Te Ariari o te Oranga

ABACUS Counselling, Training and Supervision Ltd


MINISTRY OF HEALTH
MANATŪ HAUORA
Matua Raki
National Addiction Workforce Development
ABACUS
www.acts.co.nz

Workshop 26 January 2010

- Te Ariari o te Oranga
- Coexisting Problems
- Screening
- Principles of case management
- Review

Te Ariari o te Oranga

Ariari o te Oranga – Dynamics of Health, was a term coined by tutors and students of Te Ngaru Learning Systems in 1996.

Te Ariari o te Oranga

Imagine you are dancing on a moonbeam to your favourite song

Towards well-being (2000).

Te Ariari o te Oranga: The Assessment and Management of People with Co-existing Mental Health and Substance use Problems

Todd F.C. (2010). National Addiction Centre,
Department of Psychological Medicine,
University of Otago. Christchurch

Co-existing Conditions/ Disorders?

Relationships of Co-existing Conditions

- A primary mental health disorder precipitates or leads to substance misuse
- Use of substances makes the mental health problems worse or alters their course

Relationships of Co-existing Conditions

Substance misuse and/or withdrawal leads to psychiatric symptoms or disorder.

Problems develop faster; symptoms more intense and severe; less responsive to treatment; relapse more likely

Co-existing Problems (CEP)

The word "problems" is preferred over "disorders" or "conditions" in recognition that problem gambling and mental health (including substance use) symptoms may occur at levels that do not meet criteria for disorders in their own right.

Prevalence

Substance use disorder in the past 12 months:

- 29% also suffered a mood disorder
- 40% suffered an anxiety disorder

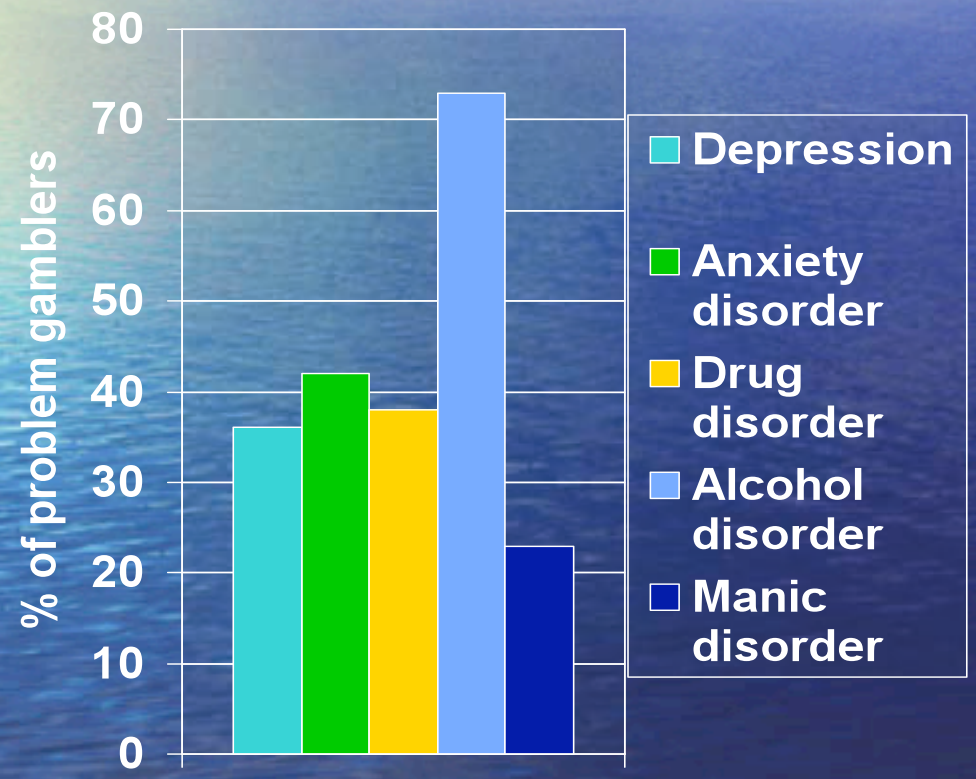
Mood disorder in the past 12 months:

- 12.9% also had a substance use disorder

(Te Rau Hinengaro)

Mental Health disorders common

Petry et al 2005



- AOD problems may occur in 75% of PGs
- Anxiety in over 40% of PGs
- Depression usually 60%+ in other research

Problem Gambling and Co-existing MH Problems

- Likely to meet criteria for other mental disorders
- Almost all PG have another lifetime MH disorder (Kessler et al 2008)
- Co-existing mental health and addiction problems are associated with suicidal behaviour and increases in service use

ALAC/MH Commission report, 2008

Coexisting

- 3.7 times likely to be a current smoker
- 5.2 times likely to be hazardous drinking
- High rates of depression and anxiety

(Focus on Gambling)


“Problem gambling may exacerbate other dependencies, and they in turn may exacerbate problem gambling”
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ALAC/MH Commission Report (2008)

People with AOD and gambling problems have greater mental health problems than the general community, most commonly depression and anxiety

Co-existing issues to address

"Counselling for problem gambling will need to also deal with these co-morbidities and treatment for other dependencies may need to take into account secondary gambling problems that may not be transparent"

Australian Productivity Commission (1999)

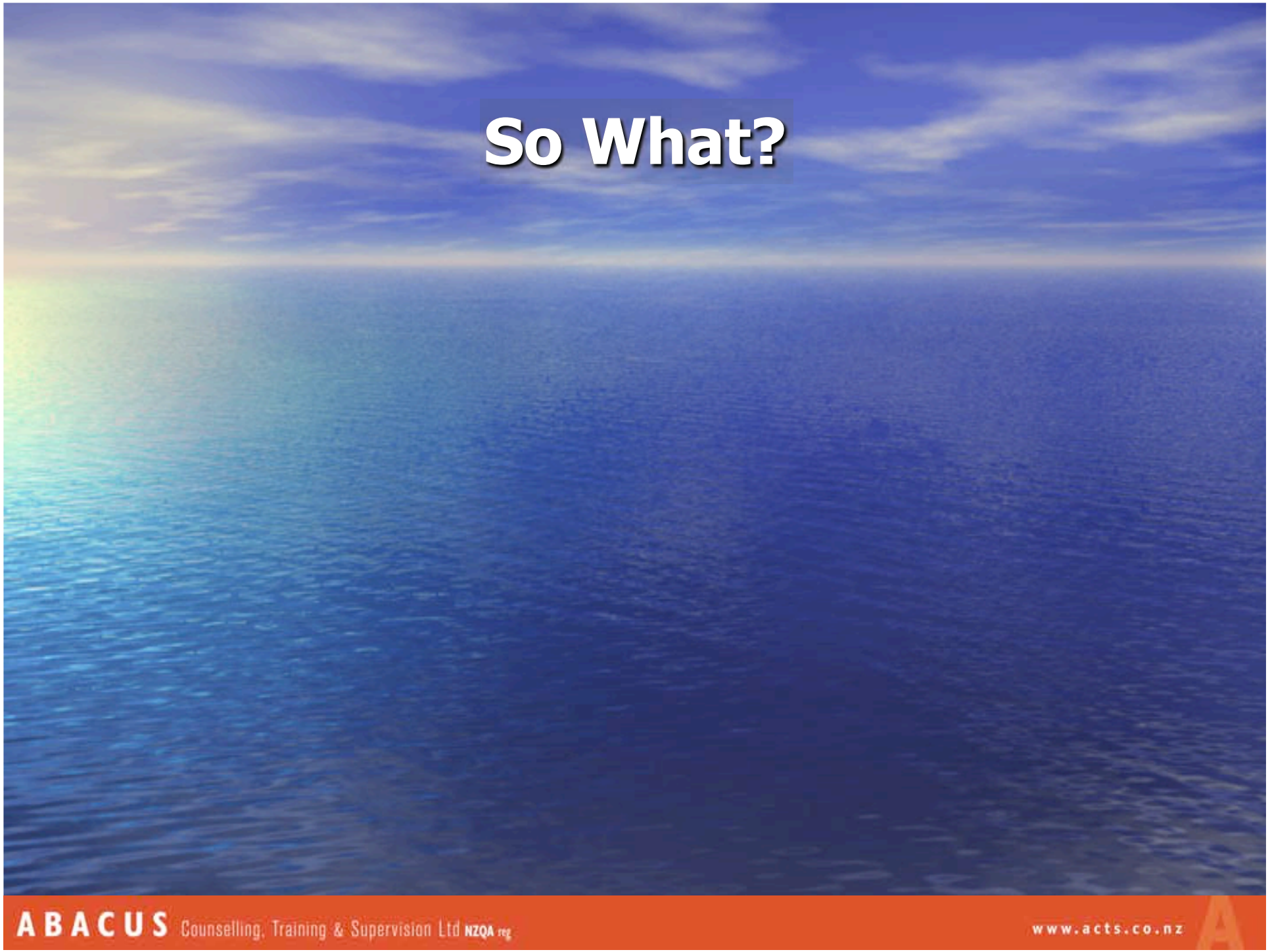
ALAC/MH Commission Report (2008)

Māori - higher mental health and substance-use disorders than the general population; also applies to problem gambling

Addiction and Co-existing Problems

- Co-existing mental health and addiction problems are associated with suicidal behaviour and increases in service use

ALAC/MH Commission report, 2008


So What?

Co-existing Problems

- Poor treatment
- Poor treatment outcome
- High service use

Issues of Stigma in Treatment

- Addiction is often linked in people's minds with criminality
- There is often a tacit belief that "addicts" invite and deserve discrimination.
- Little recognition by society that addiction is a chronic health condition for which there are proven, successful interventions

ALAC/MH Commission report, 2008

Summary

- Coexisting problems are the rule
- Substance Use, anxiety and mood
- Presentation higher in treatment populations

"Working with people with co-existing mental health and addiction problems is one of the biggest challenges facing frontline mental health and addiction services in New Zealand and overseas. The co-occurrence of these problems adds complexity to assessment, case planning, treatment and recovery"

ALAC/MH Commission report, 2008

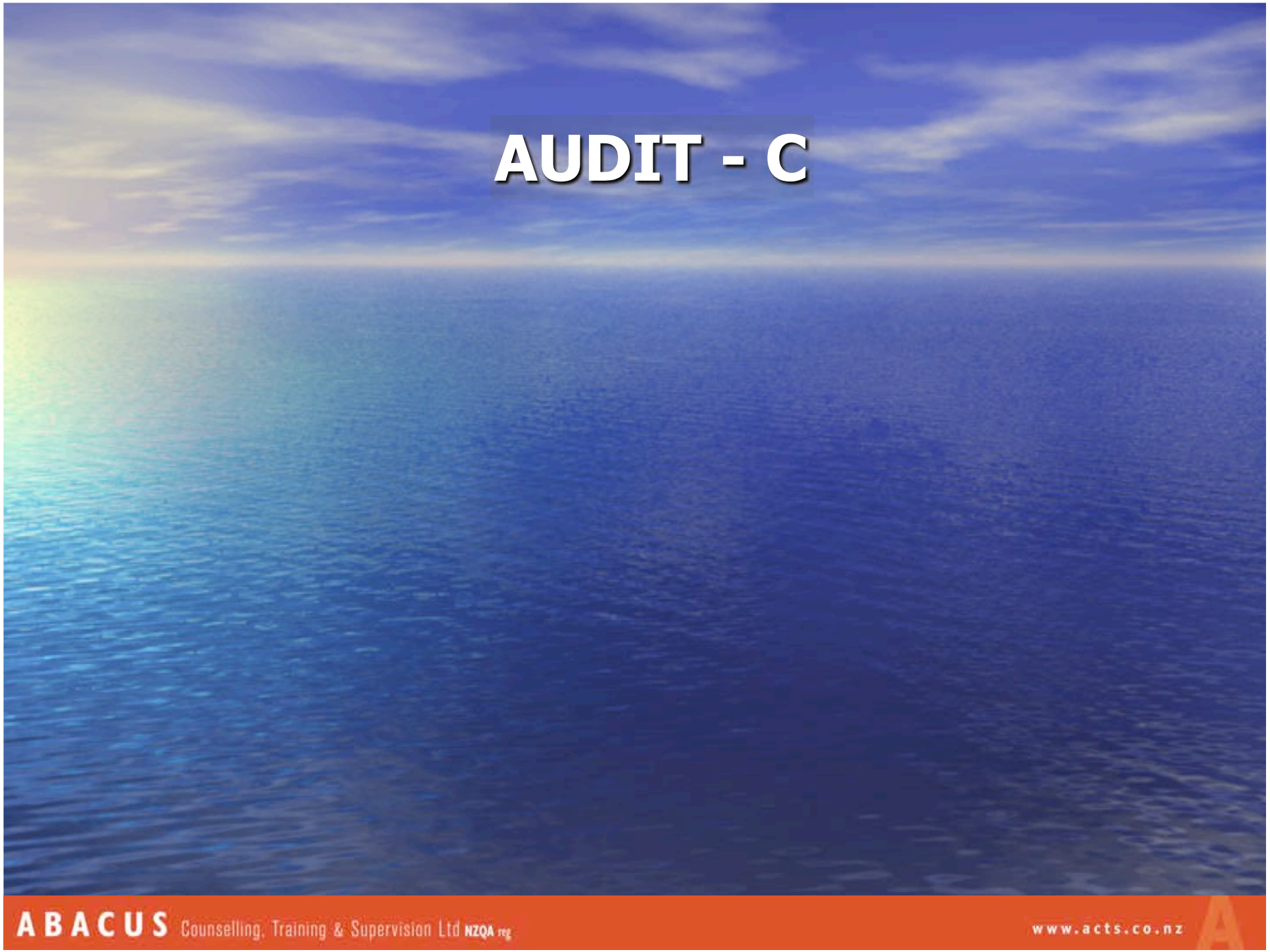
Screening

Benefits of Screening

- Reliability and Validity
- Common Language
- 'Window' of opportunity
- Provides some direction

Todays Screens

- AUDIT – C
- Kessler (10)
- SDS
- Risk


AUDIT - C

Standard Drinks

The Standard Drinks measure is a simple way to work out how much alcohol you are drinking. It measures the amount of pure alcohol in a drink. One standard drink equals 10 grams of pure alcohol.

AOD as self- medication?

- Temporary symptom reduction: arousal soothed; avoidance maintained; intrusive thoughts/memories controlled; fear calmed
- Lift sadness; increase energy/motivation
- Reduce preoccupation with delusions and intrusiveness of hallucinations – PG?
- Lack of alternative coping strategies- avoidance
- Psychophysical state made controllable

Substances:
Severity of Dependence Scale

Self-medication? (Cont'd)

- Stimulants give high arousal and sensitise to stress
- Depressants reduce energy, motivation and cognitive clarity
- AOD users place themselves in dangerous or risky situations:
- Disinhibition, reduced impulse control, deterioration of judgement
- High-risk situations associated with 'drugs'
- PG affects health, job, finance, supports – PG isolated

Kessler (10)

What happens to MH in PGs?

Does part-addressing AOD/MH mean:

- If we focus almost solely on the gambling and are successful in reducing harm from gambling, do most (74.3%) clients with pre-existing disorders retain these now minus the gambling (and risk relapse from these?), or
- Do we assume addressing the gambling somehow also successfully addresses the client's pre-existing AOD/MH disorders?

Cultural Issues

- In some cultures, depression is expressed in somatic terms, rather than sadness or guilt
- Examples: "nerves", headaches; weakness, tiredness or imbalance (Asian); problems of the heart (Middle East).

Cultural Issues

- For some, may be irritability rather than sadness or withdrawal
- Differentiate between culturally distinctive experiences and hallucinations or delusions (which may be psychotic part of the depression)
- Don't dismiss possible symptoms as always cultural

Suicidality Screen

Within the last 12 months, have you had thoughts of self-harm or suicide?

1. No thoughts in the past 12 months
2. Just thoughts
3. Not only thoughts, I have also had a plan.
4. I have tried to harm myself in the past 12 months

Risk Assessment

Identifying Risk is important but don't let it stop you from finding the positive and building on strengths

Case Management

So what should we treat?

- Many disorders very complex
- They are in addition to social needs
- But governmental approach is 'make every door the right door'
- So could identify (screen) and refer
- Or identify and further briefly intervene (in addition to referral)
- Or have specialists on-site (brought in or base PG practitioners where these available)

Quadrant

PG

High PG Low MH

PG + MH

Shared Care

High PG High MH

PG or MH

Either

Low PG Low MH

MH

High MH Low PG

Could this quadrant model work for your clients who have Co-Existing Mental health or AOD problems?

5 Key Principles (1998)

- Safety
- Stabilisation
- Comprehensive assessment and treatment planning
- Clinical case management
- Treatment integration

Integration

How do we integrate our models?
Cultural Safety and Cultural Competence?
What principles underpin our practice

RANGI MATRIX

State of	Action of	Affects	Creates	Use	Requires	Focus on
PIRANGI	KAPO Reflective Gesture	Te Ngakau	A transitory desire		Manaaki	
WAIRANGI	PIOPIO Progressive grabbing stance. Feeling of being overcome. Drowning sensation	Te Manawa	A hunger to satisfy	Whanau-ngatanga	Aroha	Kete Aronui (Esoteric)
HAURANGI	HURORI Staggering but a semblance of control. Imbalance in puku	Te Puku	An urge that needs attending to	Whanau-ngatanga	Awhi	
PORANGI	KEKA Spasmodic attempts to be free. Feeling of being trapped in darkness	Te Roro	A panic to be free	Whakapapa	Tautoko	Kete Tuauri (Tangata)
WHETURANGI	TOITU Frozen immobility. Catatonia. Numbness	Te Mauri			Whakaoho	Kete Tuatea (Spiritual)


WHAKAOTINGA: Completion of the journey, new beginning. The covenant of maintaining the relationship beyond physical sight . Unlocking the Mauri
WHAKAORANGA: Respecting of life. Honouring of living. Subscription to the need for healthier relationships.
WHAKARATARATA: Expression of openness and trust in developing relationships. The hiatus setting. Transition to a new place.
WHAKATANGITANGI: Letting the wellness spring flow. Inner mamae. Memories. Emotional commitment to common relationship.
WHAKAPUAKI: Focusing on the reason for our being there. Determining everyone's relationship to the issue.
MIHIMIHI: Honouring the people and the land. Establishing personal and social relationships. Trust
KARAKIA: Unlocking Wairua. Acknowledging presence of Atua and Higher power than us. Acknowledge divine relationship.
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Use of Whare Tapa Wha to Measure Outcomes

Dimensions	Wairua	Hinengaro	Tinana	Whānau
Dimension 1	Dignity and Respect	Motivation	Mobility/ Pain	Communication
Dimension 2	Cultural identity	Cognition / Behaviour	Opportunity for enhanced health	Relationships/ respect / trust
Dimension 3	Personal contentment	Management of emotions, thinking	Mind and Body links	Mutuality / acceptance
Dimension 4	Spirituality (non-physical experience)	Understanding	Physical health status	Social participation

Treatment Integration

- Aims to reduce gaps and barriers between services
- Integrates various treatments into a single treatment stream or package
- Adapts the various treatments to be consistent and not conflict with each other
- Need seamless, consistent, "accessible" approach to clients' pathology, deficits and problems (including criminal offending issues)

7 key Principles

- Cultural needs and values considered throughout the treatment process.
- Well-being is the key outcome rather than the absence of dysfunction.
- Increase and maintain engagement with the clinical case manager, the management plan and the service.
- Enhance motivation including use of CEP-adapted MI techniques

7 key Principles (cont)

- Assessment - Screen all and if +ve undertake a comprehensive assessment.
- Use clinical case management to deliver and coordinate multiple interventions.
- Integrated Care driven by the integrated formulation in a single setting and ensuring close linkages.

MI Principles

- Some coexisting problems can be addressed without referral to MH or AOD services
- Others will require referral for best outcomes for the PG client

Guiding Principles TIP 42, 2005

- Develop a phased approach to treatment – ME as front end (engagement/ persuasion), active treatment/follow-up and relapse prevention, together with a "stages of change" approach

Guiding Principles (cont.) TIP 42, 2005

- Address specific real-life problems early in treatment
- Use support systems to maintain and extend treatment effectiveness

Brainstorming Exercise

- List four (4) AOD/MH services in your area that you could either refer PGs to, or services you could work with if your PG clients have MH conditions
- How could you ensure this process could work for these clients?

DISCUSS

Summary I

- Coexisting Problems are common
- Coexisting problems can complicate
- Screens provide useful information
- Screens can help create dissonance
- Build on strengths

Summary II

- Single co-ordinating point
- Use compatible treatment models/concepts
- Harm minimisation approach
- Close liaison between all parties
- Deliver all treatments from one setting
- Close liaison between therapists, treatment agencies and whānau/family


Mauri Ora