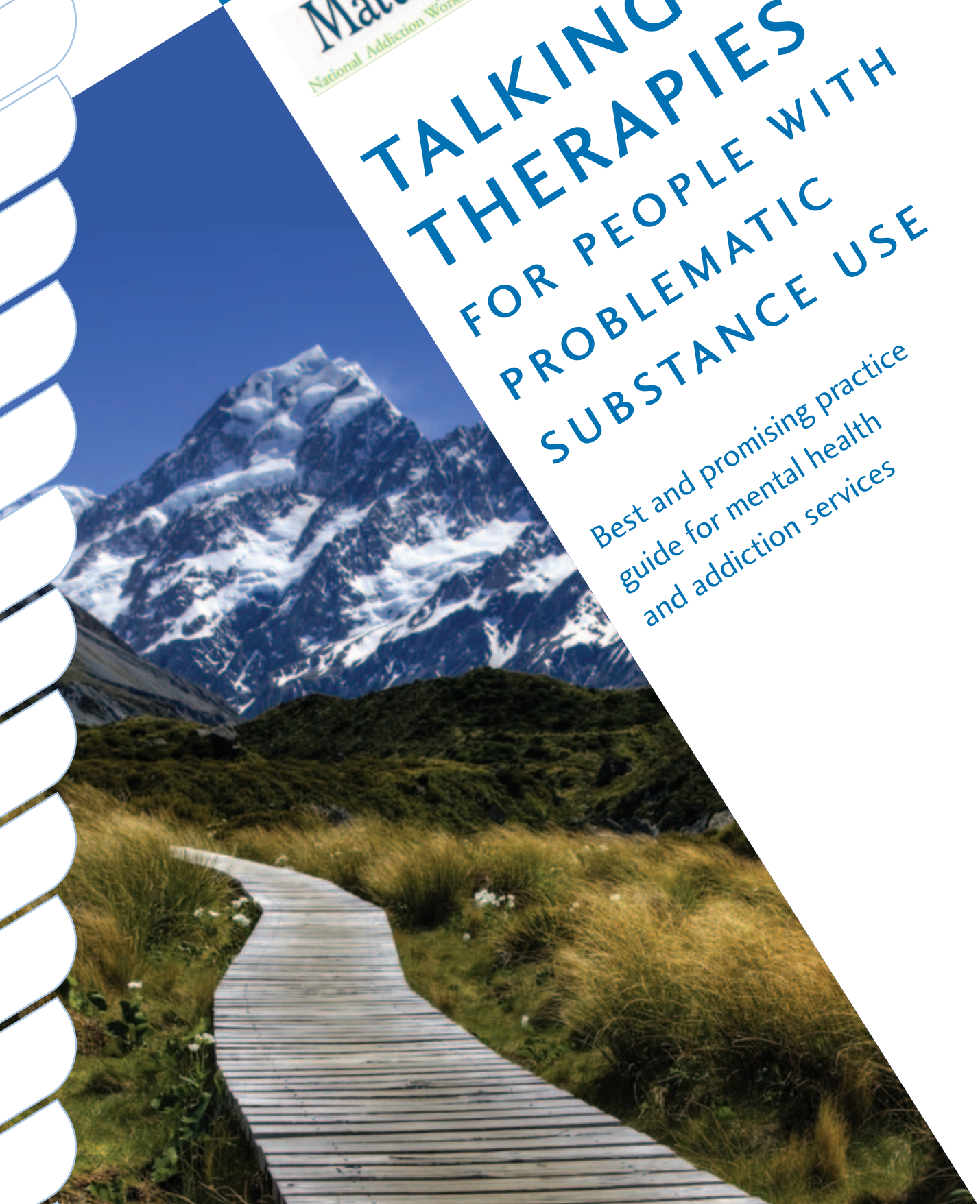
Te Pou
o Te Whakaaro Nui

Matua Raki
National Addiction Workforce Development

TALKING THERAPIES FOR PEOPLE WITH PROBLEMATIC SUBSTANCE USE

Best and promising practice guide for mental health and addiction services



TALKING THERAPIES FOR PEOPLE WITH PROBLEMATIC SUBSTANCE USE

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The National Centre of Mental Health Research, Information and Workforce Development.
PO Box 108-244, Symonds Street, Auckland, New Zealand.

Web www.tepou.co.nz
Email info@tepou.co.nz

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Disclaimer

This guide has been prepared by Matua Raki and Mental Health Programmes Ltd (Te Pou) as a general guide and is based on current medical knowledge and practice at the time of preparation. It is not intended to be a comprehensive training manual or a systematic review of talking therapies in New Zealand. Matua Raki and Te Pou will not be liable for any consequences resulting from reliance on statements made in this guide. You should seek specific specialist advice or training before taking (or failing to take) any action in relation to the matters covered in the guide.

Foreword

Talking therapies for people with problematic substance use is a resource developed to assist practitioners who work with people with addiction-related problems.

The treatment experience of people with addiction-related problems is influenced by a multitude of factors including their health, the quality of their relationships, the nature of their addiction, and the quality of the treatment interventions provided to them.

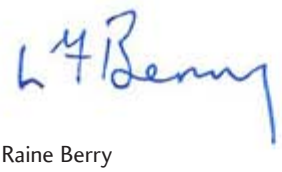
A common determinant of a positive treatment experience is the quality of the therapeutic relationship with the practitioners involved in the enhancement of the person's well-being. The emphasis on engagement in Section 2 of this guide is a welcome reminder that effective engagement, including practitioner attitude and ability, is a crucial element in treatment retention.

Treatment retention is positively correlated with better treatment outcomes. Therefore, techniques that encourage people to stay engaged in the treatment process are likely to increase our effectiveness as a treatment workforce.

Treatment for addiction-related problems involves interventions that are provided in a range of settings and modalities, which may be applied differently across the various stages of the person's treatment journey. It is essential, however, that people with addiction-related problems have access to high-quality, best practice or evidence-based treatment options, and to appropriately applied therapies.

The information provided in this guide is the latest in a series of excellent initiatives pursued and delivered by Te Pou. While it is not a definitive guide, it provides very useful background information on problematic substance use, suggestions for interventions during the various stages of treatment, and information on the range of talking therapies currently utilised by practitioners in New Zealand. It will be a useful resource for practitioners, from students through to the experienced, from both specialist and generalist fields, who encounter people with addiction-related problems.

I would like to congratulate the authors and other contributors on this valuable contribution to addiction workforce development.



Raine Berry
Director
Matua Raki
National Addiction Workforce Development

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Many organisations and individuals were involved in the development of this guide. We thank you for generously giving your time, and acknowledge your passion and commitment to your profession.

National advisory group

Bruce Levi, Waitemata District Health Board, Takanga a Fohe (Unison of Oars), service manager

Catherine Kissel, Waitemata District Health Board, Community Alcohol and Drugs Service clinical advisor

Florence Shodavaram, Salvation Army Midland Bridge Programmes, clinical programmes manager

Guy Breakwell, Mid Central Health, professional advisor psychology

Helen Warren, Auckland Institute of Technology, senior lecturer

Mark de Boer, Waitemata District Health Board, Community Alcohol and Drug Service Counselling units, consumer liaison

Terry Huriwai, Matua Raki, Senior advisor

Consultation group

Andrew Raven – Central Health
Anna Nelson – Matua Raki
Annemarie Willie – Odyssey House
Brody – consumer
Dr Bronwyn Dunnachie – Werry Centre
Claire Aitken – Moana House
Chris Alderdice – Compass Health
Chris Hutchinson – Waitemata District Health Board
Dr Daryle Deering – National Addiction Centre
Deirdre Richardson – WelTec
Fiona McDonald – Mid Central Health
Florence Shodavaram – Salvation Army
Dr Francis Agnew – Waitemata District Health Board
Frances Chisholm – Waitemata District Health Board
Dr Fraser Todd – National Addiction Centre
Ian MacEwan – dapaanz
Jenny Freedman-Hague – Northland District Health Board
Joanne Henare – Mid Central Health
Josephine Gray – Waitemata District Health Board, Tupu
Kirk Vette – Youthline
Les – consumer
Louise Lansdown – Waitemata District Health Board
Marc de Boer – Waitemata District Health Board
Marty – consumer
Mel Johns – ADANZ
Mike Hamblin – Counties Manukau AOD Consumer Network
Paraire Huata – Moana House
Assoc. Prof. Peter Adams – Auckland University
Philip Siataga – Pacific consultant
Richard Atkinson – Mid Central Health
Dr Sue Bagshaw – 198@The Clinic
Terry Huriwai – Matua Raki
Trish Gledhill – Kina Trust
VG Naidu – Waikato District Health Board
Vicky Graham – Mid Central Health
Wolfgang Theuerkauf – Waitemata District Health Board

Executive summary

Research has consistently shown that talking therapies can contribute to better outcomes for consumers with experience of mental health and problematic substance use[1–3]. In New Zealand, talking therapies are intrinsic to service delivery for people with problematic substance use, with practitioners drawing from a wide variety of modalities.

This guide provides a review of the evidence-based talking therapies commonly used by New Zealand practitioners with people experiencing problematic substance use. In order to reflect the diversity of psychosocial interventions used in the alcohol and other drug sector, this guide also provides an overview of other commonly used models. In addition, this guide takes an in-depth look at what practices can be effective in engaging a person with problematic substance use in therapy. Achieving engagement through developing a strong therapeutic relationship between the therapist and consumer is an essential element of the therapeutic process. This relationship has a moderate but consistent positive effect on therapeutic outcomes[2, 4–6, 7].

A diverse group of New Zealand practitioners and consumers were consulted to inform this guide's content. Expert opinion was combined with a review of national and international research, in order to summarise what is known about best and promising practice when delivering talking therapies and other commonly used models in the alcohol and other drug sector. This guide is intended as a starting point, to begin to build New Zealand's knowledge of what works best, and may be used as a resource to support training.

Consultation revealed a wide variety of therapeutic modalities that have proven useful when working with people with problematic substance use in New Zealand. The most commonly employed talking therapies appear to be motivational interviewing, cognitive behavioural therapy and brief interventions. Other models, such as therapeutic community and the 12-step programme, are also commonly used.

Key engagement principles to emerge from the consultation and literature review included:

- taking time in early sessions to form a human connection, before engaging in the more technical aspects of the therapy
- structuring therapy in accordance with cultural considerations
- employing a consumer-centred approach, where assessment formulations are shared, the consumer participates in developing the recovery plan, and feedback is actively sought
- involving families and whanau in the therapeutic process as early as possible
- employing motivational enhancement strategies to engage the consumer in the therapeutic process
- demonstrating competence in the talking therapy model used
- during the later stages of therapy, beginning to broaden goals to focus on re-engaging the consumer with their community and their natural supports.

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1. Introduction

Background

Talking therapies have proven their effectiveness as treatments for use in mental health and addiction services[1–3]. New Zealand consumers, families and clinicians recognise these benefits and have been calling for better access to quality talking therapies. The Ministry of Health responded to this call by commissioning Te Pou to undertake a coordinated, strategic approach to enhancing talking therapies use in New Zealand. Sector consultation was summarised in a suite of reports: *We Need to Talk, We Need to Listen*, and *We Need to Act*, which culminated in the *Action Plan for Talking Therapies 2008–2011*. This action plan was agreed by the Ministry of Health and outlines a number of activities to increase the spread of high-quality talking therapies in New Zealand. These documents can be downloaded through the Te Pou website, www.tepou.co.nz.

A key activity within the action plan was to produce a series of guides for practitioners using talking therapies with groups that have specific needs. These guides are intended to equip practitioners with a suite of practices to foster engagement with these consumer groups, as well as to identify therapies commonly used and how they might be adapted to maximise benefits. Guides have been produced for older people, Maori, Pasifika people, Asian people, and refugees, asylum seekers and new migrants. This guide for people with problematic substance use is the last of the series. The guides can be downloaded from the Te Pou website, www.tepou.co.nz.

This series is the first in New Zealand to summarise what is known about best and promising practice when delivering talking therapies to specific consumer groups. In New Zealand, talking therapies, particularly for these populations, tend to be an understudied area. Consequently, these guides are intended as a starting point to begin to build New Zealand's knowledge of what works best when delivering talking therapies to these unique groups.

In contrast to some of the other guides in this series, it is important to acknowledge that a significant body of international research exists for the efficacy of talking therapies for people with problematic substance use. This research has been drawn from in order to inform this guide's content.

Purpose

This guide intends to assist staff working therapeutically with people who primarily have substance-related problems. The purpose is to better inform practitioners about the engagement processes, common talking therapies, and other models that are particularly useful for this population. Section 1 of the guide provides a brief overview of current issues related to problematic substance use in New Zealand. Section 2 provides a suite of practices that practitioners can apply to enhance engagement with people who have substance-related problems. Section 3 provides an overview of the most commonly used talking therapies, and other models that have proven useful, when working with people with substance-related problems in New Zealand.

Target audience

This guide is aimed at practitioners who use talking therapies and other therapeutic models with people who experience problematic substance use. This may include alcohol and other drug practitioners, counsellors, GPs, occupational therapists, psychiatrists, psychologists, nurses and social workers. In addition, the engagement section of this guide is useful for all people working in mental health and addiction services who wish to develop skills to foster engagement with people with problematic substance use.

Development of the guide

This resource was developed from a variety of information sources: an international literature review to identify research-based evidence; an advisory group that guided the document's development; and consultation with experienced practitioners and consumers in New Zealand's alcohol and other drug sector.

Seven people were invited to form the national advisory group who represented a range of perspectives (co-existing, addiction and mental health, Pacific, Maori, non-government organisation, district health board, Asian), as well as a variety of professional roles. They guided the development of the consultation questions, and identified practitioners and consumers to involve in the consultation process.

Forty people were identified to include in the consultation process, representing a nationwide group comprised of a wide variety of professions (psychology, psychiatry, counselling, social work, nursing, family advisors, peer support) and who worked with a variety of consumer groups (Maori, Pacific, Asian, older adult, youth, co-existing) in a variety of settings (district health boards, training and education, non-government organisations, primary health). Of these, 36 were able to be interviewed. (Refer to the acknowledgement section for more details about the individuals involved.) The information gathered during this consultation was de-identified to maintain confidentiality, then transcribed and analysed to identify the common messages presented by practitioners and consumers.

Concurrently, an international literature review was conducted that employed key word searches, followed by internet searches to identify additional research related to talking therapies and problematic substance use. This literature was combined with the consultation content to identify the best and promising practices presented in this guide. Given that approximately 70 per cent of people receiving treatment for problematic substance use may also experience mental health concerns, this guide closely aligns its discussion with the *Te Ariari o te Oranga: The assessment and management of people with co-existing mental health and substance use problems 2010*[8], written by Dr Fraser Todd, which provides comprehensive guidelines for practitioners working with this population. *Te Ariari o te Oranga* places a strong emphasis on engagement and the therapeutic relationship across all stages of treatment, and therefore provides great synergy with one of this guide's key objectives, namely to identify key principles for engagement during talking therapy.

The guide underwent extensive peer review, firstly from the reference group and then from the consultation group. Feedback was incorporated into the final version of the guide.

Terms and definitions

Talking therapies

The National Treatment Agency[9] provides a useful operational definition of talking therapies, also often referred to as psychological therapies:

> They are based on one or more theories of human behaviour and involve a relationship between the practitioner and consumer. Issues relating to development, experience, relationships, cognition, emotion and behaviour are considered. The goal of psychological therapies varies with the model used, but is usually to increase the consumer's self understanding and /or make changes in their cognition, emotion or behaviour. (p. 3)

Talking therapies with people experiencing problematic substance use generally seek to assist people to make and sustain changes in their substance using behaviours, and to assist individuals in managing any coexisting mental health conditions. It is also important to note that a variety of additional models are used to assist consumers to address their substance-related problems, which may not be classed as pure talking therapies, for example peer support, the 12-step fellowship and therapeutic communities. However, given their important contribution to service provision in New Zealand, these models will be discussed in Section 3, which provides an overview of the main therapeutic models employed in New Zealand to address problematic substance use.

Problematic substance use

This term means use of a substance that may cause or exacerbate problems. The term problematic is used, rather than abuse or disorder, in recognition of the fact that significant substance use may occur at levels that do not meet criteria for disorders in their own right. This definition applies to any psychoactive substances, regardless of whether the substances are licit or illicit[8]. This term will be used interchangeably with substance-related problems and referred to throughout the guide, unless discussing particular research or statistics based on the disorders listed below.

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[8].

Substance use disorder

The term substance use disorder is used to represent a disorder meeting criteria for one of the DSM-IV substance use disorders[8].

Practitioner

The term practitioner is used in this guide, as it recognises the breadth of mental health and addiction professionals who may use talking therapies and other common models with people who experience problematic substance use. Other terms commonly used are therapist, clinician or health professional.

Consumer

Consumer is the term this guide uses to describe the person who is receiving the service. Other terms commonly used are service user, tangata whaiora, client, patient and people with substance-related problems.

Theories of substance use

It is useful for practitioners who are using talking therapies with people with problematic substance use to be aware of some of the theories in the sector. Models and theories about problematic substance use include the disease model. The disease model underpins the 12-step fellowship programmes, where substance misuse is perceived as a behavioural consequence of pre-existing and permanent physical vulnerability that people have to substances[10]. Behavioural learning theories suggest that problematic substance use stems from the influence of learning to use substances, through personal experience and through modelling behaviours of parents, peers, the media or other sources. This theory can also relate to socio-cultural perspectives, where the use of substances can be seen as a form of self-medication that helps to alleviate personal and social difficulty[11], thus reinforcing substance misusing behaviour. The social paradigm approach views people in terms of their relationships with others. When people become addicted they form an intense relationship with the 'object of their desire' and other relationships begin to deteriorate, creating an addictive social system that becomes the focus of interventions for change[12]. The neurobiological perspective indicates that repeated substance use can lead to long-lasting changes, which undermine voluntary control[13,14]. None of these theories, however, can provide us with a definitive answer to what causes problematic substance use. Environmental, genetic, developmental, neurobiological factors and social context could all be contributing to the problem.

Substance use in New Zealand

Who experiences substance use disorders in New Zealand?

The report *Substance Use Disorders in Te Rau Hinengaro: The New Zealand Mental Health Survey*[15] indicates that 12 per cent of the New Zealand population will experience problematic substance use at some time in their life. In terms of substance use disorders, as defined by the DSM-IV, alcohol abuse is the most common, followed by alcohol dependence, drug abuse and lastly drug dependence.

Te Rau Hinengaro[15] has indicated that certain demographic groups experience a higher prevalence rate for problematic substance use within New Zealand. Problematic substance use is higher for people with less education (4.5 per cent compared to 2.3 per cent of those with a higher level of educational qualifications), less household income (5.0 per cent compared to 2.5 per cent of those who earn one-and-a-half times over the medium income), or those who live in more deprived areas (5.6 per cent within the 9 to 10 decile, compared to 2.3 per cent within the 1 to 2 decile)[15]. *Te Rau Hinengaro* also demonstrated a higher prevalence of problematic substance use for younger people; 75 per cent of those people who will some time in their lives experience substance use disorder do so by 24 years of age[15]. Problematic substance use in older people has received little attention in New Zealand. There have been some preliminary studies with older people in Christchurch, which suggest that alcohol problems in older people often go undetected or are misdiagnosed[16].

Males have more than double the prevalence of substance use disorders, during a 12-month period, compared with females (5.0 per cent, compared with 2.2 per cent)[15]. Ethnicity is another significant factor. Maori had the highest prevalence of substance use disorders in the past 12 months, followed by Pacific people, and then the "Other" composite ethnic group (Maori, Pacific and Others were 9.1 per cent, 4.9 per cent and 2.7 per cent respectively). After adjusting for socio-demographic factors, Maori still experience a higher prevalence rate (Maori, Pacific and Others were 6.0 per cent, 3.2 per cent and 3.0 per cent respectively)[15].

Suicidal behaviour and substance use

New Zealand has one of the highest rates of suicide among countries within the Organisation for Economic Cooperation and Development (OECD)[17]. Substance use disorders are associated with suicidal ideation; 16.7 per cent of those with an alcohol disorder, and 28.5 per cent of those with a drug disorder, reported suicidal ideation. These disorders were also associated with the risk of making plans for suicide and suicide attempts. People with abuse of or dependence on alcohol or drugs were at higher risk of suicidal ideation and suicide plan even after taking account of all other comorbid disorders[15]. The analysis conducted in *Substance Use Disorders in Te Rau Hinengaro*[15] concluded that co-existing problems cannot account for the observed association between substance use disorder and suicidal behaviour.

Poly-substance use

Poly-substance use is very common among those with problematic substance use disorders. Around a quarter of those with alcohol dependence, also met criteria for drug dependence (23.5 per cent) or drug abuse (28.1 per cent) as defined in DSM-IV. Those with problematic drug use, experience an even greater prevalence of problematic alcohol use. About half (49.9 per cent) of those with drug dependence also reported alcohol abuse symptoms in the past 12 months, and 43.1 per cent of those with drug dependence were also alcohol dependent[15].

Co-existing problematic substance use and physical disorders

People with substance use disorders have a higher prevalence of some chronic physical diseases, such as chronic pain, high blood pressure and respiratory disorders, compared with people without any mental or substance use disorder[15]. Smoking and hazardous alcohol use are the health risk factors that are most elevated among people with substance use disorders, compared to people with other mental disorders.

Co-existing mental health and substance use problems

There are many terms used to describe the interaction of substance use and mental illness or distress. This guide will employ the approach that *Te Ariari o te Oranga* has taken, whereby the term co-existing substance use and mental health problems, or co-existing problems, is used. The word problems, rather than disorders, conditions, or issues, is employed, 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[8].

Prevalence

Te Rau Hinengaro's national population survey reported that, of those with a substance use disorder in the past 12 months, 29 per cent also experienced a mood disorder and 40 per cent experienced an anxiety disorder[20]. Within therapeutic settings, co-existing problem rates are higher. International research reports that between 30 per cent and 50 per cent of those in mental health settings have a co-existing substance-related problem. Few New Zealand studies have been published, but initial research has indicated similar rates[21, 22]. More New Zealand data is available for co-existing problem rates amongst people accessing alcohol and other drug services: 74 per cent of consumers with substance-related problems who were referred to two community services had a current mental health disorder as well[23]. An anxiety disorder was diagnosed in 65 per cent of people with substance-related problems, a mood disorder in 53 per cent, a specific depressive disorder in 43 per cent, post-traumatic stress disorder in 31 per cent, social phobia in 31 per cent, and bipolar disorder in 11 per cent of people with substance-related problems[23]. However, only 10 per cent of this group was currently engaged in mental health services. Other research has indicated similar high rates, where co-existing disorders were at 70 per cent within a methadone programme[8].

Why is it important to understand co-existing problems?

International research (cited in *Te Ariari o te Oranga*[8], p. 7) highlights that co-existing problems can influence a wide variety of outcomes, including:

- unstable housing and homelessness
- loss of whanau or family supports
- financial problems
- poorer subjective well-being
- higher levels of mental health symptoms
- increased rates of suicide
- increased relapses, number of hospitalisations and time spent in hospital
- poorer general health, including increased rates of blood born viruses, e.g. HCV and HIV
- financial costs to treating services
- increased rates of violence
- higher rates of offending and incarceration.

In addition, co-existing problems frequently complicate treatment and can contribute to poorer treatment response[15].

Working with co-existing problems

The practitioners consulted for this guide consistently highlighted the importance of attending to co-existing issues during talking therapy. It was recommended that practitioners should always expect to be working with a person who will experience both issues to some extent. This is particularly evident for people with more complex problems, where substance use could be a way of regulating the mental health issue. Alternatively, the substance use may have generated its own mental health issues, particularly depression and anxiety.

Given this, alcohol and other drug practitioners need to have a sound understanding of mood, depression and anxiety at the very least. It is also important to consider other co-existing issues such as physical health, justice issues, problem gambling or disability. As a consulted practitioner explains:

> It could be addiction and mental health, it may be addiction and physical health, so there could be a range of issues that are present. It's about understanding and being able to discuss what came first and how they fit together, being able to explain the links between the issues and knowing that simply dealing with either the mental health or the physical health issue is not going to solve the addiction or vice versa. There are different strategies that need to be attended to and of course they will complement and feed into each other. You need to understand the connections between the issues and what came first.

The complexity that co-existing problems can pose highlights the need for a comprehensive assessment, where the consumer is actively involved in identifying problems and developing a recovery plan. Often a number of services will be included within this recovery plan, where multidisciplinary service provision may occur across community and social services.

Limited access to services

According to *Te Rau Hinengaro*, of those who experience substance use disorders in a 12-month period, only a third (29.9 per cent) had a mental health visit to a healthcare or non-healthcare provider in the past 12 months[15]. Of these people, 20 per cent had made contact with a general medical service, 14.5 per cent had contact with a mental health specialist, and 5.7 per cent had contact with a complementary or alternative medicine provider. Treatment contact is lowest for younger people and Pacific people[15]. Most people with a lifetime substance use disorder eventually make contact if their disorder continues. However, the percentages of people accessing services at the age of onset were small across all disorders: 8.9 per cent for alcohol abuse disorder, 19.4 per cent for alcohol dependence, 13.0 per cent for drug abuse, and 25.2 per cent for drug dependence. The median duration of delay until contact was 16 years for alcohol abuse, 7 years for alcohol dependence, 8 years for drug abuse, and 3 years for drug dependence. The reality is that a significant unmet need for treatment exists for people with problematic substance use[15].

While this may mean that people who are requiring services for their problematic substance use are not receiving the support they need, it is also important to recognise that not everyone with problematic substance use requires the assistance of services to resolve their problems. Spontaneous remission, natural recovery or self-change, as this process has been referred to (among other terms), occurs for approximately 26 per cent of people who experience problematic substance use. This group is able to resolve problems without requiring any form of treatment[18]. However, according to Klingemann and Klingemann[19], the majority of self-change studies indicate a better chance for natural recovery for less severe cases of problematic substance use.

Understanding the process of spontaneous remission is complex, and seems to depend on a number of variables in the individual's life, including health concerns, pressure from family and friends, and extraordinary events[18]. While this process is an important phenomenon to be aware of, it does not negate the importance of reducing the barriers that consumers have to accessing the services that they require, or the importance of the treatments utilised once people have accessed these services (for example talking therapies).

National evidence

While considerable New Zealand research is dedicated to understanding alcohol and other drug-related issues, less national research specifically focuses on assessing the efficacy of talking therapies with people who experience substance-related problems. Instead, current New Zealand-based evidence is largely dependent on expert opinion and the practice of practitioners working in the field. *Te Ariari o te Oranga*[8] is an important contribution to New Zealand's mental health and addiction services that provides an overview of evidence-based practices for the assessment and management of people with co-existing mental health and substance use problems.

International evidence

Extensive international research has assessed the efficacy of talking therapies for people with problematic substance use[1, 2]. This research has been summarised in a number of meta-analyses, which have highlighted the effectiveness of a variety of modalities, including motivational interviewing, contingency management and brief interventions[24, 25–27]. These meta-analyses have also demonstrated the importance of the therapeutic relationship in predicting successful outcomes[4, 5].

Gaps in knowledge and evidence base

Research has yet to demonstrate that one psychological treatment is more effective than another when working with people with problematic substance use. Therefore, new research directions in talking therapies appear to be refocusing on identifying how specific therapist behaviours interact with consumer attributes to influence outcome[3, 28]. While talking therapies may currently be understudied in New Zealand, it is important to recognise that many of the talking therapies employed in New Zealand, and discussed in this guide, are well-evaluated internationally and there is no evidence to suggest that what works internationally will not work in New Zealand. Therefore, research effort could be maximised by seeking to identify the talking therapies and models that are best suited to meet the unique needs of currently understudied population groups, such as Maori, Pacific, and older adults. Formal peer support is an emerging model in New Zealand that requires research and evaluation.

TALKING THERAPIES FOR PEOPLE WITH PROBLEMATIC SUBSTANCE USE

2. Principles of engagement

Engagement

Reviews of the mental health related research literature have shown that engagement, primarily achieved through the development of a strong therapeutic relationship, is a consistent predictor of positive mental health outcomes[5, 6]. As one practitioner emphasised:

> I think if you don't actually engage with a person right from the start of the therapeutic process then you're not going to get far.

Meta-analysis of the role of the therapeutic relationship in the treatment of substance-related problems found similar, but not identical results to mental health research[4]. That is, the development of an early therapeutic alliance is a consistent predictor of engagement and retention in alcohol and other drug treatment. This alliance also predicts early improvements during treatment, but is an inconsistent predictor of post-treatment outcomes[4].

The therapeutic relationship (or alliance) is the bond dedicated to therapeutic work between the consumer and the practitioner[8]. It is founded on three main components: the relational bond, agreement on goals, and agreement on tasks. Engagement and the therapeutic relationship is essentially the glue that holds the therapy together. It is the way the therapy is delivered that supports best outcomes. Failure to engage the consumer in the therapy is often a major contributor to poor outcomes. Engagement arguably has more impact on outcome then the specific intervention used[8]. It is important to recognise that while achieving engagement in the first few sessions is vital, engagement is a fluid process and continues to influence outcomes throughout the course of therapy. Therefore, this section is structured to assist practitioners to consider ways they can develop engagement in the early, middle and late stages of therapy.

The power of the therapeutic relationship does not, however, detract from the importance of been able to competently deliver evidence-based talking therapies. That is, while the therapeutic alliance may be the glue that holds the process together, the delivery of an effective evidence-based talking therapy is the process that promotes the change. To achieve the evidence-based outcomes that talking therapies can deliver, they need to be delivered by an adequately trained and supervised workforce[9]. Section 3 discusses a variety of talking therapies and other common models that have proved effective when working with people with problematic substance use in New Zealand.

Let's get real[29] is a consumer-centred approach to develop the essential knowledge, skills and attitudes to deliver effective mental health and addiction services. Developed by the Ministry of Health, it identifies seven Real Skills that everyone working in mental health and addiction is expected to demonstrate, regardless of their role or occupation. This framework places a strong emphasis on engaging with consumers, families/whanau and communities, and will be referred to throughout this section.

Let's get real's fundamental values include respect, human rights, service, recovery, communities and relationship. The attitudes are compassionate and caring, genuine, honest, non-judgemental, open-minded, optimistic, patient, professional, resilient, supportive and understanding. All of these values and attitudes are very important for practitioners to demonstrate during therapy to foster the therapeutic alliance with the consumer. For more information on *Let's get real* see www.moh.govt.nz/letsgetreal.

Consumer and external factors

Before considering actions that a practitioner can employ to foster engagement, it is important to acknowledge the central role of the consumer.

> If we look at factors contributing to the success of treatments, it is not the clinician or treatment procedure that is key, but the motivation, awareness, expectations, and preparation of the client[30]. (p. 8)

> It is so easy to focus on our models, techniques, and skills that we sometimes forget that therapy only works to the degree that it activates the natural healing propensities of clients[31]. (p. 1)

Research has found that the following consumer factors can influence the development of the therapeutic relationship. Practitioners may need to carefully attend to:

- motivation for recovery[32], highlighting the importance of using motivational enhancement techniques
- severity of substance use and symptoms, including intrusive memories and thoughts connected to a history of trauma[32–34]
- high levels of hostility[35]
- attendance[32]
- interpersonal and attachment style[36]
- confidence that treatment will have a significant impact[37]
- lower health literacy skills[38].

External factors can also have a strong influence on engagement. "An autonomy-supportive environment is likely to enhance motivation and especially transition from extrinsic to intrinsic types of motivation, which are associated with improved engagement"[8] (p. 52). The following factors influence engagement:

- where connections with family are strong[39]
- where the consumer is engaged with the wider community and feels a valuable part of it[8]
- alignment in service provision to support a consumer-centred, strengths-based and culturally responsive service delivery model where the consumer has informed choice and a sense of control
- provision of peer support can increase early engagement, particularly for those who have previously been difficult to engage[40]
- legal pressure and court-mandated treatment is associated with early engagement. However, this coercion may reduce intrinsic motivation, which is important for ensuring the longer-term success of therapy[34]. Motivational enhancement techniques will be important in these situations.

Pre-therapy

It is recognised that accessing services is a major barrier to effective treatment for people with problematic substance use. While access to services is not a focus for this guide, as one practitioner highlights:

> Accessing services is one of the biggest problems faced by the industry where there is a significant unmet need for treatment. So if you carry this issue then you do the extra things required to engage with people...we need to be proactive and energetic in engaging with people.

Strategies that support access to services can be beyond a practitioner's control. However, the following actions were identified through the consultation as useful ways for practitioners to support engagement before the first therapy session:

- Obtain and review past clinical records to develop some ideas of what service might suit the consumer's needs, such as what ethnically and culturally appropriate processes might need to be employed
- Before the first meeting, practitioners can call the consumer to clearly outline what to expect. Take care to convey warmth and respect during the conversation, and identify any barriers that may prevent the consumer from attending the sessions. This call can also be an opportunity to clarify any cultural needs or preferred processes for engagement
- Identify practical barriers to access, such as transportation, child care, need for a translator and work arrangements, and work with the consumer to identify possible solutions
- Consider contacting the referrer, or other services currently involved in the consumer's recovery plan, to assist in clarifying ideas regarding potential service approaches.

Practitioners were careful to highlight that while it is important to thoroughly review the consumer's clinical records prior to contact, in order to understand the relevant history, care needs to be taken to enter the first session with an open mind. While some pre-established ideas about appropriate therapeutic models may be helpful, the practitioner must not assume that these are correct, and should be led by what the consumer brings to the session.

Early stages of therapy

> I think if people come and see me and feel respected and taken seriously, and go away from that first meeting with something of value to them, they'll come back.

Getting engagement right in initial sessions is crucial to the therapy's success. Outcome research has identified that most change occurs earlier rather than later in the therapy process[41, 42]. Howard, Kopte, Krause and Orlinsky's[43] now classic research showed that 60–65 per cent of people experienced symptom relief within the first seven sessions. These figures increased to 70 to 75 per cent after 6 months and 85 per cent at 1 year, therefore, diminishing returns for more effort was evident.

Te Ariari o te Oranga[8] recommend that the initial interview focuses on safety, stabilisation, assessment and engagement. It outlines the key goals as:

- attend to issues of engagement and motivation
- attend to cultural considerations
- involve and engage the whanau
- assess and ensure safety
- begin comprehensive assessment and recovery plan development
- negotiate an initial shared understanding or opinion, and strategies for managing the early treatment phase[8].

These goals were reflected in the viewpoints of practitioners and consumers consulted, who offered the following set of factors to consider at the assessment phase to foster engagement:

Clear explanations

When beginning therapeutic work with anybody, it is vital to provide a clear explanation of what the assessment and therapeutic approach entails, and what the person can expect from the role of the practitioner. For people with problematic substance use, this is particularly important as they often have a heightened need to feel in control and that the practitioner is not going to do anything without the consumer's consent.

> Anybody who's become dependent on a substance or on gambling, their focus is on the need to stay in control. If they don't stay in control everything is going to unravel very quickly. So control, and outlining that they still have control, that you are not actually doing anything to them is important, and clearly outlining your responsibilities where you would need to act.

As well as clearly outlining the purpose of the assessment, it is vital that confidentiality is discussed in the first session. Carefully go through the confidentiality form with the consumer and explain the circumstances where the practitioner is obliged to break confidentiality. This helps create clear boundaries and a safe environment for the consumer to begin to share their story. It is also important to recognise that confidentiality is an ongoing process, and that it may also need to be clarified or discussed in later stages of therapy.

Psychological safety

Zuckoff and colleagues[44] suggest that establishing psychological safety is key to achieving initial engagement with the consumer. They argue that consumers are often ambivalent or feel shame about their substance-related problem, either through negative past treatment experiences, stigma, discrimination (real or perceived), or wariness of the practitioner who can be seen as both dangerously powerful and potentially helpful. Therefore, the consumer will test the safety of the therapeutic relationship by gradually revealing more important information and reacting to the practitioner's responses. To build psychological safety within the relationship, the practitioner needs to encourage the consumer to talk openly, to explore attitudes and thoughts related to past treatment experiences, to respond with empathy and non-judgement in response to consumer disclosures, to maintain an affirming approach, and to emphasise that the consumer is in control. As safety increases, consumers become more ready to reflect and reappraise their situation and engage in behaviour change[44].

This pattern was emphasised through the consultation.

> You've got to connect with the consumer first so they feel at ease and that they can trust you and you're not going to run away and do something with the information. So it's allowing that connection first so it opens up the doors for the consumer to talk and be open about what's going on for them and even that helps them to get rid of past issues of guilt and shame around their use.
>
> If you don't have that trust you don't want to talk to people about the problem, so I think building trust is a main focus.

Take the time to connect

The practitioners interviewed emphasised the importance of taking time to form the human connection with the consumer, before beginning the formal part of the therapy. Getting to know each other is the process that begins to build the trust that is critical to successful outcomes. Some dedicate the entire first session to forming this connection. A Pacific practitioner describes this process.

> We talk about the roundabout way of starting off an interview. You don't go in with the hard questions, you chat about who your family are, where you are from, what your interests are, the rugby test on Saturday, maybe, or what church you go to. The important thing is for the consumer to know who you are, and you need to start getting a sense of who they are, in terms of a person, or family, or whatever. And when they feel comfortable with that, that they trust you, because trust is a big part of it, then you can do the assessment. Sometimes the 'mainstream' services can get exasperated by this because it's time consuming. But without this you can go into an interview with Pacific people who will sit there and say yes, yes, yes and mean no, no, no.

While other practitioners chose to begin the assessment during the initial session, they still recommended taking that time to personally connect first. They saw this conversation as the first step in beginning to form the therapeutic relationship.

> We often kind of go straight into it, I've been guilty of this myself in my earlier years where I've worked with somebody for eight weeks, I know all about the alcohol and other drug problem, but what are their interests? We often miss that, I think if you invest that currency at the beginning which can sometimes be as little as 10 or 15 minutes, that will pay for itself 10 times over in session three, session four, session five and session six.

It is important to acknowledge that taking the time to form the human connection needs to be carefully balanced with the need to begin a comprehensive assessment. This is one of the many tensions or balancing acts that a practitioner needs to manage during therapy.

A therapeutic conversation rather than a tick box exercise

Practitioners highlighted the importance of engaging in a consumer-centred conversation about their substance use, rather than conducting an assessment that is driven by gathering information that the service requires.

> All too often we end up with situations where the assessment process is service driven, rather than consumer driven, which means the service says, "Okay, you've got a problem, we have a certain protocol, before you tell me anything we'll spend the next hour and a half with a number of questions I need for my systems," and that's the last time you saw that person, because they are not engaged. Engagement has to be really focused on giving the person an opportunity to tell us their problems, in the first instance.

Eliciting the consumer's story is an initial step in Zuckoff's[44] interview process, which incorporates motivational interviewing principles to enhance engagement. Further steps involve:

- summarising what is heard and crystallising the dilemma
- exploring the consumer's hopes and fears for treatment
- identifying personal values and life goals – where the consumer wants to go and who the consumer wants to be
- developing a change plan together.

The skill of the practitioner is to create the space where the consumer feels free to tell their story, yet still to ask the right questions, to gather the information required, to create an informed opinion about the problems experienced by the consumer and possible strategies to address these.

The assessment needs to be of value to the consumer

Practitioners emphasised the importance of ensuring that the consumer left the session with something of value to them. To achieve this, it is important to spend time during the first session exploring the consumer's goals and what they would like to achieve through the therapeutic process, with the aim of making some progress towards fulfilling one of these goals be the end of the session. Another way to provide this value is to be able frame the problem in a way whereby the consumer gains more insight.

> By the end of the assessment what I want the person to have is a way of understanding how they've got to where they are now, that they didn't have before. What I never want is for someone to leave an assessment from an engagement point of view, feeling like they've spilled a lot of information and then you say, "Thank you very much I'll see you next week." I want them to go away with an understanding of their situation that is useful for them, an understanding of why they're having their problems and what's going to happen to address these problems.

Through establishing this shared understanding, where the consumer is able to see the bigger picture and the reasons for their substance use and how this impacts upon their life and reasons for change, he or she is then more likely to feel empowered to make changes.

For a good summary of guidelines for the assessment process, which focuses on methods for obtaining information, formulating an opinion and developing a treatment plan, refer to the assessment section in *Te Ariari o te Oranga*[8].

Psychoeducation

Psychoeducation plays a very important role in the treatment of problematic substance use. It can be delivered as part of a talking therapy approach, as well as within group settings. Practitioners need to be able to understand the facts and effect of substance use, such as the risks of withdrawal (e.g. the dangers of benzo withdrawal) or of not withdrawing, the types of withdrawal symptoms for various substances and what to expect, the nature of cravings, as opposed to emotions, and certain brain changes that can happen due to substance use. Practitioners need to be able to clearly explain this relevant information to the consumer and their family, provide guidance on how to manage any issues, and normalise their experience in the light of this understanding, so that the consumer, or their family/whanau can make informed decisions about what they do.

Attending to the risks

Alongside attending to general risks, such as of self-harm, suicide, violence and risk to others, and the ability to care for self and dependents, some unique risks that need to be considered during the assessment and ongoing treatment might include:

- stability of living arrangements
- relationship problems
- managing intake of dangerous substances
- illegal activity that may support substance use, e.g. buying and selling of street drugs
- conduct problems, which can mean that people with problematic substance use have a higher risk of aggression and violence
- the consumer seeing the practitioner as a potential source of drugs.

Cultural safety also needs to be considered, to ensure a person does not feel invalidated by the assessment and treatment processes used and therefore disengage. Refer to page 37 of this guide for discussion on culture.

Mid to late stages of therapy

Early engagement, achieved during the first few sessions, predicts later engagement, which can be measured by retention rates[8]. This is why initial development of the therapeutic relationship is so important. In this relationship, the consumer feels they are been treated with respect and unconditional positive regard, and the practitioner and consumer agree on the goals and tasks for the therapy. In addition, it is useful to seek some quick wins in therapy, that is, to pursue short-term goals that have a direct benefit for the consumer. For example, consumers may enter therapy with a variety of concerns, such as financial issues, child care, legal issues and housing arrangements. Linking the consumer with services that can assist with getting their basic needs met, e.g. accommodation, food and benefits, is likely to encourage further participation.

Re-engage at every session and actively seek feedback

It is important to recognise that engagement is an ongoing process, which may need to renegotiated at every session. The same principles that facilitate engagement during the assessment stage continue to apply during therapy. This means that time needs to be taken to re-engage at each session, to forge the connection that has been made. This can be as simple as sharing a cup of tea and a chat about everyday things, before beginning the more focused therapy.

> Every time you meet you still have to re-engage again. You can't assume that just because we've done well over the last 2 or 3 weeks that when I see you next week it's going to be the same old thing. That's why in terms of the Maori process there is the emphasis on every time we meet we still have to go through that mihi (protocols for meeting), no matter how brief or extended it might be, a kind of clearing the pathway to allow us to move into the space.

Once engaged in the therapeutic work within the session, the practitioners consulted recommended regular check-ins, to understand the consumer's experience of the therapy. For example, is the therapy meeting their needs, or does the therapeutic approach need to be adjusted in response to new events or information? Studies have shown that consumers whose practitioners regularly collected feedback, using a simple measure of the therapeutic alliance,

were less likely to drop out of treatment and more likely to achieve positive outcomes from therapy[28, 42]. The Session Rating Scale 3.0[45] is a brief measure that can be used at the end of each session to gauge the consumer's perception of the therapeutic relationship and effectiveness of the sessions (download from www.talkingcure.com). Open discussion of the scores provides the opportunity for the practitioner to reflect on their approach, and collaborate with the consumer to identify ways to tailor the therapeutic approach if needed.

> We need to be dynamic, we need to respond. You need to be able to quickly abort what you had pre-planned, and this is where it comes down to those skills again, ask the consumer what's going on and quickly reframe things and be very, very flexible in your approach, practitioners can get stuck in their structure, so just keep asking.

Employ a consumer-centred approach

The importance of actively gathering and responding to a consumer's feedback throughout therapy aligns strongly with the consumer-centred approach advocated throughout the consultation. Another method to support this approach is to use a consumer-driven outcome measure at the beginning of each session such as the brief Outcome Rating Scale (also downloaded from www.talkingcure.com), which measures the consumer's level of distress. Working with the consumer to understand this reported distress, develop strategies together to address the distress, track any change, and link these changes to the therapeutic strategies and the consumer's self-efficacy, can deliver better therapeutic outcomes[28, 42].

Practitioners highlighted that a consumer-centred approach begins through creating a shared understanding of the issues at the assessment stage. This shared understanding paves the way for the collaborative development of a treatment plan. Rather than a plan that the agency has developed for them, the consumer contributes to forming a plan that is focused on what well-being means from them; a plan that aligns with their life goals, hopes and aspirations for the future, and harvests their current strengths. This is a plan that the consumer can engage with, and therefore commit to. The practitioner than acts to facilitate the consumer's achievement of this plan.

> People need to commit to a plan for their own reasons, otherwise they won't do it. Talking therapy is a 1 hour per week interaction, for the rest of the week the person is their own practitioner. So the recovery plan has to be focused on what the person wants to do for their own reasons, based on their own value system, in their own world.

Motivation

Both the literature and consensus from the consultation highlight the vital role that motivation plays in achieving engagement in therapy[46, 47]. People can arrive at therapy through many different pathways. They may be attending as a justice requirement, or they may have been coerced by a family member, so identifying whether motivation is intrinsic or extrinsic is important. *Te Ariari o te Oranga* defines extrinsic motivation as motivation that arises as a result of external pressures, such as rewards or coercion. It can occur across a spectrum of autonomy, ranging from where people comply solely to avoid external pressure, through to behaviours that align with the person's own values, but that are still undertaken to achieve a separate outcome, rather than for their own sake. Intrinsic motivation is motivation to undertake an activity purely for the interest the activity generates. The more intrinsic forms of motivation have been associated with less ambivalence and more engagement in treatment[8].

The following strategies presented in *Te Ariari o te Oranga*[8] (p. 72), have been shown to increase motivation:

- the way the message is delivered
- aligning treatment goals to values and desires
- motivational interviewing (see page 56 for further discussion)
- goal setting
- mindfulness and flow activities
- the use of rewards and contingencies
- facilitative or enabling environments that support autonomy.

A passion for the work and good counselling micro-skills

Crits-Christoph and colleagues[48] meta-analysis found that a practitioner's interpersonal skills (acceptance, egalitarianism, empathy, warmth, spirit) predicted consumer cooperation and involvement in treatment of substance-related problems. This research was supported by the consultation, where practitioners emphasised the importance of conveying an attitude of genuine care and respect, driven by a passion for the work, which formed the foundation for the therapeutic relationship.

> I really think that people have to have a passion for the work, they have to believe that recovery is possible, they have to love people and care enough to give a damn…that sort of passion and care comes across to the consumer. If someone believes that you really care and it's not just a job that's the key foundation for building on a relationship, and then come the things like empathy and listening skills, basic sort of human interaction, respect, things like that.

The value of respect, where the consumer is the focus of practice, and the attitude of holding a genuine and non-judgemental attitude, are fundamental values and attitudes in the *Let's get real* framework, which all people working in mental health and addiction services need to demonstrate.

These core values and attitudes of respect and non-judgemental positive regard underpin the effective use of the following counselling micro-skills:

- demonstrate empathy through expressing an understanding and concern for the consumer's experience
- engage in reflective listening, to hear, understand and summarise back to the consumer what they are saying
- validate their concerns
- provide positive feedback
- harvest the consumer's strengths.

Practitioners highlighted:

> It's important to be constantly giving really positive feedback about how well the person has done, even though it might feel that they've slipped back a bit.

> There's a lot of acceptance written into being an addiction practitioner. That is, I may not like what this behaviour is doing to your life and the people around you but I'm still not in a position to condemn or judge.

Instilling hope and having patience

While recovery can take many different forms, it is acknowledged that overcoming a substance-related problem can take a long time. Therefore, it is important that practitioners demonstrate patience, don't expect too much too soon, and are not discouraged when slips or relapses occur. Patience is identified in *Let's get real* as a fundamental attitude that all people working in mental health and addiction services need to demonstrate. Practitioners need to be realistic about themselves as agents of change, so that they don't put unnecessary pressure on themselves or the people with whom they work.

> There's very strong predisposing factors in addiction, predisposing in terms of genetic links but also environment and that we're talking long term things and long term change. So often people just kind of expect that an addiction issue will be fixed suddenly after six sessions, and while there might be an improvement in a particular area, we're often talking long term work.

> I think that alcohol/drug practitioners should be very wary of having high expectations, not that that means that our consumers can't do amazing things, but that they are probably going to take time and that it's going to be two steps forward and one step back because it's a really difficult thing to overcome. And that we shouldn't get frustrated if people don't do what they're supposed to do, because our job is just to be there with wherever they are at.

Often it is the practitioner that will hold the light of hope within the therapeutic relationship, especially during initial sessions. Given this, it is very important for practitioners to make an effort to demonstrate this hope and optimism from the beginning. Hope can be fostered with the consumer through staging early therapy goals and tasks to encourage successful experiences and self-directedness[8]. Ultimately, the consumer needs to generate their own sense of hope, the practitioner's role is to support the consumer on their pathway towards hope and recovery.

Brief interventions can be very important in instilling hope, particularly when working with young people. These interventions can sometimes involve only one or two sessions, but aim to facilitate an experience that will at least start the young person thinking more critically about their substance use. This intervention can generate re-referral, which is sometimes self-initiated from the young person who, although only briefly engaged with the service, had a positive experience. See page 50 for further discussion on brief interventions, and page 42 for further discussion on ways to engage with young people.

Sometimes direction is required

Practitioners were clear that on occasions a consumer may benefit from honest feedback and direction. A practitioner explains:

> When people are in their addiction they can have a diminished capacity to think conceptually, to think in a future orientated way, to think strategically. And so if we follow a purely consumer- centred approach, we may just get people going in circles and being stuck in their addictive thinking. So we need to work with them to provide some direction to the counselling.

However practitioners were careful to highlight that knowing when and how to use the directive approach is a real art. Careful consideration needs to be given to the individual's potential level of resistance and openness to be challenged. This style is most effectively used once the therapeutic alliance has been formed and psychological safety established.

> Sometimes people need direction, they need challenges and sometimes they don't. The real skill of the practitioner is knowing when to put your foot on the gas and when not…We need to step off sometimes and give the consumer space to explore stuff, but at times the consumer wants more direction from us and that is a very, very skilled job, knowing when to do that.

Breakdowns in the therapeutic relationship

Breakdowns in the therapeutic relationship (sometimes referred to as therapeutic ruptures) can occur. This could be due to a reaction to a directive approach, a lapse or relapse (reaction to the abstinence violation effect), miscommunication, or a wide variety of other events. These breakdowns can actually provide an opportunity to strengthen the alliance, depending on how they are anticipated and managed by the practitioner. The following actions can assist to work through this process[49]:

- directly address the issues contributing to the breakdown and be ready to acknowledge when it is the practitioner's actions that have caused it
- paraphrase the consumer's criticisms and feelings, and ask gently probing questions to learn more
- work collaboratively to develop shared solutions for resolving the reasons for the breakdown
- apply the principles that were used to build the alliance when seeking to mend the alliance
- express your own feelings using tactful language and take care to show respect for the consumer.

Active follow up

Practitioners highlight that non-attendance can be quite common and that an active and tailored approach to follow up is recommended.

> Don't assume that the person is going to show up, and have a non-judgemental orientation towards that. Think if this were my son or daughter what would I want the practitioner to do to maximise them feeling like I really want them to come, and that it's going to be a good experience. I think phone calls and being able to text messages if you can are really helpful, and giving your appointment letters a therapeutic bent. And statements like you know people often don't feel comfortable coming in but I'm here if you want me kind of thing. So a lot of chasing is useful.

Use of narrative style letters was highlighted as a useful way to encourage a consumer to return to therapy, they can also be sent between sessions to maintain engagement.

> It summarises the session, from a narrative point of view so you're assisting a person to see their experience from a more empowered positive point of view. And so in that model, between sessions you would write letters, which are there to kind of strengthen the work that you're doing and remind them of this new way of thinking and being that they're developing. So if you were to write an appointment letter that said, "Dear Jo your appointment is at eight o'clock, I look forward to seeing you," that would be fine. But if you were to write, "Dear Jo I'm really impressed at the courage that you showed in contacting our service the other day. I was particularly impressed that you were able to tell me a little about your substance-related problem and your struggle against it," it's that kind of thing.

Active follow-up can also be discussed within the therapeutic relationship prior to its occurrence, as an adjunct to relapse prevention, where shared expectations are established about the actions to be taken should the consumer not attend the therapy session.

Incorporating the wider context

People develop problems and maintain them within a social context, therefore, considering this context is vital[12, 50]. The cultural needs and values of all consumers need to be considered throughout the therapeutic process. Family and natural supports need to be identified and involved as early as possible to support engagement with therapy. As therapy progresses, the emphasis moves from engaging the consumer and family in the recovery plan, to broadening engagement to supports in the community[8].

> I think it's essential that at every opportunity we get beyond the one-on-one concentration that we have in talking therapies. That's an important part of it, but it's only a part of it. We need to work with the context, we need to find therapeutic allies, our exposure to the consumer is tiny compared to all the other influences in their lives and those who are most going to influence their ability to address addiction are going to be the people outside of the therapy room.

Involving families

Practitioners consulted highlighted that the impact of problematic substance use is not isolated to the individual consumer.

> Addiction is a family and a social and contextual issue. It's not just an individual pathology, so to involve family is critical because the whole family will be affected by the addiction.

Family members, particularly spouses, parents and children, are often badly affected by living with someone with serious substance use[50]. This impact can be experienced in a number of different ways, including changes to family rituals, roles within the family, family routines, communication structures and systems, family social life and family finances. These changes can lead family members to develop their own physical and mental health issues. This impact can often be worse for children[51]. Therefore, family members may need their own support to address these problems.

While family members can be negatively impacted by certain behaviours related to the substance-related problem, they can also be the primary support mechanism to assist the consumer's recovery. The family member can influence the person with problematic substance use, by assisting them to decide to seek or accept assistance[51]. They can also support the person throughout their recovery process.

While involving family in the therapeutic process is important for work with problematic substance use, it can be particularly important when working with Pacific people, Maori and people from other collective cultures.

> A Pacific value base is family value based, and that still holds really. You're part of an extended family and so my business is your business, and vice versa. And some people struggle with that, but nevertheless it's true. And I find the best outcomes happen when you do involve family, because that's their source of support. And it's difficult to deal with addictions in isolation. But often what addictions do is create rifts in families, and the family is one of the things that often get cut off as a consequence of your use, and part of building bridges, and getting back on track is re-involving family, so for me it's a core intervention for Pacific. Family based, not family therapy, but family involvement.

Definitions of family

Many practitioners highlighted that family was not necessarily blood ties, but family in the eyes of the consumer (natural supports). Often people with problematic substance use have become distanced from their relatives, or certain family relationships may be so unhelpful that the person has needed to cut ties to support their current recovery. Therefore, family could mean a group of friends or other significant people.

It is also important to be aware of the difference between family and whanau. Whanau moves beyond the nuclear family to incorporate the hapu and iwi, and from there to the whenua (land). This enables broader thinking about connections. One practitioner highlighted the difference between family and whanau therapy, the latter of which involves engaging a skilled kaumatua, or person with a similar role in another culture, to intervene at an intergenerational level to address historical issues.

Family inclusive practice and family therapy

Family inclusive practice and family therapy both sit on a spectrum of interventions that involve family. Family therapy is a specialised therapy, which tends to apply a purely systemic approach to issues where the family is seen as the client. See page 55 for further discussion on family therapy. Family inclusive practice draws from some principles of family therapy and takes a contextual view of problematic substance use, where the therapeutic approach includes significant members of the individual's social environment[52]. Unlike family therapy models, the focus is not entirely on the systemic issues. A family inclusive approach may include individual counselling and medication, as well as interventions that address broader social issues which can often involve interagency work. While few of the practitioners consulted were trained in family therapy, all highlighted the importance of involving family, not only as a support mechanism, but as part of the therapeutic approach.

For more information, refer to *Family Inclusive Practice in the Addiction Field. A guide for practitioners working with couples, families and whanau*, which can be downloaded from the Kina Trust website, www.kinatrust.org.nz.

Ways to involve family

Copello and colleagues[50] review of family interventions identified three key ways to include families in the recovery process:

- work with family members to support people with problematic substance use to enter and engage with therapy
- involve the family members or significant others in the therapy approach
- provide interventions for family members in their own right.

A variety of models have been developed to assist family members to encourage people with substance-related problems to access services. One model is Barber and Crisp's pressures to change approach[53]. This model begins by engaging the family member in education, discussing their responses to substance-related problem behaviours, setting up activities that are incompatible with problematic substance use, and preparing the family member to confront the person with the substance-related problem and request that he or she access a service for support[53]. Direct work with the family members, whether using this model or other similar approaches, has been shown to lead to the engagement of the person with problematic substance use in treatment[51].

While family members can assist a person with problematic substance use to access treatment, involving family in treatment can lead to better outcomes, such as a greater reduction in substance use and other related problems[50, 51]. Practitioners highlighted that, firstly, it is important to identify who the person sees as their key support networks and the nature of the family dynamic, then to simply ask the question, who would you like to bring along? Sometimes the consumer may not be ready to involve family or natural supports in therapy, therefore, work needs to occur at the individual level to create a pathway where the consumer becomes ready for wider involvement.

> I never ask people's permission to bring a family member, I make a statement about the value of that. And then I guess in a motivational interviewing style I roll with resistance around that, but often we've had an open conversation about the value of collaboration, so why would they opt out of that, unless there are issues such as abuse.

Practitioners mentioned a range of ways to involve the family, including:

- developing recovery plans that address family dynamics and provide strategies to strengthen relationships
- creating a supportive home environment where alcohol or drugs are excluded
- forming an agreement not to expose children to alcohol or other drugs
- in situations where a consumer has damaged all their relationships, the practitioner's role can be to assist the consumer to rebuild their social networks.

The practitioners consulted provided a variety of tips to effectively facilitate sessions that involve family.

- Be very clear in establishing with the consumer the framework for the session. Emphasise that the practitioner will not take sides.
- Check with the consumer what is OK to share in this session, and what needs to remain confidential.
- If a particular issue is the focus for the session, let those attending know this beforehand.
- Provide some sort of opening, for example a karakia or a reading.
- Have food available.
- Involve children, giving them a chance in a safe place to talk a little about what their experience is and have the chance to see that their parent or parents have a plan to recover.
- Pay attention to roles within the family and traditions that may be followed.
- Give everyone present a chance to express their point of view.
- Allow enough time. It will often be longer than an individual session.
- Take care to set boundaries and facilitate discussion in a way where no-one is blamed.
- Take care to address and resolve any blame that may be directed to family members.
- Co-facilitation is often recommended given the added complexity.
- Make sure any safety issues have been addressed before closing the session.

Kina Trust[54] promotes home visiting as an approach that increases understanding of the consumer's environment, as well as increasing the likelihood of engagement with the whanau and peer networks. Being in the family's home can help to rebalance the power dynamic within the therapeutic relationship.

Working directly with family members in their own right, to assist them to respond constructively to the person's substance-related problem, can help to reduce substance-related behaviours, as well as support the family members' own well-being[51].

> It is important to provide services for family members to treat their own hurts and psychological issues that are a result of being exposed to the systematic madness and chaos that can reign in a household of somebody who has a child, or a partner or relative suffering from an addiction.
>
> About half the calls we get are from families. There is as much work to do with families, if not more, than there is with the actual individual who's calling around their own problem. They need to understand the process of change, they need to understand the time scale, they need to understand how to develop trust, respect. For me it's a whole unit, otherwise we're treating the individual and they often return back to a context where no change has happened.

Velleman and colleagues[51] have developed a simple and brief five-step therapeutic intervention to support family members.

1. Give the family member the opportunity to talk about the problem.
2. Provide relevant information.
3. Explore how the family members respond to their relative's substance-related behaviours.
4. Explore and enhance social support.
5. Discuss the possibilities of onward referral to further specialist help.

One of *Let's get real*'s seven Real Skills is working with families/whanau, where practitioners need to encourage and support families/whanau to participate in the recovery of consumers, and ensure that families/whanau, including the children of consumers, have access to information, education and support. This includes connecting with family/whanau throughout assessment and treatment planning phases, and working to understand the family/whanau perspective.

Ways to assist young family members

Velleman[51] argues that the most effective way to assist young people whose parent or parents may be experiencing problematic substance use, is to work with the parents to deal with the substance-related problem, and to help them demonstrate effective relationship and parenting skills. However, practitioners can also work directly with the young person to assist them to develop more resilience, through reducing risk factors and increasing protective factors. These risk factors are family disharmony, family violence, parental conflict, parental separation and loss, inconsistent and ambivalent parenting. Risk factors can be converted to protective factors by applying the following interventions[51, 55].

- The other parent: work with the parent that does not experience problematic substance use to enable them to provide a stable environment for the young person.
- The parental relationship: work with the parents to enable them to maintain a cohesive and united relationship in front of the young person.
- The family relationship: assist the family to maintain relationships, affection and activities.

- Other adult figures outside the nuclear family: ensure that there is at least someone that can provide the necessary stabilising influence. Assist these adults to encourage the child to develop aspects of their life that they enjoy and that give them a sense of success. These activities assist in developing the young person's self-esteem, which enables them to become resilient.
- The young person: work directly with the young person to enable them to know when to distance themselves from the disruptive behaviours of the person with problematic substance use, and to engage with stabilising others outside the family. Encourage the young person to pursue stabilising activities, such as school, clubs, sports, culture, religion, which can help to develop their self-esteem.

Challenges to involving families

It can be difficult for practitioners to engage with those families/whanau that are experiencing significant other challenges, e.g. financial hardship, legal issues, mental health issues, relationship stressors, family violence, and concern about the care of their children[56]. In addition, consumers have often alienated their family members in the course of developing and maintaining their problematic substance use. In these situations, peer networks can provide a valuable alternative social support.

> Consumers with addiction, they have to stop socialising with who they socialised with, and who they have as a peer group were other users, 'cause only users will tolerate that level of use. So, they've got no friends, quite often, and many of them have no work place to go to. They'll have burned everybody in their family, usually, bar one, there's almost always one stayer.

Another challenge is that family dysfunction is often a precursor of problematic substance use. A practitioner cannot assume that the family will provide an immediate helpful recovery context; to assume this could put the consumer at risk. First, a careful risk assessment needs to occur to identify any issues of abuse, violence, power and control, and family substance use. On some occasions, it may be necessary for the consumer to disengage from the family for a time, until they have developed the skills and fortitude to be able to cope. If the family of origin is not available, or is unsafe to involve, then the practitioner can work with the consumer to identify significant others to involve in the therapy approach.

> It can be really difficult, you often get family substance use problems in the whanau which makes it hard for them to connect or to stay supported by their whanau. It's hard to try and deal with someone with addiction and keep them engaged with their whanau if their whanau is using drugs heavily. You may have lots of abuse and damage to overcome and you may never get a close functioning family reconstituted, you may just get cordial relationships.

Despite these challenges the practitioners consulted were unanimous in acknowledging the importance of involving family and natural supports in the recovery process. Therefore, the practitioner needs to continually work with the consumer to find ways to address any challenges and involve significant others where possible.

> I started by talking with the whanau about how they were getting on. Family members started sharing how they felt guilty about the arguments, about miscommunications. There was therapy happening through talking to one another. The whanau had been so concerned about the kuia (female elder), so they were all focused on fixing her and not wanting to share with her their own feelings. Now they were able to talk with her about their own feelings and were able to form strategies. "How can I approach you if I have some concerns." We had three sessions and things improved a lot in the family. The family went into recovery, relationships were strengthened.

Support of community

Community engagement is an understudied area. However, involving the community in therapy is an important part of the recovery journey[8]. Promotion and prevention is another important community-based activity for people working in mental health and addiction services. Consulted practitioners highlighted that a major goal of treatment for problematic substance use is to assist a person to reconnect with their community, but that this can take time. As therapy progresses, the practitioner can help the consumer to gradually make links with the community, where the consumer is encouraged to apply the cognitive and behavioural changes learned in therapy within their everyday lives[8]. To make these community links, practitioners need to have a good sense of what resources are available, and which of these services might meet the consumer's needs and recovery approach. Examples of local support groups include Alcoholics Anonymous, Narcotics Anonymous, Rational Recovery and peer support groups. This community-based approach is particularly important when working with youth.

> It's absolutely imperative to get community services engaged whether that's the school or the local church where the person attends with their family or whatever, to actually have all of those services engaged is really, really important. Our intervention with a young person and their family is only a very small part of their lives and their lives are in the community not in the mental health service. So to actually have the community providing as much support as possible is going to be far more important in the longer term than having a short intervention with the young person and their family in the absence of their community.

One of the *Let's get real* seven Real Skills is working with communities, which requires that every person working in mental health and addiction treatment services recognises that consumers and their families/whanau are part of a wider community. Therefore, practitioners need to identify a consumer's community or communities of interest, and support the consumer to develop or maintain connections with these. To enable this, practitioners need to demonstrate a comprehensive knowledge of community services, resources and organisations, and actively support consumers to use them.

Practitioners highlighted that social behaviour network therapy principles as useful to apply when linking with the community. This involves identifying a group of peers or friends, who become therapeutic allies and can provide a supportive network around the person within the community.

Both the consumers and practitioners consulted indicated the importance of re-engaging in meaningful activity. Practitioners need to find out what a consumer wants to do in life, and then practically facilitate or support them to achieve these aims. The goal is to replace the function and importance that alcohol and other drugs has in their life with other, more constructive and rewarding activities. A consumer also emphasised this point:

> Often people in therapy have been using drugs all their life and then they have no idea what they even like to do, recreationally or what they want to do for a job or a career. And I found once I decided what I wanted to do, it just made my recovery so much easier, because I knew where I was going, so having that direction's really vital I think.

Applying a well-being-oriented approach is particularly useful in directing the therapy focus towards fostering the consumer's positive attributes. *Te Ariari o te Oranga*[8] provides an overview of the well-being perspective and strategies to apply this approach.

Practitioners highlighted that community education was important for creating awareness and reducing stigma. Groups run at local venues could discuss issues, provide information about substance use and the facts and effects, and provide people with ideas about how to support those around them who may have substance-related problems.

It is also important to highlight that, while there was consensus amongst those consulted regarding the benefits of involving the community in the therapeutic process, this was often not done well, given current service constraints where practitioners did not have the time to actively network and build community participation.

Culture

> Culture is who the person is, the identity the person carries, if we can't acknowledge this, how can we work with a person?

It is critical for practitioners to consider culture throughout the duration of the talking therapy process. Failure to do this can undermine engagement. Culture is a broad concept that incorporates more than ethnicity. Cultural differences can also include age, gender, and sexual orientation (among other diverse lived experiences). In addition, there is not homogeneity within groups. For example, one person's perception of their culture may differ to another person's, despite sharing the same ethnicity, gender etc.

This diversity means that practitioners cannot be expected to understand the nuances of every consumer's ethno-cultural experience. In fact, assuming this can be done may appear inauthentic. However, practitioners can demonstrate the following set of knowledge and skills to enable them to work more effectively with people from different cultures.

- Cultural safety – understanding your own cultural beliefs and preferred behaviours, and recognising that these may impact on your relationship with others. Being able to identify any overt or covert discrimination, as well as institutional discrimination, and how you may be supporting this.
- Cultural competence – the ability to be able to integrate clinical and cultural elements into the way you work with people to contribute to well-being. Practitioners advocated training to gain some knowledge of key beliefs, values and practices across different cultures, and to enhance engagement, communication and the ability to use culturally specific interventions. Key knowledge to cover is the Treaty of Waitangi and its associated principles, current and historical issues, models of health and illness, whanau or family and social structures, processes of engagement and communication, and culturally specific interventions[8].
- Cultural fluency – your ability to be understood by the consumer and their family/whanau so that they are able to make informed decisions based on the messages you give.
- Express respect for people and their ability to self-determine, which involves giving them the right to choose their therapeutic approaches, without having other cultural approaches imposed on them[8].
- Ensure you have the ability to access external supports, such as cultural advisors and representatives from the community, to provide cultural expertise.

As one practitioner explained:

> Often you can't learn everything because you're not part of that culture. It's a bit like an older person trying to be a young person, you can't. And so I think that the most important thing is to have respect and to acknowledge that there's a difference, to acknowledge we're all human beings and we all need to be treated with the same respect and to listen very carefully to what the differences are and make sure that you go with what the person wants in terms of their approach, what they're needing.

Practitioners also need to be mindful of the risk that miscommunication due to cultural differences may occur, and that this could lead to a breakdown in the therapeutic relationship. One strategy for addressing this is to be able to identify when issues are beyond the practitioner's level of cultural understanding, and that cultural advisors or others need to be brought in to assist. Another strategy is to have an open conversation about this possibility in early therapeutic sessions.

> I think there's a lot of ways to probably lose someone from another culture and hardly know it. I think if you're working across cultures and sometimes even across genders or just really different life experiences, that a conversation about how you know when you're losing someone is really useful. So I sometimes will say to somebody, you're this age and I'm this age or this is your experience and this is really different from mine. I wonder how I'll know if I do something wrong, or if you're feeling like, "I'm not coming back." What would I see, what would I notice, and ask for permission to notice that, and talk about it if it happens or ask them how they might tell me.

Te Ariari o te Oranga[8] (p. 25) lists a set of practical steps that practitioners can apply to attend to cultural considerations.

- Establish cultural needs before the first session with the assistance of culturally skilled staff. In particular, ask the consumer whether others need to be involved to facilitate decision-making.
- Obtain advice about preferred engagement processes, models of health and cultural interventions as early as possible.
- Know who to access for support and cultural advice.
- Ensure language needs are met.
- Don't assume the consumer will conform to what you might expect from people from a certain culture.
- Be careful about expressing your knowledge of their culture, sometimes you may know more than the consumer, which can lead to them feel ashamed.

Maori

For Maori, talk is the medium for healing, speech is the medicine.

> Ko te korero te kai o te rangatira. What they're saying is that I can't see you, I can't know you until I've heard the talk, you know?

However, this talk is not applied in a clinical sense through the application of talking therapy modalities, but instead takes a different approach based on concepts, and includes identifying observable practice and attending to the silence, as well as to what is spoken. A Maori practitioner explains how a Maori approach may be applied and how metaphors are used to deepen discussion.

> Creating a metaphor for meaning is often one of the better ways to access the codes that are implicit in Maori or in whakaaro Maori. And when you access those codes then you're accessing what I would call the hidden meaning. Now the fact that they may not have any scientific explanation doesn't mean that they have no relevance…for example, rather than call it addiction I might call it a taniwha. And I said, "Well what's the taniwha now, how does the taniwha live? And I'm not saying it's bad or it's good, I'm just saying it's a taniwha. And it's an enquiry that's inviting people to move to another level of understanding. So when I say, "So you know when you feed the taniwha?" "Oh yeah, yeah, that's me, getting on the piss every night." I still stay with the taniwha korero, "So when you keep feeding the taniwha, what does the taniwha do?" "Yeah, well what any good taniwha does, want's more." So what you're doing is then you're creating a different kind of vocab for them, that captures emotional understanding, and that resonates simply because it transcends the cognitive realm really, really quickly. In capturing the feeling they then begin that conversational dance with you in terms of that you're both tracking internally. And that internal tracking is a place that our people will say, "te reo o te wairua," that's the language of the spirit.

As the indigenous population of New Zealand, under the Treaty of Waitangi Maori are guaranteed access to culturally appropriate health care. Kaupapa Maori services have been set up in many regions that are designed to address health needs from a particular cultural paradigm. However, Maori still access mainstream services where they need to receive culturally appropriate care[8]. The following scenario needs to be avoided.

> I'll do the Maori, Pakeha dynamic because it's a quick and easy one. A non-Maori person might say to a Maori, "Well, look I really don't know about what's going on 'cause you're a different culture from me." And then my question is, "So what are you asking me then? Well what can we talk about if you're already telling me what we can't talk about?"

Te Ariari o te Oranga[8] (p. 26) lists a set of issues that practitioner's need to be aware of when working with Maori.

- Recognise that there is no single way of being Maori. Identity can often arise from links with whanau, hapu, iwi, ancestors and whenua. Also, people differ to the extent that they blend Maori and Pakeha beliefs and practices.
- For Maori, "The influence of the spiritual is at the heart of all thoughts, actions and relationships and underpins the expression of values and protocol"[8] (p. 27). Therefore, for many Maori it is essential to consider spiritual dimensions within the therapy.
- Te reo Maori (language) is central to identity and considered taonga (sacred). Meaning can change when translated to English, therefore, practitioners should not assume meaning is fully understood and should engage cultural advisors to facilitate communication where required. In addition, as a sign of respect, effort should be made to incorporate te reo in therapy and use correct pronunciation.
- Maori possess a number of important values, beliefs and actions, such as wairua, whakapapa, tapu, noa, mana, tikanga, whanaungatanga, which can differ significantly from Western cultural concepts. For commentary on these concepts, refer to *Te Ariari o te Oranga*[8] (p. 28) and *Talking Therapies for Maori*, which can be downloaded from the Te Pou website, www.tepou.co.nz.
- For many Maori, certain protocols are preferred when meeting and greeting people. Not following these protocols can make engagement difficult and may diminish the consumer's mana. Practitioners should seek guidance from culturally skilled staff regarding engagement protocols.

- Maori whanau's roles and responsibilities can differ to those present in Western families and can mean that certain whanau members, often kaumatua, may need to be involved in the therapy process to facilitate engagement, act as a spokesperson, and contribute to decision-making.
- Maori may present different expressions of distress to those expressed by non-Maori. Some specific states are: the capacity to experience the presence of others, especially ancestors, which could mimic psychosis; mate Maori, which arises from transgressions of ritual; and whakama (shame), which may present with symptoms similar to anxiety or depression, but requires a different intervention.

Even when social demographics are controlled for, Maori still experience a higher prevalence rate for substance-related conditions[15], therefore, other factors need to be explored. Therapy that actively incorporates components that address Maori cultural identity have been found to deliver better outcomes then services without cultural components[57]. Cultural identity has also been identified as a protective factor for suicidal Maori youth[58]. A practitioner may need to find ways for the consumer to reconnect with their whakapapa. This may not be their blood relatives, but a kaupapa whanau who the consumer sees as providing a strong support network. Cultural identity can also be fostered by incorporating Maori models of health, such as Te Whare Tapa Wha or Te Wheke, into therapy, where conversation can broaden to consider family, the community, spirituality, impacts on the body, the emotions and the mind. Culturally specific interventions can also be employed, such as traditional approaches to healing, for example, mirimiri (massage), rongoa (natural remedies), and use of karakia for healing. However, practitioners highlighted the importance of assessing the consumer's readiness, before employing these cultural approaches.

> If a tangata whaiora is feeling a bit vulnerable about their identity and you're suddenly showing more confidence than them, it can put them into a space of whakama. So sometimes you have to really gauge their readiness and therefore gauge the rate at which you engage the Maori therapeutic interventions. And some people forget you actually have to do that, they just jump right in and sometimes that can help, but sometimes that can set you back.

Key resources to assist in increasing skills when working with Maori are the Takarangi Competency Framework, which can be downloaded from Matua Raki's website www.matuaraki.org.nz, as well as the *Let's get real* working with Maori Real Skill learning modules and Te Pou's *Talking Therapies for Maori* guide, both of which can be downloaded from Te Pou's website, www.tepou.co.nz. Mason Durie's book, *Whakapiri, Whakamarama & Whakamana – Engagement, Enlightenment & Empowerment,* is also a recommended resource.

Pacific people

Pacific people have collectively-oriented cultures. The diverse Pasifika communities are made up of people from many different islands, including Samoa, Cook Islands, Tonga, Niue, Fiji, Tokelau, Tuvalu and other islands in the Pacific. All have unique beliefs, customs and social histories. Further complexity is added with the infusion of Pacific and New Zealand cultures, where consumers might have been raised in the islands and immigrated to NZ, born in the islands and raised in New Zealand, born in NZ and raised in islands, or be New Zealand born and raised.

When working therapeutically with Pacific people, the first step is to form the negotiated space. This concept is explained in the Te Pou and Le Va *Talking Therapies for Pasifika* guide[59]. Essentially, it involves taking the time up front to form the connection, before the consumer will be willing to meaningfully engage in therapy.

> The Pasifika paradigm, where relationships are privileged does not always fit comfortably into a Western-based timeframe. When working with Pasifika families, a degree of flexibility with the timeframes allocated for the engagement and assessment process is required. It is recommended that time is taken to build rapport before starting a formal assessment[59] (p. 38).

The Pacific practitioners consulted identified a range of other culturally specific factors to consider when delivering talking therapies to Pacific consumers.

- The Pacific concept of families tends to be broader, and encompasses extended family and even the village. "You're part of an extended family and so my business is your business and vice versa. So the best outcomes happen when you involve family, because that is their source of support."
- It is good to enable ethnicity and gender matching where possible, but also make sure the consumer has choice, as sometimes they may wish to engage with more mainstream approaches.
- Practitioners should consider having a cultural advisor (matua) present at appropriate sessions to enable engagement, and be aware that formal protocols may need to be followed to meet and greet.
- It is important to consider generational differences and the effects of acculturation. Often younger people find themselves needing to balance a respect for tradition and family hierarchy, with a need to form their own sense of individuality within a Western culture. "More and more they are disenfranchised from the old Pacific values and you have to suss that out before you know how to engage, that's a therapeutic skill you develop."
- Spirituality is very important for Pacific peoples. While this is often through connection to Christianity, it is not only religion, but a meaningful belief system that imbues most aspects of life. Consumers may possess a spiritual understanding of their substance-related problem that needs to be acknowledged and understood by the practitioner.

> Access to a cultural advisor or matua who is familiar with the consumer's own culture and language can help facilitate a more open conversation without the fear of being misinterpreted. Consumers and their families can also express and explain situations more fully in their language of choice and not feel embarrassed or frustrated when struggling to provide the equivalent English explanation. The use of interpreters can also help deal with these language issues[59]. (p. 22)

Key resources to assist in increasing skills when working with Pacific people are Te Pou and Le Va's *Talking Therapies for Pasifika* guide, and *Real Skills plus Seitapu: Engaging Pasifika*. These resources can be downloaded from Le Va's website, www.leva.co.nz.

Youth

A comprehensive summary of talking therapy approaches that are appropriate for youth who experience both mental health and problematic substance use is the *Evidence-Based Age-Appropriate Interventions: A guide for child and adolescent mental health services (CAMHS)*[60] produced by the Werry Centre. This guide can be downloaded from the Werry Centre website, www.werrycentre.org.nz. In addition, the Kina Trust's *Sharing the Kete*[61] is an excellent resource for practitioners to refer to when working with young people and their families in responding to alcohol and other drug use issues. The following is a summary of some of the key messages shared by the practitioners consulted who worked with youth.

- Engagement can be more difficult, as youth have often been coerced to attend therapy, either by parents, their school or the justice system. Therefore, more effort needs to be extended by the practitioner to form the therapeutic relationship and gradually move motivation from extrinsic to intrinsic sources.
- Confidentiality and involving family can generate tensions when working with youth. That is, while best practise suggests that you would not work with a young person in isolation from their home environment, sometimes that young person may not want to engage in therapy if they know their family will be involved. This often needs to be negotiated with the young person on an ongoing basis. An example would be inviting the young person to consider having a parent also attend a counselling session. The practitioner would check beforehand what is okay to share and what is not. With skill and facilitated discussion, the young person can often be supported to be more open than they might have otherwise been. When there are risk issues, the practitioner needs to find a way to be both sensitive to the young person and counselling ethics, but also to involve the critical parties who need to be involved to help support the young person and manage the risk.
- It is very important for a young person to feel that they are being heard, as young people can often feel that due to their age their opinions are not listened to.
- Employ a strengths-based approach that builds on a young person's interests, as well as their capabilities and resiliencies, e.g. How have they coped with difficult situations before now? Assisting the development of self-efficacy is crucial to young people feeling in control, and to encourage them to think earlier on in their development about making choices that are aligned with what they want out of life.
- Information provision is very important for youth who often may not understand the full consequences and risks of their problematic substance use.
- Keep messages clear and simple, use pictures to convey concepts during therapy.
- Safety is a major factor when working with youth.

As one practitioner consulted stated:

> With young people the issue of keeping them safe is key, so that you're not letting the problem get worse and worse while development helps mature them. If you can keep somebody safe for eighteen months from the age of fourteen to fifteen and a half and minimise their drug use in that time you're obviously not fixing their addiction but there are a lot of other developmental things that happen in terms of growing up that can make a big difference down the track.

Older adults

There are few specialist alcohol and other drug services in New Zealand for older adults. However, the practitioners consulted who work with this group identified a complexity of issues that need to be considered when working with problematic substance use in older adults.

- More time needs to be allowed to both build the relationship and conduct the assessment. Older adults can have a different view of relationships, where firstly they want to understand who you are as a person, often over a cup of tea and a biscuit. "Screens that we might complete in 60 minutes with the general population might take me three one hour sessions with a person who is 65 plus."
- Older people face a range of unique and challenging changes that can lead to problematic substance use, such as "loss of friends, loss of houses, loss of jobs, loss of income, loss of health." Therefore, generating hope that life is not over is very important, and linking the person with community networks is a crucial part of this.
- Cognitive processes can be slower and early dementia needs to be considered. If dementia is more advanced, talking therapy may not be effective.
- Home visits are very important for older adults and to ensure that risks to physical safety are minimised, e.g. falls.
- Older people may want to put health professionals in expert roles. Therefore, often extra effort needs to be made to try to begin to rebalance the power relationship and encourage the consumer to have involvement in building the recovery plan. However, sometimes a directive approach can catalyse change: "If the doctor says, 'Stop or you're going to die' it's actually a really powerful intervention for an older person."
- Grief counselling can be a particularly useful intervention for older adults.
- Education often needs to occur to make older adults aware that alcohol affects the body differently with age, and that no more than one standard drink per day is recommended for older people. ALAC has produced a useful education resource called *Alcohol and Older People: Information for older people, family, friends and carers* that can be accessed using the following web link: http://www.alac.org.nz/DBTextworks/PDF/AlcoholOlderPeople.pdf
- Given health risks it can be too dangerous for older people to go on waiting lists for access to detoxification facilities and they often need longer to recover.
- Often it is important to address topics such as death and dying, as well as spiritual perspectives during talking therapy.

A key resource to assist in developing skills when working with older adults is Te Pou's *Talking Therapies for Older Adults* guide, which can be downloaded from Te Pou's website, www.tepou.co.nz.

Stigma

Research has indicated that stigma is greater among those with substance-related problems than those with mental health disorders[62]. The illicit nature of drug use and the fact that it is illegal can also heighten stigma. People labelled with an addiction can be viewed as more blameworthy and dangerous, and assumptions made that their inability to control their substance use suggests that they are weak willed. Research has indicated that people's belief that a person is responsible for his or her mental illness or problematic substance use suppresses helping behaviour in others[62].

> I don't like calling myself an addict as I see it as a term that is perceived negatively by the public so why would I want a label that defines me in a negative way.

Not only is there public stigma around substance use disorder, but the concept of self-stigma can also have a strong impact on the well-being of someone with substance-related problems[63]. Self-stigma can be defined as shame, evaluative thoughts, and fear of enforcing stereotypes, which all serve as a barrier to well-being. As a consumer consulted describes:

> Most of the stigma I experienced was my own stigma. Self-stigma, I still struggle with that at times. I see myself through a distorted lens.

It is interesting to note that stigma also occurs between groups, depending on their substance of choice and that people can actually wear their stigma as a badge.

> Subcultures occur and people can have strong attachments to those groups. They experience enormous amounts of stigma which they are aware of and there is a kind of counter defensive element. That is, that they live life to the full and straight people are boring.

Stigma can have a strong negative impact on a person; it can prevent a person from seeking help, make them reluctant to openly share during therapy, and make it more difficult for them to re-engage with the community as therapy progresses. Practitioners suggested different approaches to help a consumer deal with stigma.

- Take the time to understand how stigma may be impacting on the consumer's experience.
- Carefully use valuing language to assist in normalising substance-related problems, rather than reinforcing stigma.
- Encourage the consumer to begin to rebuild bridges in their relationships with others, which often involves forgiving themselves and asking for forgiveness.
- Normalise the experience and highlight that substance misuse is a common problem.
- Use peer groups to help a person realise that they are not alone and that others are experiencing similar issues.
- Educate family and community to understand the nature of the condition and equip them with techniques to support people with problematic substance use.

Medication

While there is a lack of research in this area, there are a range of potential interactions between prescribed medications and psychoactive substances that can be significant. These are summarised in Appendix 3 of *Te Ariari o te Oranga*[8]. While prescribing medication is the responsibility of the consumer's GP or psychiatrist, practitioners need to be aware of possible effects, and perhaps even side-effects, the consumer may experience. They may in some instances take on some responsibility to monitor medication compliance.

TALKING THERAPIES FOR PEOPLE WITH PROBLEMATIC SUBSTANCE USE

3. The therapies

There is a strong body of evidence to support the effectiveness of a range of talking therapies to achieve reductions in, or abstinence from, problematic substance use[9]. In addition, a combination of prescribed substitutes and talking therapies is frequently more effective than either medication or talking therapies alone, particularly for opiate, tranquiliser and alcohol users[9].

Talking therapy was described as core business by the practitioners consulted.

> It's central to our work, it's the most significant tool we have regardless of which therapy you use, it's the central backbone for people making change to their alcohol and other drug use.

Talking therapies can cover a broad range of interventions. This was reflected in the consultation where practitioners provided a wide variety of definitions. The working definition[9] used in this guide defines talking therapy as:

- based on one or more theories of human behaviour
- involves a relationship between the practitioner and consumer
- explores issues relating to development, experience, relationships, cognition, emotion and behaviour
- holds the goal of increasing the consumer's self-understanding and making changes in their cognition, emotion or behaviour.

No one therapeutic model or theory is clearly superior[64] when working with people with problematic substance use. Therefore, rather than seeking to identify the best therapies, this section provides a brief overview of common talking therapies and other models that have a good evidence base and are used successfully by New Zealand alcohol and other drug practitioners. In order to reflect the diversity of interventions employed within the alcohol and other drug sector, this section moves beyond a review of 'pure' talking therapies, to include other commonly used models. This section does not intend to provide a comprehensive review of each therapeutic modality. Instead, key research evidence and experiences of New Zealand practitioners who use this model for treating problematic substance use is summarised, and further reading materials indicated.

While no one therapeutic model or theory is clearly superior[64], UK[9] and Australian[27] based reviews of the literature do present some evidence that certain talking therapies may be more effective for different groups.

- For tranquiliser users, the evidence is largely limited to cognitive behavioural therapy, which appears effective with this group.
- For stimulant users, any psychological treatment is better than no treatment. However, there is strongest evidence for combining cognitive behavioural therapy with motivational interviewing, relapse prevention, and contingency reinforcement approaches.
- For cannabis users, motivational interviewing, cognitive behavioural therapy and family therapy appear to be most effective.
- For poly-drug users, family interventions, community reinforcement and contingency management approaches have been shown to be superior to counselling and 12-step programmes.

These reviews are useful to help identify therapies that may be particularly useful depending on a consumer's substance of choice. However, lack of systematic research discourages definitive conclusions. A recent meta-analysis of 30 studies that directly compared at least two psychotherapies found no difference between the efficacy of any of the studied therapies for treating alcohol use disorders. While meta-analyses are not currently available for other problematic substance use populations, the key message is that a variety of therapies are useful to address problematic substance use[3]. Therefore, when deciding what talking therapy to employ, it may be useful to firstly identify whether the therapy has a sound evidence base for people with substance-related problems. Secondly, consider what therapy the consumer is likely to feel most comfortable with. This can occur by discussing therapy choices with the consumer, where different therapy options are clearly explained using simple and easily understood language. Thirdly, consider what therapies the practitioner is competent to deliver[8].

It is also important to note that practitioners often employ an integrated or eclectic approach to therapy. "The pragmatic blending of various approaches remains the most popular clinical orientation among practicing therapists"[28] (p. 2). Practitioners tend to blend their therapy delivery to accommodate the consumer's preferences and situation, which resonates with the consumer-centred approach that is so important in achieving engagement in the therapeutic approach.

> I always come from a client centred perspective. It's not an exact science but I then try to line up a consumer's key values and beliefs with the most appropriate therapy for them.

> One size does not fit all. Practitioners need to be aware of a variety of models and the theories that underpin those models, not just use them randomly in an eclectic approach that they don't actually understand, but they should be able to choose a particular style or model or way of working that suits the individual.

While an eclectic approach was advocated, as the last quote demonstrates, being able to competently use the talking therapy model remains important. Research indicating the effectiveness of psychological treatments has been conducted with trained, experienced and supervised practitioners.

Finally, it is important to acknowledge that certain talking therapies and other common models can be delivered at both an individual and group level. Group work is very important and widespread within New Zealand's alcohol and other drug sector. Other interventions, such as skills development, psychoeducation and self-help models, can also use this group-based format. Practitioners highlighted the immediate social validity that groups provided.

> In a group when you say something, everybody nods and you think, "Wow, I've said something valuable". And the group, the representation of the world out there has just confirmed that "I'm not mad, others share my thoughts".

> It's about the hope that other people in the group have had similar problems and have actually done really well with them and this is how they managed. The hope is there, that change is possible, this really comes through in a group.

Overview of therapeutic models

Table one: Evidence and application: A summary of therapeutic models used in New Zealand for problematic substance use

Therapy	Research evidence	NZ application
12-step fellowship programme	Evidence for use for alcohol dependence.	Widespread use.
Bibliotherapy	A range of evidence for bibliotherapy's use for alcohol dependence.	Common use, as a complement to other therapies, or for those who are reluctant to engage with services.
Brief intervention	A range of evidence for brief intervention's use for alcohol dependence. Some evidence for efficacy with cannabis and methamphetamine use.	Widespread use, particularly in primary health settings.
Cognitive behavioural therapy	A range of evidence for cognitive behavioural therapy's use with problematic substance use.	One of the most widely used therapies in New Zealand.
Complementary therapies	Tentative evidence for acupuncture's use with problematic substance use populations.	Some application as an adjunct to other treatments.
Computerised cognitive behavioural therapy	No known research evidence for problematic substance use populations. However, there is tentative evidence for the effectiveness of general computer-based interventions for alcohol use.	Rarely used in New Zealand currently.
Contingency management	A range of evidence for contingency management's use with problematic substance use populations.	Rarely used in New Zealand currently.
Community reinforcement approach	Evidence for community reinforcement approach's use with problematic substance use populations.	Not commonly used to treat problematic substance use, aside from the Salvation Army Bridge programmes.
Counselling	A range of evidence for telephone counselling's use with smoking cessation.	Commonly used.
Dialectical behavioural therapy	Some evidence for reduction in substance use for people with co-existing problems.	Not commonly used to treat problematic substance use, but developing in popularity for co-existing problems.
Family therapy	Some evidence for family therapy's use with problematic substance use, particularly with adolescent populations.	Not commonly used, although family inclusive practice is widespread.
Motivational interviewing	A range of evidence for motivational interviewing's use with problematic substance use populations.	One of the most widely used therapies in New Zealand.
Multi-systemic therapy	Tentative evidence for substance reduction in juvenile offenders.	Not commonly used.
Peer support	Little known evidence for use with problematic substance use populations. However, this is a new approach.	An emerging treatment in New Zealand.
Pharmacotherapies	Large evidence base for use of opioid substitution treatment, Naltrexone and Disulfiram with people with problematic substance use.	Commonly used.
Psychodynamic psychotherapy	Little known evidence for use with problematic substance use populations.	Not commonly used.
Relapse prevention	Evidence for use with problematic substance use, particularly alcohol and poly-substance use disorders.	Widespread use, as an adjunct to other treatments.
Therapeutic communities	A range of evidence for therapeutic communities' use with problematic substance use populations.	Commonly used.
Traditional therapies	No known research evidence.	Some application as an adjunct to other treatments.

Talking therapies

Brief intervention

Brief intervention is a short structured therapy (between 5 minutes and 1 hour), typically offered on a single occasion, although it can extend to further sessions. Brief intervention strategies range from relatively unstructured advice and information, through to more formal manualised approaches. A typical intervention might involve offering feedback on problematic substance use, identifying high-risk situations and coping strategies, increasing motivation, and developing a personal plan to reduce the substance use[24].

Why this therapy is used

An international review of 22 random controlled trials in primary care settings, where 7619 participants who drank excessively were randomly chosen to receive a brief intervention or assessment only, found that after a year or more, people who received the brief intervention drank less alcohol than the control group[24]. Research also indicates that conversations around change during a brief intervention are usually a strong indication of follow-through action. That is, the more a consumer expresses the ability to change during the intervention, the more weekly alcohol use decreased[65]. Brief intervention has also demonstrated its ability to deliver reductions in substance use post-treatment with young cannabis and methamphetamine users[66, 67, 68].

Those consulted all advocated the use of brief interventions. While most are carried out in primary health settings, brief interventions still play an important role in secondary services.

> Even in our setting if we only see somebody for half an hour, we wouldn't ask them long questions without giving them some brief advice or information before they leave because you never know if a person will come back, ever. So you maximise the opportunity.

Potential issues

There are a variety of perspectives on what a brief intervention is. Most practitioners seemed to agree that a brief intervention could last anywhere between 2 to 60 minutes, and that a series of brief interventions could occur, which then became a brief encounter. This encounter is shorter than standard therapy and focused on the immediate situation. Gender issues may influence this therapy's efficacy. The international review noted above found that, for men, alcohol consumption tended to decrease after the brief intervention, however, these effects were not observed for woman. The research was not able to explain these differences[24].

Reading list

Manual for Brief Intervention Tools with Substance Use, produced by the Werry Centre: **www.sacsinfo.com/docs/SACSBImanualsum08.pdf**

Brief Intervention for Substance Use: A manual for use in primary care, available from: **www.who.int/substance_abuse/activities/en/Draft_Brief_Intervention_for_Substance_Use.pdf**

Cognitive behavioural therapy

Cognitive behavioural therapy (commonly referred to as CBT) is a form of therapy that aims to adjust thoughts and behavioural patterns to create more adaptive outcomes. Sessions are highly structured and focus on identifying the cognitive and environmental factors controlling the problem behaviour. Cognitive techniques (e.g. challenging negative thinking) and behavioural work (e.g. rehearsing new skills and increasing pleasant activity) are employed to achieve behavioural change[9]. These may be provided in a group or individual format.

Why this therapy is used

CBT is a well-recognised intervention, with long proven results for problematic substance use. Numerous studies have reported CBT's positive outcomes for problematic use across a variety of substances, including tranquiliser, stimulant, cannabis and alcohol users[9, 27, 69–71]. CBT was one of the most common therapies practitioners identified as being useful, and was widely applied in the treatment of problematic substance use.

A consumer consulted highlighted the benefits he had gained from CBT.

> Now I look at what can I put in place to help regulate these emotions. And then educate myself as to the purpose of my emotions and that thoughts are just thoughts, that the longer you hold on to something the more it's going to affect you. So the sooner you can let it go the better.

Practitioners highlighted CBT's value in supporting relapse prevention work, where thinking patterns could be challenged, triggers identified, urges assessed and coping strategies applied. As one practitioner explains:

> People can break it down a little when they have a slip, into components in terms of their thinking and their behaviours and their emotions then they don't globalise or catastrophise it, they can actually compartmentalise it a little bit more.

With cultural adaptation, CBT has been shown to deliver positive outcomes for different cultural groups (e.g. Maori, Asian and other ethnicities)[72, 73].

Potential issues

Some practitioners highlighted that only a limited number of practitioners were actually trained in this therapy in the alcohol and other drug sector; "The highly specialised person is less common, a rarity actually". Instead, most practitioners would have been exposed to cognitive behavioural techniques as part of their undergraduate or postgraduate training, and therefore CBT tends to be applied at principles level, rather than maintaining fidelity to the model.

> Cognitive behavioural therapy has really infiltrated the sector, once again, at the principles level. Sort of like, small c, small b, small t.

Reading list

Web manual for CBT in the treatment of cocaine addiction: **http://archives.drugabuse.gov/txmanuals/CBT/CBT1.html**

The Association of Psychological Therapies UK, resources on CBT with problematic substance use: **www.cbtfromapt.com/cbt-with-substance-misuse.html**

An article on CBT for substance dependence and coping skills training: **www.bhrm.org/guidelines/CBT-Kadden.pdf**

Computerised cognitive behavioural therapy

Computerised CBT is CBT provided using a website, CD or DVD format. A range of programmes for general populations have been developed in Western countries and evidence supports the therapy's use for mild to moderate depression and anxiety[67]. However, the literature search was unable to locate any research evidence for this approach with people with alcohol and other drug-related problems. Some research has been conducted on the efficacy of more general computer-based interventions for alcohol problems amongst university students. While mixed results were observed, overall online interventions were found to be more effective than no treatment for reducing substance use, and sometimes equivalent to other talking therapies[74, 75]. More research is needed to qualify these results.

Why this therapy is used

While most practitioners consulted saw value in this approach, particularly for the more technically savvy younger age group, few knew of its current application in New Zealand.

Currently the Alcohol Drug Helpline offers an online chat feature, which is experiencing steady use. Anecdotally, through using this medium, consumers tend to get straight to the issue and the brief intervention, rather than taking the time to engage with the practitioner that tends to occur during phone or face-to-face interactions. Online self-help resources have the benefit of being available 24/7, and therefore can complement other therapeutic interventions.

Potential issues

While computerised CBT has demonstrated it's efficacy for mental health problems such as deppression and anxiety[67], more research is needed to identify its use with people who experience problematic substance use.

Reading list

A free self help program to teach cognitive behaviour therapy skills to people vulnerable to depression and anxiety: **http://www.moodgym.anu.edu.au/welcome**

The RID trial will test whether a set of web-based self-help programmes work for reducing depression in New Zealand: **http://www.otago.ac.nz/rid**

Counselling

Counselling helps people to increase their understanding of themselves and their relationships with others, to develop resourceful ways of living, and to bring about change in their lives. Counselling can involve sessions with an individual or with couples, families/whanau, or groups. Counsellors are usually trained in a number of techniques and can help with a variety of issues[76].

Why this therapy is used

The literature search revealed that research tended to focus on specific talking therapies' efficacy for problematic substance use, as opposed to the more generic counselling approach. However, a comprehensive review of 65 controlled trials reported the effectiveness of telephone counselling to assist smoking cessation. Multiple sessions and call-back counselling were found to be most helpful. Telephone counselling can take place alongside other treatment, and has the ability to service a large number of people[77].

Counselling is a term commonly used within the alcohol and other drug sector, as people in the community can easily relate to it.

> We call our service CADS counselling service rather than CADS adult outpatient addiction services because that would put people off, they don't know what you are going to do to them. We're a counselling service so people think "Oh somebody who has empathy, who will listen to me and help me talk through my problems". It's a helpful term to engage people.

Practitioners highlighted that counselling covers a wide variety of techniques where counsellors tend to be trained in a certain modality. However, all counsellors consistently apply basic counselling micro-skills, such as attending, positive regard, respect, active listening, probing, reflecting and summarising. Others highlighted key tasks that may occur during a counselling session:

- monitoring substance use
- monitoring the consumer's progress
- providing reinforcement for change.

Potential issues

Practitioners highlighted that while unconditional positive regard and active listening were important foundations for the therapeutic work, a structured approach is also often required within the counselling session to promote behaviour change.

Reading list

New Zealand Association of Counsellors' website: **www.nzac.org.nz**

Dialectical behaviour therapy

Dialectical behaviour therapy aims to improve interpersonal, self-regulation and distress tolerance skills, by integrating behaviour strategies and mindfulness practices. The dialectical aspect of the therapy refers to its focus on validating the consumer's acceptance of themselves as they are, whilst creating motivation for change. Dialectical behaviour therapy is a relatively new form of therapy, designed for use with people diagnosed with borderline personality disorder for which other modes of therapy have had little success. Dialectical behaviour therapy delivered in outpatient settings typically involves individual psychotherapy, group skills training, and telephone counselling[78].

Why this therapy is used

Dialectical behaviour therapy is a relatively new therapy, meaning that it has been subjected to less research when compared to some other therapies. However, controlled trial studies are beginning to reveal tentative evidence for dialectical behaviour therapy's efficacy in treating problematic substance use. An analysis of two dialectical behaviour therapy control trials by Hayes and colleagues[79] indicated a significantly greater reduction of substance use among those with borderline personality disorder who were accessing dialectical behaviour therapy, compared to those receiving standard treatment. A study by Linehan[80] showed that heroin-dependent women with borderline personality disorder receiving either 12 months of individual or group-based dialectical behaviour therapy experienced durable reductions of substance use, both throughout the treatment period and up to 16 months afterwards. Similar results were noted for women diagnosed with opiate dependence in a second controlled trial[80]. However, in a controlled trail conducted by Van ben Bosch and colleagues[81] with women with co-existing problems, while reductions in self-harm and treatment compliance were noted, no improvements in substance use were noted, as a result of receiving a 12-month dialectical behaviour therapy programme.

The practitioners consulted commented that while they had some knowledge of dialectical behaviour therapy, its application appeared to be less common when treating people with problematic substance use. Instead practitioners tended to know of its effective application when working with co-existing issues involving complex mental health illnesses, such as borderline personality disorder.

> DBT's a more specialised approach… in terms of treating a straight addiction, I think it's a bit of overkill. I don't think I would refer somebody to a DBT programme just for treatment of an addiction. There would have to be other diagnoses as well, to warrant it.

Potential issues

Practitioners highlighted the resource intensive nature of this therapy, where well-trained practitioners needed to follow strict protocols for therapy delivery, as a barrier to widespread use. However, its promising evidence base meant that practitioners saw dialectical behaviour therapy as an important option for treatment, particularly for complex co-existing issues.

Reading list

For information regarding the future directions for dialectical behaviour therapy in New Zealand: **www.tepou.co.nz/file/PDF/publications/2010/future-directions-for-dbt-in-nz-final-2010.pdf**

Article on the development of dialectical behaviour therapy and its application with problematic substance use: **www.nida.nih.gov/pdf/ascp/vol4no2/Dialectical.pdf.**

Family therapy

Family therapy refers to therapy that focuses on the relationships and systems of the family. Other forms of talking therapy may involve families, but still maintain their focus on the individual. Family therapy typically draws on methods from other therapies, with the aim of improving communication, supporting family strengths and using these as a mechanism for change[78].

Why this therapy is used

Family therapy has received less research attention compared with some other talking therapies for use with problematic substance use. However, studies that have investigated the efficacy of family therapy have revealed positive results. When compared with treatment as usual, alcohol and other drug use decreased in the runaway adolescents, across a 15-month period, as a result of family therapy[82, 83]. Similarly, family therapy revealed greater numbers of drug-free days at 6 and 12 months, compared to standard treatment, for people undertaking a methadone reduction programme[84].

A major theme from the consultation was the importance of involving family in the treatment process for problematic substance use. Therefore, practitioners were consistent in highlighting the value of family therapy. However, they also highlighted the variation in application of this approach, which is discussed below.

Potential issues

While family therapy is present in the New Zealand alcohol and other drug sector, it is less common, with practitioners indicating that few people are trained in the model. Some practitioners had received limited training in family therapy, and highlighted the importance of knowing when to refer on to specialists or when to engage other therapists to co-facilitate sessions.

While application of the pure family therapy model appeared less common, family work or family inclusive practice was consistently cited as a vital therapeutic approach. Practitioners highlighted that problematic substance use can complicate relationships and impact family members. Family members in turn impact the individual. Therefore, interventions need to occur with this context in mind. A number ways to involve the family are discussed in Section 2, on page 30 of this guide.

Reading list

US-based National Institute on Drug Abuse website provides a comprehensive outline of the method, and application of family therapy with adolescent drug use: **http://archives.drugabuse.gov/txmanuals/bsft/bsftindex.html**

Motivational interviewing

Motivational interviewing aims to generate behaviour change by assisting the consumer to resolve ambivalence about treatment and reduce their substance use. This is achieved through assisting the consumer to become more aware of the implications of change, or not changing, in a non-judgemental interview where the consumer does most of the talking[25]. While person-centred, the approach is also directive in that it guides the consumer towards behavioural change. During the interview, four key skills are employed by the practitioner to enable this change:

- expressing empathy
- developing discrepancy where the consumer can begin to see gaps between their values and current problematic behaviours
- rolling with resistance, where reluctance to change is respected
- supporting the consumer's self-efficacy[25].

Motivational interviewing can be used alongside other treatments, to build motivation to address emotional distress or engage in other forms of therapy. Motivational enhancement therapy uses the principles of motivational interviewing and incorporates them into a more structured series of four sessions that include assessment, development and monitoring of strategies for substance use reduction[85].

Why this therapy is used

A meta-analysis of 119 studies that researched motivational interviewing's effect on problematic substance use revealed that motivational interviewing delivers small, but significant and durable positive effects, on a variety of outcome measures, including reduction in tobacco, alcohol and other drug use. In addition, motivational interviewing significantly increases consumers' engagement in treatment and their intention to change. However, when compared with other talking therapies, motivational interviewing did not deliver significantly better results[25]. In a separate study, motivational enhancement therapy was found to deliver similar reductions in alcohol intake, compared to cognitive behavioural therapy or the 12-step programme, but in less time[86].

All practitioners consulted highlighted the effectiveness of motivational enhancement techniques (including motivational interviewing) when working with people with problematic substance use. Many described it as the foundational talking therapy, as it addresses ambivalence (which is common amongst people with problematic substance misuse) and stimulates change.

> We work with ambivalence now, we never used to. We used to call those people unmotivated. Now we work with where the consumer is at, to work with ambivalence without developing too much resistance in the therapeutic relationship.

Practitioners described motivational interviewing as subtly directing, where the practitioner facilitates understanding through asking a number of questions.

> I remember a quote a psychologist taught me "You don't know what you think until you hear yourself saying it". So if you are saying "I don't have an addiction. I don't need treatment" that's what you are going to believe. Motivational interviewing switches this by getting the person to say "Yes, I do have a problem. Yes, I do need treatment". You need them to say this.

Potential issues

Some practitioners consulted suggested that while most practitioners tended to apply the basic principles of motivational interviewing, the sophisticated application of this technique was rarely seen, due to a lack of ongoing training and supervision.

Reading list

Resources on motivational interviewing, including general information, links, discussion board, and training resources: **www.motivationalinterview.org**

The Pacific Centre for Motivation and Change Ltd (New Zealand): **www.pacificcmc.com**

Multisystemic therapy

Multisystemic therapy is an intensive, time-limited, home-based therapeutic approach that focuses on the known causes and correlates of antisocial behaviour. Problematic behaviours are thought to develop across multiple connected systems, such as the individual, family, peer group, school and community. Interventions to increase responsible behaviour and reduce problematic behaviour are applied within all of these systems, where strengths are identified and used as a lever for change[87].

Why this therapy is used

While multisystemic therapy has been regarded as the treatment of choice for working with youth with antisocial behaviours[87], the literature search revealed little research of multisystemic therapy's efficacy for problematic substance use. However, one study found that juvenile offenders with a diagnosis of substance abuse reported less substance use, and had greater reductions in criminal arrests, following an multisystemic therapy intervention, compared to treatment as usual[88].

Potential issues

While most practitioners knew of the application of multisystemic therapy within New Zealand, and viewed it positively, its use appeared uncommon. Similar to dialectical behaviour therapy, its resource intensive nature appeared to be a barrier to wider use.

Reading list

New Zealand Multi-Systemic Therapy website: **www.mstnz.co.nz**

Psychotherapy

Psychotherapy is a term often used to refer to a wide variety of talking therapies. This discussion will focus on psychodynamic approaches, which typically involve analysis of previous life events and the influence of the unconscious on current behaviours and thoughts. It uses the relationship between the person accessing therapy and the therapist to explore interpersonal issues[78].

Why this therapy is used

Psychodynamic psychotherapy is understudied with problematic substance use populations. Instead, the literature has tended to rely on clinical observation[89]. However, some evidence has been found that group psychotherapy (20 sessions over 20 weeks) was effective when used during methadone maintenance treatment. This study highlighted a significant reduction in the use of opiates, over a 6-month period post-treatment, in comparison to the group who received only methadone maintenance treatment[90].

While most practitioners consulted knew of psychotherapy been used, it was not commonly cited. It was suggested that psychotherapy could be useful when people had actually overcome their substance use-related problem, and now wanted to explore underlying issues.

> People go "Right, I'm in a good place, I'm drug free, I've made the changes I want to, but there is still this lingering issue which I am concerned might come up again and bite me in the future". In my experience, I couldn't put a number on it but maybe about 10 per cent of consumers needed this. The rest don't need to have an answer to all their unresolved issues in order to move forward.

Potential issues

Most practitioners acknowledged that some people needed to take an in-depth look at past events to then move on. However, practitioners saw focusing on the present as a more useful approach for most consumers, where effort is concentrated on beginning to generate behaviour change.

Reading list

New Zealand Association of Psychotherapists Te Ropu Whakaora Hingengaro:
http://nzap.org.nz

Relapse prevention

Relapse prevention is commonly used as a component of cognitive behavioural therapy. It works on the assumption that there are common cognitive, behavioural and emotional factors that underlie the process of relapse. It applies a range of self-control strategies, skills training, identification of high-risk situations, impulse control, advantage–disadvantage analysis, and lifestyle changes to address these factors, in order to avoid relapse[91]. It can be delivered in an individual format, where a targeted plan is developed based on the consumer's relapse patterns and needs. It can also be used in group treatment, which provides opportunities for practising new skills and social support.

Why this therapy is used

A meta-analytic review of relapse prevention interventions, based on 26 studies, indicated a consistent small positive effect on reducing substance use for people with problematic substance use. Relapse prevention was also found to have a large positive impact on people's psychosocial functioning[92]. The treatment effects were strongest for alcohol and poly-substance use and significantly weaker for smoking cessation. This latter finding was supported by a further review, which found that overall relapse prevention did not prevent smoking relapse[93].

Rather than a stand-alone therapy, practitioners consulted tended to view relapse prevention as an important component of most recovery plans. Practitioners highlighted that relapse prevention could be interwoven into different stages of treatment, and that even during brief interventions people could still be given some skills to avoid relapse. Practitioners highlighted that it is important to recognise the difference between slips and relapse, and to build plans that accommodate both. This assists in avoiding the scenario where a consumer becomes so discouraged by a slip that they relapse.

> People can still be intent on the goal of abstinence or controlled use but have slips along the way. But relapse is when you give up on the goal, you say "No more, I'm not even going to try, I'm going to return to the drinking and the drug using that I did before I tried to stop". Relapse prevention covers both; how can you see the signs that a slip is coming up, and what are the alternative actions, and then what to do if you actually slip? The same applies for relapse and what do you do to minimise harm once you have relapse.

Reading list

Article providing clinical guidelines for implementing relapse prevention therapy for problematic substance use and other addictions: **www.bhrm.org/guidelines/RPT%20guideline.pdf**

A brief outline of relapse prevention therapy, as provided by the US National Institute of Drug Abuse: **http://archives.drugabuse.gov/btdp/Effective/Carroll.html**

Other common models

12-step programme

The 12-step programme offers emotional support and a model of abstinence for people recovering from problematic substance use. A familiar example of this model is Alcoholics Anonymous (AA), or Narcotics Anonymous (NA)[94]. Three key aspects predominate: acceptance, that problematic substance use is a chronic progressive disease, that life has become unmanageable, control has been lost and abstinence is the only alternative; surrender, giving oneself over to a higher power, accepting the fellowship and following the 12-step programme; active involvement in 12-step meetings and related activities[85].

Why this approach is used

A recent review of eight trials involving 3,417 people found that 12-step programmes were effective in reducing alcohol use, but no evidence that they were more effective in reducing alcohol intake when compared with other treatment methods[95]. This review found some tentative evidence that the 12-step approach may be more effective than other treatments in assisting people to accept and stay in treatment.

Practitioners consulted were consistent in acknowledging the importance of the 12-step approach, as a long-standing, easily accessible and effective treatment.

> They're an evergreen approach that has been around for 80/90 years and they've saved the lives of many, many people. Like all therapies they work for some but not for others but if I am thinking of addiction treatment, the self help groups, that peer support, including the 12-step (approach) is an important part and at our peril do we ignore it.

Its strengths were identified as its focus on relationships, both in accountability to and support from the sponsors, as well as the fellowship of others. The 12-step programme provides ongoing support for problematic substance use treatment, which is often a long-term process. This enables strong friendships to be built, where deep familiarity is often achieved. Also, because everyone in the fellowship is in a similar position, stigma is diminished and people can feel more able to be themselves, rather than feel the need to pretend to be normal. Many saw the fellowship as a highly effective form of peer support, where people learned together and the learning was reinforced. Another strength of the fellowship is that a person can access an international network and get support anywhere, anytime, for free.

Potential issues

Despite these strengths, many practitioners identified that the 12-step programme did not suit everyone. The abstinence approach and genetic explanation for problematic substance use, as well the focus on a belief in a higher power, were cited as aspects of the programme that were barriers for some people.

> One of the things I find missing in the AA is sometimes you don't do that deep underlying work, because it is basically a medical explanation, it's down to genetics, what I need to do is be abstinent and that's pretty much it.

> I couldn't get past the first step. What was it? I hand my addiction over to a higher power or something? And I think, okay, that's fair enough but I kind of didn't want to not own my own addiction. And I remember some people saying "Yeah, I've been clean for twenty five years" and I'm thinking "Well what are you still doing here? Get out there and live bro. Are they addicted to groups now or something?"

Challenges aside, the key message from consultation on the 12-step programme is that it is an important and effective treatment for problematic substance use that has worked for many.

Reading list

Alcoholics Anonymous New Zealand: **www.aa.org.nz**

Aotearoa New Zealand regional website for Narcotics Anonymous: **www.nzna.org**

Access to international resources and information about the 12-step programme: **www.12step.org**

Bibliotherapy

Bibliotherapy is a therapeutic intervention presented in a written format, designed to be read and implemented by the consumer. Format will vary, from short pamphlets through to comprehensive self-help manuals and books[96].

Why this therapy is used

A meta-analysis by Apodaca and Miller[96] evaluated the effectiveness of self-help material across 22 studies and found that it was useful for helping reduce at-risk and harmful drinking behaviour. Positive outcomes were greater for those who self-referred, as opposed to those identified as at risk through health screening. Studies with longer follow-up periods have shown very little, if any, reversal of the initial reductions in drinking associated with bibliotherapy[96]. It was concluded that bibliotherapy was a cost-effective method for helping problem drinkers who wished to reduce their consumption of alcohol. It was also suggested that people who are likely to request self-help material may be more reluctant to talk about their problems via the telephone or in person[96]. The literature search revealed no recent research investigating bibliotherapy's efficacy with other types of problematic substance use.

Practitioners consulted reported that bibliotherapy was commonly used as part of treatment for people with problematic substance use. It was seen as a useful complement to therapy, providing people with a chance to read and reflect on key principles. It can also be a valuable intervention for people who are reluctant to access services for treatment, but are willing to engage in self-directed effort towards recovery.

> I think we can use bibliotherapy from a basic through to very elaborate level, starting with giving everyone a pamphlet when they come in, provided they are literate, through to giving people books to accompany some of the face-to-face therapy.

The consumers consulted highlighted the importance of reading to support their own recovery journey, where they learned key self-management techniques.

Potential issues

The ALAC resources (www.alcohol.org.nz) are useful sources of information to educate people about the effects of alcohol, how to reduce use and maintain this change. However, there appears to be fewer resources available to address other drug use.

Practitioners highlighted that bibliotherapy was not appropriate in all cases. Consumers who are very depressed may find it difficult to concentrate and reflect on reading materials. Some consumers may not be motivated enough to complete reading between sessions. However, as one practitioner observed, the people who invested the time to do the follow-up reading between sessions were often the ones who tended to achieve the best outcomes from therapy.

Reading list

Article taking a closer look at the use of bibliotherapy: **www.kirkwood.k12.mo.us/parent_student/khs/arenske/biblio.pdf**

Community reinforcement approach

The community reinforcement approach is a broad-spectrum behavioural treatment approach originally developed for alcohol dependence. It utilises social, recreational, familial, and vocational reinforcers to aid a consumer's recovery. It is based on the principles that individuals will have their own positive reinforcers in the community, which maintain their behaviour (both substance and non-substance using behaviours). The outcome of altering these reinforcement contingencies (and involving the consumer's social network in this process) is that the individual will make changes in their lifestyle that will support the person's goal of abstinence or reduction in substance use. The approach involves specific types of counselling and skills training, tailored to the recovery goals of the consumer[9, 97].

Why this therapy is used

Community reinforcement approach's efficacy has been demonstrated with a variety of groups with problematic substance use. Community reinforcement approach, in combination with medication, was found to reduce alcohol use[98, 99]. Its effectiveness was also demonstrated with cocaine-dependent people when used in combination with a voucher incentive program[100, 101]. A recent review of the community reinforcement approach supported its effectiveness with people receiving methadone maintenance or those withdrawing from opioids[97]. A range of outcomes were revealed in this review, including reductions in substance use, improved legal status, reduction of some psychiatric symptoms and improved social functioning.

Some of the practitioners consulted knew of this approach, with most identifying the Salvation Army Bridge programme as the primary provider of this model in New Zealand. Practitioners highlighted that applying the approach in its pure form was quite resource intensive and therefore less common. Practitioners saw this technique's strength being in its active engagement with the person's life context, so that treatment does not happen in a vacuum. The focus is on reintegrating people back into the community, through positively reinforcing non-using behaviours and finding activities to replace the role that alcohol or drugs performed.

> It addresses the context of the drinker or the drug user, it seeks to directly intervene with their substance use, it seeks to mend relationships that are critical to the consumer and it seeks to address Maslow's hierarchy of needs with housing, employment, alternatives to the substance using lifestyle. So it really tackles a whole range of domains for the consumer, not just their pathology.

Potential issues

Aside from the Salvation Army's Bridge programme, application of this technique again tended to be at the principles level.

> I think if you said to someone "Do you use the community reinforcement approach?" they would probably say "What?". But if you asked them to look at what that involved, they probably do all those things.

Reading list

A comprehensive overview of the community reinforcement approach and its application in treating problematic substance use: **www.bhrm.org/guidelines/CRAmanual.pdf**

Complementary therapies

Complementary therapies can occur alongside talking therapies. They often employ a holistic view of heath and focus on building the immune system. Common therapies are massage, yoga, acupuncture, aromatherapy and meditation. Tai Chi is offered as a class for people using the medical detoxification services at Waitemata community alcohol and drug services through Pitman House.

Why this therapy is used

This is an understudied area, although there is some tentative evidence to support the use of acupuncture to treat chemical dependency[102, 103].

Feedback from the consultation suggested that complementary therapies, such as massage, aromatherapy, music therapy, breath work, acupuncture and shiatsu, were used on occasions in some agencies. Practitioners tended to see their value during detoxification programmes, and to provide symptom relief and manage cravings.

> Complementary therapy is often about reducing symptoms of distress and to help create the focus or stability that allows them to engage in talking therapies.

Reading list

The College of Auricular Acupuncture website provides information about what it is, how it works and access to training (UK based): **www.auricularacupuncturecollege.com/aboutaa.php**

Contingency management

Contingency management treatment is derived from basic behavioural principles, particularly the principle that reinforced behaviours will increase in frequency. Typically, contingency management treatments involve providing low-cost incentives, usually in the form of vouchers that are exchangeable for retail goods and services, whenever abstinence is noted[104].

Why this therapy is used

The efficacy of contingency management interventions for retaining people with problematic substance use in therapy and enhancing abstinence has been demonstrated in numerous clinical trials. A review of 47 controlled studies revealed increased rates of abstinence during treatment[26]. Largest effect sizes were cited for treating opiate use and cocaine use, compared with tobacco or multiple drugs. This positive effect declined over time, following treatment. This review concluded that contingency management is among the more effective approaches for promoting abstinence during treatment, and can be used alongside other therapies to maximise benefits[26]. Contingency management has also been found to effect other therapeutic outcomes, such as attendance, goal performance and medication adherence[104].

Many of the practitioners consulted were aware of this technique and highlighted its strong research base, primarily drawn from work in America. However, few knew of its actual application in New Zealand. Practitioners commented that use of rewards, such as outings or takeaways, could be useful for consumers who were less intrinsically motivated.

Potential issues

Limited resources were cited as a barrier to widespread use of this technique in New Zealand. Also, it can be difficult to objectively verify abstinence for alcohol-dependent people. Accurately identifying alcohol abstinence would require testing two to three times daily, which is generally not feasible, therefore, only a few studies have evaluated the efficacy of contingency management for alcohol dependence. These initial studies, however, point to similar effects in reduction in alcohol consumption and improvements in treatment adherence[104].

Reading list

A publication on the use of contingency management therapy to treat alcohol and other drug issues: **http://pubs.niaaa.nih.gov/publications/arh23-2/122-127.pdf**

A publication on the use of contingency management therapy for the treatment of methamphetamine use disorders: **http://ajp.psychiatryonline.org/cgi/reprint/163/11/1993**

Peer support

Peer support is person-centred and underpinned by recovery and strength-based philosophies. The life experience of the worker creates common ground from which the trust relationship with the person is formed. Empowerment, empathy, hope and choice, along with mutuality, are the main drivers in purposeful peer support work. There is great deal of strength gained in knowing someone who has walked where you are walking, and who now has a life of their choosing[105].

Why this therapy is used

Peer support has always played an important role in alcohol and other drug services. The 12-step fellowships, such as Alcoholics Anonymous and Narcotics Anonymous, and therapeutic communities all include peers supporting peers as an important part of their programmes. However, this section is dedicated to the emerging practice of peer support as a new pathway to the alcohol and other drug workforce, outlined in the Matua Raki *Consumer and Peer Roles in the Addiction Sector*[106] discussion document.

Peer support workers work individually and with groups with whom they share the experience of substance-related problems. The work focuses on providing support to consumers, and their families/whanau, to assist people to navigate health systems, to encourage people to seek treatment pathways, and to provide continuing care[106]. This model is different to self-help groups, where peer support workers are people with personal experience of mental health, addiction issues and recovery, who are trained, and then employed. They are accountable to the service in which they are employed, whereas models such as the 12-steps fellowship do not have this accountability. Formal peer support roles are new to the sector, and currently only a small number of roles are funded. The majority of peer support work is voluntary.

Given that formal peer support is an emerging practice, it has yet to be researched. No outcome-based evidence was sourced through the literature search. However, a qualitative study examined the ability of outreach assisted peer support models to help active street addicts to control, reduce or stop their use of drugs[107]. The study found that this model improved self-esteem, and widened the skills and resources available to each member in making the transition from user to non-user. *Te Ariari o te Oranga*[8] highlights that, while there is not current evidence showing that peer support influences treatment outcome, there is evidence to show that it is useful for early engagement in treatment, particularly for consumers who may typically be difficult to engage[8].

The consulted consumers spoke very positively about peer support.

> It actually saved my life, I came to the group, I found great support. …the caring I've had, whether it is through phone calls or support, after hours or in the weekend if I've been in a bad way, the sharing the listening to other people sharing, this has actually made a big difference to me.

Potential issues

Debate was noted about whether peer support was a form of talking therapy. While some suggested that it was an important form of support, others went further.

> The quality of conversations and the quality of openness, and the very specific advice that peers give each other can't be matched through any other modality. I think that peer support is a talking therapy in its own right.

A commitment to ongoing research and evaluation of evolving peer support models and activities is needed to determine the scope and effectiveness of peer support.

Reading list

Counties Manukau AOD Consumer Network members aim to develop their own initiatives, and help support each other on their recovery journeys:
www.alcoholdrugconsumernetwork.org.nz/consumer-network.html

Consumer and Peer Roles in the Addiction Sector. This document creates discussion around the roles and activities of the consumer and peer workforce, and the skills, knowledge and competencies around three specific roles: advice and consultancy, peer support, and advocacy. Available at: **www.matuaraki.org.nz/index.php?option=com_content&view=article&id=172:consumer-and-peer-roles-in-the-addiction-sector&catid=17:consumer&Itemid=4**

SMART Recovery® is a self-empowering addiction recovery support group:
www.smartrecovery.org

Rational Recovery provides a source of information, counselling, guidance and direct instruction on independent recovery through planned, permanent abstinence: **https://rational.org/index.php?id=1**

Pharmacotherapies

Commonly used pharmacotherapies for problematic substance use in New Zealand include the use of opioid substitution treatment, as well as the use of Naltrexone (for alcohol and opioid dependence) and Disulfiram (for alcohol dependence). They are included in this section of the talking therapies guide because many of them are widely used in the addiction sector and, because unlike many other medications, they not only work to reduce symptoms of problematic substance use (reduce cravings), but also to block or mimic the effects of certain drugs (opioids).

Opioid substitution treatment is a commonly used model of treatment for people with opioid dependence. The term opioid has been traditionally used to describe synthetic drugs, which have been developed to have the same action and effects as natural opiates derived from the poppy (raw opium). However, the term is now used to describe both opiates and their synthetic alternative. Opioids include drugs like heroin, morphine and methadone. Opioid substitution treatment generally involves the replacement of short-acting opioids (often injected), with longer-acting opioids designed to be taken by mouth[108]. The most commonly used long-acting opioid used for opioid substitution treatment in New Zealand is methadone, although other pharmacotherapies, like buprenorphrine, are being increasingly used. Opioid substitution treatment specialist services are currently provided in New Zealand by 16 district health boards and one non-government organisation, as well as by a number of GPs who are authorised by specialist services to prescribe opioid substitution treatment[109].

Naltrexone is an opioid receptor agonist, which means that it blocks (while it is being taken) the reinforcing effects of opioids, and reduces alcohol cravings and consumption. Internationally, Naltrexone is commonly used for the treatment of people who are opioid dependent (as it blocks any euphoric effect if opioids are taken), and for rapid detoxification. The use of Naltrexone for opioid dependence is not, however, currently funded for use in New Zealand. While it is unclear exactly how Naltrexone works for this group, Naltrexone is primarily used in New Zealand for people who have alcohol dependence, as it acts to reduce cravings (the urge or desire to drink), helping people to reduce alcohol consumption or remain abstinent from alcohol. Naltrexone was first funded in New Zealand for use with people who have alcohol dependence in 2004. In order for the drug to be funded, people with alcohol dependency must be receiving comprehensive treatment through community alcohol and drug services, and only doctors working in, or with, these services are able to prescribe it.

Disulfiram (Antabuse) is used with people who have alcohol dependency. It is designed to be a deterrent to alcohol consumption, as it induces a number of unpleasant symptoms if a person drinks while taking this medication. Some of these symptoms include flushing of the face, difficulties breathing, headaches, nausea and vomiting[110].

Why are pharmacotherapies used?

Opioid substitution treatment works by relieving the withdrawal symptoms associated with opioid dependence, and by inducing high levels of tolerance in individuals who are then less effected by taking short-acting opioids[108]. That is, the effects of any short-acting opioids are minimised in people on opioid substitution treatment, which in turn can assist the individual to reduce their use. Opioid substitution treatment, being a harm-reduction measure, is also concerned with reducing injected drug use and preventing blood-borne diseases, particularity HIV and hepatitis C.

There is a large evidence base to support the effectiveness of opioid substitution treatment, especially where it is delivered in an open-ended long-term way and where it is supported by other psychosocial support, including talking therapies and social interventions to assist with employment, housing and relationship issues[108]. Although not everyone receiving opioid substitution treatment will require psychosocial interventions, including talking therapies, the research does show that offering people these interventions, especially contingency management, family and couples-based interventions, peer support and advocacy, will substantially improve treatment outcomes[111, 112]. Due to this evidence, it is recommended that opioid substitution treatment should always involve a psychosocial component aimed at addressing assessed needs[112].

Naltrexone and Disulfiram are two more pharmacotherapies (among others) commonly used in New Zealand that are well-researched as being effective for people who have particular problematic substance use (opioid and alcohol dependence)[113, 114]. While they can be used in isolation, it is generally recognised that these medications have better long-term outcomes for people if they are prescribed alongside engagement with other types of treatment for problematic substance use, including talking therapies[113, 114].

Potential issues

Opioid substitution treatment has always been controversial, because it is viewed by some as prolonging and supporting addiction, or as legalised drug dealing. Because of this, there is a substantial stigma attached to people who may be on opioid substitution treatment, and a perception by some that there is a moralistic and controlling nature to opioid substitution treatments, based on this stigma.

While the evidence base for opioid substitution treatment is clear, the attractiveness of abstinence from opioids is difficult to argue. One of the key concerns about harm reduction interventions, including opioid substitution treatment, is that they may be used to the detriment of supporting consumers to believe that they can achieve abstinence. It is clear that consumers should be offered a range of treatment options and be able to choose what is best for them.

Reading list

Berry, R. (2009). *Defining psychosocial interventions in opioid substitution treatment: Report for Ministry of Health*. Wellington: Ministry of Health.

Ministry of Health. (2008). *Practice guidelines for opioid substitution treatment in New Zealand 2008*. Wellington: Ministry of Health.
http://www.moh.govt.nz/moh.nsf/0/240146BCB713DD47CC25752700734EDC

Therapeutic communities

There is considerable variation in the definitions for therapeutic community. A concise definition is proposed by De Leon[115], "therapeutic community provides a total environment in which transformations in the consumer's conduct, attitudes and emotions are fostered, monitored and mutually reinforced by the daily regimen"[116] (p. 41). Often therapeutic communities are described as a 'community as method' approach.

Why this therapy is used

Therapeutic communities are a widely recognised method for treating substance-related problems[117] and have been present since the 1950s[118]. A review of 34 studies investigating therapeutic communities' efficacy found that overall levels and frequency of substance use reduced significantly following therapeutic community treatment[116]. The degree of reduction was found to be similar to those demonstrated by methadone maintenance treatment. Reductions in criminal behaviour and psychological symptoms were also noted. This review found that time in treatment was a significant determinant of treatment outcome, where people generally needed to stay within the therapeutic community for at least 3 months to achieve positive outcomes[116].

One practitioner provided a detailed view of what therapeutic communities involve.

> It's a stepped intervention that interrupts, or at least shocks people into not being in situations where they can repeat that pattern of behaviour, or talk the talk…For a lot of people they would have been using from 12, 13 or 14 so it's not rehab it's more of a habilitative approach… There's someone on the next level up from them who is turning around and saying to them "Okay, we don't do that here". So there's intervention happening constantly.

Practitioners highlighted that while a therapeutic community model would often include talking therapies, such as motivational interviewing, CBT and narrative therapy, a full spectrum of interventions tended to be employed, including group work, and social, parenting and vocational skill development. It was stated in the consultation that peer support is a major component of the programme, where more experienced residents guide new entrants through the stages.

> A senior resident who's got 6 or 9 months up kind of takes that person under their wing. For me the most important parts of the programme actually happen outside of the 9 to 5, it's the conversation that occurred between residents at nine o'clock at night when you're sharing a bedroom.

Note that this is a unique type of peer relationship that can occur in residential services. In community settings, formal peer support workers can support the consumer to set and achieve goals in different areas of their life by using a strengths-based approach that empowers the consumer.

Potential issues

Practitioners highlighted that therapeutic community is a model that tends to fit with a specific consumer type. For people who have come from backgrounds where they haven't learned how to live in a community or family effectively, the therapeutic community model offers them the chance to develop interpersonal skills and learn how to function in a community setting:

> The basis of therapeutic community is that you learn how to function in a way that most people would take for granted in daily life, without conflict and without misunderstandings, and without fears of interaction. In the alcohol and other drug field there are a number of clients who are not highly functioning in those areas. Part of this might have been caused by long term use of substances, but part of it might have been what drove them to using substances in the first place.

Therapeutic communities can involve a commitment of up to a year, and are a 24/7 intervention, which may be too intensive for some people. Research indicates that only between 30 per cent to 50 per cent of those entering therapeutic communities remain in treatment at the 3 month mark, indicating that this approach does not suit all[116]. The consumers consulted who had personal experience with therapeutic communities, had not found them particularly beneficial. They found that either the situation was not supervised enough, or over-supervised, in that activities were too constricted, or that a lack of follow up after discharge meant that relapse was likely. While this last point was the experience of a consumer consulted, it is important to acknowledge that therapeutic communities normally employ an approach where phased withdrawal from treatment occurs, and the person is supported to re-engage with the community.

Reading list

The World Federation of Therapeutic Communities website: **www.wftc.org**

Association of Therapeutic Communities website (UK based): **www.therapeuticcommunities.org**

Traditional therapies

Traditional therapies can include, but are not limited to, the use of natural remedies, culturally-based methods of healing, and the inclusion of wairua or spirituality[8]. For Maori, the use of karakia (prayer), rongoa (herbal remedies), mirimiri (massage) and wai karakia (blessing with water) are all examples of traditional therapies. Traditional therapies can complement talking therapies.

Why this therapy is used

The importance of culturally specific interventions for Maori, Pacific and Asian people has been outlined in *Te Ariari o te Oranga*[8]. Traditional healing can be more encompassing of the spiritual and psychological dimensions of health, and demonstrates a holistic perspective by taking into account wider family, along with the social, cultural, economic and environmental context of an individual[78].

When considering Maori traditional therapies, some practitioners knew of the application of traditions such as karakia (a prayer or chant), whakatauki (proverbs), mirimiri (massage), waiata (song) and rongoa (plant medicine) to complement therapeutic practice. Engaging with whakapapa, reconnecting people back to where they are from and who they are, was a well-recognised intervention. Practitioners emphasised that while these would rarely be stand-alone therapies, and instead would contribute to a treatment package, attending to a person's culture, and finding the vehicles for healing within their worldview were important.

> The cultural variables that bring healing or change or help maintain change often revolve around finding a place where people can find support, find the resilience and protection to keep themselves well.

Chinese herbal medicines and acupuncture have been used to treat both mental and physical symptoms. There is some tentative evidence to support the use of acupuncture to treat chemical dependency[102, 103]. In China, herbal medicine is also often involved in detoxification practices[78]. Tai Chi is offered as a class for people using the medical detoxification services at Waitemata District Health Board's community alcohol and drug services through Pitman House.

Feedback from the consultation suggested that traditional therapies were not commonly used for problematic substance use. A Pacific practitioner consulted raised the interesting point that, for a lot of Pacific cultures, substance-related problems are a recent phenomenon associated with migration. Therefore, traditionally, there has not been a need for therapies. For many Pacific people, the church is a strong part of their culture, and a source for support and healing.

Potential issues

Consumers may value traditional therapies as an important part of their recovery plan. However, historically main stream services have tended to omit them:

> 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 models of care[8] (p. 31).

Practitioners need to convey a supportive, accepting approach that encourages the consumer to share their views on their use of traditional therapies.

Reading list

Traditional Maori methods of healing can be accessed through Nga Ringa Whakahaere o te Iwi Maori (Inc) website: **www.nrw.co.nz**

Ministry of Health Maori health website: **www.Maorihealth.govt.nz/moh.nsf/pagesma/194**

New Zealand School of Acupuncture and Traditional Chinese Medicine: **www.acupuncture.ac.nz**

Other therapies

A variety of other techniques were identified by practitioners as useful when working with people with problematic substance use. These included narrative therapy, social behavioural network therapy, psychodrama, solution-focused therapy, art therapy, grief counselling, Gestalt therapy, and rational emotive behaviour therapy.

4. Resources

Websites

Alcohol and Drug Association New Zealand (ADANZ)
www.adanz.org.nz/ADANZ/Home
ADANZ aims to improve health and well-being by reducing the harm associated with alcohol, other drugs and gambling. It does this by "providing information, challenging thinking and stimulating action on alcohol and drug Issues". It manages the Alcohol Drug and Gambling Helplines.

Addictions Treatment Directory
www.addictionshelp.org.nz/Services/Home
This website contains a regionalised database of all the addiction treatment and advice services available anywhere in New Zealand.

Addiction Research Network
www.fmhs.auckland.ac.nz/faculty/arn
A collaboration of researchers at the University of Auckland, with expertise and knowledge of issues relating to substance misuse and other addictive behaviours.

Addiction Treatment Research Interest Group (ATRIG)
www.addiction.org.nz
ATRIG aims to foster interest in scientific research on the treatment of people with addiction-related problems in New Zealand. It also aims to disseminate and promote these research findings in support of the development of improved treatment services for people with addiction-related problems in New Zealand.

Alcohol Advisory Council of New Zealand (ALAC)
www.alac.org.nz
ALAC was established in 1976 to encourage responsible use of alcohol and reduce its misuse. This website provides a number of useful resources related to alcohol use.

Canterbury Mental Health Education and Resource Centre Trust (MHERC)
www.mherc.org.nz/services.htm
MHERC provides information, education, and support within the Canterbury region to people with mental health and addiction issues, the families/whanau, caregivers and associates of mental health consumers, non-government organisation mental health, addiction and social service agencies, and the community.

Chur Chur Bro
www.churchurbro.co.nz/entry_page.html
This website is a bilingual mental health self-help care website for rangatahi (those aged 12 to 18 years).

Drug and Alcohol Practitioners' Association of Aotearoa–New Zealand (DAPAANZ)
www.dapaanz.org.nz
Represents the professional interests of its members, who are practitioners and clinicians working in addiction treatment.

Drug Foundation of New Zealand
www.drugfoundation.org.nz
The New Zealand Drug Foundation's aim is to prevent and reduce the harms associated with drug use. The foundation has also developed two websites, which provide information and resources, as well as personal stories from drug users.
www.methhelp.org.nz
www.drughelp.org.nz

Dual Diagnosis Australia and New Zealand
www.dualdiagnosis.org.au/home
This website is a resource repository created to contribute to better outcomes for persons with co-existing substance use and mental health disorders.

Kina Families and Addictions Trust
www.kinatrust.org.nz
The trust fosters service development for families involved with alcohol and drug treatment services.

Matua Raki – The National Addiction Workforce Development Programme
www.matuaraki.org.nz
Matua Raki provides addiction workforce development programmes, to build the capacity and capability of practitioners who work with people who have addiction-related problems.

Mental Health Commission
www.mhc.govt.nz
The Mental Health Commission's task is to give the Government independent advice on how well mental health and addiction services are meeting the needs of people. The commission also advocates for improvements in the way that mental illness and addiction are perceived and responded to.

Mental Health Foundation
www.mentalhealth.org.nz/page/15-about-us
Works towards creating a society free from discrimination, where all people enjoy positive mental health and well-being. The foundation provides free information and training, and advocate for policies and services that support people with experience of mental illness, and their families/whanau and friends.

National Addiction Centre (NAC)
www.chmeds.ac.nz/departments/psychmed/treatment
Otago University-based, the NAC is dedicated to developing and promoting effective interventions for people with addiction-related problems.

National Association of Opioid Treatment Providers (NAOTP)
www.matuaraki.org.nz/index.php?option=com_content&view=article&id=21&Itemid=41
NAOTP is the representative body of the primary and secondary care providers involved in opioid substitution treatment.

National Committee for Addiction Treatment (NCAT)
www.ncat.org.nz
NCAT is the national voice of the addiction treatment sector, providing expert advice on treatment for alcohol, other drugs, and problem gambling.

Needle Exchange Programme
www.needle.co.nz/fastpage/fpengine.php?templateid=1
The programme is a health education and health promotion service for people who inject drugs.

Problem Gambling Foundation of New Zealand
www.pgfnz.org.nz/Home/0,271,1132,00.html
The Problem Gambling Foundation's mission is to eliminate harm caused by gambling by providing counselling and support throughout New Zealand for individuals and families.

Substances and Choices Scale (SACS)
www.sacsinfo.com
A New Zealand adolescent screening and outcome measurement instrument.

Te Pou – The National Centre of Mental Health Research, Information and Workforce Development
www.tepou.co.nz
This website is aimed at anyone interested in mental health, but especially those who work in the mental health sector in New Zealand.

Publications

Todd, F. C. (2010). *Te ariari o te oranga: The assessment and management of people with co-existing mental health and substance use problems 2010*. Wellington: Ministry of Health. Available online at: www.moh.govt.nz/moh.nsf/indexmh/assessment-mang-people-coexisting-mental-health.

Ministry of Health. (2010). *Service delivery for people with co-existing mental health and addiction problems: Integrated solutions*. Wellington: Ministry of Health. Available online at: www.moh.govt.nz/moh.nsf/pagesmh/10054/$File/service-delivery-for-people-13-04-10.pdf.

Pega, F., & MacEwan, I. (2010). *Making visible: Improving services for sexual minority people in alcohol and other drug addiction prevention and treatment*. Wellington: Matua Raki.

*Principles of drug addiction treatment: A research-based guide***.** Produced by the American National Institute of Drug Abuse, the guide summarises more than three decades of research. Available online at: www.nida.nih.gov/podat/podatindex.html.

"NIDA InfoFacts: Treatment approaches for drug addiction". A fact sheet, produced by the American National Institute of Drug Abuse, covering research findings on effective treatment approaches for drug abuse and addiction. Available online at: www.nida.nih.gov/Infofacts/treatmeth.html.

Kina Trust family inclusive practice guide. A resource is intended for addiction practitioners who have an understanding of drug and alcohol assessments and interventions, and who want to acquire skills to work in a more inclusive and contextual fashion. Available online at: www.kinatrust.org.nz/myfiles/FIP.pdf.

Kina Trust has also produced a suite of family inclusive practice skills and assessment tools. Available online at: www.kinatrust.org.nz/practice-assessment.asp

Helplines

Alcohol Drug helpline **0800 787 797**

Gambling helpline **0800 654 655**

Pasifika helpline **0800 787 799**

References

1. Asay, T. P., & Lambert, M. J. (2009). The empirical case for the common factors in therapy: Quantitative findings. In Duncan, B. L., Miller, S., Wampold, B., & Hubble, M. (Eds.), *The heart and soul of change*, pp. 23–55. Washington: American Psychological Association.

2. Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. New Jersey: Lawrence Erlbaum.

3. Imel, Z. E., Wampold, B. E., Miller, S. D., & Fleming, R. R. (2008). Distinctions without a difference: Direct comparisons of psychotherapies for alcohol use disorders. *Psychology of Addictive Behaviors, 22*(4), 533–543.

4. Meier, P. S., Barrowclough, C. & Donmall, M. C. (2005). The role of the therapeutic alliance in the treatment of substance misuse: A critical review of the literature. *Addiction, 100*(3), 304–316.

5. Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*(2), 139–149.

6. Martin, D. J., Garske, J.P. & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*(3), 438–450.

7. Duncan, B., Miller, S., & Sparks, J. (2004). *The heroic client*. San Francisco: Jossey-Bass.

8. Todd, F.C. (2010). *Te ariari o te oranga: The assessment and management of people with co-existing mental health and substance use problems*. Wellington: Ministry of Health.

9. Wanigaratne, S., Davis, P., Pryce, K., & Brotchie, J. (2005). *The effectiveness of psychological therapies on drug misusing clients*. London: National Treatment Agency.

10. Barber, J. (2002). *Social work with addictions* (2nd ed.). Basingstoke: Palgrave Macmillan.

11. Taggart, L., McLaughlin, D., Quinn, B., & McFarlane, C. (2007). Listening to people with intellectual disabilities who misuse alcohol and drugs. *Health and Social Care in the Community, 15*(4), 360–368.

12. Adams, P. (2008). *Fragmented intimacy: Addiction in a social world*. New York: Springer.

13. Volkow, N. D., & Li, T. K. (2004). Drug addiction: The neurobiology of behaviour gone awry. *Nature Reviews Neuroscience, 5*, 963–970.

14. Balera, R. D., & Volkow, N. D. (2006). Drug addiction: The neurobiology of disrupted self-control. *Trends in Molecular Medicine, 12*(12), 559–566.

15. Wells, J. E., Baxter, J., & Schaaf, D. (2007). *Substance use disorders in Te Rau Hinengaro: The New Zealand mental health survey.* Wellington: Alcohol Advisory Council of New Zealand.

16. Khan, N., Davis, P., Wilkinson, T.J., Sellman, J.D., & Graham, P. (2002). Drinking patterns among older people in the community: Hidden from medical attention? *The New Zealand Medical Journal, 115*(1148), 72–75.

17. World Health Organisation. (2005). *Country reports and charts available.* Retrieved from www.who.int/mental_health/prevention/suicide/country_reports/en/index.html.

18. Walters, G. (2000). Spontaneous remission from alcohol, tobacco, and other drug abuse: Seeking quantitative answers to qualitative questions. *American Journal of Drug and Alcohol Abuse, 26*(3), 443–460.

19. Klingemann, H., & Klingemann, J. (2009). *How much treatment does a person need? Self change and the treatment system: Evidence-based addiction treatment*. New York: Academic Press.

20. Oakley Brown, M. A., Wells, J. E., & Scott, K. M. (Eds). (2006). *Te rau hinengaro: The New Zealand mental health survey*. Wellington: Ministry of Health.

21. Ministry of Health. (1997). *The national acuity review.* Wellington: Ministry of Health.

22. Bushnell, J., Wells, J., Mckenzie, J., Hornblow, A., Oakley-Browne, M., & Joyce, P. (1994). Bulimia comorbidity in the general population and in the clinic. *Psychological Medicine, 24*, 605–611.

23. Adamson, S. J., Todd, F. C., Sellman, J. D., Huriwai, T., & Porter, J. (2006). Coexisting psychiatric disorders in New Zealand outpatient alcohol and other drug clinical population. *Australian and New Zealand Journal of Psychiatry, 40*(1), 164–170.

24. Kaner, E. F. D., Beyer, F. R., Campbell, F., Schlesinger, C., Heather, N., Saunders, J. B., Burnand, B., & Pienaar, E. D. (2007). Effectiveness of brief alcohol interventions in primary care populations *Cochrane Database of Systematic Reviews, 2*, Art. No.: CD004148. DOI: 10.1002/14651858.CD004148.pub3.

25. Lundahl, B. W., Kunz, C., Brownell, C., Tollefson, D., & Burke, B.L. (2010). A meta-analysis of motivational interviewing: Twenty-five years of empirical studies. *Research on Social Work Practice, 20*(2), 137–160.

26. Prendergast, M., Podus, D., Finney, J., Greenwell, L., & Roll, J. (2006). Contingency management for treatment of substance use disorders: A meta-analysis. *Addiction, 101* (11), 1546–1560.

27. Gowing, L., Proudfoot. H., Henry-Edwards, S., & Teesson, M. (2001). *Evidence supporting treatment: The effectiveness of interventions for illicit drug use.* Canberra: Australian National Council on Drugs.

28. Miller, S. D., Duncan, B. L., & Hubble, M. A. (2004). Beyond integration: The triumph of outcome over process in clinical practice. *Psychotherapy in Australia, 10*(2), 2–19.

29. Ministry of Health. (2008). *Let's get real: Real skills for people working in mental health and addiction.* Wellington: Ministry of Health.

30. Beutler, L. E., Bongar, B., & Shurkin, J. N. (1998). *A consumer's guide to psychotherapy*. New York: Oxford University Press.

31. Sprenkle, D. H., & Blow, A. J. (2004). *Common factors and our sacred models.* Retrieved from http://findarticles.com/p/articles/mi_qa3658/is_200404/ai_n9394462/?tag=content;col1.

32. Broome, K. M., Simpson, D. D., & Joe, G. W. (1999). Patient and program attributes related to treatment process indicators in DATOS. *Drug and Alcohol Dependence, 57*(2), 127–135.

33. Conrod, P. J., & Stewart, S. H. (2005). A critical look at dual-focused cognitive-behavioral treatments for comorbid substance use and psychiatric disorders: Strengths, limitations, and future directions. *Journal of Cognitive Psychotherapy, 19*(3), 261–284.

34. Joe, G. W., Simpson, D., Dansereau, D. F., & Rowan-Szal, G. A. (2001). Relationships between counseling rapport and drug abuse treatment outcomes. *Psychiatric Services, 52*(9), 1223–1229.

35. Howells, K., & Day, A. (2006). Affective determinants of treatment engagement in violent offenders. *International Journal of Offender Therapy and Comparative Criminology, 50*(2), 174.

36. Ross, E. C., Polaschek., D. L. L., & Ward, T. (2008). The therapeutic alliance: A theoretical revision for offender rehabilitation. *Aggression and Violent Behaviour, 13*, 462–480.

37. Kolden, G.G., Howard, K. I., Bankoff, E. A., Maling, M. S., & Martinovich, J. (1997). Factors associated with treatment continuation: Implications for the treatment of drug dependence. In Onken, L. S., Blaine, J. D., & Boren, J. J. (Ed), *Beyond the therapeutic alliance: keeping the drug-dependent individual in treatment*, (pp. 110-130). Rockville: National Institute on Drug Abuse. Division of Clinical and Services Research.

38. Ministry of Health. (2010). *Korero marama: Health literacy and Maori*. Wellington: Ministry of Health.

39. Stanton, M. D. (1997). The role of family and significant others in the engagement and retention of drug-dependent individuals. In Onken, L. S., Blaine, J. D., & Boren, J. J. (Ed), *Beyond the therapeutic alliance: keeping the drug-dependent individual in treatment*, (pp. 157-180). Rockville: National Institute on Drug Abuse. Division of Clinical and Services Research.

40. Sells, D., Davidson, L., Jewell, C., Falzer, P., & Rowe, M. (2006). The treatment relationship in peer-based and regular case management for clients with severe mental illness. *Psychiatric Services, 57*(8), 1179.

41. Hansen, N. B., & Lambert., M. J. (2003). Evaluation of the dose response relationship in naturalistic treatment setting using survival analysis. *Mental Health Service Research, 5*, 1–12.

42. Whipple, J. L., Lambert, M. J., Vermeersch, D. A., Smart, D. W., Nielsen, S. L., & Hawkins, E, J. (2003). Improving the effects of psychotherapy: The use of early identification of treatment failure and problem-solving strategies in routine practice. *Journal of Counseling Psychology, 50*(1), 59–68.

43. Howard, K. I., Kopta, S. M., Krause, M. S., & Orlinsky, D. E. (1986). The dose effect relationship in psychotherapy. *The American Psychologist, 41*, 159–164.

44. Zuckoff, A., Swartz, H. A., & Grote, N. K. (2007). Motivational interviewing as a prelude to psychotherapy for depression. In H. Arkowitz, H. A. Westra, W. R. Miller, & S. Rollnick (Eds), *Motivational interviewing in the treatment of psychological problems* (pp. 324-342). New York: Guildford Press.

45. Miller, S. D., Duncan, B. L., & Johnson, L. D. (2000). *The session rating scale 3.0.* Chicago: Authors.

46. Simpson, D. D., & Joe, G. W. (1993). Motivation as a predictor of early drop out from drug abuse treatment. *Psychotherapy, 30*, 357–368.

47. Simpson, D. D., & Joe, G. W (2004). A longitudinal evaluation of treatment, engagement and recovery stages. *The Journal of Substance Abuse Treatment, 27*, 89–97.

48. Crits-Christoph, P., Gallop, P., Temes, C. M., Woody, G., Ball, S. A., Martino, S., & Carroll, K. M. (2009). The alliance in motivational enhancement therapy and counseling as usual for substance use problems. *Journal of Consulting and Clinical Psychology, 77*(6), 1125–1135.

49. Castonguay, L. G., & Constantino, N. J. (2004). The working alliance: Where are we and where should we go? *Psychotherapy: Theory, research, practice, training, 43*(3), 271–279.

50. Coppello, A. G., Velleman, R. D. B., & Templeton, L. G. (2005). Family intervention in the treatment of alcohol and drug problems. *Drug and Alcohol Review, 24*, 369–385.

51. Velleman, R. (2010). *Supporting families whose lives are affected by alcohol or drug problems: Risk, resilience and effective interventions*. Paper presented at the Cutting Edge 2010 Conference, Auckland, New Zealand.

52. Kina Families and Addictions Trust. (2004). *Family inclusive practice in the addiction field.* Retrieved from www.kinatrust.org.nz.

53. Barber, J. G., & Crisp, B. R. (1995). The 'pressures to change' approach to working with the partners of heavy drinkers. *Addiction, 90*, 269–276.

54. Kina Families and Addictions Trust. (2010). *Creating spaces: Guidelines for home visiting.* Retrieved from www.kinatrust.org.nz.

55. Velleman, R., & Templeton, L. (2007). Understanding and modifying the impact of parental substance misuse on children. *Advances in Psychiatric Treatment, 13*, 79–89.

56. Kina Families and Addictions Trust. (2010). *Creating spaces: Guidelines for fostering engagement with families*. Retrieved from www.kinatrust.org.nz.

57. Huriwai, T., Sellman, J. D., Sullivan, P., & Potiki, T. L. (2000). Optimal treatment for Maori with alcohol and drug-use-related problems: An investigation of cultural factors in treatment. *Substance Use & Misuse, 35*(3), 281–300.

58. Coupe, N. M. (2000). The epidemiology of Maori suicide in Aotearoa/New Zealand. *South Pacific Journal of Psychology, 12*(1), 1–12.

59. Te Pou. (2010). *Talking therapies for Pasifika peoples*. Auckland: Te Pou o te Whakaaro Nui.

60. Dunnachie, B. (2007). *Evidence-based age-appropriate interventions: A guide for child and adolescent mental health services (CAMHS)*. Auckland: The Werry Centre for Child and Adolescent Mental Health Workforce Development.

61. Kina Families and Addictions Trust. (2009). *Sharing the kete.* Napier: Kina Families and Addictions Trust.

62. Corrigan, P. W., & Kuwabara, S. A. (2009). The public stigma of mental illness and drug addiction: Findings from a stratified random sample. *Journal of Social Work, 9*(2), 139–147.

63. Luoma, J. B., Kohlenberg, B. S., Hayes, S. C., Bunting, K., & Rye, A. K. (2008). Reducing self-stigma in substance abuse through acceptance and commitment therapy: Model, manual development, and pilot outcomes. *Addiction Research & Theory, 16*(2), 149–165.

64. Prochaska, J. O., & Norcross, J. C. (2007). *Systems of psychotherapy: A transtheoretical approach.* South Melbourne: Thompson Brooks/Cole.

65. Gaume, J., Gmel, G., & Daeppen, J. B. (2008). Brief alcohol interventions: Do counsellors and patients' communication characteristics predict change? *Alcohol and Alcoholism, 43*(1), 62–69.

66. Lang, E., Engelander, M., & Brooke, T. (2000). Report of an integrated brief intervention with self-defined problem cannabis users. *Journal of Substance Abuse Treatment, 19*(2), 111–116.

67. Proudfoot, J., Ryden, C., Shapiro, D. A., Goldberg, D., Mann, A., Tylee, A., Marks, I., & Gray, J. (2004). Clinical efficacy of computerised cognitive-behavioural therapy for anxiety and depression in primary care: randomised controlled trial. *The British Journal of Psychiatrists*, 185, 46-54.

68. Martin, G., & Copeland, J. (2008). The adolescent cannabis check-up: Randomized trial of a brief intervention for young cannabis users. *Journal of Substance Abuse Treatment, 34*(4), 407–414.

69. Kadden, R. M., Litt, M. D., Cooney, N. L., Kabela, E., & Getter, H. (2000). Prospective matching of alcoholic clients to cognitive-behavioral or interactional group therapy. *Journal of Studies on Alcohol, 62*(3), 359–369.

70. Carroll, K. M. (1998). *Therapy Manuals for Drug Addiction Manual 1: A Cognitive-Behavioral Approach: Treating Cocaine Addiction.* Rockville: US Dept of Health and Human Services.

71. Barrowclough, C., Haddock, G., Tarrier, N., Lewis, S. W., Moring, J., O'Brien, R., Schofield, N., & McGovern, J. (2001). Randomized Controlled Trial of Motivational Interviewing, Cognitive Behavior Therapy, and Family Intervention for Patients With Comorbid Schizophrenia and Substance Use Disorders. *American Journal of Psychiatry, 158*, 1706-1713.

72. Bennett, S. T., Flett, R. A., & Babbage, D. R. (2008). *The adaptation of cognitive behavioural therapy for adult Maori clients with depression: A pilot study.* Paper presented at the Claiming Spaces: 2007 National Maori and Pacific Psychologies Symposium. Retrieved from http://hdl.handle.net/10289/1549.

73. Wong, D. F. K. (2008). Cognitive behavioral treatment groups for people with chronic depression in Hong Kong: A randomized wait-list control design. *Depression and Anxiety, 25*(2), 142–148.

74. Elliot, J. C., Carey, K. B., & Bolles, J. R. (2008). Computer based interventions for college drinking: A qualitative review. *Addictive Behaviors, 33*, 994–1005.

75. Vernon, M. L. (2010). A review of computer-based alcohol problem services designed for the general public. *Journal of Substance Abuse Treatment, 38*(3), 203–211.

76. Te Pou. (2009). *A guide to talking therapies in New Zealand*. Auckland: Te Pou o te Whakaaro Nui.

77. Stead, L. F. Perera, R., & Lancaster, T. (2006). Telephone counselling for smoking cessation (review) *Cochrane Database of Systematic Reviews*, *3*, Art. No.: CD002850. DOI: 10.1002/14651858. CD002850.pub2.

78. Te Pou. (2010). *Talking therapies for Asian people: Best and promising practice guide for mental health and addiction services.* Auckland: Te Pou o te Whakaaro Nui.

79. Hayes, S.C., Masuda, A., Bissett, R., Luoma, J., & Guererro, F. (2004). DBT, FAP, and ACT: How empirically oriented are the new behavior therapy technologies? *Behavior Therapy, 35*(1), 35–54.

80. Linehan, M. M., Dimeff, L. A., Reynolds, S. K., Comtois, K. A., Welch, S. S., & Heagerty, P. (2002). Dialectical behavior therapy versus comprehensive validation therapy plus 12-step for the treatment of opioid dependent women meeting criteria for borderline personality disorder. *Drug and Alcohol Dependence, 67*(1), 13–26.

81. van den Bosch, L. M., Verhuel, R., Schippers, G. M., & van den Brink, W. (2002). Dialectical behavior therapy of borderline patients with and without substance use problems: Implementation and long-term effects. *Addictive Behavior, 27*(1), 911–923.

82. Slesnick, N., & Prestopnik, J. L. (2009). Comparison of family therapy outcome with alcohol-abusing, runaway adolescents. *Journal of Marital and Family Therapy, 35*(3), 255–277.

83. Slesnick, N., Bartle-Haring, S., & Gangamma, R. (2006). Predictors of substance use and family therapy outcome among physically and sexually abused runaway adolescents. *Journal of Marital and Family Therapy*, *32*(3), 261–281.

84. Yandoli, D., Eisler, I., Robbins, C., Mulleady, G., & Dare, C. (2002). A comparative study of family therapy in treatment of opiate users on a London drug clinic. *Journal of Family Therapy, 24*, 402–422.

85. National Institute on Drug Abuse. (2010). *Principles of drug addiction treatment: A research based guide.* Retrieved from www.nida.nih.gov.

86. Project MATCH Research Group. (1998). Matching alcoholism treatment to client homogeneity: Project MATCH three year drinking outcomes. *Alcoholism: Clinical and Experimental Research, 23*, 1300–1311.

87. Russell, C. J. (2008). *Multisystemic therapy in New Zealand: Effectiveness and predictors of outcome* (Unpublished thesis presented in partial fulfilment of the requirements for the degree of Doctor of Philosophy in Psychology). Massey University, Turitea Campus, Palmerston North, New Zealand.

88. Henggeler, S. W., Pickrel, S. G. & Brondino, M. J. (1999). Multisystemic treatment of substance-abusing and -dependent delinquents: Outcomes, treatment fidelity, and transportability. *Mental Health Services Research, 1*(3), 171–184.

89. Van Horn, D. H. A., & Frank, A. F. (1998). Psychotherapy for cocaine addiction. *Psychotherapy of Addictive Behaviors, 12*(1), 47–61.

90. Scherbaum, N., Kluwig, J., Specka, M., Krause, D., Merget, B., Finkbiener, T., & Gastpar, M. (2005). Group psychotherapy for opiate addicts in methadone maintenance treatment: A controlled trial. *European Addiction Research, 11*(4), 163–171.

91. Weiss, R. D., Najavits, L. M., & Greenfield, S. F. (1999). A relapse prevention group for patients with bipolar and substance use disorders. *Journal of Substance Abuse Treatment, 16*(1), 47–54.

92. Irvin, J. E. (1999). Efficacy of relapse prevention: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 67*(4), 563–570.

93. Hajek P, Stead LF, West R, Jarvis M, Lancaster T. (2009). Relapse prevention interventions for smoking cessation. *Cochrane Database of Systematic Reviews, 1*, Art. No.: CD003999. DOI: 10.1002/14651858. CD003999.pub3.

94. Ferri, M., Amato, L., & Davoli, M. (2006). Alcoholics Anonymous and other 12-step programmes for alcohol dependence. *Cochrane Database of Systematic Reviews, 3*, Art. No.: CD005032. DOI: 10.1002/14651858.CD005032.pub2.

95. Ferri M, Amato L, Davoli M. Alcoholics Anonymous and other 12-step programmes for alcohol dependence. *Cochrane Database of Systematic Reviews, 3*, Art. No.: CD005032. DOI: 10.1002/14651858. CD005032.pub2.

96. Apodaca, T. R., & Miller, W. R. (2003). A meta-analysis of the effectiveness of bibliotherapy for alcohol problems. *Journal of Clinical Psychology, 59*(3), 289–304.

97. Abbott, P. J. (2009). A review of the community reinforcement approach in the treatment of opioid dependence. *Journal of Psychoactive Drugs*, *41*(4), 379.

98. Meyers, R. J., & J. E. Smith. (1995). *Clinical guide to alcohol treatment: The community reinforcement approach*. New York: Guildford Press.

99. Azrin, N. H., Sisson, R. W, Meyers, R., & Godley, M. (1982). Alcoholism treatment by disulfiram and community reinforcement counseling. *Journal of Behavior Therapy and Experimental Psychiatry, 13*, 105–112.

100. Higgins, S. T., Budney, A. J., Bickel, W. K., Hughes, J. R., Foerg, F., & Badger, G. (1993). Achieving cocaine abstinence with a behavioral approach. *American Journal of Psychiatry, 150*(5), 763–769.

101. Higgins, S. T., Budney, A. J., Bickel, W. K., Foerg, F. E., Donham, R., & Badger, G. J. (1994). Incentives improve outcome in outpatient behavioral treatment of cocaine dependence. *Archives of General Psychiatry, 52*, 568–576.

102. Brumbaugh, A. G. (1993). Acupuncture: New perspectives in chemical dependency treatment. *Journal of Substance Abuse Treatment, 10*, 35–43.

103. McLellan, A. C., Grossman, D. S., Blaine, J. D., & Haverkos, H. W. (1993). Acupuncture treatment for drug abuse: A technical review. *Journal of Substance Abuse Treatment, 10*, 569–576.

104. Stitzer, M., & Petry, N. (2006). Contingency management for treatment of substance abuse. *Annual Review of Clinical Psychology, 2*, 411–434.

105. Te Pou. (2010). *Service user workforce development: What is peer support?* Retrieved from www.tepou.co.nz.

106. Matua Raki. (2010). *Consumer and peer roles in the addiction sector*. Wellington: Matua Raki.

107. Levy, J. A., Gallmeier, C. P., & Wiebel, W. W. (1995). The outreach assisted peer-support model for controlling drug dependency. *Journal of Drug Issues, 25*, 507-529.

108. Nixon, L. (2010). *Opioid substitution treatment.* Unpublished paper for the National Association of Opioid Treatment Providers.

109. Ministry of Health. (2008). *Practice guidelines for opioid substitution treatment in New Zealand 2008*. Wellington: Ministry of Health.

110. Medsafe. (2007). *Information for health professionals: Antabuse, Disulfiram Tablets*. Retrieved from www.medsafe.govt.nz/profs/datasheet/a/Antabusetab.htm.

111. National Institute of Health and Clinical Excellence. (2007). *Drug misuse: Psychosocial interventions: NICE clinical guidelines 51*. London: National Institute of Health and Clinical Excellence.

112. Berry, R. (2009). *Defining psychosocial interventions in opioid substitution treatment: Report for Ministry of Health.* Wellington: Ministry of Health.

113. Health Technology Inquiry Service. (2010). *Disulfiram for alcohol dependence: Clinical effectiveness and safety*. Retrieved from www.cadth.ca/media/pdf/k0175_disulfiram_alcohol_dependence_htis-1-5.pdf.

114. Medsafe. (2009). *Information for health professionals: ReVia, Naltrexone Hydrochloride 50mg tablets*. Retrieved from www.medsafe.govt.nz/profs/datasheet/r/reviatab.htm.

115. De Leon, G. (1995). Therapeutic communities for addictions: A theoretical framework. *International Journal of the Addictions, 30*(12), 1603–1645.

116. Gowing, L. C. R., Biven, A., & Watts, D. (2002). *Toward better practice in therapeutic communities*. Bangalow, NSW: Australasian Therapeutic Communities Association.

117. Marcus, M. T., Schmitz, J., Moeller, G., Liehr, P., Cron, S. G., Swank, P., Bankston, S., Carroll, D. D., & Granmayeh, L. K. (2009). Mindfulness-based stress reduction in therapeutic community treatment: A stage 1 trial. *American Journal of Drug and Alcohol Abuse, 35*(2), 103–108.

118. Mandell, W., Edelen, M. O., Wenzel, S. L., Dahl, J., & Ebener, P, (2008). Do dimensions of therapeutic community treatment predict retention and outcomes? *Journal of Substance Abuse Treatment, 35*(3), 223–231.

Matua Raki
National Addiction Workforce Development

web www.matuaraki.org.nz

email administrator@matuaraki.org.nz

Te Pou
o Te Whakaaro Nui

web www.tepou.co.nz

email info@tepou.co.nz