Addiction Treatment Research NEWS

NEWSLETTER OF THE ADDICTION TREATMENT RESEARCH INTEREST GROUP

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EDITORIAL

Welcome to the latest Addiction Treatment Research News. In this edition we have started the first in a series that will profile members of the ATRIG executive. First up we hear from Catherine Lowry-Hanlon, an executive member and the Clinical Team Leader at CADS North Shore.

Anna Nelson
Acting Editor ATRN

ATRIG EXECUTIVE PROFILE – CATHERINE LOWRY-HANLON

I was raised in Ireland until I was nineteen and throughout most of my teens nursed a desire to travel. I left to spend time in England and both countries are in my bones. With my camera, walking boots, and notepad I carried on through Europe and Asia, finally arriving in NZ. Over 25 years later I've lived in Godzone longer than anywhere else and love it. I have a 23 year old daughter, Cait, who without knowing it has given me many years of free psychotherapy. I still take my camera, walking boots and notepad when my partner drags me out fishing, boating or skiing. He hasn't managed to get me on a road bike yet but if you see a lycra clad cyclist with a camera, walking boots and a notepad wave and lie by telling me it's not far.

Professionally I have worked in a clinical role in alcohol and drug services for 18 years. Prior to that, I specialised in critical care at Auckland Hospital and then as a charge nurse manager for nine years. Working with people who had severe physical injury turned my focus to prevention. I joined Lifeline, followed by work with the New Zealand Heart

Foundation, while studying psychology. I was offered a job in alcohol and drug services in south Auckland teaching early intervention to general practitioners and practice nurses. I was also expected to have a small caseload of 'light' clients, however I soon discovered that clients can appear 'light' initially but may then reveal childhood sexual abuse or other difficulties that make their cases much more complex.

My foundational training was client centered Rogerian counselling and Motivational Interviewing. I learnt that this wasn't enough to manage the complexity of the clients presenting in that environment, and my already steep learning curve became a vertical line. Unfortunately, my psychology studies were not immediately applicable. Feeling frustrated and inept, I changed course and have spent the last sixteen years studying, qualifying in and applying Transactional Analysis (TA) psychotherapy as my main modality. My education in other modalities include Psychodrama, and in 2009 I completed the Dialectical Behaviour Therapy intensive training with Behaviourtech.

Alongside this study I have worked as a clinical supervisor and now as the clinical team leader at CADS North Shore. I continue to have a clinical caseload which gives me an understanding of the demands on clinicians and increases my interest in supporting 'coal-face' research. In our service we have had to be innovative by working with large open revolving groups and now need to capture the wealth of information about the efficacy and sustainability of these groups.

Essential in my work with substance using clients is stabilising their physiological needs so they can think and learn. I often apply the cognitive behavioural aspects of TA when clients need to achieve behavioural social control to stop things getting worse, while the psychodynamic aspects of TA assist with self-understanding, and working through missed developmental stages to prevent relapse. In repairing these stages the clinician and client can experience transference phenomena, in particular erotic transference; a topic that I studied for my masters qualification, *Finding the 'genie' in the self: Exploring the erotic transference in the psychotherapy of clients with addictions.*

As part of my study in TA psychotherapy I researched treatment efficacy outcomes for various modalities from behavioural to psychodynamic. The important factor is the 'person' of the clinician and their ability to integrate and apply the clinical modalities they have been trained in with any given client. There appears to be a trend in current practice that encourages the use of one modality over another which seems to put pressure on clinicians who have studied one or two modalities in depth to then learn preferred modalities often at a superficial level. What appears to have been left out is the evaluation of current practice. We do need to ensure our AOD clinicians are well trained to engage clients in a treatment pathway that results in the client reversing a potentially disastrous life course. However, before we ask them to train more, let us evaluate what they are doing right now and from these findings we may be able to develop a treatment pathway according to what is clinically relevant and effective.

We are fortunate that four years ago we established a Dialectical Behaviour Therapy programme in our service involving trained clinicians working for clients with Borderline Personality Disorder, or who demonstrate multiple traits and misuse substances. We have collaborated with Massey University in Albany and have had two research papers completed using the Behaviourtech tools to validate the usefulness of this programme across genders in the New Zealand setting. We evaluate clients at the beginning, middle and end of treatment. They complete daily diary cards to assess their application of the skills 'to build a life worth living'. The exciting thing about the research findings is that they were a perfect mirror of the extremely hard struggle the DBT clinicians and their clients had faced. It confirmed that the clients had acquired many of the skills for cognitive, emotional and interpersonal regulation which they have the option to translate into 'lives worth living'.

In the future I hope to have similarly useful research undertaken to allow service delivery matching for mainstream (non BPD) clients. I would like to see us assess what interventions and techniques our clinicians use now and build a body of practice based evidence that informs our future practice. Let's measure our clinical innovations and validate our 'vital' people.

Catherine Lowry-Hanlon MSc, Clinical Team Leader at CADS North Shore and ATRIG executive member

CHARTING THE DEVELOPMENT OF A TREATMENT PLANNING SCREENING TOOL FOR USE IN DUAL DIAGNOSIS

Mental health and substance use problems affect large numbers of people worldwide (Ministry of Health, 2006), accounting for 15% of the global burden of disease in the developed world (World Health Organization, 2009). Locally, the New Zealand Ministry of Health (NZ MOH) estimate that 20% of the population have a mental health and/or substance use disorder at any one time, and of these estimates approximately 3% are severely affected (Ministry of Health, 2003). These figures provide an indication of the highly prevalent nature of dual diagnosis disorders; however, the numbers of individuals that are affected is not the only problem. In addition to problems that are directly associated with psychiatric and substance use disorders, persons who are dually diagnosed experience a range of other problems, including psychosocial problems, and often lead lives that have very few developmental opportunities and they lack the protection offered by jobs, families and social networks (Brunette & Mueser, 2006; Cleary, Hunt, Matheson, Siegfried & Walter, 2008; Drake, 2007; Drake & Wallach, 2000; Ford, 1994; Todd, 2010; Wagstaff, 2007).

These factors are among some of the key reasons that individuals with a dual diagnosis withdraw from treatment. Hence, researchers suggest that attention to psychosocial risks is essential to help dual diagnosis patients recover (Drake & Wallach, 2000). In order to address these multiple problem domains, Hawkings and Gilbert (2004) suggest that an holistic approach to treatment is needed, which should involve social services and a range of providers in both statutory and voluntary sectors. However, in practice it can be difficult to coordinate inputs from the many services that should be involved, who all have their own policies and procedures (Hawkings & Gilbert, 2004). This leads to inevitable gaps within and between services who offer treatment interventions for people who are dually diagnosed, which are further complicated by poor communication and coordination between services, leaving clients to fall through the gaps.

Current literature suggests that in addition to managing acute and chronic health needs, services should address social service needs, housing, education and employment in collaboration with other sectors, in conditions which are chronic or have a relapsing pattern (World Health Organization, 2009). In order to achieve this aim, treatment providers need to adopt a multi problem viewpoint. Furthermore, the diversity of problem domains would suggest that there will be a need for both long and short term treatment goals and a variety of stakeholders. Therefore, all stakeholders should be involved in planning treatment strategies. Without an integrated treatment system in place to ensure continuation of care, clients may continue to fall through gaps between services (Drake & Mueser, 2000; Ministry of Health, 1994; Mueser, Noordsy, Drake, & Fox, 2003; Rethink Dual Diagnosis Research Group, 2004; Staiger et al., 2011; Winnipeg Regional Health Authority, 2001).

While 'dual diagnosis' is not currently the preferred term in New Zealand where 'coexisting problems' is currently favoured, the term 'dual diagnosis' has been adopted for use with this project because it continues to be well known, common terminology, particularly in other parts of the world such as the United Kingdom. Furthermore, there are strong links between this project and the Auckland based Community Alcohol and Drug service whose related facility is called the Dual Diagnosis Service.

Aims and Objectives

Clinicians can experience problems in supporting people with complex mental health and substance use problems, which have been recognised as one of the biggest challenges to treatment providers (Mueser et al., 2003). In response to these problems a treatment planning screening tool has been developed by the author called the Service Intervention Matrix (SIM) which aims to close some of these gaps. The SIM has several functions which are: identification of problem domains, assessment of treatment prioritisation, and identification of treatment providers.

Methods

This was a small qualitative study, using a general inductive approach in order to analyse raw data. The project was undertaken in two key phases: 1) Development of the prototype SIM and face validity testing; 2) Implementation

phase within a tertiary dual diagnosis service setting. Participants (n=11), who were dual diagnosis clinicians, took part in this project from its inception. The SIM was implemented over a three month period. Each phase culminated in a focus group, which was audio recorded, transcribed and analysed.

Results

Findings were organised according to the two phases of the project. Phase 1: findings indicated that the SIM achieved face validity and clinical utility. Results included finding the SIM encouraged the use of clinical judgment, helped to identify the impact of problems, clarified problem domains, provided a structure for making clinical recommendations, helped to identify treatment strategies, and had a check list utility. Phase 2: findings indicated that the SIM was useful in treatment planning, captured dual diagnosis complexities, was efficient to use, helped to identify problem domains, was holistic, and helped to identify the need for specialist input.

Conclusion

Findings from this project were encouraging. Clinicians found the SIM helpful in a range of areas such as treatment planning, including problem formulation and as a care coordination tool. However, this was a small project which was carried out in a single, tertiary dual diagnosis service and further research is needed therefore to discover whether these findings are generalisable and transferable across other settings.

For further information regarding this research please contact pauline.tucker@waitematadhb.govt.nz

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NATIONAL ADDICTION CENTRE UPDATE

Research projects at various stages of development are keeping us busy at the NAC. Four key projects at progressively more advanced stages are outlined as follows.

Daryle Deering and Ria Schroder are in discussion with Pegasus Health, a PHO with 95 medical practices in Canterbury, about a potential project exploring opioid substitution treatment (OST). In particular, the experience of clients and practitioners (GPs and pharmacists) of OST received under "GP authority" and what recovery means in this context.

Ria Schroder is also leading a project developing a scale to measure compulsive overeating. This is one part of a larger body of work at the NAC looking at the nature of and treatment for addictive overeating. In the process of undertaking this work it has become apparent that currently there is not a satisfactory validated measure of this phenomena. Data collection is currently underway.

Meanwhile, data collection has been completed for the TEAM Study: Treatment Evaluation for Alcohol and Mood. This randomised controlled trial has recruited and treated 142 people currently experiencing both depression and alcohol dependence. All patients received supportive clinical case-management over 24 weeks and a 12 week course of naltrexone, and were randomised also to receive citalopram or placebo, also for the first 12 weeks. We are now in the process of preparing these data for analysis.

The primary question is whether or not adding an antidepressant to this treatment process improves outcome. A number of additional papers will be written examining the concept of primary versus secondary depression, the relationship between change in mood and drinking, predictors of treatment outcome and pharmacogenomics.

One area of particular interest for PhD student Deirdre Richardson is the importance of therapeutic relationship in the treatment of this population: how it affects outcome and its relationship to other measures of engagement and functioning.

A supplementary study will examine patient functioning 12 months after the end of the medication phase of the TEAM study, with data collection almost complete.

Finally, James Foulds has recently had two papers accepted for publication examining data from the 2006/2007 New Zealand Health Survey. In the first, to be published in *Acta Psychiatrica Scandinavica,* James demonstrated that harmful and hazardous drinking are common and that this population are just as likely to attend primary health services as their lighter or non-drinking counterparts. However, overall only about 9% of heavy and harmful drinkers reported that their alcohol use was discussed during these health service contacts.

The second paper will be published in the International Journal of Alcohol and Drug Research and examines alcohol use measures as a predictor of psychological distress. AUDIT scores were found to be associated with psychological distress as measured by the K10, with a J-shaped curve of somewhat elevated distress in abstainers, lower levels for moderate drinkers and the highest levels of psychological distress found in the heaviest drinkers. James then went

further to examine which components of the AUDIT most closely related to distress scores, finding that it was alcohol-related problems that had the best fit, rather than the consumption items. This finding is important as use of the AUDIT-C, using the three consumption items only, is more common in epidemiological research and would appear to not be the best measure to use when understanding the impact of alcohol consumption on mental health.

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I'VE BEEN READING …

Early Intervention for Coexisting Problems in New Zealand Youth

The negative impacts of the combination of having mental health problems and substance use problems are challenging. Youth with coexisting problems (CEP) have more functional impairment, greater symptom severity, higher rates of substance relapse and generally poorer outcomes than those without CEP (Hawkins, 2009). Once CEP is identified, intensive integrated treatment is the only current solution to this difficult issue (Hawkins, 2009); (Todd, 2010).

The impending publication by the Werry Centre of two reports on the treatment of CEP in NZ youth (The Werry Centre, 2012a, 2012b) is an opportune time to examine the current focus of treatment services. As CEP is the norm rather than the exception in youth (Hawkins, 2009), there is merit in examining opportunities to prevent initial development. Two options are early intervention and the development of well-being.

Opportunities for Prevention and Early Intervention

Due to the work of the Christchurch and the Dunedin longitudinal studies, we are now much better informed of the risks and resiliencies that are associated with mental health issues and substance abuse (Fergusson, Poulton, Horwood, Milne, & Swain-Campbell, 2003). Our growing knowledge allows us to better target risk factors and promote protective factors for different age groups. This emphasis on developmentally appropriate risk and protective factors may lead to a new way of conceptualising mental health services for youth (Beardslee, Chien, & Bell, 2011).

Prevention strategies should focus on young people because half of all lifetime cases of mental, emotional, and behavioural disorders start by age 14, and three-quarters by 24 (Kessler et al., 2005). NZ research suggests the greatest vulnerability occurs between 15-18 (Fergusson et al., 2003). Importantly, in the context of CEP, first symptoms typically occur 2-4 years before progressing to diagnosable disorders (Beardslee et al., 2011).

McGorry (2007) has argued that there is a need for effective health care services that can rapidly engage young people and provide the comprehensive, integrated treatment and support services they need to achieve clinical remission and full functional recovery. Many young people can be successfully managed through enhanced youth-oriented primary care service models, for example, 'Youth One Stop Shops' (Communio, 2009), although some will require more comprehensive, multidisciplinary, youth-specific specialist mental health services (SMHS) (McGorry, 2007).

In the model anticipated by McGorry, youth-specific SMHS would be available to young people, aged 12-25 years, with emerging, potentially severe or complex mental disorders. These services would be qualitatively and structurally different from both adult and child-oriented services. Early intervention for emerging, potentially serious, mental disorders would be a key objective and could be ensured through close cooperation with the primary care workforce.

> *"Specialised substance use services for young people should also be expanded and integrated within this youth health model under a single service system, thus avoiding many of the chronic fracturing and staff-centred tensions of the current system. This integration could prove a*

> *prototype for the widely sought, but elusive, full reintegration of mental health and drug and alcohol services"* (McGorry, 2007, p. s55).

In the NZ (MoH, 2010) service guidance document for CEP there are a number of suggestions to enhance CEP responsiveness for young people, including: *"devolving (in whole or in part) mental health and addiction services into less stigmatising, youth-friendly environments such as community-based youth one stop shop (YOSS) services that can provide client centred wrap-around services"* (MoH, 2010, p. 17). Steps towards better SMHS for youth have been announced by the Prime Minister.

> *"The Ministry of Health will work with effective YOSS on service enhancements while undertaking work on how primary care can be made more youth-friendly…There will also be a requirement for integrated case management between CAMHS, Alcohol and Drug Services (AOD) and other NGO agencies"* (Key, 2012, p. 1).

The strengthening of protective and resiliency factors that all young people need to lead a healthy life are important aspects of all stages of management of CEP. While the identification and management of deficits is now a well advanced field, promotion of strengths is an area that is in its infancy.

Resiliency Programmes

The concept of well-being is an important aspect of the NZ CEP Clinical Practice Guidelines (Todd, 2010). A well-being perspective involves care that aims not just to alleviate problems but also to enhance positive attributes. Seligman (2002) has focused attention on 'positive prevention', arguing that building strengths such as optimism, future-mindedness and perseverance, acts as a buffer against mental illness and is more successful in the prevention of serious health problems than disease model approaches. (Penn Resiliency Program, 2007)

Its original aim was to prevent adolescent depression, but it now has a broader remit of building resilience and promoting optimistic thinking, adaptive coping skills and social problem-solving in youth. One small study has evaluated a pilot group application of positive psychology to alcohol-misusing adolescents (Akhtar & Boniwell, 2010). As well as demonstrating the value of applying positive psychology to alcohol misusing adolescents, the study extends the reach of positive psychology programmes beyond primary prevention into secondary prevention for people who already have symptoms of a disorder.

Summary

Integrated care that puts the client, not the system, at the centre of the treatment approach involves identifying and working with both the problems and strengths of the young person, their family and whanāu and their supporting networks. Such an approach requires a good understanding of youth development and the structures that support healthy development (The Werry Centre, 2012a).

While still in its infancy, the ability of positive psychology programmes to improve symptoms of mental illness and substance misuse may be an interesting addition to the limited treatment options currently available for youth CEP. Certainly, the potential of early intervention to 'nip problems in the bud' before CEP can develop is a powerful argument for a change to existing youth service configurations.

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Addiction Treatment Research News is the official newsletter of the **Addiction Treatment Research Interest Group (ATRIG).**

ATRIG was established in 1997 to promote research in the addiction treatment field in New Zealand.

ATRIG's objectives are:

- To foster interest in scientific research on treatment of people with addiction related problems within Aotearoa NZ.
- To disseminate and promote research findings related to effective treatment of people with addiction related problems in Aotearoa NZ.
- To support the development of improved treatment services for people with addiction related problems within Aotearoa NZ.

The **executive committee members** are:
Klare Braye (Chairperson), Simon Adamson, Janie Sheridan, Robin Shepherd, Ria Schroder (ATRN Editor), Catherine Lowry-Hanlon, Lindsay Atkins (Secretary)

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Addiction Treatment Research Interest Group (ATRIG)

MEMBERSHIP/RENEWAL FORM

Please note all individuals wishing to be a member of ATRIG must join by completing this form regardless of current membership status.

Membership in ATRIG entitles you to the following:

- Four issues of the Addiction Treatment Research News via email

PLEASE ENROL ME AS A MEMBER OF ATRIG (ADDICTION TREATMENT RESEARCH INTEREST GROUP). I HAVE READ AND SIGNED THE DECLARATION BELOW.

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The objectives of ATRIG are:

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Declaration

I support the objectives of ATRIG and wish to be a member of ATRIG for the 2013 calendar year. I understand membership fee is $20.

Signed _____ Date _____

- Please make cheques payable to ATRIG and return with membership / renewal form to address below
- Payment can also be done online: **03 0855 0424992 00** (Westpac) – Reference: name and membership. If using this payment method, please post or fax membership / renewal form.

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