BEST PRACTICE

28

JUNE 2010

He Hauora Wairua

Māori Mental Health

Ruia taitea kia tū ko taikākā anake

Cast off the sapwood, leave only the heartwood

When you strip away the outer layers you are left with the essence of a person

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better medicine

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E te rau o tītapu, e te rau o Huna

Nei ko te reo maioha e tangi atu ki a koutou i runga i te au o aumihi.

Ko te hunga wehiwehi kua mene ki te pō, kua rau atu ki te pūtahi nui o Rēhua, moe mai okioki mai. Ko tātou o te ao kikokiko, o te ao hurihuri tēnā tātou.

Ki tēnei putanga o te tuhinga hauora nei ka aro atu ki te hauora o te wairua, te wairua kua mau i te whakaaro keka, kua waroa e te waipiro, e te tarukino, e te taumaha o mataporehu rānei. He take kua hora whānui ki te iwi, ahungarua mai, pakeke mai, taitamariki mai.

Mokori anō te tuku mihi ki ngā tautōhito, ngā matanga nā rātou i tuku kokomo hei kai mā tātou.

Koutou mā te ihu o te waka hauora e wāwāhi ana ngā ngaru o te moana kia tau ai te waka ki uta.

Tēnā koutou

To our distinguished readers

This is the voice of welcome, calling out to you a greeting.

To our loved ones who have gathered in the night, rest now. To the living in this, the physical world, the ever-changing world, greetings.

This edition of the Best Practice Journal focuses on mental health, an issue that affects us all in some way, from the elderly to the young child.

Thanks must also go to our knowledgeable contributors.

And also to you, the prow of the canoe that cuts through the waves of the sea, so that the canoe may land safely ashore.

Greetings

Welcome to BPJ 28, "He Hauora Wairua" our third journal focused on Māori Health

This edition aims to provide an overview of some important issues surrounding Māori mental health. For Māori, a person's mental health can be considered in terms of the health of their wairua (spirit). Hence the title "He Hauora Wairua" – the health and wellbeing of the spirit.

Evidence shows that disparities in mental health care are significant and there is a continuing unmet need for Māori.

Primary care practitioners can make a significant contribution to lessening these disparities. A framework for the management of mental health problems in Māori is provided along with a focus on more specific topics of particular importance, including:

- Youth suicide
- Alcohol addiction
- Cannabis misuse
- Problem gambling

Some indicators from the PHO performance programme have also been included to show gains that have been achieved over the past few years. However, there is still further progress to be made to reduce disparities and achieve targets.

A holistic approach is important in all areas of medicine however it is vitally important when dealing with people with mental health problems, and is especially important for Māori. A secure cultural identity can assist in recovery from mental health problems.

Whānau ora is the aim – Māori families supported to achieve their maximum health and wellbeing.

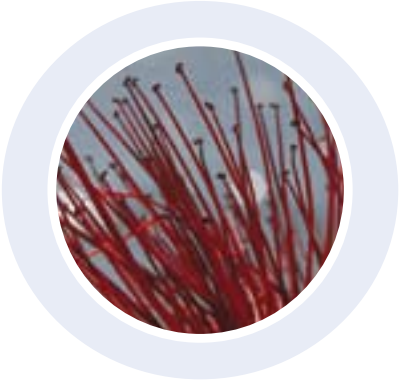
Tīhei mauri ora!

Glossary

Hinengaro	Psychological
Iwi	Tribe
Karakia	Prayer, incantation
Kaumātua	Elder
Kaupapa	Principle
Marae	Traditional meeting place
Mauri	Life force
Mihi	Greeting
Mirimiri	Massage
Rongoā	Traditional Māori healing including medicines produced from native trees and plants
Tangata whaiora	Mental health patient
Tangi	Funeral, to cry
Te Reo Māori	Maori language
Tikanga	Customs, right way of doing something
Tinana	Body, physical
Tohunga	Skilled person, expert
Waiata	Song
Wairua	Spirit
Whakamomori	Suicide
Whakapapa	Genealogy
Whānau	Family
Whānaungatanga	Relationships, kinship

Te whakahaumanutanga me te oranga hinengaro o mua – Ka mātaia ngā huanga o te rongoā

Traditional healing and mental health – measuring the effectiveness of rongoā



He kākano i ruia mai i Rangiātea

A seed sown from the heavens

Contributed by: **Professor Sir Mason Durie**, Deputy Vice-Chancellor, Massey University, Palmerston North

MĀORI PERSPECTIVES ON HEALTH have been important in shifting attitudes to health care in New Zealand. Other indigenous groups have voiced similar perspectives adding support to the notion that medical science, although remarkable for major breakthroughs in the treatment of mental disorders, does not necessarily hold all the answers to health and wellbeing.

Recent appreciation of non-medical interventions has reinforced long standing beliefs in methods of treatment shaped by indigenous world views.[1]

Effectiveness of rongoā

In New Zealand the use of rongoā (native plant extracts and preparations) is a key element of traditional healing. With this greater enthusiasm for the use of rongoā, there has been an interest in determining its effectiveness. The justification for any type of treatment is linked to gains in health. Satisfaction with a service is a useful customer-oriented measure but does not correlate closely with an actual gain in health. Nor does the number of visits to a health practitioner necessarily mean the treatment is effective – it could imply the opposite. Effectiveness depends on being able to show that there has been an improvement in health that would not have occurred without that particular intervention.

It is also important to realise that an intervention is not necessarily the same as a course of treatment. A doctor who prescribes penicillin for an infection may also offer advice about diet, rest, avoidance of contact with others, and how to prevent further infection. Tests such as x-rays or blood analysis may also be arranged. The pharmacological treatment is only one aspect of a wider intervention and occurs within a particular cultural context – in this case within the culture associated with a medical consultation.

Gains in health

In considering the effectiveness of health interventions, it is also important to distinguish between symptoms and syndromes. A symptom may be somatic (such as pain or nausea) or psychic (such as unhappiness, confusion or suspiciousness). A syndrome, however, represents a cluster of symptoms. Although symptoms are useful in making a diagnosis and then monitoring progress, modern medical management focuses more on the syndrome than the individual symptoms.

A crucial question for health outcomes is whether a good result is the relief of symptoms, the cure of a syndrome or the attainment of a higher level of wellbeing.

Hua Oranga is a health outcome tool which, based on a Māori health perspective, measures gains in wairua

(spiritual), hinengaro (psychological), tinana (physical) and whānau (family).[2] This approach endorses the notion that there are at least four basic dimensions to health and comprehensive health interventions should lead to gains across all four, even if the identified problem has only been in one of those areas.

Outcomes and rongoā

Early written accounts of rongoā generally refer to the alleviation of symptoms. It appears unlikely that Māori had classified disease states according to syndromes. Instead, the particular effects of rongoā were linked to specific symptoms.[3] Table 1 provides some examples.

Rongoā are dispensed as part of a wider healing tradition, rather than for just the removal of symptoms. The healer identifies the problem and decides on the most suitable approach. It may involve rongoā, karakia (incantations), whānau participation or, more often, a combination of several methods. Effectiveness is not simply related to the pharmacological action of a plant, but to a process conducted within the context of traditional healing.[4]

Levels of outcome

The aims of traditional healing, against which outcomes might be measured, can be grouped into three levels: the alleviation of distress, improved wellbeing and the modification of lifestyle.

Most people who seek advice from a healer do so because they are distressed. The distress may be spiritual (e.g. a preoccupation with a recurring image), emotional (e.g. a feeling of depression), physical (e.g. an irritating skin rash) or social (e.g. failed relationships with family members). An immediate outcome sought by the distressed person will be relief from discomfort, no matter what its origins. This result can be described as a level one outcome. Given a holistic approach to health, and the emphasis placed on relationships with others, including the natural

Table 1: Impacts of Rongoā

Plant	Healing Ingredient	Indication
Akeake	Juice extracted from leaves	Surface bleeding
Houhere	Juice made from bark	Fever
Karamu	Leaves	Constipation
Kawakawa	Liniment made from leaves	Skin wounds, skin itch
Kowhai	Infusion made from bark	Bruising, muscular pains
Kumarahou	Poultice made from leaves	Cuts, skin sores and rashes
Makomako	Juice from boiled leaves	Painful joints
Mamaku	Juice from boiling young shoots	Constipation, expulsion of afterbirth
Matipo	Infusion from leaves	Toothache
Pohutukawa	Juice from bark	Diarrhoea
Pukatea	Lotion made from bark	Skin sores
Puahou	Infusion made from leaves	Cuts, burns, wounds, boils, skin ulcers

environment, traditional healing also aims to improve levels of wellbeing. This is not only by alleviating symptoms but also by delivering a sense of mental, spiritual, physical and social contentment, described as a level two outcome.

A third level of outcome is about generating an awareness of health, in all its dimensions, and fostering a lifestyle that is compatible with the highest possible state of wellbeing. Every healing intervention creates an opportunity for reviewing patterns of living, reinforcing the balance between spiritual and physical dimensions, consolidating identity and encouraging the development of positive relationships. Changes in attitudes and behaviour do not occur overnight but for many indigenous people the catalyst for long lasting change has often been a healing encounter.

If rongoā are to be used for health and wellbeing, their effectiveness needs to be determined. Ultimately, this will be a task for healers themselves.

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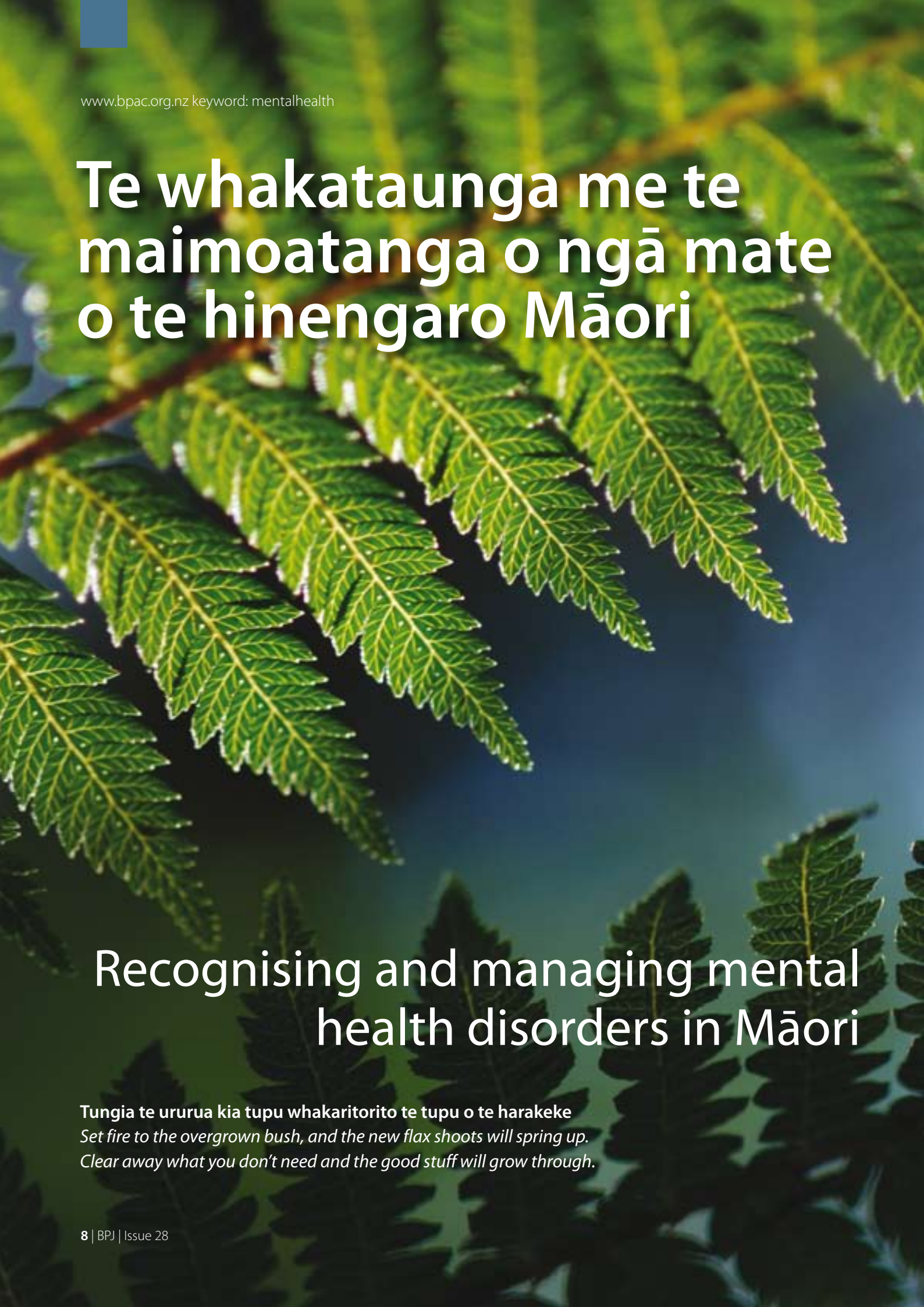
Te whakataunga me te maimoatanga o ngā mate o te hinengaro Māori



Recognising and managing mental health disorders in Māori

Tungia te ururua kia tupu whakaritorito te tupu o te harakeke
Set fire to the overgrown bush, and the new flax shoots will spring up.
Clear away what you don't need and the good stuff will grow through.

Dispelling myths – what we know about Māori mental health

Until recently, there has been a lack of research and information about the nature and extent of Māori mental health needs, and even less known about how effectively Māori mental health problems and disorders are managed. Key areas of concern include the growing suicide rate among young Māori and the increasing rate of hospitalistion for psychiatric illness.

Over the past decade there have been some important new sources of information that have helped describe the nature and extent of Māori mental health. Te Rau Hinengaro, the New Zealand Mental Health survey, was a key study in providing this insight. This was the first national mental health survey to report on a representative population of Māori adults. The study was undertaken from 2003 to 2004 and included 2595 Māori aged 16 years or over. Results of the survey reinforced some ongoing concerns about Māori mental health.[1]

Key concepts:

- Recognise that Māori have a high prevalence of mental health problems and an unmet need for receiving treatment
- Make Māori a priority for identifying mental health problems and providing early intervention
- Acknowledge that the presentation, definition and treatment goals of mental health problems may differ for Māori
- Ensure that care is delivered in a culturally appropriate manner
- Form partnerships with Māori health providers and know who to refer to for treatment that is acceptable to the patient and their whānau

Key findings of Te Rau Hinengaro included:[1]

- Almost one in three Māori adults (30%) met criteria for at least one mental health disorder in the previous 12 months and just under half of Māori had experienced a mental health disorder during their lifetime
- Having more than one mental health disorder was common
- The most common disorders were anxiety disorders (19%), mood disorders (11%) and substance misude disorders (9%)
- Socioeconomic status was important. Higher prevalence of mental health disorder was associated with low household income and fewer years of education.
- Mental health disorders were most prevalent among people aged 16–44 years, but much less common among Māori in older age groups, particularly those aged 65 years and over.
- Māori women had a higher prevalence of mental health disorder (one in three) than Māori men (one in four) in the previous 12 months
- Contact with health services for Māori with mental health disorders was lower than for non-Māori. Those who did seek treatment most commonly saw a GP.
- Approximately half of Māori who met criteria for having a serious mental health disorder, had contact with any services.

The findings from Te Rau Hinengaro, along with other important research have helped to challenge some early views about Māori mental health.

Depression and anxiety disorders DO occur in Māori at rates that are as high, or higher, than the total population. A recent study of over 7000 patients in Auckland general practice found that the level of major depression among Māori was at least as high as that in non-Māori and most

likely to be higher, particularly for Māori women.[2] These results support the findings of Te Rau Hinengaro and other studies. It is noted that when age and socio-economic factors are taken into account, differences between rates of depression among Māori and non-Māori are reduced.

Māori from all regions of New Zealand DO experience similar rates of mental health problems. Results of Te Rau Hinengaro indicated that there was no significant difference in the prevalence of mental health disorders between regions of New Zealand, including both urban and rural areas.[1]

There is NO evidence that Māori are genetically predisposed to mental disorder. Research highlights social, economic, environmental and other influences as contributing towards disparities in rates of mental health disorders, rather than genetic factors.

There is NO evidence that the high rates of hospitalisation for mental health disorders among Māori are due to poor compliance with medication. No research has been undertaken that proves Māori to be less compliant with medicines than non-Māori.

Although socioeconomic status is an important contributor to mental health problems among Māori, it is NOT the only contributing factor. Te Rau Hinengaro identified that 40% of Māori in the lowest household income quartile had a mental health disorder in the previous twelve months. However one in six Māori in the highest income quartile also experienced a mental health disorder. Socioeconomic determinants do contribute to ethnic differences in mental health disorders, but do not explain all differences. After adjusting for socioeconomic status, the prevalence of substance misuse and other serious mental health disorders was still higher in Māori.[1]

Eating disorders DO affect Māori. There was a very low prevalence overall for eating disorders in Te Rau Hinengaro. However, the highest prevalence of eating disorders, particularly bulimia, was in Māori.[1]

Messages for primary care

There is an unmet need for mental health care in Māori. It is of concern that research indicates that half of Māori with a serious mental health disorder had no contact with healthcare services.[1] The high rates of suicidal behaviour, among young Māori males in particular,[3] indicate the importance of exploring mental health issues with this group.

Mental health problems affect Māori in every region of New Zealand, both rural and urban. Māori experience the same range of mental health problems as all New Zealanders. Mental health problems are often silent, so the challenge is to find ways in which to communicate with Māori patients, be aware of the relationship between physical and mental health, be open to alternative ways of expressing mental health, form partnerships with Māori mental health service providers and support Māori health initiatives.

Practical measures for managing mental health problems in Māori

The Ministry of Health Māori Mental Health and Addiction National Strategic Framework – Te Puāwaiwhero, outlines actions that can be taken to maximise positive outcomes for Māori with mental health problems. Applying this framework to a primary care setting, the following points may be considered:[4]

- Implement practice initiatives that recognise and respond to whānau
- Plan and deliver effective, responsive and culturally relevant care
- Develop effective partnerships with mental health and addiction services, especially Māori health service providers

The ultimate goal for primary health care providers is effective communication with Māori, in order to identify and provide early intervention for mental health problems.

Recognising mental health disorders in Māori

In most cases, Māori will present with a mental health problem in much the same way as non-Māori, but clinicians should be open to presentations involving more physical and spiritual expressions of distress. There are also several states specific to Māori which may appear on the surface to mimic symptoms of a mental health problem, e.g. experiencing the presence of ancestors (see "Māori concepts relating to health", Page 15). Mainstream health professionals need to be aware of these presentations so they can seek expert advice to clarify the issue and provide appropriate intervention.[5]

A significant factor in being able to detect a mental health problem is effective communication. Taking the time to build a trusting therapeutic relationship (whānaungatanga) is important. The clinician should introduce themselves and their background and find out about the patient, where they come from, who their whānau is, and try to establish a connection. Time pressures may make this difficult, however it can be the difference between a positive outcome or treatment failure. It is important that the patient is given time to tell their story in their own way and time.[6]

Understand both patient and whānau views of illness

Ask Māori who present to a consultation alone whether they would like to have whānau present. Whānau not only support the patient, but can also help the clinician and the patient understand each other.

However do not assume that just because the patient is Māori, that whānau support is required or wanted.

Listening to the views of the patient and whānau about the illness will assist in the assessment process and enhance the therapeutic relationship. It may be appropriate to ask the patient and their whānau the following questions:[6]

- What do they think is wrong?
- Is there a name for it?
- What may have caused it?
- What, in their view, should be done now?
- What do they think will be the outcome?

Screen Māori for mental health problems

Target Māori for opportunistic screening for mental health problems, especially those in the 16–44 year age group. Also screen new patients and those who are seen infrequently.[7]

Consider that mental health disorders commonly co-exist with substance misuse problems and that people may experience more than one mental health problem simultaneously.[5]

Verbal screening tools

Two to three question verbal screening tools (see over page) have been validated for detecting anxiety and depression and have also shown effectiveness in detecting substance misuse[7] and addictive behaviour such as gambling.[8] These questions have been validated in a New Zealand population, but not specifically for Māori.

If a patient responds positively to screening questions, it may indicate a need to explore the issues more thoroughly. Discussing specific factors may be useful to put the problem in context, however consider that for Māori, roles and responsibilities within the whānau and wider community may be even more important than individual wellbeing. Ask about:[7]

- Duration of symptoms
- Interventions trialled
- Functional impairment
- Whānau and personal history of similar issues and how they were managed
- Precipitating factors (e.g. psychosocial stress – domestic violence, sexual abuse)
- Perpetuating factors (e.g. feelings of uselessness)
- Protective factors (e.g. self-insight, whānau support)
- Specific risk behaviours (e.g. manic episodes, suicidal ideation or attempts)

Examples of verbal screening questions:

Depression

- During the past month, have you been bothered by feeling down, depressed or hopeless?
- During the past month, have you been bothered by little interest or pleasure in doing things?

If yes to either question, ask the help question

Anxiety

- During the past month have you been worrying a lot about everyday problems?

If yes, ask the Help question

Alcohol and drug problems

- Have you used drugs or drunk more than you meant to in the last year?
- Have you felt that you wanted to cut down on your drinking or drug use in the past year?

If yes to either question, ask the help question

Gambling

- Have you ever felt the need to bet more and more money?
- Have you ever had to lie to people important to you about how much you gambled?

If yes to either question, ask the help question

Help question

- Is this something that you would like help with?

Consider cultural appropriateness of care

Practice points for providing culturally appropriate care:[5]

- Consider establishing cultural needs of Māori prior to a first consultation, using culturally skilled staff, however do not assume that all Māori will conform to this cultural identity.
- Obtain advice about appropriate processes, models of health and key issues likely to have an impact on treatment, as early in the process as possible.
- Ensure a welcoming environment (e.g. waiting room space for whānau, information available in Te Reo Māori)
- Determine whether it is the patient or another whānau member who is the decision maker and who needs to be involved in each consultation (e.g. whānau, kaumātua)
- Do not assume it is always appropriate to involve others – always ask
- Allow culturally appropriate processes where possible (e.g. mihi, karakia and waiata)
- Ensure language needs are met – use a Te Reo Māori translator or interpreter if required
- Acknowledge when you are uncertain about cultural processes
- Know who to contact for support, translation and cultural advice

All practitioners need to be competent in dealing with patients whose culture differs from their own. Simply recognising that people from different cultures might perceive and deal with mental health problems in different ways is an important first step.

Pharmacologic treatment is only one aspect of patient care – spiritual, emotional/intellectual, physical and whānau functioning are other important aspects. Medicine can be viewed as an adjunct to other approaches.

Traditional Māori perspectives challenge some treatment goals, such as the focus on developing individuality and self advocacy. Therapies that focus on the individual may be less relevant and less appropriate for Māori, who may place more emphasis on wider relationships.

Whānau play an important role in the wellbeing of an individual and in the recovery process. Poor dynamics within the whānau and lack of support can contribute to, or worsen, the illness. There can be a lack of understanding and often a stigma associated with mental health problems. Information can be provided to the patient, their whānau, friends, workplace and community.

> *"My recovery is about my hinengaro (mind), tinana (body), wairua (spirit) and whānau (family), my treatment seems to be only about my tinana with pills and injections."*
>
> ***— Tangata whaiora group[9]***

Kaupapa Māori mental health services

Kaupapa Māori services are specifically designed to reflect the cultural needs of Māori, alongside mainstream medical treatments. It is important to know who the local Kaupapa Māori service providers are and to establish effective working relationships with them. Consider how shared care with Māori providers could work.

Kaupapa Māori providers deliver services within a Maori framework including:[10]

- Whānaungatanga (networks, relationships)
- Whakapapa (genealogy)
- Cultural assessment
- Empowerment of tangata whaiora (people seeking wellness, mental health service users) and their whānau
- Te Reo Māori (Māori language)
- Tikanga Māori (customs, protocols)
- Kaumātua (elders) guidance
- Access to traditional healing
- Access to mainstream health services
- Quality performance measures relevant to Māori

Kaupapa Māori mental health services are contracted by district health boards (DHBs) throughout New Zealand and also provide specific services such as residential mental health, child and youth services and alcohol and other drug services.

The availability of specific services differs across regions. DHBs and Primary Health Organisations (PHOs) are a first point of contact for finding out what Kaupapa Māori Mental Health services are available locally.

The definition of wellbeing for Māori

Contemporary health services, including general practice, tend to focus on physical and psychological wellbeing as a measure of treatment progress or cure. For Māori the wairua (spiritual wellbeing) of the individual and whānau, as well as the wider physical and spiritual environment, plays a significant role in the wellbeing of a person. The mauri (life force) of people and of objects, and the strength of cultural identity, are key contributors to health in a Māori world view.[11]

There are several Māori models for health and wellbeing that incorporate these considerations. These models provide an insight into the definition of wellbeing for Māori. When managing mental health problems, clinicians need to be aware of, and acknowledge, alternative views of health and wellbeing and measures of treatment gains.

Te Whare Tapa Whā and Te Wheke are two commonly used Māori models of health. However other models are used.

Te Whare Tapa Whā

This model, developed by Professor Mason Durie, recognises four components to Māori health. It can be compared to the four sides of a house, all of which need to be healthy for the house to be strong.[12]

Taha Tinana (physical health)
The physical health of Māori is connected to a person's spirit, mind and whānau

Taha Wairua (spiritual health)
Wairua encapsulates the mauri around a person and its impact on an individual's spirit. Wairua requires a consideration of environment, a link to past generations and a connection to higher powers. Traditionally, an examination of an unwell person would include an assessment of the impact that wairua was having on that person's health. Wairua can impact on both illness and treatment.

Taha Whānau (family health)
Whānau play an important role in the wellbeing of a person. They can contribute to sickness as well as assisting in curing illness. The sense of belonging and strength that whānau provide is one of the key foundations of Māori health.

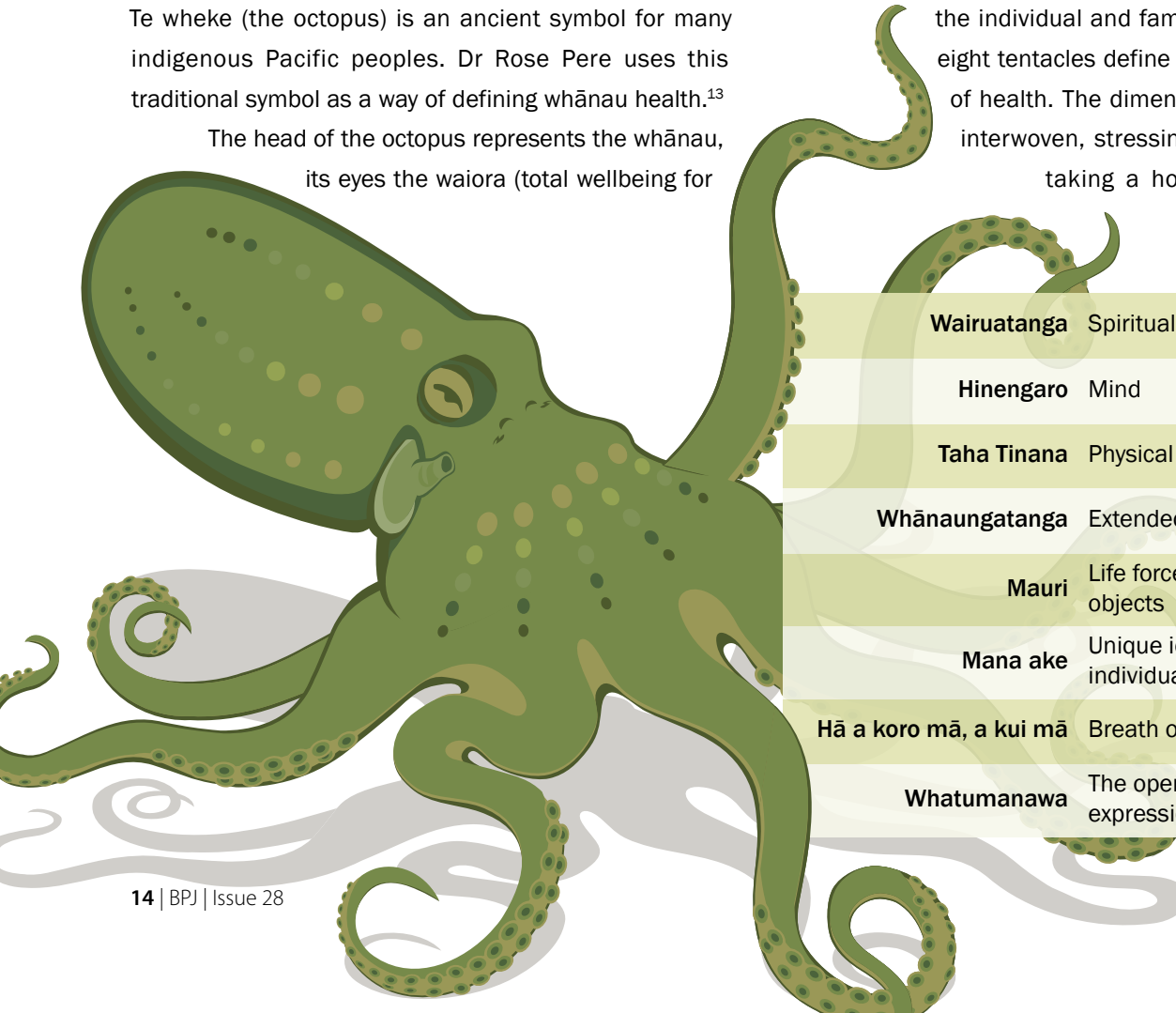
Taha Hinengaro (mental health)
Thought, feeling and emotions are invariably linked to physical and spiritual wellbeing. Māori acknowledge the vital link that thoughts, feelings and emotions have to overall health.

Adapted from Durie, 1994[12]

Te Wheke

Te wheke (the octopus) is an ancient symbol for many indigenous Pacific peoples. Dr Rose Pere uses this traditional symbol as a way of defining whānau health.[13]

The head of the octopus represents the whānau, its eyes the waiora (total wellbeing for the individual and family), and each of the eight tentacles define a specific dimension of health. The dimensions are linked and interwoven, stressing the importance of taking a holistic view to Māori health.[13]



Wairuatanga	Spirituality
Hinengaro	Mind
Taha Tinana	Physical wellbeing
Whānaungatanga	Extended family
Mauri	Life force in people and objects
Mana ake	Unique identity of individuals and family
Hā a koro mā, a kui mā	Breath of life from forbears
Whatumanawa	The open and healthy expression of emotion

Māori concepts relating to health

Adapted from Te Ara Poutama[11] and Te Iho[14]

Some mental and behavioural states experienced by Māori cannot be explained by mainstream medical classifications. Traditional Māori explanations for poor health can be quite different from those based on western beliefs.

Health professionals should be aware that these specific cultural syndromes occur in Māori and be familiar with the terms, but it is important that attempts to treat these conditions are not made. This is the area of expertise of tohunga and kaumātua assisted by kaitakawaenga (Māori cultural workers). It is important to seek expert cultural assistance if these concepts arise when working with Māori.

Mauri ora and mauri mate

Mauri is an energy which is present in all things. However, people (and living or moving things) are also vessels for mauri ora, "life energy".

"Tīhei mauri ora!" a common beginning of a speech on the marae, literally translates as the "sneeze of life". This is a call for life energy to be brought into the hui.

Mauri mate is the opposite of mauri ora. It relates to the energies of sickness and death. At a tangi, speeches often start with "Tīhei mauri mate" to acknowledge the "death energy" which is present.

Tapu and noa

Traditionally tapu was the means by which a place, person or thing is set aside from normal everyday use. People in various states such as illness and grief, or while engaged in important work like whakairo (carving) or tāmoko (tattooing), are also considered tapu. Visitors to a marae are considered tapu when they first arrive, as are various parts of the body or the marae itself.

When situations involve something which is tapu, the outcome is uncertain. A positive outcome requires things to be done correctly, following tikanga.

Noa is the opposite of tapu. Water and food are considered noa and have the ability to remove

tapu. While tapu is associated with uncertainty and restriction, noa represents certainty and freedom. Things that are noa are clean and safe.

Applying these concepts to health, the process of becoming well involves harmonising the tapu and noa of a person.

Mana

Mana can be described as having two aspects, one relating to authority and the other associated with power.[15] The authority in this sense is God-given and the power is dependent on action and performance.

On a personal level, mana is associated with the qualities that an individual is born with. Some people are naturally athletic, some show a tendency toward academic achievement, others are musical.

However, although a person may be born with certain abilities and qualities to enhance their mana, they must also prove their abilities through achievement. Achievement provides them with additional power and authority to exercise that mana, and through their words and actions, influence and lead others. In this way mana is not something a person can claim with their words. It can only be attributed by others. Mana is not about ego or pride.

The wellbeing of a person is directly linked to their mana. Someone who has suffered a substantial loss of mana, or has had few opportunities to develop their mana, may become depressed and unwell. Providing opportunities for people to enhance their mana, by realising their potential, is important in improving health outcomes.

Mate Māori

Mate Māori is a cause of ill health or uncharacteristic behaviour which results from an infringement of tapu or the infliction of an indirect punishment by an outsider (mākutu). It may take several forms, both physical and mental, and various illnesses may be attributed to it. Mate Māori is related to spiritual causes and may require the intervention of a tohunga or priest.

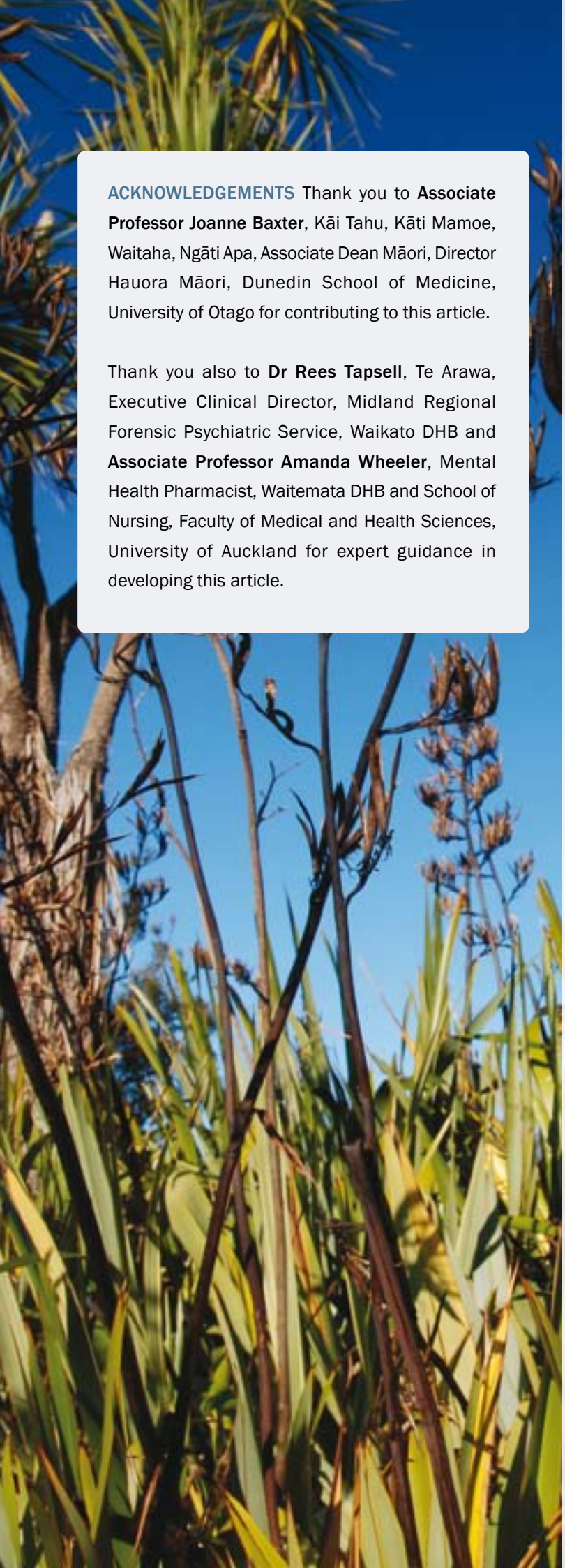
Māori may be reluctant to discuss mate Māori fearing ridicule or pressure to choose between psychiatric and Māori approaches. However, one approach need not exclude the other. Mate Māori does not mean there cannot be a mental disorder. It may be used to explain the cause of the illness rather than the symptoms. Mate Māori remains a serious concept within modern Māori society, and may be more convincing to Māori than complex clinical explanations.

Whakamā

Whakamā is a mental and behavioural response that arises when there is a sense of disadvantage or loss of standing. It can manifest as a pained, worried look, marked slowness of movement, lack of responsiveness to questioning and avoidance of any engagement with the questioner. These signs may be suggestive of depression or even a catatonic state, but the history is different and the onset is usually rapid.

Other concepts

Māori may report seeing deceased relatives or hearing them speak. However, in the absence of other mental health signs or symptoms, this is not a firm basis for diagnosing a serious mental disorder.



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Kua warea te Māori e te tarukino, e te whakapōauau

Substance misuse and addiction in Māori

www.bpac.org.nz keyword: substance-misuse

Key concepts:

- It is estimated that substance misuse and other addictions are experienced by over one quarter of Māori in their lifetime
- Substance misuse disorders commonly co-exist with other mental health problems and co-addictions are also common
- Take advantage of any opportunity to discuss substance misuse and addiction and consider routine screening
- Ensure that issues are understood, and care is delivered, in a culturally appropriate manner
- Be aware of Māori providers of substance misuse and addiction services

He taru tawhiti

A weed from far away

Te Rau Hinengaro, the New Zealand mental health survey (2006) revealed that substance misuse disorders (mainly alcohol and cannabis) are experienced by over one quarter (27%) of Māori in their lifetime, second only to anxiety disorders (31%).[1] Substance misuse disorders were the third* leading cause of hospitalisations for mental health disorders among Māori males (82 per 100,000) between 2003 and 2005.[2]

Substance misuse disorders commonly co-exist with other mental health problems. Te Rau Hinengaro identified that 40% of those with a substance misuse disorder, also had an anxiety disorder and 29% had a co-existing mood disorder.[1] It has been reported that up to 95% of people receiving treatment for substance misuse, e.g. in community alcohol and other drug (AOD) units, have co-existing mental health disorders.[3]

Misuse of multiple substances and co-addictions are common.

Substance misuse is associated with:

- Other mental health disorders
- Chronic general health problems
- Accidental and intentional injury and death
- Violence
- Criminal offending
- Negative work, educational, social and financial consequences
- Risky sexual behaviour
- Adverse effects on foetal development
- Negative child and adolescent outcomes from parental substance misuse

Primary care is well placed to recognise and address substance misuse and addictions, and provide early intervention and general management.[4]

Identifying and discussing substance misuse

Raising the subject of substance misuse and addiction with any patient presents challenges for many clinicians. Barriers may include the perceived sensitivity of the subject, fear of harming the therapeutic relationship, reluctance to document illicit drug use and time pressure. Discussion is dependent on the acuteness and complexity of the presenting complaint and the priority given to multiple other health issues for discussion.[4]

Cultural fluency enhances communication

A lack of confidence in the area of cultural fluency can further complicate addressing addiction-related issues with Māori.

> Cultural fluency is defined as appropriate application of respect, empathy, flexibility, patience, interest, curiosity, openness, a non-judgemental attitude, tolerance for ambiguity and sense of humour. It implies a cultural familiarity and enhances the communicators understanding of cultural context and the degree to which a message is received and understood.[5]

The key aspects of cultural fluency are acknowledging differing definitions of health and wellbeing, supporting choice of treatment approaches and presenting health care (and options) in a culturally responsive manner.

Cultural fluency goes beyond sensitivity, awareness and cultural safety. It can include, for example, understanding how or by whom decision making is made in a whānau, and considerations of how Māori values, beliefs and experiences might impact on the establishment and maintenance of a therapeutic relationship.

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* Schizophrenia and bipolar disorders were first and second respectively

Framework for managing substance misuse and addiction

Māori are a priority population for identifying and managing substance misuse and other addictive behaviours. Primary care intervention is effective and important.

- Be aware that substance misuse and addictions are common problems
- Be alert for opportunities to discuss substance misuse and addiction and consider routine screening when time allows
- Be culturally aware
- Use direct, open questions
- Reassure that information will remain confidential
- Offer hope and support

A general framework for identifying and managing a substance misuse disorder is set out in Table 1. Treatment is usually shared between general practice and specialist care teams.

Table 1: Key treatment goals for substance misuse disorder (adapted from Todd, 2010)[3]

Identification	▪ Problem identified through informal or formal screening or self-identification ▪ Determine and liaise with appropriate services for patient ▪ Ascertain specific needs and any barriers regarding initial contact with services ▪ Ask about and consider cultural needs ▪ Identify further sources of information needed ▪ Involve whānau or other support people if possible
Early treatment	▪ Ask about and use culturally appropriate processes ▪ Assess for co-existing substance misuse or mental health problems ▪ Assess level of risk and manage any acute clinical needs ▪ Engage and motivate patient to seek treatment ▪ Establish the patient's concept of what wellbeing means for them in order to set a treatment goal ▪ Involve key supports and whānau
Middle treatment	▪ Active treatment of substance misuse and mental health problems e.g. therapies, medicines ▪ Increase focus on steps to enhance wellbeing ▪ Maintain engagement and motivation ▪ Continue to involve key support people
Late treatment	▪ Maintain treatment gains, monitor adherence to treatment strategies and prevent relapse ▪ Restore wellbeing ▪ Increase self-management and autonomy (e.g. occupational and social skills) and begin transfer of engagement to whānau and social supports
Independence	▪ Self-motivation ▪ Self-responsibility ▪ Independence from specialist services

Characteristics of discussion about substance misuse

A recent study of GP consultations in New Zealand, revealed significant issues surrounding discussion about the misuse of alcohol and other drugs (AOD).

Opportunities for discussion were not acted upon in one quarter of the consultations. When use of AOD was discussed, it was observed that both GPs and patients had a degree of discomfort, and changed the subject when it became too uncomfortable. GPs were often seen to talk down the importance of the topic or suggest a change in substance intake, but not necessarily to the recommended safe levels.[4] Alcohol and tobacco were most commonly discussed and cannabis use was not discussed at all.[4]

AOD issues were generally raised by the patient or identified in the context of presenting symptoms or in screening for related symptoms. AOD was not the primary reason for presentation in any of the studied consultations.[4]

Harmful drinking and alcohol dependence

Māori are more adversely affected by alcohol than other New Zealanders

Alcohol misuse affects all New Zealanders, however there are three identified population groups that suffer the most harm – young people, Pacific peoples and Māori.[6]

It is well established that the highest level of alcohol related harm occurs in young adults. As half the Māori population is aged under 24 years, they are especially affected.

Māori are more adversely affected by alcohol than non-Māori in New Zealand:

- 76% of Māori aged 18 years and over identify themselves as drinkers, and 36% as binge-drinkers[7]
- The prevalence of severe alcohol-related problems in Māori is more than twice that in non-Māori[6]
- Māori are more likely to experience harm from their own or other people's drinking[8, 9]
- Māori are four times more likely than non-Māori to die of an alcohol related condition[8]

The 2007/08 New Zealand Alcohol and Drug Use Survey found that although there was no significant difference between the number of Māori and non-Māori who drink (adjusted for age), Māori were significantly more likely to binge drink (i.e. consume a large amount of alcohol, three or more times a week).[9]

Drinking culture and youth

New Zealanders generally accept, tolerate and often celebrate binge-drinking and being drunk. The normalisation of alcohol has seen it become an accepted part of culture and offering alcohol is regarded as part of being a good host. For some Māori youth, alcohol is increasingly being linked to their identity and what it means to be Māori.[6]

- 43% of Māori first consumed alcohol when aged 14 years or younger, significantly more than the total population (32%)[9]
- 45% of Māori aged 15 – 17 years reported getting drunk the most recent time they drank alcohol and 25% reported that they had planned to do so[7]
- The majority of Māori youth who drink believe that it is acceptable to get drunk in most situations[7]

Involve whānau in reducing harms from alcohol

Whānau have an important influence on other whānau members when it comes to drinking. In a survey among Māori, 19% of parents thought it was acceptable for their teenagers to get drunk sometimes and 57% admitted that they or other parents/caregivers supplied alcohol to their teenagers.[7] Targeting parents and other whānau members and providing them with information on the harms of drinking and what they can do to keep their youth safe is important.

Ask parents to:

- Encourage a delay in the onset of drinking
- Reconsider supplying alcohol to underage youth
- Supervise youth while drinking

Receiving help for alcohol misuse

The 2007/08 New Zealand Alcohol and Drug Use Survey identified that approximately 1% of women and 2% of men had received help to reduce their level of alcohol consumption in the past year. Overall, Māori (2.4%) were significantly more likely than Europeans (0.9%) to have received help with their drinking.[9]

In addition to those who had received help, 1.2% of New Zealand adults wanted help in the past year to reduce their drinking, but did not receive it. Māori (2.4%) were twice as likely as non-Māori to have wanted help but not received it.[9]

Barriers to receiving help reported by Māori included:

- Psychosocial factors such as fear (34%), social pressure (27%) and lack of time (9%)
- Organisational barriers such as not knowing where to go (26%), not being able to get in touch with the service (10%), no appropriate service (8%), no local service (5%), appointment time unsuitable (5%), lack of transport (15%) or childcare (2%) and cost (3%).[9]

The results of this survey highlight that there is a proportion of people who want help with their drinking and for various reasons are not receiving it. There is an even greater proportion of people who need help but are yet to recognise that their drinking is a problem.

Consider the barriers to receiving treatment and whether there are ways to assist people in overcoming these e.g. know what local services are available, especially Māori providers, and make an appointment for the patient with a suitable service. Addressing access issues may in turn reduce some of the personal barriers to receiving treatment.

Managing alcohol misuse in general practice

The Alcohol Advisory Council of New Zealand (ALAC) has developed a three-year action plan to address alcohol misuse and alcohol related harm in Māori.

Primary care is well placed to contribute to the implementation of this action plan and to help address the disproportionate harm from alcohol affecting Māori.

The action plan recognises six key areas:

1. Creating effective partnerships
2. Initiating conversation about alcohol use and its effects
3. Providing quality information to parents/caregivers of young adults
4. Establishing better research
5. Working collaboratively
6. Supporting Māori communities to develop their own solutions

Screen for alcohol misuse

Take every opportunity to ask about drinking. A simple two to three question screen may be used initially:[10]

Have you ever drunk more than you meant to in the last year?

Have you felt that you wanted to cut down on your drinking in the past year?

If yes, is this something you would like help with?

Answers to these questions should be recorded in the patient notes and used as a comparison for subsequent screening.

There are several more in-depth screening tools suitable for use in general practice to detect alcohol misuse.

The Alcohol Use Disorders Identification Test (AUDIT) is a well-validated ten question tool, covering alcohol consumption, drinking behaviour and alcohol-related problems. The aim of AUDIT is to identify hazardous or harmful drinking before dependency or serious harm occurs.

AUDIT-C is a briefer, three question version of the original test, which has similar validity to the full test in detecting heavy drinking and dependence.[11]

See **www.bpac.org.nz** keyword: **addiction-tools** for a copy of AUDIT and AUDIT-C.

AUDIT can also be accessed within the *bestpractice* Decision Support Depression module. An electronic version of the results is incorporated into the patient record.

AUDIT may be administered as an interview or as a self-report questionnaire. While a particular score is considered to be representative of overall drinking behaviour, it is important to look at the responses of each question. This will help identify patterns of use, inform possible strategies for intervention and indicate areas for further assessment. In general, AUDIT scores:[12]

- Between 8 and 15 indicate that advice and education materials on alcohol reduction is required

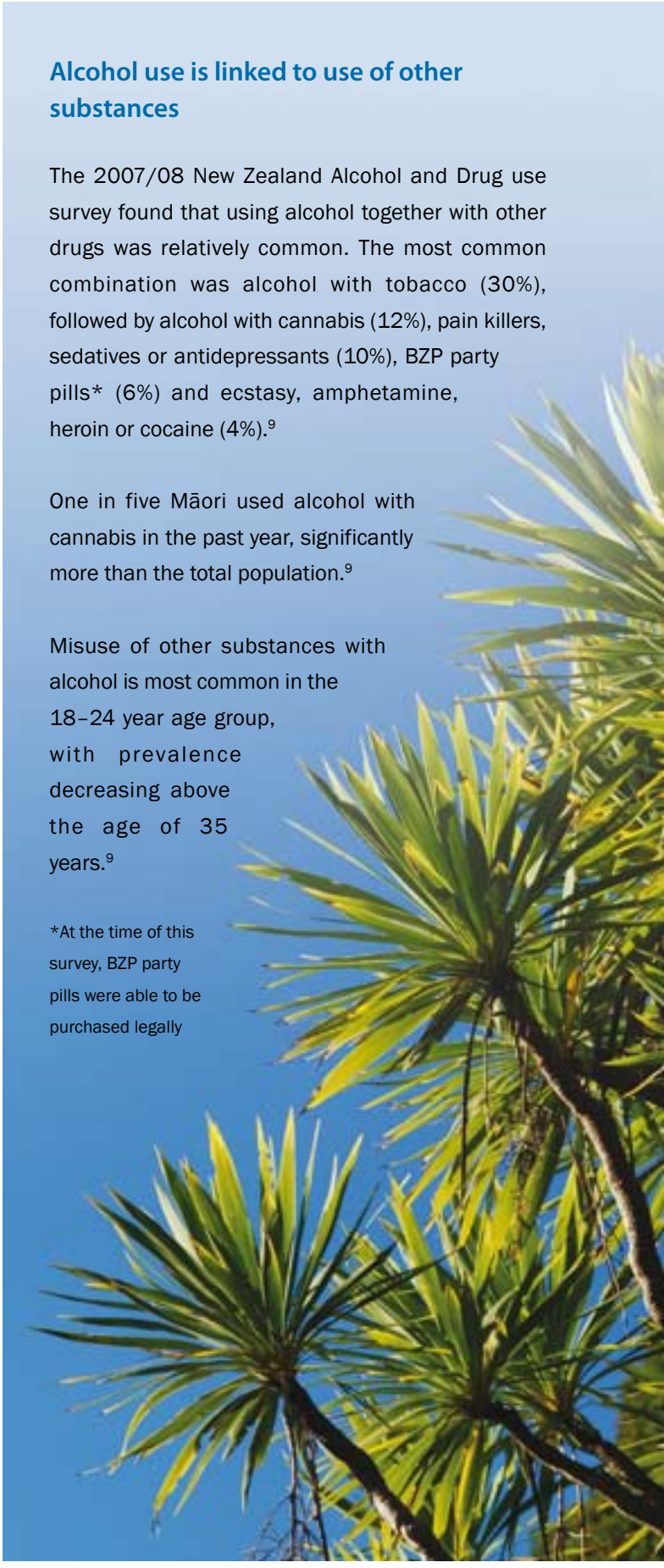
Alcohol use is linked to use of other substances

The 2007/08 New Zealand Alcohol and Drug use survey found that using alcohol together with other drugs was relatively common. The most common combination was alcohol with tobacco (30%), followed by alcohol with cannabis (12%), pain killers, sedatives or antidepressants (10%), BZP party pills* (6%) and ecstasy, amphetamine, heroin or cocaine (4%).[9]

One in five Māori used alcohol with cannabis in the past year, significantly more than the total population.[9]

Misuse of other substances with alcohol is most common in the 18–24 year age group, with prevalence decreasing above the age of 35 years.[9]

*At the time of this survey, BZP party pills were able to be purchased legally



- Between 16 and 19 indicate that in addition to advice and information, brief counselling and continued monitoring is required
- Of 20 or above indicate that further diagnostic evaluation for alcohol dependence is required

Regardless of their score, if a patient does not respond to the initial intervention, they should be referred to the next level of care.[12]

The WHO publication "The Alcohol Use Disorders Identification Test. Guidelines for use in primary care" provides additional information on interpreting the results of AUDIT. Available from: **http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf**

A brief alcohol intervention

For patients who require a brief intervention for alcohol-related problems, the following method may be used:[12]

1. Present AUDIT screening results
2. Identify risks and discuss consequences
3. Provide medical advice about the harms of excessive alcohol consumption and information about safe drinking limits
4. Seek patient commitment to addressing the problem
5. Identify a goal – reduced drinking or abstinence
6. Follow up and re-administer AUDIT regularly to monitor alcohol use

Alternatively, some clinicians may be more familiar with the FRAMES approach to a brief intervention:[13]

1. **F**eedback – explain that alcohol use may be causing problems
2. **R**esponsibility – encourage the patient to take responsibility for changing their behaviour
3. **A**dvice – recommend a reduction in drinking or abstinence
4. **M**enu of options – provide information about services where they can receive help from
5. **E**mpathy – acknowledge that the process may be difficult but will result in health gains
6. **S**elf-efficacy – express praise for the patient's willingness to consider a change

The methodology behind the FRAMES approach is to avoid confrontation and lead the patient towards making their own decisions.[13]

Referral for possible alcohol dependency

Patients who have been identified with a possible alcohol dependency may be referred for specialist treatment. Many patients are reluctant or unwilling to seek treatment so following up with both the treatment provider and the patient to ensure that treatment has been commenced and is acceptable, is helpful. The GP has an opportunity to begin motivating patients to consider change.

An alcohol withdrawal regimen may be necessary for some patients if they are likely to experience moderate to severe symptoms when alcohol is stopped. This includes symptoms such as shaking, sweating, panic and anxiety that are apparent after a period of abstinence, e.g. overnight, or in people who drink to avoid these symptoms.[13] Community based withdrawal can be used successfully in the majority of cases.[12] In areas where specialist treatment is not available, patients may be managed in primary care, along with support from community-based organisations.[12]

Patients who do not require (or decline) a formal withdrawal process can be advised to slowly reduce their daily intake of alcohol over a period of days or weeks.[13] Abrupt cessation of alcohol without support or a withdrawal regimen is not recommended due to the risk of complications such as delirium tremens and seizures.[13]

Medical assessment prior to referral

If a patient is to be referred for treatment of alcohol dependency (or if community withdrawal is to take place),

assess for the following:[14]

- Alcohol-related medical problems such as gastritis, gastrointestinal bleeding, liver disease, cardiomyopathy, pancreatitis, neurological impairment, electrolyte imbalances, nutritional deficiencies
- Use of other substances e.g. drugs, sedatives
- Unstable mental health conditions e.g. delirium, psychosis, severe depression, suicidal ideation

A focus on alcohol withdrawal

An alcohol withdrawal regimen may be required for patients who are likely to suffer moderate to severe symptoms when alcohol is stopped. The patient must be both physically and psychological ready for the withdrawal and prepared for the subsequent abstinence.

Withdrawal management can be done on an inpatient or outpatient basis.

Indications for inpatient detoxification include:

- Alcohol intake exceeding 150 g per day (equivalent to 15 standard drinks e.g. approximately two bottles of wine, 15 cans of regular strength beer or a 500 mL bottle of 37.5% spirits)
- Co-existing serious general medical or mental health conditions e.g. ischaemic heart disease, epilepsy, psychosis
- Severe symptoms anticipated e.g. past history of delirium tremens following withdrawal
- Previous failure of outpatient withdrawal
- Poor psychosocial support
- A living situation that encourages continued alcohol consumption

In areas where speciality services are not available, or if there is a shortage of space or personnel, GPs may be asked to assist in a community-based withdrawal. GPs should be cautious when assessing a patient who requests a community based withdrawal that does not involve the local AOD service. They may have been advised to undergo inpatient withdrawal or may be drug seekers.

Community withdrawals can be safely carried out in cases where mild to moderate withdrawal is expected and adequate support/supervision is present.

The greatest risks are unforeseen complications and drinking reoccurring. Both of these risks can be monitored by daily observations and daily supply of medicine.

Remember that:

- It is not possible to safely withdraw patients with alcohol dependence who continue to use alcohol
- Medical treatment should always be accompanied by psychosocial support

Management of withdrawal symptoms

Use of a benzodiazepine, such as diazepam, combined with supportive care can assist in reducing the severity of withdrawal symptoms.[15] During withdrawal, benzodiazepines serve as a substitute for alcohol and also reduce the incidence of delirium tremens and seizures.[14]

Benzodiazepines should not be continued for more than seven days due to their addictive potential. It is recommended that medicine is supplied by the GP or practice nurse to the patient on a daily basis.

There are several regimens that can be used, based on reducing the dose of diazepam over a five to seven day period. Regimens should be tailored to each patient's individual circumstances and likely severity of symptoms.

Alcohol withdrawal syndrome

Alcohol enhances the inhibitory effect of gamma-aminobutyric acid (GABA) on neurons, lowering neuronal activity and increasing the excitatory response. Over time, chronic alcohol use leads to tolerance to this response and more alcohol is required to produce the same inhibitory effect. If alcohol is then removed acutely, the excitatory response remains, but without the suppressive GABA effect. This then leads to the signs and symptoms of alcohol withdrawal, caused by neuropsychiatric excitability and autonomic disturbance.[14]

Common signs and symptoms which may occur after reducing or stopping alcohol after chronic use include:[14, 15]

- Tremor of tongue, eyelids and extended hands
- Anxiety, agitation, confusion
- Sweating
- Palpitations
- Nausea, vomiting, diarrhoea, loss of appetite
- Insomnia
- Vivid dreams
- Craving for alcohol
- Headache

Rarer but more concerning symptoms include hallucinations, seizures and delirium tremens (DTs). DTs may present within two to four days of the last drink and are characterised by disorientation, persistent visual and auditory hallucinations, agitation, trembling and autonomic signs caused by activation of stress hormones (tachycardia, hypertension, fever).[14]

Withdrawal symptoms usually start to resolve within several hours, although may take up to four to six days.

An example regimen based on a five day treatment period is:

Treatment day	Dose instructions	Total dose
Day 1	10 mg, 4 times per day	40 mg
Day 2	10 mg, 4 times per day	40 mg
Day 3	5 mg, 4 times per day	20 mg
Day 4	5 mg, 2 times per day	10 mg
Day 5	5 mg, at night	5 mg

Anticonvulsants e.g. carbamazepine, are not traditionally used for alcohol withdrawal,[15] but may be considered by specialists in some situations.

Antidepressants e.g. SSRIs, are not indicated in the early stages of withdrawal but may be appropriate at a later stage.[15]

Antiemetics such as metoclopramide may be required for nausea in the first two to three days.

Nutritional supplements should be given, especially in under-nourished people. Thiamine deficiency is common in those with chronic alcohol use and can result in Wernicke's Encephalopathy. Thiamine hydrochloride (vitamin B1) tablets or a multivitamin containing thiamine and folate may be prescribed.

Fluid intake should be increased to prevent dehydration.[15]

Complementary therapies such as massage (e.g. mirimiri), acupuncture and herbal remedies (e.g. rongoā) may be helpful to some patients to assist coping with withdrawal symptoms.

Monitor the patient daily

Ask the patient to attend the practice each day for observations that can be performed by the practice nurse.

Monitor pulse, temperature and blood pressure and observe for:

- Tremor
- Orientation
- Dehydration
- Decreased level of consciousness
- Evidence of continued drinking

The Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar) may be used to formally evaluate the severity of withdrawal symptoms.

CIWA-Ar available from: **http://images2.clinicaltools.com/images/pdf/ciwa-ar.pdf**

What to do if detoxification fails

If a person recommences drinking during their withdrawal, diazepam should be ceased immediately and the patient asked to consider trying again when they are feeling more prepared.

Scheduling a follow up appointment with the GP in a few days time is worthwhile as it allows the discussion of "what went wrong" and "what could be put in place next time to avoid this"?

Consider consulting the local AOD service for further advice if required.

Avoiding relapse

It is important to ensure that following withdrawal, a relapse prevention programme is organised in conjunction with the patient's support network of whānau and friends. Referral to a self help group e.g. Alcoholics Anonymous, should be considered.

Identify individual triggers that may contribute to relapse such as stress, anxiety, social phobia or depression.[15] Discuss ways these triggers can be managed to avoid drinking. The treatment of any underlying mental health problem, including co-existing addiction is an important safeguard against alcohol relapse.

Medicines to assist in preventing relapse

Anti-craving medicines, such as naltrexone and acamprosate, may be prescribed as an adjunct to psychological support, to assist patients in their long-term withdrawal from alcohol and to reduce the severity of relapse if it does occur. Naltrexone is associated with reduced number of days to first drink, reduced number of drinking days and reduced amount of alcohol consumed per occasion.[16] There is less evidence for acamprosate but people taking this medicine have also shown success in maintaining abstinence.

An alcohol deterrent, such as Disulfiram, may be considered for highly motivated patients. This is a negative behavioural reinforcement.

Choice of an anti-craving or deterrent medicine depends on drug interactions, patient experience, likely adherence to dosing, potential adverse effects and cost.

Naltrexone is a narcotic antagonist. It is not fully understood how naltrexone works in alcoholism, but it exerts its effect through interruption of alcohol reward pathways. Naltrexone has been shown to support abstinence, reduce alcohol consumption and lessen craving in some people. It does not cause an alcohol aversion. Naltrexone is contraindicated in acute hepatitis or liver failure and liver function monitoring is usually recommended in long-term treatment. Naltrexone is available under Special Authority and is fully subsidised for up to 12 weeks. To be eligible the patient must be enrolled in an alcohol dependence treatment programme. The usual dose of naltrexone is 50 mg/day.[16]

Acamprosate is a psychoactive drug which decreases the desire for alcohol. It does not cause an alcohol aversion. Its mechanism of action is not fully understood but it acts on the brain's glutamatergic pathways through NMDA receptor systems that are involved in alcohol dependence and withdrawal. Treatment is initiated as soon as possible after withdrawal has been completed and may be continued for up to one year, even if relapse occurs.[15] Acamprosate is generally well tolerated and may

be particularly useful in patients with hepatic impairment (for which naltrexone is contraindicated). Acamprosate is not subsidised and the approximate cost to the patient for one month's supply is $300. The usual dose of acamprosate is two 333 mg tablets, three times per day (lower doses are recommended for patients with renal impairment).[16]

Disulfiram (Antabuse) reacts with alcohol by inhibiting the enzyme aldehyde dehydrogenase, causing an accumulation of acetaldehyde. This results in adverse symptoms such as flushing, palpitations, nausea, faintness and in some cases collapse and acts as a disincentive to alcohol consumption. In rare cases the consequences of combining disulfiram and alcohol may be fatal.[15] Disulfiram is best used in patients who appear to be motivated and psychologically stable. Disulfiram can be commenced 24 hours after alcohol is ceased and may be continued for up to six months or longer if required. It is contraindicated in people with severe renal or hepatic impairment or ischaemic heart disease. It is not recommended in people with hypertension or diabetes. Disulfiram has been associated with severe (sometimes fatal) hepatitis or hepatic failure (even without a prior history of abnormal hepatic function) and onset of depression or psychosis - mental status should be monitored. In addition, patients should be educated to avoid "hidden" sources of alcohol such as mouthwash. Disulfiram is fully subsidised. The usual dose is 500 mg/day for one to two weeks, followed by an average maintenance dose of 250 mg/day (range 125 – 500 mg per day depending on adverse effects).[16]

Cannabis misuse

Cannabis use is prevalent among Māori

According to the 2007/08 New Zealand Alcohol and Drug Use survey, almost half of New Zealand adults have used cannabis at some point in their life.[17] Māori have significantly higher rates of cannabis use than the total population. One in four Māori had used cannabis in the past year, compared to the national average of one in seven.[17] Although the most common age for first trying cannabis was 15–17 years, Māori were significantly more likely than non-Māori to have been aged 14 years or younger when they first tried cannabis.[17]

Young people, particularly Māori, have been consistently identified as a high risk group with regard to cannabis-related harm. Cannabis use has been linked to truancy, poor academic performance, behavioural problems and a pattern of multiple substance misuse from adolescence to young adulthood.[18]

People with co-existing mental health disorders and those who also use other drugs have been identified as being at greater risk of cannabis related harm.[18]

Effects of cannabis

There are three main forms of cannabis:

- Marijuana – dried leaves, flowering tops and stalks of the cannabis plant. The most common and least potent form of cannabis.
- Hashish – dried blocks of cannabis resin which produces a more intense effect than marijuana
- Hash oil – the thick oily liquid extracted from hashish and the most potent form of cannabis

The primary psychoactive ingredient in cannabis is THC (Delta-9 tetrahydrocannabinol). The most common way of using cannabis is by smoking it, which is associated with similar health risks to tobacco smoking.[19] Effects of cannabis use vary from relaxation and altered perception to more serious psychological sequelae (Table 1).

People with mental health disorders are especially vulnerable to the adverse effects of cannabis and are at risk of worsening their condition or illness.[19]

Concurrent use of cannabis significantly compounds the effect of alcohol.[19]

The use of cannabis has also been linked to decreased libido, irregular menstrual cycles in women and lower sperm counts in men.[19]

Cannabis dependence and overdose

Cannabis can induce dependence in a significant number of regular users. Sudden withdrawal may result in symptoms such as anxiety, appetite loss and gastrointestinal disturbance. Symptoms usually resolve within one week, although sleep disturbance may persist for several weeks.[19]

Acute toxicity from an overdose of cannabis is unlikely. It has been estimated that a lethal dose of cannabis is 40,000 times that of a usual intoxication dose.[19]

Identifying patients that may be using cannabis

All patients should be assessed for substance misuse periodically and routinely. It is recommended that patients

Cannabis psychosis

Cannabis use, particularly heavy and frequent use, has been associated with a condition known as "cannabis psychosis", characterised by delusions, confusion, memory loss and hallucinations, lasting several days.[19]

Cannabis is also known to exacerbate pre-existing psychoses and bring forward latent psychoses, such as schizophrenia, depression and psychotic episodes.[19]

Use of cannabis by a person with an existing or previous mental illness, or a family history of mental illness is strongly advised against.

Table 1: Effects of cannabis use[19]

Level of use*	Common signs and symptoms
Small to moderate amounts	▪ Relaxation ▪ Loss of inhibition ▪ Altered perceptions; heightened sense of sound and vision ▪ Impaired coordination ▪ Laughter ▪ Increased appetite
Moderate to high amounts	▪ Confusion ▪ Hallucinations ▪ Paranoia ▪ Loss of coordination ▪ Restlessness ▪ Depression
Long-term/chronic use	▪ Memory loss and altered brain function: impaired ability to learn and remember, especially short-term memory ▪ Concentration: difficulty in concentrating for longer periods of time ▪ Motivation: lack of motivation for sport, school and work, decreased energy levels

* It is difficult to quantify how much small, moderate and high amounts of cannabis are as it depends on the potency of the source plant and the tolerance of the user.

Interactions between cannabis and other drugs and medicines

Interactions between cannabis and other drugs include:[3]

Medicine/drug	Adverse effects when combined with cannabis
Amphetamines, cocaine, other sympathomimetics	Additive hypertension and tachycardia, possible cardiotoxicity
Atropine, scopolamine, antihistamines, other anticholinergics	Additive tachycardia and drowsiness
Amitriptyline, amoxapine, desipramine, other tricyclic antidepressants	Additive tachycardia, hypertension, drowsiness
Benzodiazepines, alcohol, lithium	Additive drowsiness and CNS depression
Theophylline	Increased theophylline metabolism

There have been isolated reports of hypomania occurring with concurrent use of cannabis and fluoxetine or disulfiram.[3]

over the age of 14 years be assessed at least every three years.[20] Given the evidence of early use,[17] screening for cannabis use in Māori may need to begin at an earlier age.

Screening for cannabis use

Include questions about cannabis and other substance misuse within the context of a general health review. This may help to "normalise" the issue and lessen both doctor and patient discomfort. Careful listening, accurate understanding of the patient's concerns and a non-judgemental attitude are key to establishing trust and empathy.

A simple two to three question screening tool may be used to ask about substance misuse. This could be combined with the alcohol screening questions (see Page 23).

> Have you ever used drugs more than you meant to in the last year?
>
> Have you felt that you wanted to cut down on your drug use in the past year?
>
> If yes, is this something you would like help with?

The **Cannabis Use Disorders Identification Test–Revised (CUDIT–R)** is a more formal screening tool that may be used to identify problem use of cannabis. This tool has been developed by New Zealand researchers, based on the well-validated AUDIT tool for alcohol screening.[21] CUDIT–R is an eight item questionnaire with a maximum possible score of 32. Scores of 8 or more may indicate hazardous cannabis use. Scores of 12 or more indicate a possible cannabis misuse disorder, for which further intervention may be required.

A copy of CUDIT-R is available from **www.bpac.org.nz** keyword: **addiction-tools**

Managing problem use of cannabis

If screening has identified a possible cannabis misuse disorder, the next step is to decide whether brief

intervention or referral to specialist services is necessary, depending on the magnitude of the problem and the patient's wishes.

Brief intervention may include:

- A discussion about the harms associated with cannabis use, both in general and in relation to the individual circumstances of the patient
- An agreement that cannabis use is ceased or reduced
- Provision of educational material and web-based resources
- Arranged follow up to ensure that action has taken place

Cannabis is an illegal drug with a well recognised potential for causing harm, and any use should be discouraged. However in reality some people will continue to use this drug. In these situations, people should be advised about the health impacts and recommended to limit intake to occasional use only.[19]

If a patient's use of cannabis is creating significant medical, mental health or social problems, or if brief intervention has failed, refer to (or seek advice from) a specialist addiction service.

Contact details of local alcohol and other drug counselling and treatment services is available by phoning the Alcohol Drug Helpline (0800 787 797) or visiting **www.addictionshelp.org.nz/Services/Home**

Problem gambling

Māori are at increased risk of problem gambling

Problem gambling is a significant social and health issue in New Zealand, with Māori and Pacific peoples disproportionately affected by gambling harm.[22]

The 2006/07 New Zealand Health Survey identified that 1.7% of the New Zealand adult population were classified as problem or moderate-risk gamblers. This represents one in 58 adults, most commonly in the 35–44 year old age group.[22]

After adjusting for differences in age, Māori were approximately four times more likely to be problem gamblers than people in the total population.[22] Those who were problem gamblers were nearly four times more likely to be current smokers, five times more likely to have hazardous drinking behaviours and also had higher rates of anxiety and depression.[22]

Sociodemographic factors found to be significantly associated with problem gambling include:[22]

- Being aged 35-44 years
- Being of Māori or Pacific ethnicity
- Having fewer educational qualifications
- Living in more socioeconomically deprived areas (Deprivation quintiles 4 and 5)

Identifying and managing problem gambling in general practice

Problem gambling is a behavioural addiction which can be identified, understood and managed in a similar way to substance misuse.

Due to issues such as shame and stigma, people who have a problem with gambling will not always reveal this information to their GP or other primary healthcare provider.[24] Be alert to conversational "red flags" which may

arise in the course of a consultation, such as discussion surrounding:[22]

- Loss of control – betting more than can be afforded
- Escalating behaviour – needing to gamble with more money to get the same feeling of excitement
- Chasing – returning to try to win back losses
- Borrowing – borrowing money or selling items to get money to gamble
- Lying – about how much money is spent on gambling, how often gambling is taking place
- Problem recognition – feeling that there might be a problem with gambling
- Criticism – other people criticising gambling
- Feelings of guilt – feeling guilty about gambling
- Negative effects on health – e.g. stress, anxiety, headaches, sleep disturbance
- Financial problems – for the individual or household

Screening for gambling

Consider routine screening for problem gambling, especially in at risk populations (e.g. Māori, Pacific, age under 50 years, presence of depression, substance misuse). Many people with a gambling problem do not seek help until they reach a crisis point, preferring to try to cope by themselves. Early intervention may help to alleviate the pressure of dealing with a gambling problem alone and prevent it from escalating into a more serious problem.[26]

A simple two to three question screen is:[27]

> Have you ever felt the need to bet more and more money?
>
> Have you ever had to lie to people important to you about how much you gambled?
>
> If yes, is this something you would like help with?

Insights from Ngā Ringa Ringa Tūmanako: Hands of Hope – the Māori gambling helpline[23]

In addition to its main service, Gambling Helpline New Zealand provides a subsidiary service specifically for Māori affected by gambling, staffed by Māori counsellors. The counsellors say that Māori contacting the Gambling Helpline have several factors in common. Many grew up to view gambling as a normal part of life, it was viewed as a "fun thing" that adults did. When gambling became a problem, it was difficult to stop as they were being encouraged by the rest of the whānau to keep gambling and they felt alone and alienated. On the other hand, Māori with whānau who did not gamble felt unable to talk about their gambling problems and seek support due to overwhelming feelings of shame.

For many, gambling began with betting on horses and playing housie but now a significant proportion of problem gambling stems from the use of pokie machines (non-casino gambling machines). Māori women in particular often speak about the social aspect of gambling. They meet their friends at the pokie machines and this, along with the hope of a big win, provides a temporary escape from their normal life. However this may soon be followed by feelings of remorse and fear when money is lost that is needed for food and rent. Interestingly, the largest concentration of pokie machines is in low socioeconomic areas where there is a higher than average Māori population.

The Eight Gambling Screen is more comprehensive self-administered screening test which can help to identify early signs of problem gambling. This is an eight item questionnaire, with four or more "yes" answers indicating that gambling may be a problem. It was developed for use by New Zealand GPs and validated in New Zealand in a variety of primary and secondary care settings.

A copy of the Eight Gambling Screen is available from: **www.bpac.org.nz** keyword: **addiction-tools**

Managing problem gambling

The extent of an identified gambling problem guides further management.

If the patient has indicated that they are a regular gambler, but it is not currently affecting their wellbeing, intervention may include:[26]

- A discussion about how gambling can easily get out of control
- An agreement to reduce the level of gambling or maintain it at a responsible level
- Encouragement to seek support from whānau
- Flag the patient's notes to follow-up discussion at the next appointment

If the patient is a regular gambler and it appears to be causing them harm, but they are not ready to acknowledge this, intervention may include:[26]

- A discussion about controlling gambling and harm minimisation
- Investigation of possible mental health issues and other substance use
- Provision of educational materials and direction to web-based resources
- Encourage use of gambling helpline services (see below for details)
- Flag the patient's notes for follow up and reassessment

Whānau of problem gamblers are affected too

Problem gambling significantly affects the health and wellbeing of not only the person gambling, but also their whānau and friends. In a study of over 1500 general practice patients in New Zealand, just under one-fifth (18%) had been negatively affected by another's gambling behaviour.[25] Some of these patients indicated that they would like support or help from their GP to deal with this. Those who were affected by another's gambling, were also significantly more likely to be affected by depression.[25]

When screening for problem gambling, consider that people other than the person gambling may require support and treatment.

If the patient acknowledges a problem with gambling that is causing them harm, intervention may include:[26]

- Positive affirmation for acknowledging that help is needed
- Discussion about referral options (including Māori providers) and what best suits the patient's needs
- Make an appointment for the patient if possible
- Consider if any further treatment is required e.g. treatment for depression or anxiety
- Make an appointment for follow up

The Gambling Helpline Service is a 24 hour freephone service, offering immediate support for people with gambling problems and their families. The service may be accessed anonymously if required. The helpline offers specific services for Māori, Pacific and youth, as well as an online chat room and forum and support by email and text.

Ph: **0800 654 655**

Web: **www.gamblingproblem.co.nz**

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Resources

Addictions Treatment directory:

A directory containing regional data of all addiction treatment and advice services in New Zealand. This database is searchable by region, type of addiction service, category (e.g. Kaupapa Māori) and type (e.g. one-on-one, group counselling)

Web: **www.addictionshelp.org.nz/Services/Home**

Help lines:

Alcohol Drug helpline

Ph: 0800 787 797 (10am -10pm)

Web: **www.alcoholdrughelp.co.nz**

Gambling Helpline New Zealand

Ph: 0800 654 655

Web: **www.gamblingproblem.co.nz**

Educational resources:

Alcohol Advisory Council of New Zealand (ALAC)

Resources, information, guidelines

Web: **www.alac.org.nz**

Alcohol and Drug Association New Zealand (ADANZ)

Alcohol and other drug information (management of addictions treatment directory and alcohol drug helpline)

Web: **www.adanz.org.nz**

Foundation for Alcohol and Drug education (FADE)

Resources and education

Web: **www.fade.org.nz**

Matua Raki

National addiction workforce development programme

Web: **www.matuaraki.org.nz**

New Zealand Drug Foundation

Education and resources

Web: **www.nzdf.org.nz**

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ADULT DEPRESSION

Depression in Young People is activated for patients over the age of 18 years when the Depression module is opened.

The module has targeted screening questions for common mental health disorders. If the patient wants assistance the module offers additional assessments such as PHQ9 or K-10 and suicide assessment. These assist in the diagnosis of depression.

At any stage management options are available to assist in step wise management based on the severity of depression. This provides management options that are the least intensive to achieve clinical change for your patient.

bestpractice will write back assessment scores and read codes as well as saving a complete summary.

There are many additional resources within the Depression module with links to NZGG resources and to patient information.

MINISTRY OF HEALTH
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DECISION SUPPORT FOR HEALTH PROFESSIONALS

Te aukatinga o te whakamomoritanga o te taiohi Māori

Suicide prevention in Māori youth

Kia korowaitia āku mokopuna ki te korowaitanga hauora

Let our future generations be embraced with good health

www.bpac.org.nz keyword: suicide

Key concepts:

- The rate of suicide in young Māori males is higher than in any other population group in New Zealand
- Mental illness is strongly associated with suicide but is not the only risk factor
- Suicide risk is influenced by both static background factors and changeable factors
- In primary care, assessing wellness at every opportunity, providing culturally appropriate care and identifying risk early are important factors for suicide prevention in Māori

Young Māori are most at risk of suicide

Youth suicide rates in New Zealand have been decreasing since a peak in the mid 1990's, however suicide remains a significant cause of death for young people.[1]

Māori are a youthful population. Almost half (45%) of the Māori population in New Zealand are aged between 0–19 years.[2] Suicide rates for Māori youth (28 per 100,000) are higher than those for non-Māori youth (12 per 100,000).[3] Of the 96 young people who died by suicide in 2007 in New Zealand, 35% were of Māori ethnicity.[3]

Young Māori males are most at risk

Suicide rates for young Māori males (15–24 years) in particular have been very high for the last decade. Although this rate now appears to be reducing, it still remains high – 40 per 100,000 in 2007 for young Māori males compared to 19 per 100,000 for young non-Māori males.[3]

Age distribution of deaths by suicide changes with ethnicity

Younger Māori are more likely to die from suicide than older Māori.[3] This is in contrast to the age distribution of suicide deaths in non-Māori. In 2007, 65% of all deaths attributed to suicide in Māori were in those aged less than 35 years. This compares to approximately 32% in non-Māori, in the same age group.[3]

Risk factors for suicide

Both background risk factors, which are mainly static, and changeable risk factors can increase the overall risk of suicide.

Mood disorders and substance misuse (including alcohol) are strongly linked with suicide among young people. Young people who die by suicide often had a history of being irritable, impulsive, volatile and prone to angry outbursts.[4] Conduct disorder* was also common in young males who died by suicide.[4]

Other background risk factors may include:[5,6]

- Past history of suicidal behaviour
- Past trauma including physical or sexual abuse
- Social and educational disadvantage
- A history of exposure to a dysfunctional living situation
- Identity issues e.g. ethnicity, sexual orientation

The risk of suicide is sensitive to changeable factors, which can increase vulnerability. For example, a male with a history of sexual abuse has background risk factors for suicide which may be increased by the onset of alcohol or drug binges, a relationship breakdown or other life crisis.

Accumulative risk of suicidal behaviour

Suicidal behaviour in young people is unlikely to be solely due to a stressful life event or psychiatric disorder, but rather, a response to an unhappy or adverse life course, which has been characterised by the accumulation of risk factors during childhood and adolescence.[5] Profound hopelessness is a strong risk factor for depression and suicide.

*Conduct disorder is defined as a repetitive and persistent pattern of behaviours in which the basic rights of others, or major age-appropriate norms or rules of society, are violated.[19]

The influence of culture on suicide

Beliefs and attitudes towards mental health disorders and suicide may vary depending on the cultural background of the individual and the community in which they live. Differing attitudes, religious and spiritual beliefs may influence the way in which distress is manifested and also the way friends and family respond to this distress.[10]

For Māori, whakamomori is the term often interpreted as suicide. However, whakamomori has a broader meaning which includes feelings, thoughts, emotions and actions that may escalate and result in an attempt at suicide.[11] It has been defined in several ways including "committing suicide or any other act of desperation", "a deep seated underlying sadness", "in built tribal suffering" and a "psychological, spiritual and cultural or collective state of being that may, or may not result in death".[11]

Factors that may protect against suicide, arising from a cultural perspective, include:[11]

- An understanding of Māori concepts and experiences
- A strengthening of cultural identity
- Access to cultural resources e.g. kaumātua and marae
- Reconnecting and maintaining cultural connections

Māori ethnicity and the risk of suicide

Risk factors for suicide in Māori are likely to be no different to those for non-Māori youth.[5] However, there may be differences in the magnitude and prevalence of these risk factors specifically those relating to social, educational and economic disadvantage.

As with other cultures, Māori are diverse and not all young Māori will have strong ties to their culture. Māori ethnicity should therefore be thought of as a risk marker rather than a risk factor.[5] It may alert GPs to the possibility of increased risk, but does not always guarantee it.

Protective factors against suicide

For Māori, a strong cultural identity and support within a caring community is thought to strengthen resilience to mental disorder, even in the presence of adverse socioeconomic conditions.[7,8] This may also provide a protective effect against suicide.[5,7,9]

Key protective factors against suicide include:[10]

- A strong sense of self-esteem and self-worth
- Well developed coping skills
- Whānau support and harmony
- Positive school experiences
- Cultural and religious beliefs that discourage suicide

Prevention of suicide in young people

What can be done at a primary care level to prevent suicide?

- Recognition is the key - assess wellness at every opportunity
- Ensure effective, youth friendly communication
- Ensure confidentiality - if whānau are to be part of the solution, the patient must consent to the sharing of information
- Identify and treat any mental health problems and provide active follow-up and referral if required

Recognising the risk of suicide in young people

Primary care is the first point of contact for most young people with any health problem, therefore primary care clinicians are ideally placed to identify and help young people in distress.[12] Every interaction can be regarded as an opportunity to assess psychosocial, as well as physical, wellbeing.

It is important to ask the right questions, consider the presence of any suicidal behaviour and continually assess suicide risk. Although a recognisable mental health problem (e.g. depression or substance misuse) has been reported in 80–90% of young people who die by suicide, or who have made a serious suicide attempt,[5] many other reasons may contribute to suicidal behaviour. Ask about relationships with whānau and friends, how school or work is and if the young person is experiencing any stressful life events. Be aware of all of the risk factors for suicide in young people including the potential for increased risk due to issues surrounding ethnicity.

Early detection of distress should allow effective interventions within a primary care setting, with the aim of preventing a suicide attempt.[13]

Applying a Māori health framework

For Māori, a framework such as Te Whare Tapa Whā (see page 14 and Table 1) incorporates the four cornerstones of Māori health; spiritual, psychological, physical and whānau and provides a holistic view of health. This framework can be used to identify issues that need to be addressed to restore wellbeing.[14]

Communicating with young people

Consultations with young people can be difficult. History taking may be challenging especially when the young person has feelings such as embarrassment, fear, shame and shyness.

The aim is to establish effective, non-judgemental communication, to be empathic and to gain trust. Ask open questions to encourage conversation. Consider cultural context as this may help in the correct interpretation of a person's behaviours, fears and thoughts.[5,15] A behaviour that is regarded as "normal" in one cultural setting may not be normal in another.[5,10]

Be aware that some young Māori may be unwilling or unable to speak up and potentially challenge their elders.[15]

Table 1: Applying Te Whare Tapa Whā framework to suicide prevention[14]

Wairua (Spiritual)	Hinengaro (Psychological)	Tinana (Physical)	Whānau (Family)
Assist in the development of a strong and positive cultural identity	Help the young person recognise their strengths and encourage effective coping strategies and problem solving techniques	Encourage good nutrition, rest, recreation and exercise	Encourage reconnection with whānau to ensure a sense of belonging

Issues of confidentiality

Reassure the patient that the consultation will remain confidential. However be aware that confidentiality has limits. If a high risk of suicide is suspected then there is an obligation for the GP to inform others, such as parents or a mental health team, even if the young person has not given their consent.

With consent from the patient, establish an effective relationship with their whānau. Involvement of whānau is important, not only to provide support, but also to allow the GP to gain an accurate appreciation of the problems faced by the young person.

Identifying mental health problems in young people

Young people are faced with challenges on many levels – physical, emotional, behavioural, educational and social. Determining what is normal and what may constitute a mental health problem can be difficult.[16] Young people may be reluctant to seek help or may not know who to approach, therefore take every opportunity to ask about mental health issues.

The following criteria may be useful to help distinguish normal behaviours from behaviours that may be indicative of a mental health disorder:[16]

- Duration – e.g. problems that persist for more than a few weeks
- Severity – changes in mood and behaviour that are beyond the normal fluctuations for that age group
- Impact – how the symptoms are affecting schoolwork, relationships with family and friends, involvement in activities

Young people, particularly young Māori, with mental health problems may be more likely to describe physical symptoms such as nausea, stomach ache, headache, weight change and alterations in sleep patterns, than to express feelings of sadness, hopelessness or unhappiness.[9] Be aware that any patient who presents with a minor physical complaint may have a "hidden" primary reason for attending. Other presentations of adolescent depression may include behavioural disturbances, problems at school and social withdrawal.[17]

Best practice tip: If suicidal ideation has been identified in a young patient, design and write an action plan with them. This could be in two parts:

1. Specific actions appropriate for that young person that may help distract them if they feel at risk of self harm e.g. talking to someone they trust, taking the dog for a walk or playing music
2. Contact details (covering 24 hours) of who they can turn to urgently if they are suicidal. Give several options such as contacting a parent or other trusted adult, phoning their general practice during work hours (especially if whānau support is limited or

Group therapy may be preferable for Māori

Consider referral to Child and Adolescent Mental Health Services (CAMHS). Feedback from Māori who have accessed these services show that many prefer to work within a group situation and to have their whānau and iwi connections acknowledged.[15] Services in both primary and secondary care are also likely to be more effective if they are youth friendly.

Youth friendly secondary care services are likely to provide:[15]

- Comfortable, informal surroundings
- Group therapy sessions
- Creative methods of participation
- Activities that include food, humour and movement

Check with your DHB for services available in your area.

absent), or contacting an emergency after hours service e.g. after hours general practice service, hospital emergency department

Indications for referral to secondary mental health services

Immediate (same day) referral to secondary mental health services should be made for any young person who has:[18]

- Serious suicidal intent
- Psychotic symptoms
- Severe self-neglect

Urgent (within 24 hours) referral should be made if the young person has:[18]

- Severe depression or anxiety
- Persistent symptoms
- Profound hopelessness
- Other serious mental health disorder (including substance misuse)
- Significant functional impairment
- Suspected bipolar disorder

Referral to secondary services may be required if a mental health problem is suspected but an accurate diagnosis has not been made. Referral should also be considered for young people who fail to respond to treatment in a primary care setting, or who may require medication.

Management of mental health problems in young people in primary care

Early intervention has been identified as a key priority to help improve health outcomes. For youth with mental health problems early intervention may potentially prevent these problems from continuing into adulthood.[19] Psychological problems, such as behaviour and conduct issues, significant truancy and excessive anxiety, may be the precursors to adult mental health disorders.

In any young person presenting with mental health problems, an assessment of suicide risk should always form part of the initial consultation and risk should be continually monitored.

Structured clinical assessment tools

A structured clinical assessment tool can be used to help gain a more complete understanding of the patient's wellbeing. These tools are intended as a guide for questioning. Other factors, such as the specific presenting problem and clinical judgement, may alter the flow of questions within a consultation.

The following tools could be used:

HEARTS[5]

Home: general behaviour, conduct, manageability
Education: behaviour, progress
Activities: attention span, anxiety, ability to finish tasks, friendship
Relationships: with peers, parents, whānau, recent changes, bullying
Temper: mood
Size: weight change, appetite

HEEADSSS[5]

Home: existing and new relationships, communication
Education/Employment: school grades, work hours, responsibilities
Eating: body image, weight changes, dieting, exercise
Activities: with peers, whānau
Drugs: tobacco, alcohol, other drugs, use by self, whānau, friends
Sexuality: sexual identity, relationships, coercion, contraception, pregnancy, sexually transmitted infections
Suicide and depression: sadness, boredom, sleep patterns, loss of enjoyment
Safety: injury, violence, rape, bullying, weapons

A strengths-based approach to management

Most young people with mild to moderate mental health problems can be managed in primary care with advice, active support and monitoring. Referral to other services may be required for severe problems and for some conditions, e.g. a suspected psychotic disorder. Referral may also be required to access specialised therapies, e.g. cognitive behavioural therapy or psychotherapy.

The overall aim of management is to promote a positive attitude and encourage development of the skills required to help overcome issues affecting the person. Using a strengths-based approach helps to identify and develop these strengths and positive attributes.

A strengths-based approach for mental health problems

A strengths-based approach helps to build confidence, motivation and self esteem. Key components include:

- Identification and development of skills and strengths – these may not always be obvious or recognised by the young person or the people around them
- Building of motivation to deal with problems
- Increasing social interaction and enhancing relationships. Encourage social interactions especially with whānau, friends and school or work contacts.

Encourage the young person to adopt coping strategies and to take an active role in their management, as this may be empowering and a significant influence in promoting recovery.[15]

Listening to and appreciating the unique perspective of a young person may help them feel valued and appreciated.[15]

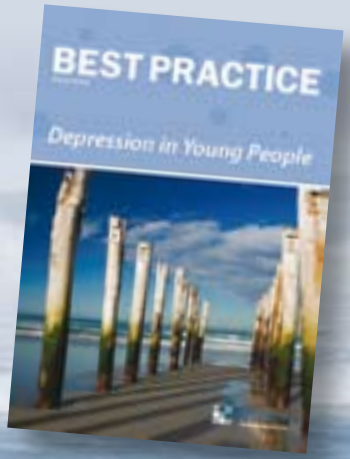
Help the young person to think of a trusted adult that they can talk to. This may not necessarily be a parent, particularly if the parental relationship is the cause of any distress. Support may come from someone else in the whānau such as a grandparent, uncle or aunt. In some cases the trusted adult may be an outreach worker, practice nurse or GP. Ensure the patient knows how to access urgent help if required.

Offer self management advice including guidance on exercise, sleep hygiene, stress management and misuse of alcohol and other substances. Provide educational information for the young person and their whānau, including web-based resources. Ensure there is a plan for follow-up and ongoing monitoring of suicidality. Consider referral to support services such as counselling, group therapy and other outreach services. Check if follow-up is in place for young people, who have been discharged from secondary care following admission for self-harm or mental health problems.

Medication in young people with mental health problems

Some young people with moderate to severe mental health problems, particularly depression, may require medication. However, it is recommended that GPs only prescribe antidepressants for young people in consultation with a psychiatrist or paediatrician. Fluoxetine may be used for major depression in young people, but requires careful monitoring to detect any worsening of symptoms, suicidality or changes in behaviour.[20]

For further information see BPJ Special Edition (Feb, 2010), "Depression in Young People" and the *bestpractice* Decision Support Depression module.



Resources:

The Lowdown is a free website aimed at young people, with downloadable self-management resources and youth counsellors available to provide online and text-based support services.

Web: **www.thelowdown.co.nz**

The Ministry of Health, as part of the **New Zealand National Depression Initiative**, has launched a website including information, case studies, video stories and an online self-management programme, fronted by John Kirwan.

Web: **www.depression.org.nz**

Out of the Blue from the Mental Health Foundation of New Zealand provides information and personal stories.

Web: www.**outoftheblue.org.nz**

Reach Out Central is an Australian based website which provides information, support, and an interactive game for youth aged 16–25 years.

Web: **www.reachoutcentral.com.au**

ACKNOWLEDGEMENT: Thank you to **Dr Nicole Coupe**, Kai Tahu, Te Atiawa, Manager Te Ira Tangata: Cutural Assessment for Suicide Prevention, Auckland for expert guidance in developing this article.

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THE JOURNAL - A NEW TOOL FOR THE DEPRESSION CAMPAIGN

The National Depression Initiative will enter a new phase when John Kirwan returns to promote self-management strategies for people with depression. To support the new campaign the Ministry of Health is launching a leading edge internet-based self-management programme. The programme will be promoted in a series of television ads featuring JK talking about how he stays well.

DEVELOPED WITH MENTAL HEALTH PROFESSIONALS

JK has teamed up with three mental health professionals to deliver the six-week programme in a series of video clip sessions. For many New Zealanders this will be their first introduction to an online programme of this kind.

JK 'coaches' people through the programme and is joined by Dr Simon Hatcher, Elliot Bell and Dr Lyndy Matthews to cover the range of topics.

Dr Hatcher has translated his expertise in Structured Problem Solving therapy into an accessible, user-friendly programme that people with mild to moderate depression can use on their own, or in the context of clinical treatment. It is also likely to be helpful for people in recovery from more severe bouts of depression.

Dr Simon Hatcher

Dr Lyndy Matthews

Elliot Bell

AN ONLINE SELF-MANAGEMENT PROGRAMME

The Journal has been designed to guide people through evidence-based techniques they can apply to their everyday life to help manage depression. It covers:

- staying positive
- the benefits of a healthy lifestyle
- using Structured Problem Solving

The programme is made up of six sessions. Participants will learn the theory behind each strategy and are set enjoyable tasks to build into their daily routine. The programme includes text and email reminders to encourage participation. The Journal programme will be available through the www.depression.org.nz website in June.

SUPPORTED BY THE DEPRESSION HELPLINE

The programme is backed up by the Depression Helpline which provides optional personalised support, accessed either online or by phone or text. The service offers help with getting through the programme itself, and where necessary supports journal users by providing information on treatment options and appropriate local services. Team members are experienced and qualified to provide effective support to service users in crisis as well as supporting people through the self-management Journal.

ONLINE SELF MANAGEMENT TOOL

'THE JOURNAL' - A six session programme with personalised support via phone/text/email/online if required at any stage.

1 Staying Positive

Two sessions doing something you enjoy

Examples:

- Walking the dog
- Going to a café
- Playing with the kids
- Visiting family

PHQ9 Test

2 Lifestyle Changes

One session from a selection of four topics

Examples:

- Eating right
- Getting active
- Learning to relax
- Getting better sleep

3 Problem Solving

A session on how to identify problems

Example:

List problems you face and examine one problem in detail

PHQ9 Test

4 Finding Solutions

How to improve your thinking skills

Examples:

- Creative thinking
- Analytical thinking

5 Creating a plan

The importance of having a plan

Examples:

- Using the SMART test
- The importance of small steps

6 Review of your progress

Learning from what you have achieved

A review of your personal progress throughout the programme and what you have achieved

PHQ9 Test

Results

On completion of the Journal participants receive a certificate and a summary review page which outlines their activity and their PHQ9 and mood scores throughout the programme.

Te mahere whakatutuki o te PHO – Te marea rawakore

PHO Performance Programme – high needs populations

He tawhiti kē to koutou haerenga
Ki te kore e haere tonu
He tino nui rawa o koutou mahi
Kia kore e mahi nui tonu

We have come too far not to go further,
we have done too much not to do more

www.bpac.org.nz keyword: pho

PERFORMANCE PROGRAMME

The PHO Performance Programme (PPP) recognises the increased health needs of Māori, Pacific peoples and those living in lower socioeconomic areas (high needs populations).

The Programme has developed a number of performance indicators to measure PHO achievements.

While a greater financial incentive is offered for achieving targets for indicators that have a high needs component, there have been improvements across most indicators, even after financial incentives are no longer offered.

Indicators where reliable information is specifically available for the high needs populations include:

- Cervical cancer screening coverage
- Breast cancer screening coverage
- Age appropriate vaccinations for two-year-olds
- Influenza vaccinations in people aged 65 years or over

It is thought that people with mental health problems may be represented at a lower rate across all PHO indicators. Specific primary care initiatives should be considered to ensure these people are not only receiving appropriate mental health care, but are also receiving other essential healthcare services.

PHO Performance Programme[1]

The PHO Performance Programme aims to improve the health of enrolled populations and reduce inequalities in health outcomes, through supporting clinical governance and rewarding quality improvement processes. Its success depends on the engagement and commitment of District Health Boards, Primary Health Organisations, providers and professional groups.

The Programme aims to:

- Encourage and reward improved performance by PHOs in line with evidence based guidelines
- Measure and reward progress in reducing health inequalities by including a focus on high needs populations

Cervical Screening

Key messages:

- Target Māori, Pacific and Asian women and women from areas of high deprivation for cervical screening
- Target women over 30 years, who have never had a smear, or have not had a smear for over five years
- Target interventions carefully to avoid increasing disparities

Programme goal

The PPP goal is for 75% or more of all women aged 20–69 years to have had cervical screening within three years.

There has been a steady increase in cervical screening rates over the past two years (Figure 1).[2] However, there is still greater improvement required and a significant gap persists between the total and high needs populations.

There is significant regional variation, with screening rates ranging from 43% to 86% for the total population and 43% to 79% for the high needs population.[3]

As rates of screening have improved, the rate of cervical cancer in Māori women has fallen. However, Māori women still have higher rates of cervical cancer than non-Māori women, and are four times more likely to die from cervical cancer than European women.[4] It is likely that suboptimal rates of screening are a major contributor to this.

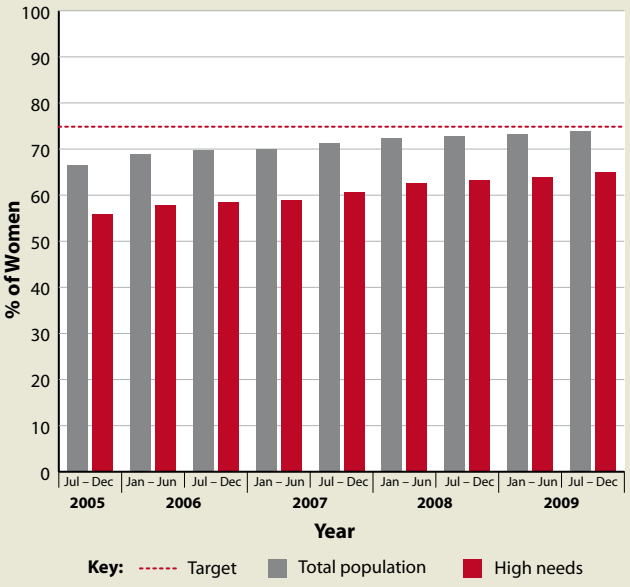

Figure 1: Percentage of enrolled women aged 20–69 years who have received a cervical smear in the past three years[2]

There are many barriers that may explain the reluctance of some woman to attend for cervical screening. Some are common to all women, such as shyness or cost, while other reasons may be specific to some groups, such as cultural and language barriers.

See BPJ 23 (Sep, 2009) "Cervical smears – achieving equity" for further information

Breast screening

Key messages:

- Māori and Pacific women have lower rates of breast screening and as a result, have a higher mortality rate from breast cancer
- General practice can play a key role in addressing this inequality by ensuring all eligible women are assisted to enrol and participate in the breast screening programme
- Practices that have made a commitment to increasing breast screening rates for Māori and Pacific women are finding they can make significant improvements in screening rates

Programme goal

The PPP goal is for 70% or more of all high needs women aged 50 to 64 years to have had a mammogram within two years. While this target currently measures screening rates for women aged between 50 and 64 years, in the future it

will align with the National Breast Screening Programme (i.e. 45 to 69 years).

There has been a steady increase in breast screening rates over the past two years (Figure 2).[2] However, improvement is still required, and a significant gap persists between the total and high needs populations.

There is also significant regional variation in breast screening rates, which range from 33% to 84% for the total population and from 31% to 77% for the high needs population.[3]

See BPJ 24 (Nov, 2009) "Breast Screening – achieving equity" for further information

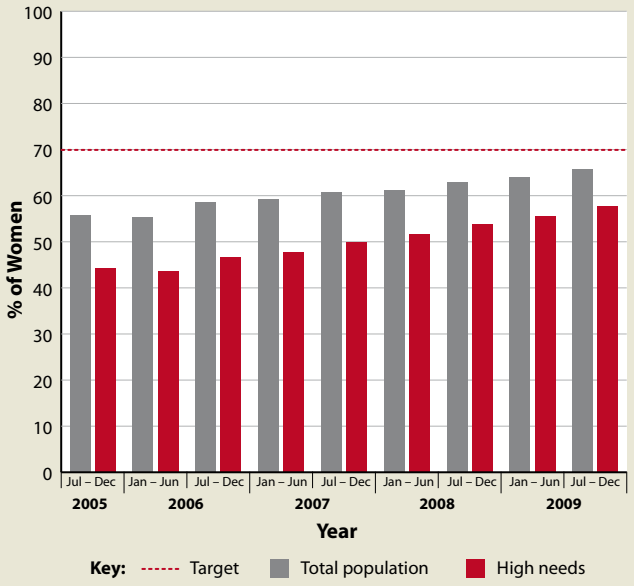

Figure 2: Percentage of enrolled women aged 50 to 64 years who have received a mammogram from an authorised provider in the past two years[2]

Age appropriate vaccinations for two-year-olds

Programme goal

The PPP goal is for 85% or more of a PHO's target population to have received their complete set of age appropriate vaccinations.

Immunisation rates are increasing (Figure 3), however, again there appears to be significant regional variation with rates ranging from 32% to 93% for the total population and 30% to 96% for the high needs population.[3]

Reported immunisation rates may be lower in some regions due to technical difficulties in collecting data.

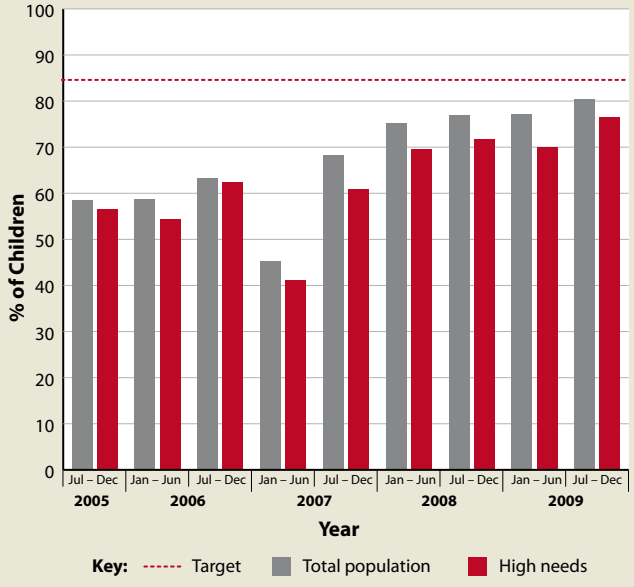

Figure 3: Percentage of enrolled children aged two to three years who have received full vaccinations[2]

Influenza vaccinations in people aged 65 years or older

Programme goal

The PPP goal is for 75% or more of a PHO's target population to have had a flu vaccination by 30 June of each year.

Influenza vaccine coverage has remained relatively steady over the past two years, but is still below the target of 75% for all populations (Figure 4).

There is significant regional variation with influenza vaccination rates ranging from 31% to 76% for both the total and high needs populations.[3]

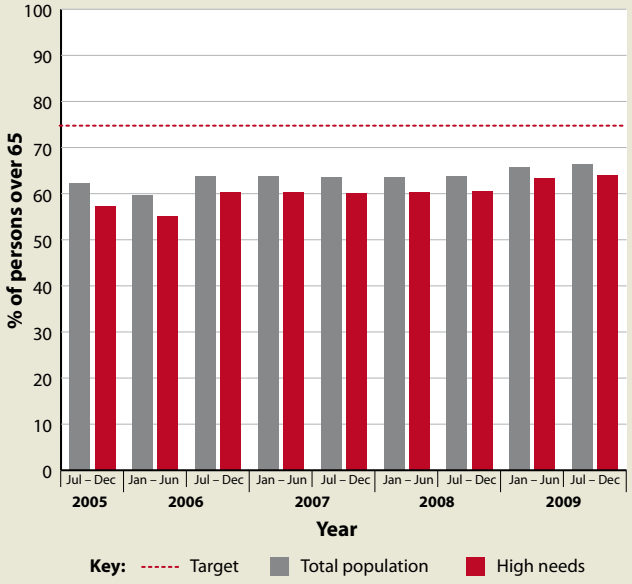

Figure 4: Percentage of enrolled persons aged 65 years or older who have been vaccinated within the flu season[2]

Other indicators

There are additional indicators that are also important for the high needs population. However, data is not complete and as a result they have not been included in this discussion. These indicators include:

Cardiovascular risk assessment

- PPP goal: 80% of the target population to have been assessed for their risk of developing cardiovascular disease.

Diabetes detection

- PPP goal: 90% of those estimated to have diabetes to have been identified and coded by their GP.

Diabetes follow-up

- PPP goal: 80% of those estimated to have diabetes to have had a diabetes review.

What can your practice do?

Know how to identify and contact the high needs population in your practice:

- Use your practice management system to identify and flag Māori and Pacific peoples and people living in lower socioeconomic areas
- Send invitations encouraging these patients to receive targeted services (e.g., influenza vaccinations, cervical screening)
- Ask these patients about their screening and immunisation status and record it in their notes in a way that is accessible or searchable

Reflect on barriers that may prevent people in high needs populations from accessing services. Strategies to overcome some of the common barriers include:

- Encourage all practice staff to have an understanding of barriers that may exist and be aware of strategies to overcome these barriers

- Actively assist these patients to enrol in national screening programmes and make an appointment for them where necessary
- Ensure these patients know the cost of services and that some services, e.g. breast screening, are free
- Provide appropriate information about services
- Allow enough time to talk through any concerns
- Support patients who are shy or apprehensive
- Ensure patients know they can bring a support person

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ADULT DEPRESSION

Depression in Young People is activated for patients over the age of 18 years when the Depression module is opened.

The module has targeted screening questions for common mental health disorders. If the patient wants assistance the module offers additional assessments such as PHQ9 or K-10 and suicide assessment. These assist in the diagnosis of depression.

At any stage management options are available to assist in step wise management based on the severity of depression. This provides management options that are the least intensive to achieve clinical change for your patient.

bestpractice will write back assessment scores and read codes as well as saving a complete summary.

There are many additional resources within the Depression module with links to NZGG resources and to patient information.

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This Conference is RNZCGP CME endorsed.

Humalog - an accident waiting to happen

There have been an increasing number of significant events from both primary and secondary care concerning the prescribing and dispensing of Humalog insulin preparations.

There are now three Humalog insulin preparations:

- Humalog – a rapid acting insulin (containing 100% insulin lispro)
- Humalog Mix 25 – a mixture of rapid and intermediate acting insulin (containing 25% insulin lispro and 75% insulin lispro protamine)
- Humalog Mix 50 – a mixture of rapid and intermediate acting insulin (containing 50% insulin lispro and 50% insulin lispro protamine)

Errors have been reported where:

- The wrong product has been selected from a drop down menu in electronic prescribing or dispensing systems
- A patient has described the insulin they are on as Humalog 25, twice daily, and been prescribed Humalog (rapid acting alone, not the mix) 25 units, twice daily, when they were actually on Humalog Mix 25.

Prevention of incidents:

- Inform the patient about the risk of incidents so they are fully informed about which Humalog insulin preparation they are on and the importance of describing it accurately. This can also be written on a patient medicine card.
- Always prescribe insulin using the full brand name
- Check with the patient about which sort of insulin preparation they are on, e.g. not only the brand name but also rapid, intermediate or long acting – this acts as an extra check.

Safer prescribing of tramadol

From 1 June, 2010 tramadol will be available fully subsidised on the Pharmaceutical Schedule.

Tramadol has been used widely in hospitals for several years, but experience of its use in primary care is limited. A Prescriber Update article from Medsafe is planned to be circulated, and prescribers are advised to consult the Medicines Safety Datasheet for detailed information.

The following are some important prescribing tips for the safe and appropriate use of tramadol:

- Tramadol is not a first line analgesic. It is classed as a weak opioid on the analgesic ladder and is neither more effective, nor better tolerated, than other weak opioids such as codeine.
- For people coming off dextropropoxyphene, a straight switch to tramadol is not recommended. The patient's analgesic requirements should be initially assessed with regular paracetamol, and then codeine added if necessary.
- Drug dependence, withdrawal reactions and misuse have all been reported with tramadol, although they are generally less problematic than with other opioids.
- Tramadol acts at opioid receptors and shares some of the typical adverse effects of opioid analgesics, including nausea, constipation and

respiratory depression. However, it has additional pharmacological actions which result in a different spectrum of adverse effects and drug interactions.

- Tramadol has serotonergic effects similar to SSRIs, such as fluoxetine and paroxetine. Serotonin toxicity (and syndrome) has been reported after use of tramadol with other serotonergic agents such as antidepressants and St John's wort.
- Changes in the INR have been reported in people taking warfarin. Monitor INR in these patients if tramadol is added or stopped.
- The seizure threshold is reduced by tramadol and the effect appears to be dose related. Extreme caution is required in people with epilepsy (only consider if epilepsy is well controlled), a history of seizures or those already taking medicines that reduce seizure threshold, such as antipsychotics and antidepressants.
- Tramadol should not be used in people:
    - With acute alcohol intoxication or taking hypnotics, analgesics, opioids or psychotropic medicinal products
    - Who are receiving monoamine oxidase inhibitors (MAOIs) or have taken them in the past 14 days
    - With epilepsy that is not adequately controlled by treatment
    - With severe renal impairment (creatinine clearance <10 mL/min)

Recommended reading

1. Waitemata DHB. Tramadol- safe prescribing; consider the risks. Safer Rx. Available from: **www.saferx.co.nz/full/tramadol.pdf**
2. Medsafe datasheet. Available from: **www.medsafe.govt.nz/profs/Datasheet/a/arrowtramadolcap.pdf**

NEWS UPDATE: On 26 May, 2010 the US Federal Drug Agency issued an alert, notifying prescribers of increased safety concerns with tramadol. The FDA strengthened warnings of the risk of suicide for patients prescribed tramadol, who are prone to addiction or currently taking tranquilisers or antidepressants. This follows reports of tramadol-related deaths that have occurred in patients with a previous history of emotional disturbance, suicidal ideation or substance misuse (including prescription medicines).

For further information visit:
www.fda.gov/Safety/MedWatch/default.htm

New evidence shows less benefit of gabapentin for neuropathic pain

The effectiveness of gabapentin for neuropathic pain, including data from previously unpublished trials, has been re-evaluated. Recent litigation procedures in the United States have revealed that the promotion of Neurontin (gabapentin), for the treatment of pain conditions, was assisted by selective publication and citation of studies with favourable outcomes.

Countries which have licensed gabapentin for neuropathic pain (including New Zealand) would not have had access to these hidden trials and would have based recommendations only on the available published data.

Previous data indicated that gabapentin has a moderate analgesic effect in about 25 % of patients with neuropathic pain (NNT* of 4).[1] Inclusion of the hidden data indicates that gabapentin has a minor role in pain control and that

the NNT is about 6–8, that is, only about 15% of patients will derive some benefit. Furthermore, newly available information shows that adverse effects can occur such as dizziness (NNH† of 8), confusion or ataxia (NNH of 10) and oedema (NNH of 11). Finally, there is very little evidence that the degree of analgesia is dose related, whereas toxicity is dose dependent.

Conclusions and recommendations (adapted from Therapeutics Initiative, 2010[2])

- Evidence from all clinical trials suggests that gabapentin has a minor role in pain control
- Gabapentin reduces neuropathic pain by less than 1 point on a 0 – 10 scale and may benefit about 15% of patients
- Adverse effects occur in about the same number of people, although these can be relatively mild.
- A test of benefit versus harm can be made after one to two days at a low dose (100 – 900 mg daily)
- Benefit is unlikely to increase with higher doses or longer treatment
- Gabapentin should be used with caution in people at risk of cognitive disturbance, falls or when oedema may aggravate an underlying condition
- Regularly assess patients taking gabapentin. Assessment of benefits or adverse effects can be made by stopping for one to two days.

As with other antiepileptics, gabapentin can increase suicidal thoughts and behaviour. Patients should be monitored for the emergence or worsening of depression, suicidal thoughts or behaviour, or any unusual changes in mood or behaviour.[3]

* Number need to treat

† Number needed to harm

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Department of General Practice
Dunedin School of Medicine, University of Otago

Ethics in General Practice

GENX 824

Semester Two, 2010 – 15 points

Offered by distance learning and can be credited towards the Postgraduate Diploma in General Practice (PGDipGP)

This paper looks at ethical issues inherent in modern medicine and explores ways of thinking about them, and of dealing with them.

The particular focus lies on the ethical challenges that are relevant to general practice, which include informed consent, confidentiality, patient autonomy, rights and duties, rationing of health care resources, the ethics of screening and genetic testing, and end of life dilemmas.

This paper provides a platform for open discussion, exchange of ideas, self-reflection, and testing out some ethical theory.

Two Dunedin residentials allow in-depth immersion in the subject matter, and the formation of an invaluable collegial study environment.

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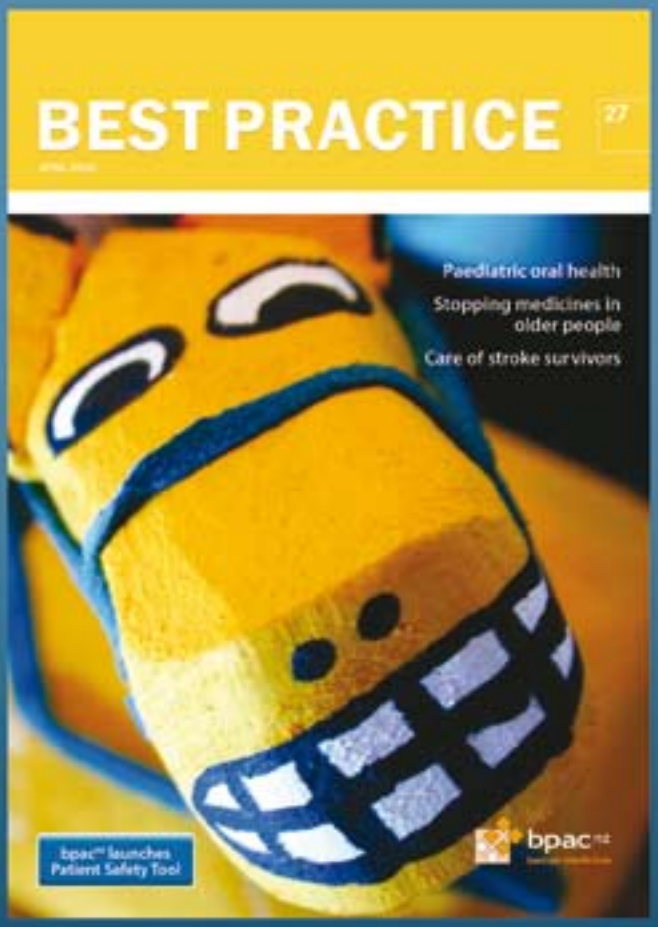

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