Living With It: A Grounded Action on Family Involvement in Compulsory Treatment for Severe Addiction

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed   Date   07 October 2015

Abstract

This grounded action research sought to first understand the involvement of family and whānau in the process of committing a whānau member for compulsory addiction treatment under the Alcoholism and Drug Addiction Act 1966 (ADA Act) and second to develop an action plan to address the issues identified. Although several reviews have been undertaken there is little known about the impact of this Act on the people whom it directly affects. The aims of the research were to: (1) identify the process occurring in this situation and produce a grounded theory to explain what is happening for family as they seek to place their family member, who is experiencing the severe effects of addiction, in compulsory treatment; and (2) develop a grounded action plan to address the concerns identified in the theory. Data were collected using semi-structured interviews with 11 participants involved in placing a family member under the ADA Act, addiction practitioners, reviewing court reports and conducting informal conversations with key informants. Data were analysed using constant comparative analysis and coded using open, selective and theoretical coding. Analysis using memoing and theoretical sampling was also used to generate a substantive grounded theory and further comparative analysis was undertaken using the theory components to develop a cohesive systemic action plan. The theory 'living with it' was identified as the families' key strategy for managing living with and supporting a family member with severe addiction. 'Living with it' is an interactive system comprised of the main categories; 'fracturing relationships', 'working it out myself' and 'holding my breath'. These categories and their properties that tell the story of a profound lack of professional support for families seeking help. The grounded action plan resulting from this theory includes: influencing the proposed wording for the revised legislation so family are recognised in this process, improving the responsiveness of the workforce through training in the use of evidence based models of family inclusive practice and building families' resilience using a website redesign (www.kina.org.nz) that specifically provides tailored information and support for family members. These activities will contribute to a change in practice for addiction practitioners to enable them to effectively engage and support family who are 'living with it'.

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Acknowledgements

This work would not have been possible without the generosity and openness of the family members who shared their stories with me. It was my aim to manage your stories as taonga and hope with the changes that will be bought about, this has been achieved.

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Whakatauki

Mā te pai oneone, mā te wai, mā Tamanui-te-rā te māhuri e tōtara haemata ai

Only through fertile soil and life giving sun and water does the tōtara stand strong

Gifted by

Keri Opai, (Te Atiawa, Ngāti Ruanui, Parihaka)

Paearahi, Te Pou O te Whakaaro Nui

Chapter 1:   The Research Problem

Background to the Research

The genesis for this research started when I was invited to be part of a Ministry of Health working group to revise the current legislation, the Alcoholism and Drug Addiction Act 1966 (ADA Act) which facilitates compulsory treatment for those who are experiencing the severe effects of addiction and who are deemed by the court to be in need of treatment even if they have refused. Many aspects of the legislation are no longer in line with other legislation which supersedes this including the NZ Bill of Rights Act 1990 (McSherry, 2011). It was evident that much of the process of the ADA Act was not well supported by either the health or justice sectors. As a result the vulnerable group of people this legislation was designed to protect are no longer being well served. In addition, the lack of research to inform the decisions that needed to be made about changing this legislation, for example, the optimal length of the committal period, has meant no action has been taken to amend this legislation to date.

I reflected on my last 20 years as a psychologist, addiction practitioner and service manager in the addictions field and recalled the concerns I had several years ago about our management of those in treatment under a committal order. Many people under a committal order arrived at the treatment facility, at which I was a manager at the time, in distress and unwilling to participate in the treatment process. They were very unwell physically, and mentally unable to cope with the demands of the treatment programme which had, at that time, limited flexibility to allow for this. This inflexibility and our interpretation of the subsequent non-compliant, agitated and sometimes aggressive behaviour of clients as an unwillingness to engage resulted in their discharge from the Act very soon after arrival at the treatment centre. These clients were in fact exhibiting behaviours consistent with brain damage related directly to their addiction, but we were still prepared to dismiss them as 'inappropriate for this facility'. Although we endeavoured to find safe housing, we were not obligated to find alternate care for those whom we removed from the Act. In the absence of any other requirements relied on our understanding that to inform others of this occurrence (that is, family or support people) would have been a breach of the Privacy Act 1993. The phone calls from concerned family members following these actions, which were usually our first

contacts with them, bothered me and also left me feeling powerless to answer their questions to their satisfaction.

My initial thoughts in relation to this as an area worthy of further investigation was to examine how revised legislation could be used to improve the engagement process for those entering treatment. The rationale was that if there was opportunity for the legal and health systems to work concurrently at the entry point rather than one after the other, both the person and the treatment facility would be more prepared for the care required.

In order to ensure that the working party was including the voice of those directly involved in this process, I facilitated a focus group with clients, who were in treatment under committal, to obtain their feedback about proposed improvements and changes to the legislation. As part of that discussion, the idea of researching this area was discussed and the group advised that they were poor informants regarding the early phases of the committal process as they were unable to recall much of that period of time and events other than those that were particularly salient (for example, being handcuffed and put in a police car for the first time). They encouraged me to consider asking their family members about the process involved. All the attendees at this forum acknowledged that while they had not wanted to be where they were and had been angry about how they had come to be there (and some still were), they all knew they needed to be there and were grateful (even if begrudgingly) for their family members' interventions.

Thus the aims of this research was to firstly develop an understanding of what was happening for family members involved in the compulsory addiction treatment process and secondly to use the resulting theory to address key issues identified by family members in this situation. It was anticipated that this could also inform the revised legislation and addiction treatment providers about the needs of family/ whānau members in this situation. This information could be used to show how to work with family and whānau to ensure our shared goals of protecting and assisting the person with severe addiction, are met more effectively. This thesis does have a focus on the specific area of health practice of addictions treatment as one of the key aims of this research under the Doctor of Health Science programme is to inform and impact on practice.

Background Context

This study is located in the junction of addiction treatment and the use of the civil commitment process in the judicial system to order people who have the severe effects of addiction to receive treatment. The problem area specifically being examined is what is happening for the family members who use this system to seek compulsory treatment on behalf of the individual with the addiction. In this first section, I have outlined a detailed background of the New Zealand addiction treatment sector, the current Alcoholism and Drug Addiction Act 1966 and the profile of who this legislation is for.

Addiction Treatment

Addiction is defined by the clinical characteristics of a substance use disorder outlined in the Diagnostic and Statistical Manual DSM 5 (American Psychiatric Association, 2013b, pp. 490-491) as shown in Table 1. The level of severity of this condition is based on the assessed severity of these symptoms and can range from mild to moderate to severe. At its most severe, addiction is a chronic, debilitating, relapse-prone condition that affects several aspects of a person's health including their cognitive functioning. Some of these health effects will be enduring even if the substance use is discontinued, and may contribute to early death.

For severe alcohol addiction, the withdrawal process from stopping alcohol consumption can have fatal consequences and requires medical management, which typically occurs in a hospital detoxification facility. The detoxification process has its own negative health impacts including delirium tremens (can include shaking, hallucinations, seizures, rapid heart rate, heavy sweating), and repeated withdrawals can increase the severity of these symptoms.

Alcohol addiction can contribute to several other health conditions including cancer, respiratory conditions, emphysema, poor oral health, increased risk of falls and accidents. A recent report identified alcohol as a significant risk factor in intentional and unintentional injury across all ages and an estimated 24% of all injury related health loss was attributable to alcohol. Alcohol was also the key risk factor in over a third of the health loss from injuries resulting from transport accidents in males, and assaults for males and females (Ministry of Health & Accident Compensation Corporation, 2013, p. 28). In addition, severe alcohol addiction is the primary cause of alcoholic cardiomyopathy, alcoholic liver disease, alcoholic neuropathy and Wernicke-Korsakoff syndrome.

The focus of this research is on how family members manage those with the severe from of the condition, and in particular those that are deemed unable to make a decision for treatment themselves due to the effect of their alcohol or drug use. Only 75 people were committed for compulsory treatment under the Alcoholism and Drug Addiction Act in 2013 (Ministry of Health, 2014b). However, data reporting the utilisation of medical detoxification indicated that during 2011, 1265 people required this level of intervention and over 11,650 hospital bed nights were utilised for this purpose (Ministry of Health, 2014a). If medical detoxification is used as an indicator of the severity of the substance use disorder then it is likely that there are several more people that would have benefitted from this form of intervention if they were able to access it.

Table 1.
Criteria for Alcohol Use Disorder

A. A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period.
  1. Alcohol is often taken in larger amounts or over a longer period than was intended.
  2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
  3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
  4. Craving, or a strong desire or urge to use alcohol.
  5. Recurrent alcohol use resulting in a failure to fulfil major role obligations at work, school, or home.
  6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
  7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
  8. Recurrent alcohol use in situations in which it is physically hazardous.
  9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
  10. Tolerance, as defined by either of the following:
  a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
  b. A markedly diminished effect with continued use of the same amount of alcohol.
  11. Withdrawal, as manifested by either of the following:
  a. The characteristic withdrawal syndrome for alcohol
  b. Alcohol (or a closely related substance, such as benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

Specify current severity:
305.00 (F10.10) Mild: Presence of 2-3 symptoms.
303.90 (F10.20) Moderate: Presence of 4-5 symptoms.
303.90 (F10.20) Severe: Presence of 6 or more symptoms.

Note: Reprinted with permission from the Diagnostic and Statistical Manual of Mental Disorders. (2013b). American Psychiatric Association (5th ed.). (see Appendix 1)

Addiction treatment in New Zealand is based on a stepped care, person-centred approach using the least invasive option as possible to achieve positive life change as desired by the individual affected. It comprises a loose system of community based facilities offering outpatient assessment and counselling services, psycho-educational day programmes and residential facilities offering short-term, intensive live-in interventions to meet more complex needs. The people who meet the criteria for assistance under the ADA Act require medical intervention during withdrawal and a period of time in residential care. They are also likely to require long term community care.

The predominant philosophy of treatment is harm reduction, which seeks to minimise the level of harm (as defined by the individual) that is experienced as a result of substance use. Abstinence or ceasing the use of the substance falls at one end of the continuum of harm reduction. Successful treatment is seen to rely on the concept of the individual being motivated to make a life change. Access to treatment is via self-referral, other health service referral, or increasingly via the corrections system through probation as part of a criminal sentence. In the situation of treatment being part of a criminal offending sentence, it is not seen as compulsory because the offender has to agree to this option within a suite of options for sentencing.

A further option for accessing treatment is available for those experiencing the effects of severe addiction, and is the focus of this study. The Alcoholism and Drug Addiction Act 1966 (ADA Act) is a civil commitment procedure that operates to provide for the "compulsory detention and treatment of alcoholics and drug addicts at certified institutions" (*Alcoholism and Drug Addiction Act 1966, definitions).* This compulsory addiction treatment Act is currently under review by the Ministry of Health who manage this piece of legislation. The ADA Act is based on the application of therapeutic jurisprudence which has been defined as, ""a legal rule or practice that promotes the psychological and physical well-being of the people it affects" (Slobogin, 1995, p. 737). That is, it is the use of the legislative process via the ADA Act, as a last resort option to affect a positive health outcome. It attempts to utilise judicial process to decide the balance of rights: the individual's right to self-determination (refusal of treatment) versus the paternalistic desire to reduce harm in another person's best interests (Diesfeld & Freckelton, 2003). In the criminal courts one may be directed to undertake treatment by the judiciary as an alternative sentence. However, the distinction with the ADA Act is that there has been no criminal offending by the

individual. The ADA Act is also distinct from the widely supported implementation of 'drug courts', recently piloted in Auckland, which also operate from a therapeutic jurisprudence approach and offer treatment as an alternative sentencing option within the criminal court system (Simon Power, Ministry of Justice media release, 19 October 2011).

A similar health law that operates in New Zealand is the Mental Health (Compulsory Assessment & Treatment) Act 1992. The MH(CAT) Act 1992 which provides for the detention of a person determined to be mentally disordered for the purposes of psychiatric assessment and treatment necessary to mitigate the immediate risk to the person posed by their condition (Wellington Community Law Centre, 2002). The MH (CAT) Act section 4 (d) para 1. excludes an application for anyone who has a sole diagnosis of a substance related disorder. In theory, people who have developed a mental health condition secondary to their substance use would be eligible under this Act for immediate assistance where necessary. In contrast to the Mental Health Act, the ADA Act legislation is not a crisis intervention and the period of 'detention' lasts for up to two years. A person is detained for the purposes of treatment (including initial medical detoxification) for their addiction.

Post-detoxification treatment in New Zealand for those committed under the ADA Act is provided for by two gazetted providers, the Salvation Army and Nova Trust. These intensive residential services are focused on providing abstinence-based programmes for a period of 8 to 24 weeks, which is followed by outpatient counselling (typically weekly or fortnightly). This outpatient follow-up is voluntary on the part of the client, and relies on their initiation. The Salvation Army programme is an 8 week psycho-education programme and is open to all clients with substance dependence issues whereas Nova Trust operates a longer term work-based programme to treat more severely affected individuals.

The abstinence based focus of these programmes is supported by some research which shows that long-term abstinence from alcohol can facilitate neuro-regeneration and improve cognitive abilities in some long-term drinkers. Some will never recover full cognitive function (Harper, 2009; Marshall, Guerrini, & Thomson, 2009). Much of the cognitive dysfunction is related to the deficiency in thiamine (vitamin B1), and thus, a large dose of vitamin B is the standard course of treatment in the initial stages of withdrawal. Evidence suggests that older alcoholics are more

susceptible to the effects of alcohol than younger alcoholics, and that the rate of improvement varies with the age of the individual and type of cognitive function affected (Cash & Philactides, 2006).

Patient profile

The annual report of the Director General of Health indicated 72 applications for committal were granted in 2012 (Ministry of Health, 2013) and 75 were granted in 2013 (Ministry of Health, 2014b). In comparison, during the period 1990-1996 there were between 277 (in 1991) and 176 (in 1996) committal orders made per year. The steady decline in the use of the ADA Act, I would argue, is not a result of a lack of need but rather a system that is difficult to navigate and which fails to cater for the group it was designed to protect. Delegates at a recent national addictions conference (Cutting Edge, Auckland, September 1-2, 2011) consistently told me following a presentation of the review of the ADA Act being undertaken, that they had found the current Act unworkable. If they were successful in getting a client through the process and accepted into a treatment facility, because there are no secure facilities (such as those available for mental health), the chances were high they would abscond very soon after, frustrating everyone trying to help. The ADA Act was also criticised in a recent coroner's report for being too difficult for families to navigate, and the report's summation indicated this difficulty was pertinent in the resulting death of a person experiencing severe alcohol dependency (Smith, 2014).

Unfortunately, no demographic data is collected by the courts to indicate who the people are that are committed to treatment under this Act. It is only through examining treatment facility records that this information can be obtained. There are currently 14 institutions that are gazetted to accept people under committal including ten hospitals (for detoxification), three Salvation Army Programmes (Auckland, Wellington and Christchurch) and Nova Trust in Christchurch. I requested an examination of the client records from Auckland Bridge and Nova Trust to ascertain a profile of those committed to treatment over this past year and was provided with summary data from each of these facilities. No individual was able to be identified form the data provided.

During 2011, of the 139 clients admitted to Nova Trust under civil commitment orders 84% were New Zealand European and 11% were New Zealand Māori. Approximately 75% of those clients had a mental health diagnosis in addition to their substance dependence, and many of those had

notes indicating deterioration in cognitive functioning although no formal diagnoses were indicated. The age range of those admitted was between 22 and 77 years, and the median age was 48.2 years. One third of admissions was female and all clients had at least one previous admission to intensive addiction treatment. According to the centre manager, Joy Green, all have chronic physical conditions and behavioural problems require long-term interventions (personal communication, 13 September 2011). This was echoed by the Director of the Auckland Bridge Programme, Major Mike Douglas, who has a policy of admitting only one committed client at a time in order to reduce disruption (personal communication 15 September, 2011). Of the seven male admissions they have had during this year, three were under the age of 30 years and all identified as NZ European.

Outline of current application process

Figure 1, over the page, outlines the process undertaken to make application for committal to addiction treatment under the ADA Act (1966). The coordination of this process requires the ability to navigate these services and systems involved, arrange appointments and associated activities, and are typically done by a family member.

Review of the Alcoholism and Drug Addiction Act 1966

There have been several reviews of the ADA Act prior to this current review, the most recent in 1999 (Ministry of Health, 1999). However, in spite of ongoing practical and legal concerns about this Act, to date no changes have been made. This latest review was initiated by the Prime Minster and Cabinet as part of a suite of initiatives aimed at reducing the harm from methamphetamine (Policy Advisory Group & Department of the Prime Minister and Cabinet, 2009). The primary goal of the review under this initiative was to improve access to treatment, particularly in times of crisis, with a focus on those with serious methamphetamine related concerns. This was consistent with the government's health strategy to provide 'better, sooner more convenient' health services (Ministry of Health, 2011b).

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│ Person (typically family member but can be anyone) is concerned │
│ about another person's using behaviour and fearful of their life │
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┌─────────────────────────────────────────────────────────────┐
│ Application papers section (9) * obtained from District Court. │
│ The application requires the following:                         │
│  •  2 medical certificates (requires being assessed by 2 medical │
│     practitioners; and                                          │
│  •  An affidavit from family member outlining concerns          │
└─────────────────────────────────────────────────────────────┘
                              ⇩
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│ Application is lodged and case heard in the Family Court with both │
│ parties present.  If successful, application is granted for up to two years. │
│ Person is detained for detox and treatment.                    │
└─────────────────────────────────────────────────────────────┘
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│ Book a bed in a detoxification facility – a typical requirement for this │
│ booking is that a treatment bed in a residential facility has already been │
│ booked to follow on from the intended detox process.           │
└─────────────────────────────────────────────────────────────┘
                              ⇩
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│ A treatment bed is booked at certified facility – this requires a │
│ comprehensive assessment from an addiction specialist although some │
│ facilities may only require updated information if the person's details are │
│ already on file from previous treatments.  A treatment facility can refuse │
│ to accept an admission on various grounds.                     │
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Figure 1. The process for lodging an application for compulsory addiction treatment

Note: *Section 8 applications allow the person with the addiction to make application to commit themselves for treatment. This does not require medical certificates as required in section 9 but is also enforceable for up to two years once granted. Court papers indicate that some Judges will offer the person who is in court facing section 9 applications, the opportunity to choose a section 8 as a last chance to put themselves into treatment

In response, the Law Commission suggested a number of changes to this legislation to address concerns relating to its alignment to the Bill of Rights 1990, and the provision of appropriate treatment (NZLC, 2010). The Law Commission indicated that taking away one's right to refuse treatment must be balanced by the seriousness of the risk to one's safety in not undertaking treatment. The duration of detainment in treatment must also be limited, so that it is applicable only until such time as the person has regained the capacity to make an informed decision regarding engaging in treatment for oneself. Thus, the threshold criteria for a compulsory treatment order to apply must be high so as not to unduly restrict a person's liberty.

New Zealand legislative environment

Since the inception of the Alcoholism and Drug Addiction Act (ADA Act) in 1966, a number of other pieces of legislation and statutory bodies have come into being. These reflect changes in the way New Zealanders view the State's involvement in their lives, the move towards increased personal responsibility and acceptance of diversity. They have also had an influence in the way in which the current ADA Act is used. These include:

- **The NZ Bill of Rights Act 1990** which outlines the rights of all people in New Zealand and emphasises the fundamental right of freedom of individual choice including the right to refuse medical intervention. Reviews of recent case law (NZFLR, 2008a, 2008b) shows the dilemma for judges in balancing the right to choose medical intervention, as established in the Bill of Rights, against the provisions in the ADA Act for detaining a person for treatment against their wishes. This dilemma is compounded by the prolonged duration for which the Act is enforceable (2 years), which on balance of rights is excessive for any detainment when no crime has been committed. The lack of any opportunity for appeal or review of a committal order once it has been made is also cause for concern for judges in making their final decisions. A clear alignment to the Bill of Rights by addressing these two features; duration of the order and opportunity for appeal, are key to ensuring that the judiciary will have confidence in utilising the new legislation.

- **The Human Rights Act 1993** includes protections for individuals and specifies grounds for anti-discrimination. As the current ADA Act does not have any criteria relating to a lack of decision making capacity, there is no legal or clinical tool to advise the court at which point a person is choosing to live their life a certain way and when they no longer have the capacity to make that decision for themselves. Thus, someone deemed to be an 'alcoholic' by a General Practitioner can be detained for up to 2 years, well beyond the point at which it could reasonably be assumed that they had regained the capacity to make a decision regarding treatment, unless there was evidence of an acquired brain injury (ABI). This is also well past the point at which someone would be considered to be at any immediate risk of harm.

This situation does leave the ADA Act open to be used in a discriminatory manner. Arguably, alcoholics, and latterly drug users, are a population that have a history of being stigmatised, and thus do need overt protection within legislation to avoid potential abuses. Ensuring free access to advocates for a proposed detainee is available at the outset will mitigate opportunities for abuse of this law to occur. The inclusion of peer support services throughout the court process and duration of treatment will also assist in limiting abuses of power by allowing a voice to any concerns, real or perceived.

- **The Privacy Act 1993** outlines the protection for the collection, use and storage of personal information. The Health Information Privacy Code is specifically important to the management of personal information obtained in mental health and addiction services. In the operation of the ADA Act there are some potential challenges in the management of patient/client information between justice and health sectors, and also between mental health and addiction services within the health sector. There is a question around how much information regarding someone's health condition is required to be recorded in court documents for the purposes of enacting this legislation. At the present time, it is sufficient for two general practitioners to certify someone as being substance dependent to qualify for compulsory treatment under the ADA Act. That is because there is no appeal process so those assessments are not called into question. In the proposed new legislation, the threshold criteria will change and an appeals process will be introduced (as provided for under the Bill of Rights). This implies that more information may be required to demonstrate how a clinical determination of substance dependency and the severity of that condition that would warrant detention. How much information will be necessary to demonstrate to the court that a person does not have the capacity to make a decision regarding treatment has yet to be determined. A key task in ensuring the effective implementation of new legislation will be to develop standardised forms, which clearly outline the information required and guidelines for the use of a person's information as well as ensuring the person is informed at each stage of the process what is happening with the information they are providing. These forms then need to satisfy the court's need for sufficient 'evidence' that the criteria have been met to enact the law, as well as satisfy the clinical need to protect the health information of the patient wherever possible.

The provisions in the Privacy Act are balanced in clinical practice by a clinicians own professional Code of Ethics to determine the limits of confidentiality of information based on an assessment of risk. In their research into analysis of risk, Slovic and Peters (2006) indicated that affect, and particularly, feelings of dread are the major determinants of perceptions of risk. This suggests that family members who are emotionally involved with their family member may perceive severe risk more quickly than professionals who are not emotionally engaged with the person concerned. Slovic and Peters (2006) further added that it is these unpleasant feelings that are the primary motivator for action that people take, doing what they can to avoid them. This would be interesting to investigate further as it could imply the utilisation of intensive interventions relatively late in the progression of one's addiction when these are less likely to be effective. This argument suggests that as professionals perhaps we may not perceive risk sufficiently early enough to intervene at a time when treatment is more likely to be beneficial. On the other hand, this approach upholds the right of the person to choose treatment right up until the time at which they are deemed to no longer have the capacity to make that choice. Perhaps there is a case, however, for making the benefits of treatment more appealing or more proactive encouragement for people to utilise treatment options earlier than is currently done.

- **The Health & Disability Commissioner Act 1994** established a body that had a mandate to investigate and uphold any complaints relating to the Health and Disability Consumer Rights. This recognises the right of people to appeal any court decision made against them, including those made for compulsory treatment. Under a new or revised legislation, people will be able to utilise this body for the purposes of managing any complaints regarding treatment as an impartial forum. This will give those people under committal the same rights as everyone else undertaking treatment services.

- **The NZ Public Health and Disability Act 2000** forms the basis for the overarching legislative framework for all health and disability services, including mental health and addiction services. It encompasses the rights of New Zealanders who are in receipt of health services

to be treated with respect and dignity as outlined in the Bill of Rights 1990 and the Human Rights Act 1993.

Any proposed changes to the ADA Act must be underpinned by the tenets expressed in those Acts described above in order to ensure consistency and equity. In aligning these pieces of legislation the ADA Act becomes centred on the rights of the individual concerned and ensures that people experiencing severe, chronic problems with alcohol and other drugs are treated with respect and dignity. To meet these requirements, proposed changes to the process of application (as described in Figure 1, page 9) include removing the requirement for two medical certificates and replacing this with a comprehensive addiction assessment to determine the lack of capacity to make a decision for treatment, and a medical certificate. The duration of the compulsory period would also be significantly reduced to eight weeks, or until such time as the person regains the capacity to make the decision to remain in treatment on a voluntary basis or leave. The potential impact of these changes on those who are living with or supporting people with severe addictions has not yet been commented on or considered.

Mental Health (Compulsory Assessment & Treatment) Act 1992

The Mental Health (Compulsory Assessment & Treatment) Act 1992 (Mental Health Act) provides for the detention of a person determined to be mentally disordered for the purposes of psychiatric assessment and treatment necessary to stabilise the immediate risk to the person posed by their condition (Wellington Community Law Centre, 2002). Currently the Mental Health Act excludes application for anyone who has a sole diagnosis of a substance related disorder (section 4d). In theory, people who have developed a mental health condition secondary to their substance use would be eligible under this Act for immediate assistance where necessary. Discussions with alcohol and other drug practitioners who attended the Cutting Edge Conference in 2011 confirmed that some elevate the presence of mental health concerns in order to get the assistance via the Mental Health Act rather than attempting to navigate the cumbersome ADA Act. They also reported incidents of their clients who had suicidal ideation being 'treated' in emergency departments if they were clearly intoxicated, until such time as they 'sobered up' and the immediate risk had been reduced sufficiently for them to return to the community to continue

treatment as usual (Cutting Edge conference attendees, personal communications, 1-2 September 2011).

A number of amendments have been made since the Mental Health Act came in to force, the most recent in 1999. However, there have been calls for an overall review. Notably in relation to the Alcoholism and Drug Addiction Act review, the current MH Act does not include any criteria relating to decision making capacity as has been suggested for the revised ADA Act. The criteria are based on an assessment of immediate risk to oneself or others. In fact, Dr David Chaplow, then Director of Mental Health, noted the problems associated with a move to a 'competency based' legislation would be "profound" (Te Pou, 2009). This is because assessing competence to make decisions is a legal construct rather than a clinical one. It also has several complicating features to consider. A set of four legal standards have long been the benchmark for assessing any deficit in one's ability to make informed consent for medical treatment:

1. Understanding of information and choices available for treatment;
2. An appreciation of the impact of each of these choices on one's own circumstance;
3. Demonstration of reasoning in regards to the logical processing of information above (weighing up the options); and
4. Expressing a choice

(Grisso & Appelbaum, 1998)

The presence of a mental disorder or addiction alone does not mean that there is a loss of capacity to make decisions. However, many people with these conditions may be at a greater risk of experiencing deficits in this area at certain periods of time. The lack of ability to make decisions does not typically affect someone globally so that a person may be quite capable of making every day decisions about what to eat, or what to buy at the supermarket but may not be able to make a decision about getting treatment for their condition or taking their medication regularly. Thus, the assessment for the capacity to consent for treatment must specifically demonstrate that the person is unable to understand the information about treatment choices or cannot process the information properly. Decision making capacity is also not usually fixed in time. For some disorders, including dementias, this typically gets progressively worse over time. However, for

other conditions, including addictions, the capacity to consent can be regained after some days of being abstinent or stabilised on substitution therapies. The person must be able to show they are making a choice on their own and not coerced by another person. Simply making a decision that the doctor or one's family disagrees with is insufficient to meet this criterion as the Bill of Rights (1990) expressly gives adults the right to make their own choices for treatment, even when that decision is against medical advice. Taking these features into account, it is a complex process to assess capacity to consent for treatment.

During the past year, 5216 applications for compulsory treatment orders were made under the Mental Health Act; 4626 were granted for community treatment orders while 1881 were granted for inpatient treatment (Ministry of Health, 2011a). When this is compared to the 100 people being committed under the ADA Act (Ministry of Health, 2011a), it is interesting to consider why the option to rescind section 4d in the Mental Health Act is not considered feasible (NZLC, 2010) and consequently why we would persist in expending the necessary resources to treat these disorders so differently.

Added to this, research indicates that almost 30% of the population with a substance use disorder will have a co-occurring mood disorder, and 40% will have an anxiety disorder (Oakley Brown, Wells, & Scott, 2006). A study of 105 patients of two outpatient alcohol and drug clinics in New Zealand found 75% had a coexisting psychiatric condition, while 90% had experienced a psychiatric condition within their lifetime (Adamson, Todd, Sellman, Huriwai, & Porter, 2006). The prevalence of a co-existing mental health and addictive disorder is more pronounced when the addiction becomes more severe. Statistics provided by Nova Trust, a primary treatment provider for people under ADA Act committals, shows that of their admissions during 2011, 90% of females and 67% of males had a co-existing mental health condition they were being prescribed medication to treat.

These figures above, however, do not include issues relating to cognitive dysfunction or neuropsychological deficits, as these are rarely assessed (Joy Green, Manager Nova Trust, personal communication, 9 September 2011). Given these statistics, the feasibility of managing people with severe addictions, who are deemed 'at risk' or incapable of self-care, in the same process as those with severe mental health disorders needs to be considered carefully. Those

that meet the criteria for compulsory addiction treatment are most likely to also meet clinical criteria for a co-existing mental health condition, which arguably is likely to be exacerbated by the severity of their addiction and should be treated as well (Todd, 2010). As Todd (2010) explains, these conditions negatively impact on each other in various ways including increased relapses, increased rates of suicide, violence and other offending, higher levels of mental health symptoms, poorer general health, social relationships and wellbeing. Despite the presence of these conditions also impacting on a person's relative ability to engage in the treatment process the presence of a co-existing condition (including poor cognitive functioning) is not always assessed or treated within the addiction treatment setting.

The Mental Health & Addiction Treatment Divide

An investigation about why those with severe addiction issues cannot currently be managed within the Mental Health (Compulsory Assessment & Treatment) Act 1992, led me to examine how the current system, which supports a 'treatment by disorder' approach, has developed. A number of barriers including workforce and systemic issues were identified and are presented in the following section.

Workforce barriers

The division of mental health and addiction service development and their respective workforces are rooted in the philosophical underpinnings and history of mental health and addiction treatment sectors. This in turn has affected the training of each workforce such that undergraduate and postgraduate training programmes have evolved that treat these workforces as distinct groups with specialist training required (http://www.weltec.ac.nz/SUBJECTAREAS/Addiction counsellingandHealthStudies/AddictionStudies/tabid/1342/Default.aspx). Mental health disorders are treated within in the domain of the predominant medical discourse. Most conditions are successfully managed with a medication regime under the care of a general practitioner or a psychiatrist for more complex situations. Ongoing management and care within the community is undertaken by primary care or multidisciplinary teams headed by a consultant psychiatrist, and including mental health nurses.

In contrast, addiction treatment has developed within the context of the psychosocial domain, which has seen counselling and self-help models as the overriding forms of therapy regimes. This stems from enduring societal attitudes that addictions are a lifestyle choice rather than a disease or disorder that is out of the person's control, as in the case of a mental health condition (Wild, 1999). It wasn't until the mid-1990s that the first formalised training programme was developed for alcohol and drug treatment practitioners at the Central Institute of Technology (now known as Weltec course link above) as a means of starting to professionalise the workforce (Cave, Robertson, Pitama, & Huriwai, 2008). The 2008 addiction workforce survey, undertaken by the National Addiction Centre, indicated the addiction workforce is made up predominately of counsellors and therapists (60%). Other professions that comprise the workforce include nurses (15%), social workers (16%), psychologists (5%) and medical practitioners (2%) (Adamson, Deering, Schroder, Townshend, & Ditchburn, 2008).

A more recent workforce stocktake shows some changes to this mix in that of the 1,832 full time equivalent (FTE) positions funded by Vote Health for adult addiction services, 63% of these roles are clinical of which 48% are addiction practitioners or counsellors and 28% are nurses. This is in comparison to the mental health specific workforce which totals 7,097 FTEs funded by Vote Health, 56% of whom are nurses and 25% are allied health (including psychologists and social workers) (Te Pou O Whakaaro Nui, in press). Twenty three percent of the adult addiction service workforce are Māori, although this information was provided by managers and so ethnicity was not self-identified. Therefore, the actual number may be higher as many employers do not record ethnicity. While 27% of the mental health workforce working in non-government organisations are Māori, only 12% of the mental heatlh clinical workforce working in district health boards are indicated as Māori. These statistics are somewhat reflective of the 26% percent of consumers of mental health and addiction consumers who are Māori and do compare favourably to the overall 2008 health workforce statistics in which only 3.2% are Māori (Morgan & Simmons, 2009).

While most practitioners in both fields are keenly aware they are often treating people who have co-existing mental health and addiction conditions, the division of labour can be seen starkly by the following comments taken from an unpublished report commissioned by Matua Raki to understand the workforce perspectives of each respective area:

"The alcohol and drug counsellors in the local NGO wouldn't recognise a mental health problem if it slapped them in the face. Waste of time and money. Any real work is done by my nurses." - Manager, Mental Health, DHB

"Alcohol and drug is talking therapy. They are untrained. Real medicine is by mental health".
- Manager, Mental Health Service (including alcohol and drugs)

"Eighty percent of my patients have alcohol and drug problems and No, we don't address these problems." - Clinical Director, Mental Health, DHB service

"Mental health nurses are so medication focused. There is a hell of a lot more about people than giving them a pill." - AOD Practitioner, NGO service

"The difficulty we have at the moment is training our alcohol and drug staff in mental health. They resist what they insist on calling a medical model approach." - Manager, Mental Health, DHB

"I am here to treat her depression. If she is using cannabis what am I supposed to do? Depression is my business." - Nurse, Mental Health, talking about a service user.

Excerpts from MacEwan (2007)

It is easy to get the impression that resistance to collaboration is a signal of the fear of losing distinct identities and ways of working. As noted by MacEwan (2007), for addiction practitioners this resistance is about being subsumed by the larger and more powerful "medical model". The Matua Raki study by MacEwan (2007) found that alcohol and drug practitioners were not well trained in identifying mental health conditions, and mental health workers were not well trained in or interested in identifying addiction problems. Workers from both areas experienced difficulties with each other in liaising over shared cases. Clearly, for any significant change to occur there will need to be some attitudinal changes to address the fragmentation that exists between these sectors.

Systemic barriers

Funding for treatment services in both areas is sourced from the Ministry of Health and distributed by District Health Boards (DHBs) to address local and regional demand. Funding allocation for mental health services has been directed over the past fifteen years by the Blueprint for Mental Health targets (Mental Health Commission, 1998). Addiction services received 11% of the total allocated funding for mental health in 2013-14 (Te Pou O Whakaaro Nui, in press). It is acknowledged that both arenas are underfunded, hence the targets set, and it is also recognised that funding for addictions has not increased at the same rate as for mental health during this time (Alcohol Liqour Advisory Council & Mental Health Commission, 2008).

Attention has been given to the effective use of limited resources while maintaining two systems (mental health and addictions) and ensuring that service users are receiving the most appropriate support. The systemic issues that these challenges present are not new issues and there have been several high level strategic documents published which have attempted to address these concerns including:

- Te Kōkiri: the Mental Health & Addiction Action Plan 2006-2015 (Minister of Health, 2006)
- Blueprint for Mental Health: How things need to be (Mental Health Commission, 1998),
- Te Tāhuhu: Improving Mental Health 2005-2015 (Minister of Health, 2005)
- Te Puāwaiwhero: The second Māori Mental Health and Addiction National Strategic Framework 2008-2015 (Ministry of Health, 2008b)

Although these documents have all outlined specific actions to improve the coordination of addiction and mental health services they have continued to develop largely in isolation of each other. In 2010, each DHB received a written directive from Dr David Chaplow, the then Director of Mental Health, which required a plan outlining how they were increasing the capability of their services to respond to co-existing conditions in their 2011 report to the Ministry of Health. In a clear demonstration of the need for strong leadership to drive complex system level and organisational change, this letter was the catalyst for the subsequent integration in various forms of several mental health and addiction teams in DHB services across New Zealand. The need for this level of leadership to underpin sustainable change was highlighted in the framework published by the State Services Commission (2008) to assist agencies to co-ordinate more

effectively. This framework outlines nine factors for successful inter-agency coordination (see Table 2).

Table 2.

Factors for Successful Inter-agency Coordination

Mandate	• Leadership commitment
	• Ministers' & key stakeholder buy-in
	• Defined and agreed outcomes
Systems	• Appropriate governance frameworks
	• Sufficient & appropriate resources
	• Performance measures
Behaviours	• Representation, team leadership
	• Organisational culture to support coordination
	• Shared culture, language & values

Note: State Services Commission (2008, p. 11)

A series of workshops, which also emphasised the Ministry backing of these changes, accompanied this directive. The framework (see Table 2) stressed the need for participants "to establish working relationships based on mutual support and trust acknowledging their differences and sharing information openly" (State Services Commission, 2008, p. 16). As noted above, this is likely to be a challenge for those entrenched in their own ways of working.

Notwithstanding the systemic and workforce issues facing the effective treatment delivery for clients, I contend that ongoing social stigma is still prevalent and plays a part in the continued under resourcing of treatment facilities. The Ministry of Health has embarked on a number of campaigns to reduce stigma for mental health. The most recent, and perhaps most successful to date, has been fronted by former All Black, Sir John Kirwan. This media campaign has led to an unprecedented number of people (approximately 18,000 in the first year) registering for assistance via a purpose built website designed for self-management of mild to moderate depression (Derek Thompson, Ministry of Health, personal communication, 27 October 2011).

Somewhat understandably, given the often illegal behaviour involved in drug use, there is still a perception that addiction is a personal choice rather than a disorder that requires long-term treatment (T. Wild et al., 2001)

Notwithstanding the challenges of increasing collaborative working between mental health and addiction workforces, the introduction of the Health Practitioners Competence Assurance Act 2003 has had an unintended but significant impact within the New Zealand addiction treatment sector itself. This Act serves to assure the public that health professionals are competent to practise within the scope of their professional domains, as monitored by each respective professional body. The intention of this Act was to limit the risk for the health professions whose interaction with patients could potentially be harmful. In response, a number of addiction District Health Board (DHB) provider-arm services initially implemented a policy to employ those whose professions are HPCA registered. These practitioners include medical practitioners, nurses, psychologists and occupational therapists.

The majority of the current alcohol and drug treatment workforce who have qualifications in social work or alcohol and drug counselling and who are registered only with the addiction practitioners association (dapaanz) are not HPCA registered, and therefore, ineligible for employment in these services. Thus, alcohol and other drug practitioners sought employment in community-based services operated by non-government organisations (NGOs), which include charity or not-for-profit organisations such as The Salvation Army, CareNZ, Odyssey House and iwi trust organisations. This had the potential to create a two–tiered workforce structure within the addictions sector, which is seen to value the HPCA registered workforce located in DHB services more highly through significantly higher pay rates and more training opportunities. Of course this served also to increase the division noted earlier where higher paid medically trained staff were no longer working alongside alcohol and drug practitioners. This unintended consequence was redressed somewhat with dapaanz accreditation being formally recognised within several DHBs alongside HPCA registration for the purposes of those working in the addiction services. However, the two years or so that the policy was in place reignited some of the divisions noted above, causing confusion in the workforce.

This situation poses a particular concern for the population that is in part a focus of this study. The people that family members are seeking assistance for within this study are typically the most complex and challenging of patients experiencing the enduring effects of severe addiction, including cognitive impairments usually compounded by mental health conditions. After a medical detoxification, they are likely to be treated long-term in community-based residential services by those arguably less well trained to manage the complexity of their problems.

Summary

The reforms proposed in the review of the Alcoholism and Drug Addiction Act 1966 seek to ensure the rights applicable to all New Zealanders equally apply to those experiencing the most severe effects of addiction. These changes are in line with recent changes to similar legislation made for similar reasons in other countries with which we generally compare ourselves. There has been no consideration given, to date, of the impact of these proposed changes on those that live with and support people who would or would not be eligible for compulsory treatment.

Perhaps the most cost effective and quickest way to achieve this objective would be to incorporate the people that would meet the criteria for compulsory addiction treatment within an amended Mental Health (Compulsory Assessment & Treatment) Act 1992. At present this is not a viable option due to the 'treatment by disorder' approach that has evolved and the corresponding division of workforces. Significant work over a sustained period of time will be required to address this divide if we are to create a treatment structure which is truly client/patient/tangata whaoira centred and that serves to address their needs. Since the publication of Te Ari Ari O te Oranga (Todd, 2010) and the companion service guidance document; Integrated Solutions (Ministry of Health, 2010a), a programme of work to enhance the capability of the workforce to respond to those with co-existing problems has been underway. A recent survey to evaluate progress towards this has shown a high degree of variability across the country in regards to interpretation of what effective integration and enhanced service delivery comprises (Matua Raki, 2014). One potential outcome of this research is to encourage the involvement of those most affected by this situation to contribute to this process both directly via the submission process and indirectly through their

contributions to this study, which in turn will inform the development of appropriate resources and training for the workforce.

Significance of the Study

This study is focused on family members who have used the current compulsory addiction treatment legislation in order to seek treatment on behalf of a family member effected by severe addiction. There are four main areas that suggest this is an area worthy of attention. Although compulsory addiction treatment under the Alcoholism and Drug Addiction Act (1966) affects few people in New Zealand at present, it is argued that not only does the current process not address the potential demand for this level of intervention well, but as the next section will show, population changes and changes in our drinking behaviour and drug consumption will result in a growing need to provide for this level of intervention into the future. It is an opportunity to examine what is happening for those family members who need to engage with this process in order to better understand and support them in the future. It is hoped that the findings could be used to support the revision of the existing legislation, particularly in relation to meeting basic human rights and seeking to appropriately support family members and under-represented groups, such as Māori.

Population changes

Projected population statistics indicate that New Zealand's population would eclipse five million by 2025. The population aged over 65 years will increase to one million and will exceed the number of children aged 0-14 years. One in five people in New Zealand will be aged over 65 years by 2030, compared to one in eight now. The Māori, Asian and Pacific Island populations will grow at a much faster rate than European New Zealanders over this time and will also age comparatively. (www.stats.govt.nz)

Although people are living longer on average there continues to be disparity in the life expectancy of Māori and non-Māori for both males and females (www.stats.govt.nz). It is expected that the number of people experiencing mental health and addiction problems will increase. The risk of chronic disease and dementia increases with age, and older people may be more vulnerable to co-existing and mental health problems such as depression in relation to physiological changes

(Ministry of Health, 2010a). Māori have more risk factors for age-related conditions including dementia, cardiovascular conditions, depression and are at least three times more likely to experience a substance use disorder in their lifetime (Baxter, 2008; Oakley Brown et al., 2006). These findings are supported by more recent surveys (Ministry of Health, 2010b). Health services must prepare for these forecasted changes in the demographics of those likely to require intensive health services if they are to be effective and meet the demands of the people who will be accessing them.

Drinking patterns

In addition to general population changes, there are changes in the way in which the consumption of alcohol and other substances may impact on the future utilisation of addiction treatment services. Binge, or heavy episodic drinking, has been defined as five standard drinks for men and four standard drinks for women on a single occasion within the past two weeks (Courtney & Polich, 2009). This pattern of drinking seems to be prevalent amongst younger people and is an increasing trend in many Western countries including New Zealand (Serulda, Brewer, Gillespie, Denny, & Mokdad, 2004). A report from the Ministry of Health (2007) estimated that almost 25% of New Zealand drinkers aged 12-65 years consumed alcohol in large amounts on a typical drinking occasion. This has increased for those aged 18-24 years to 50%. Although there were no differences in the frequency of drinking episodes between Māori and non-Māori, Māori were significantly more likely to consume large amounts of alcohol in a typical session which is commonly termed a binge drinking pattern. This data was further confirmed in research relating to Māori health that found that while Māori and non-Māori were equally likely to have consumed alcohol and Māori were less likely to drink daily. When they did drink, Māori were twice as likely to have consumed large amounts at least weekly (Ministry of Health, 2010b). Baxter (2008) reported that almost one in three Māori will develop a substance use disorder over their lifetime, and of those Māori with any alcohol use disorder one in three also had a drug abuse disorder.

A binge pattern of drinking is associated with a number of health issues later in life, including negative impacts on the cardiovascular and metabolic systems. In addition, binge drinking is associated with a higher likelihood of developing alcohol dependency (Jennison, 2004; Stranges & Trevisan, 2008). Binge drinking in midlife has also been shown to be a risk factor for developing

dementia later in life (Järvenpää, Rinne, Koskenvuo, Räihä, & Kaprio, 2005). Added to this, older people tend to show complex patterns of substance use, for example mixing alcohol with prescribed medications. The high rates of mental health problems in older people (including cognitive disorders) result in frequent, complex co-existing psychiatric and substance use disorders (Royal College of Psychiatrists, 2011).

Almost exclusively, at present, admissions for ADA Act committals are as a result of alcohol dependence. However, there is an emerging group that are long-term polydrug abusers who may exhibit drug-induced brain injury and require such interventions over the coming decades (Rota-Bartelink, 2006).

Treatment paradigms not meeting needs

A critical analysis of the treatment models applied to those with severe and chronic substance dependence, as well as an examination of the potential populations that may require intensive intervention but do not have access, is long overdue. The Law Commission has been very clear that the current law does not provide protections for individuals as outlined in the Bill of Rights 1990 (NZLC, 2010). For example, the current ADA Act has been enforceable for up two years. While this may have come from well intentioned, paternal motives to provide care for people over a long period of time, it does not uphold the right of individuals to not be detained for longer than is absolutely necessary. Furthermore, this provision far exceeds the duration of any treatment programme available.

The two programmes that do provide treatment for this population are the Salvation Army and Nova Trust. Both these programmes operate abstinence-based programmes; one of which is a psychosocial education programme (life skill education and group therapy classes daily from 9-3pm) and the other an activity work-based programme. After the 'intensive' treatment phase at these facilities, any ongoing support is provided by various outpatient services. The outpatient services are typically client-initiated counselling services that operate on the basis of weekly or fortnightly 50 minute sessions and use talking therapy models. Client statistics provided by Nova Trust indicated that 100% of ADA Act committed clients have had at least one prior treatment, with an estimated average of four prior treatments per client. This is strongly suggestive of a group for whom current treatment models are ineffective. As previously mentioned this group of clients

are likely to be experiencing some form of substance related brain damage. A recent literature review showed this treatment mismatch is not unique to New Zealand. Brighton, Moxham and Traynor (2012) found that the complex symptoms associated with alcohol related brain injury in particular, consistently resulted in incorrect diagnosis, incongruous treatment and unsuitable medications being prescribed. One study they reviewed (Thomson & Marshall, 2006) found that 90% of people with alcohol related brain damage were not diagnosed until after they had died. Practitioners were rarely identifying brain injury or cognitive damage, instead interpreting poor behaviour such as inattention, lack of impulse control and or difficulty managing emotions and stress in isolation. This failure to diagnose results in people not receiving the correct treatment for what can be, in many cases, a reversible condition.

Current treatment models are heavily influenced by the prevailing understanding of the causes of substance abuse. Our beliefs about the causes of substance abuse moved from a moral model, whereby drinkers and drug users were seen as weak and sinful, to a 'disease model' in which substance abuse was seen as a consequence of a pre-existing vulnerability inherent in the addicted person (Jellinek, 1960). More recently the development of psychological theories and behavioural learning theories has also tried to explain addiction and substance misuse. These theories include the concept of substances being used by the individual to 'self-medicate against life's negative experiences' (Barber, 2002, p. 16). As none of these theories completely explain the phenomenon, earlier understandings, including the notion that addiction is a moral weakness, are still evident. The disease model was the foundation for the 12-step movement and tends to still pervade abstinence-based treatment models offered today. McLellan, Lewis, O'Brien, and Kleber (2000) have undertaken research which indicated addiction followed a similar path to other chronic conditions such as diabetes, asthma and hypertension. As a chronic medical condition, addiction should be treated with a long-term care plan that includes medication and ongoing monitoring. McLellan et al. (2000) recommended long-term care plans that include brief periods of higher intensive treatment focused on the development of self-management skills. Alternative models of care and treatment to improve outcomes for this group are paramount to the effective utilisation of such legislation. It would seem counter to the intent of the Bill of Rights 1990 to repeatedly detain someone in a treatment regime that has proven to be ineffective. Therefore attention needs to be paid to developing training for practitioners in the recognition of cognitive

impairment and treatment programmes designed to adequately manage and treat this severe form of addiction.

Meeting the needs of Māori

A specific group that is underrepresented in this treatment population are Māori. Although this research does not specifically target Māori, it is important in the context of New Zealand health research to examine the impact of this study on Māori whānau and also the implications of any changes proposed as a result. The lack of Māori involved in addiction treatment under this compulsory regime raises the question of whether this group of older Māori chronic alcohol dependents with complex needs actually exists. Health statistics for Māori are discouraging. Statistics New Zealand's (2015) data indicates Māori life expectancy, although improving is still less than non-Māori. Life expectancy for Māori males is 73.0 years compared to non-Māori males of 80.3 years. The life expectancy for Māori females is 77.1 years compared to non-Māori females of 83.9 years.

Māori experience greater rates of health effects related to violence and are almost twice as likely to experience depression or anxiety. Māori adults are also one and a half times more likely to be hospitalised for unintentional injuries and twice as likely as non-Māori to die from unintentional injuries including car accidents (Ministry of Health, 2010). It is reasonable to assume that many of these incidences may be alcohol-related, as alcohol has been implicated as a contributing factor to all of these events (Connor, Broad, Rehm, Hoorn, & Jackson, 2005).

These figures tend to suggest that many Māori who would otherwise perhaps be in need of compulsory treatment for alcohol-related factors are probably dying much earlier than their non-Māori counterparts, or perhaps are otherwise engaged in other health services due to other health factors related to injuries sustained from falls, violence, or poor physical or mental health. This rationale is supported by Oakley Brown et al. (2006) whose survey strongly suggested that the higher prevalence rates experienced at younger ages of conditions, including cardiovascular disease and head trauma, contributed to a lower life expectancy amongst Māori.

A further consideration is whether Māori experiencing severe effects from drinking behaviour are more likely to be managed through the justice system. New Zealand police statistics (Stevenson,

2009) show markedly higher offending rates, where the offender had consumed alcohol prior to an offense, for Māori than any other ethnic group in the population (See Table 3). This is consistent with the higher levels of binge drinking behaviour noted earlier (Ministry of Health, 2010b) which is associated with increased levels of intoxicated behaviour, including petty crime and violence. However, closer examination of the statistics in Table 3 indicates the percentage of people being apprehended where alcohol is a factor against the total number of apprehensions show European and Māori are very similar (29.8% and 27.9%, respectively). This does suggest that many Māori experiencing problematic drinking behaviours, are being managed through the justice system rather than through health services, and may explain in part why Māori are underrepresented in health interventions such as civil commitment.

Table 3:

Number of Apprehensions Overall and Those Where the Alleged Offender Consumed Alcohol

	Apprehensions (2005/06 FY) (per 10,000 population)	
	Total Apprehensions	Apprehensions where alcohol was consumed prior
European	295	88
Māori	1414	394
Pacific Island	580	215

Note: Source (Stevenson, 2009, p. 60)

Notwithstanding the above factors, family and whānau members, who are frequently the initiators of a committal process, may be less inclined to engage the justice system for health-related issues (Jansen, Bacal, & Crengle, 2008). In addition the application process for an order is made within the context of New Zealand's adversarial justice system. This does not align well with traditional Te Ao Māori justice, which aims to achieve balance and restoration of mana (pride) by being forward looking, and using a more relational and principled based approach (Toki, 2010). Given there are no Māori specific treatment services certified to accept committed patients, those who could otherwise benefit from mandated treatment may remain in the care of whānau with little support from appropriate health providers. There is an obligation when reviewing the ADA legislation to make an appropriate treatment pathway accessible and viable for Māori, not least

of which needs to include the recognition of Te Ao Māori (the Māori worldview). For services, adopting this holistic worldview with whānau at the centre of the process requires, in practice, the co-ordination of health and social services to meet the needs as determined by the family whānau.

In summary, New Zealand has an ageing population which will include a higher percentage of Māori. As a nation, New Zealand tends to have a pattern of binge drinking in respect to alcohol consumption, and is more likely than previous generations to be polydrug users over longer periods of time. Binge drinking is associated with increased health risks (and associated costs) as well as an increased likelihood of becoming alcohol dependent and experiencing dementia later in life. Ageing itself is associated with declining cognitive functions and increased health issues and health service consumption. Therefore, in relation to alcohol affects alone, the demand on health services that cater for this group of people is likely to increase significantly. Similarly, there is likely to be an increased need for treating the needs of older, alcohol dependants who may have complex physical and mental health issues, such as those needing to be managed through mandated compulsory treatment. Effective interventions to address this issue for Māori tangata whairora and their whānau must also be considered and resourced.

Early engagement and the role of family and whānau

Several studies have demonstrated that early engagement in addiction treatment is significantly associated with increased retention, improved therapeutic relationships, and reduction in the addictive behaviour (Dowling & Cosic, 2010; Fiorentine, Nakashima, & Anglin, 1999; Villano, Rosenblum, Magura, & Chunki, 2002). When poor family and whānau relationships exist, this has been shown to increase levels of motivation to seek treatment for drug dependency but also to negatively impact long-term post-treatment outcomes (Griffith, Knight, Joe, & Simpson, 1998). Where families are involved in the early engagement of treatment such as parents of children hospitalised for emotional disturbances, research has shown that the rates of repeat admissions were positively correlated with the level of engagement and satisfaction of the parents in earlier admissions (Brinkmeyer, Eyberg, Nguyen, & Adams, 2004).

This suggests that success in treatment could be highly influenced by the manner in which a person under a civil commitment for compulsory treatment is engaged in the process of treatment and how their significant others are similarly engaged in the process. In relation to the ADA Act,

many applicants are family members of those severely affected by substance dependency. Judges' decisions following an application for committal under the ADA Act, which were reviewed in preparation for the research reported in this thesis, identified that the basic social psychological process affecting parties involved in the court process was *resistance*. Resistance bought about by balancing competing interests and values was evident at each stage of the process, and this was particularly highlighted in relation to family members for example; "J's position is that he believes that this order must be made to preserve his brother's welfare, if not his life. L's position is that she wants to help her brother P but is loath to be part of any detention of him against his will" (NZFLR, 2008a). Family and whānau not only have to risk their relationship with the person of concern, but also navigate complex and powerful systems (health and justice) to achieve an outcome that arguably is not as effective as they anticipated. Smith(2014) reports that one death from alcohol dependency was attributed in part by the Coroner to the person's family finding the process of the ADA Act too difficult to access and get the help needed. Appreciating the complexity underlying how these decisions are made, in light of the competing interests and powers at play, would greatly assist in understanding the process by which family members resolve these dilemmas and is the focus of this research.

There are no statistics collected about applicants or initiators of civil committals. A focus group that I facilitated in preparation for this research with the consumer forum at Nova Trust in November 2011 was attended by nine people currently under ADA Act committal and attending addiction treatment. Each of those present indicated that the initiators of their committals were close family members (parents, siblings, spouses). It was clear from the discussion that due to being severely unwell at the time of the committal, people did not recall anything other than very salient events (such as being handcuffed and put in the back of a police car for the first time) about the process leading up to and including the court proceedings or detoxification. Every participant in that focus group were keen to see reforms, but stated that in respect to gathering information about the committal process itself, they were poor informants and encouraged me to instead seek this information from family members involved. It is for this reason that the focus of this research is on the family and whānau and the process they go through to undertake a civil commitment, rather than on tangata whai ora themselves.

As the literature review will also demonstrate, there is a lack of research that focuses on the experience of key stakeholders especially family and whānau involved in a compulsory treatment regime. It is most often the family member who initiates this process and who is engaged over the long-term with the client/tangata whai ora. It could be seen as valuable to have a greater understanding of their experiences with a purpose to identify key strategies to improve the level of support given to them by health services.

A grounded theory-action approach was seen as the most appropriate methodology as this research is focused on understanding the underlying group processes that are at play for family and whānau involved the civil commitment procedure via the ADA Act and then developing a systematic action plan to address issues that are identified. A grounded theory approach was also supported as this process takes place over an extended period of time and intermittently, therefore a participant observation study for example was not deemed feasible. Similarly, as the area of interest is identifying the group patterns of behaviour an interpretative or narrative study which focus on the individual stories of participants was also discounted in favour of a grounded theory.

Clarifying Key Concepts

The following key concepts are used frequently throughout this thesis. I have defined these terms below and indicated where some words can be used interchangeably.

Family/Whānau

The terms family and whānau are used in this thesis to refer to anyone in a family-like relationship but not necessarily blood ties (eg: parent, sibling, partner, spouse, adult child) with a person affected by severe addiction, and who has been involved in the civil commitment process using the Alcohol and Drug Addiction Act 1966. In honouring recent research findings that indicated participants were concerned with attempts by academics to define whānau and the various constructs around whānau (T. Walker, 2006, p. 33), the following definition outlined in He Korowai

Oranga – the Māori Health Strategy is used: "Whānau (kuia [grandmother, elder women], koro [grandfather, elder male], pakeke [adults], rangatahi [young people] and tamariki [children]) is recognised as the foundation of Māori society. As a principal source of strength, support, security and identity, whānau plays a central role in the wellbeing of Māori individually and collectively. It is up to each whānau and each individual to define for themselves who their whānau is" (Ministry of Health, 2002, p. 1).

Civil commitment for addiction treatment

A civil commitment is undertaken outside the criminal justice system because no law has been broken by the affected person. Instead the civil court system via the Family Court is used to seek an order to detain someone to undertake an addiction treatment programme. The legislation under investigation for this thesis is the Alcoholism and Drug Addiction Act 1966 (ADA Act).

Client/Patient/Tangata whai ora

These terms are used interchangeably to describe a person who is in receipt of care in the health system, and specifically in this study, someone who is committed for addiction treatment under the Alcoholism and Drug Addiction Act 1966. Typically, a person undergoing detoxification in a hospital setting is termed a 'patient' and is termed a 'client' once they enter a residential or outpatient addiction treatment programme. This reflects the predominant paradigms operating within each of these settings; medical within the hospital and psycho-social within non-hospital addiction treatment settings: Tangata whai ora literally means a person seeking health or well-being (Ministry of Health, 2000).

Structure of the Thesis

Chapter one has set the scene for this thesis, providing background to the topic under study, outlining the focus of the research and presenting myself as the researcher, my fit with this study and the assumptions I have brought to this research. An initial discussion of the significance of the study provides a context and rationale for this research. Key terms used throughout this thesis have been defined in order to clarify the meaning of each concept for the reader.

Chapter two reviews the literature that outlines the legislation as the mechanism by which people are committed for addiction treatment for severe addictions within a global context. Countries including Australia and Canada have recently undertaken similar reviews of their legislation frameworks for compulsory addiction treatment, so it is important to include similar perspectives and issues and how these have been addressed in other jurisdictions. I have also summarised research that supports the effectiveness of mandated addiction treatment. I do not wish to re-litigate the issue of whether compulsory treatment as a mechanism is effective in itself but rather focus this study on the use of the process by which people enter compulsory treatment. The dearth of literature that examines the involvement of family members in accessing health care on behalf of someone else suggests a clear gap in knowledge, which this research aims to start to fill.

Chapter three presents the rationale for utilising a Glaserian grounded theory and the grounded action methodology employed in this research. The key features of this classic grounded theory and grounded action, including memoing, theoretical sampling and data saturation are explained. The method of data collection, and the management of the data including coding and constant comparative analysis that was undertaken are described. Ethical considerations that were important for this research are outlined.

Chapter four presents the findings from this research. I explain the substantive theory which comprises the basic social psychological process 'living with it' which is underpinned by the categories of, 'fractured relationships', 'working it out myself' and holding my breath'. 'Living with it' provides a theory which explains how family members manage seeking help for a person experiencing the severe effects of addiction and resolve this on an ongoing basis. The grounded action approach takes this theory and seeks to apply a systematic analysis to resolving the issues that have become evident. An action plan is presented, of which several components have been implemented or are currently being planned further to this research.

Chapter five outlines the practice implications from the grounded theory-action arising from the findings of this research and locates these findings within existing literature. The recommendations for practice improvement are made supported by the evidence base from current literature. The barriers which have hindered addressing these issues are explored to

ensure that due consideration has been given to increasing the likelihood of successful implementation and sustainability of the suggested solutions.

Chapter 2   Initial Literature Review

This grounded action research is underpinned by the initial development of a Glaserian Grounded Theory. A key feature of a Glaserian Grounded Theory is the delay of any literature review until the development of the emergent theory. This is to limit the possibility of directing the research in a predetermined path and to allow "the literature to be used as additional data" (Heath & Cowley, 2004, p. 143). Glaser's concern regarding literature reviews prior to the research was aimed at avoiding preconceptions of the problem area by the researcher and subsequently wasting time on issues not pertinent to the participants (B. Glaser, 1998). The literature review should function to both locate the emergent theory and challenge the theory in the current context in which it is positioned (Heath, 2006). As such, a general literature review was undertaken in order to gain an understanding of current knowledge in this area and how the Alcoholism and Drug Addiction Act (1966) compares to jurisdictions outside New Zealand. I have done this to position the area of study within the international context of similar legislation and research to ensure it is a relevant area for research consideration. A focused literature review has been undertaken in response to the substantive theory generated and the action plan that the findings of this research proposes and is presented in chapter five.

This section reviews the literature that positions the legislation as the mechanism by which people are committed for addiction treatment within a global context. The literature also provides a summary of the research that supports the effectiveness of mandated treatment. I have done this so that the focus of this study is about how families and whānau manage the process of engaging compulsory treatment itself rather than look to validate whether or not there should be such a mechanism as compulsory treatment. The literature search was conducted using the following databases: Pro-Quest, Lexis Nexis, Scopus, PsychINFO, and using the keywords: compulsory AND treatment, addiction, family involvement AND addiction, Alcoholism and Drug Addiction Act. In addition, the literature to support the methodology section also included books and articles sourced from Sociology Press. Originally the date span of the literature reviewed was limited to post 2000, however, given this area of work relates to legislation dated 1966, this was extended to include any significant works or meta-analyses since 1995 and includes allied legislation

implemented since 1966. The dearth of literature that examines the involvement of family members in accessing health care on behalf of someone else indicates that there is a knowledge gap in understanding the impact of this on both families and health services.

Background: Other Jurisdictions

One of the intended outcomes of this research is to provide information in the draft revision of the compulsory treatment legislation of the importance of recognising family, whānau and support people as part of the process. As the current legislation is the context in which this research is conducted, a literature review of similar legislation that operates in other jurisdictions which New Zealand frequently compares itself was undertaken. It was noted that many of these legislative frameworks had also undergone significant reviews, and were subsequently updated.

The New Zealand Law Commission reviewed a number of jurisdictions that also make provision for the civil commitment of those with severe problematic substance use disorders (NZLC, 2010). These similar laws from Australia, the United Kingdom, Canada and the United States of America and the main differences to the ADA Act 1966 and proposed changes to this New Zealand law are explained in relation to their underlying philosophies. It was noted that of the international jurisdictions reviewed the only other similar addiction legislation that makes reference to support people (rather than family members) is the Mental Capacity Act 2005 in the United Kingdom.

Further, the 1999 amendment (section 7a) to the New Zealand Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act) required consultation with a proposed patient's family/whānau during the assessment and treatment of the patient. It specifies that consultation with a patient's or proposed patient's family/whānau must take place during the assessment and treatment, unless it is not reasonably practicable to do so or is not in the patient's best interests. The impact of this addition to the legislation, for those that experience acute mental health distress, will be examined later in this chapter.

Victoria, Australia

In March 2011, the Severe Substance Dependence Treatment Act 2010 came into operation in Victoria, Australia. This was the result of a similar review process to that being undertaken in New

Zealand of an outdated legislation; the Alcoholism and Drug-dependent Persons Act 1968. The principles guiding this revised legislation are similar to those being proposed in the review of the New Zealand ADA Act. It specifies that any detention for treatment is seen as a last resort and that all other options are exhausted so that any interference on one's human rights is kept to a minimum.

The threshold for committal under this new Severe Substance Dependence Treatment Act has been set very high, requiring "immediate treatment which is necessary and urgent to save the person's life or prevent serious damage to the person's health" (section 8). The focus on the use of this Act is much more closely aligned to the New Zealand Mental Health (Compulsory Assessment and Treatment) Act 1992, which aims to stabilise the person via medical intervention. 'Treatment" in this sense is confined to anything that is required in a medically assisted withdrawal or detoxification. The time limit for the duration of the order is 14 days, which is deemed to be sufficient time to treat the acute phase of an assisted detoxification. This is consistent with their definition of "severe substance dependence", which focuses only on the physical criteria (such as increased tolerance and evidence of withdrawal symptoms) and relate to the diagnostic criteria for dependency current at that time found in DSM IV (American Psychiatric Association, 1994).

The objective of the Severe Substance Dependence Treatment Act 2010 is to achieve physical stabilisation and minimise the immediate risk of harm to self. The proposed NZ legislation goes further by seeking to offer an opportunity to undertake rehabilitation and give sufficient time in order for a person to make that decision voluntarily. Therefore, the NZ legislation will continue to involve treatment services beyond hospitals, and the duration which has been suggested is an initial 8 weeks with a further 8 weeks if required.

One other difference is the availability of 'wet programmes' in Victoria. These programmes operate similar to methadone programmes in providing stabilisation via a monitored regime of alcohol doses. This is primarily aimed at those people for who continued detoxification episodes are no longer viable due to health risks, and those for whom repeated compulsory treatments have been unsuccessful. These programmes also provide for long-term safe housing and an individual treatment programme designed to improve overall wellbeing (Rota-Bartelink & Lipmann, 2010). The lack of these types of services in NZ results in a small number of people

revolving through the court system without being effectively treated, or being repeatedly 'detoxed' in police cells. They tend to be homeless as they are not suitable for any shelter or boarding facility, and remain very vulnerable. It could be argued that such programmes should be considered for this group of people in order to provide stabilisation and safer living conditions.

New South Wales (NSW), Australia

A trial of the Drug and Alcohol Treatment Act 2007 is currently underway in West Sydney, while other areas of NSW are still operating under the Inebriates Act 1912 (New South Wales Government, 2004). An independent review of the trial will inform the future planning of treatment services across NSW (J Bosca, NSW Minister of Health, media release, 16 Feb 2009). At the time of writing, this review had yet to be completed.

There are increased safeguards for the protection of a person's rights in the updated legislation, similar to that proposed for New Zealand. These include using this Act as a last resort, ensuring the interests of the person concerned are paramount, and that treatment occurs in the least restrictive environment to be effective. Like the New Zealand proposal, this Act seeks to facilitate stabilisation through medically assisted detoxification and then give an opportunity to engage in treatment and restore decision making capacity. The duration of the treatment order is for a period of up to 28 days. An additional 3 months can be applied for if there is evidence the person is suffering from alcohol or drug related brain injury.

There is provision for the person to be discharged from the Act at any time they no longer meet the criteria, and if they consistently refuse to engage in treatment. One of the challenges for treatment facilities in New Zealand is the interpretation of difficult and challenging behaviour as being resistant to treatment. As noted in discussions with the managers of the providers of treatment in this area, there are a number of people discharged from the Act once they are in a treatment facility due to behavioural problems and refusing to engage (Major, M Douglas, Director Salvation Army Bridge Auckland, personal communication 15 September 2011, Joy Green, Manager Nova Trust, personal communication, 13 September 2011).

It does seem somewhat counterintuitive to place a person under a committal order for addiction treatment because their addiction is so severe, and then discharge them from treatment because

they are difficult and 'resistant' to engaging. People experiencing this level of addiction are also likely to have a level of cognitive dysfunction which most commonly manifests as being agitated, irritable, having difficulty with memory, difficulty regulating and managing emotions, difficulty managing stress and change, and difficulty communicating clearly (Ricketts, Bliss, Murphy, & Brooker, 2005). Many are also traumatised from prolonged histories of being abused, victimised and taken advantage of (Royal College of Psychiatrists, 2011). It also seems somewhat inhumane to go through the court process to establish a need for this level of imposed intervention only to have the treatment facility decide that they are too difficult or don't want to be there and discharge them with no other suitable alternative to place them. In addition, people who are committed for treatment typically have at least three previous treatments and thus are being detained in a treatment programme that has been repeatedly ineffective (personal communication, Joy Green, Manager Nova Trust 13 September 2011). This would suggest that the current use of compulsory treatment is in fact for the benefit of society rather than the individual. This appears to be both a result of a system failure to develop alternative models of care and an agency issue whereby treatment providers are entrenched in a model of abstinence and compliance as a signal of engagement.

United Kingdom

The Mental Capacity Act 2005 (UK) allows for the assessment and treatment under a committal order for alcohol and drug dependent people who meet the mental capacity test. The lack of capacity to make a decision about one's welfare can be due to substance use alone. This is a significantly different from Section 4d of the NZ Mental Health Act 1992, which specifically excludes alcohol and drug affected behaviour separate from mental health conditions. Therefore, the UK does not require separate legislation to cater for severe mental health conditions and alcohol and drug dependency. The objective is to restore capacity which is indicated as occurring after acute detoxification in the case of alcohol and drug dependents (Section 17(1d) Mental Capacity Act (UK), 2005). The duration of the committal order, therefore, is typically under 14 days during which the person is treated for a medically assisted withdrawal in a hospital environment. This is based on the underlying philosophy that once capacity is restored the person is able to make their own decision to continue with treatment or not, and that they have the fundamental right to make that choice. In New Zealand the timeframe proposed for the duration

of the committal is eight weeks at which time it is believed likely that a person will have regained capacity to choose to remain in treatment voluntarily or not. There will be provision for an extended period of treatment if there is evidence of ongoing brain dysfunction which is likely to require more long-term care. It is expected that the use of the Protection of Personal and Property Rights Act 1988 will be enacted, if needed, for people requiring long-term intervention. This Act is the legislative authority for the appointment of a welfare guardian to make decisions about the person's care and treatment.

North America & Canada

An interesting extension of the argument for civil liberties versus mandated treatment can be seen in the interpretation of civil commitment laws in Canada and the United States. In both the USA and Canada any laws allowing civil commitment are only for specified substances, namely narcotics. The strong civil rights movement has not allowed consideration of any compulsory treatment for a legally sanctioned substance such as alcohol, and therefore, only those drugs that were illegal and deemed particularly harmful have been considered (Fischer, Roberts, & Kirst, 2002). The treatment indicated was focused on harm reduction and almost exclusively involved the use of methadone as the preferred treatment regime. For example, British Columbia enacted the Heroin Treatment Act 1978 which allowed for the compulsory treatment of someone deemed being dependent on narcotics of a period up to six months.

The Heroin Treatment Act 1978 was ruled unconstitutional in 1979, however, due to its impact on civil rights (Wild, 1999). That is not to say that people are, in general, against the concept of mandated treatment for addiction. For example, research in Ontario asked respondents to rate their agreement with the statement that "anybody with an alcohol or drug problem should be forced by law to enter treatment" (Wild, 1999, p. 91) showed that 56% of the general population agreed or strongly agreed with that statement. In contrast, only 10% of treatment providers agreed with that statement (Wild, 1999). This study also showed that treatment providers who did support compulsory treatment were likely to support abstinence-focused goals rather than harm reduction. This might suggest why there has been little use of the civil commitment laws available in some jurisdictions in both Canada and the USA.

Several states within the US do have civil commitment laws for narcotics treatment. However, it has been noted that they are not widely used as they are not well administered or supported economically (C. Wild et al., 2001). It was also noted that in both Canada and the USA there have been developments in the use of drug courts to divert people into treatment within the criminal system. As the civil commitment laws are so specific to narcotics and the treatment regime of methadone, there is arguably another system that can manage mandated treatment for this group with more options through the drug courts (Gostin, 1991).

Unlike New Zealand and Australia where the civil commitment law applies to people who have not committed a crime, the only people eligible for compulsory treatment in both the US and Canada are those already committing an offense by virtue of their use of narcotics. Therefore, they can be 'tried' via either the civil or criminal system. As the criminal system, via a drug court, has more treatment options available and seems to be better supported financially and philosophically, it is the system that is used almost exclusively.

The Mental Health (Compulsory Assessment and Treatment) Act 1992 New Zealand

As mentioned earlier, there is a separate piece of legislation in New Zealand that provides for the stabilisation of severe mental health conditions. Although this legislation excludes those experiencing substance related disorders, the similarities of purpose, the inclusion of family and subsequent learning from this approach are considered worth investigating for this study. An amendment to the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA) in 1999 made consultation with a proposed patient's family and whānau compulsory during the assessment and treatment of the patient. Section 7A of the amended Act indicates that consultation with a patient's or proposed patient's family/whānau must take place during the patient's assessment and treatment unless it is not reasonably practicable to do so or is not in the patient's best interests. To assist with implementing this amendment in practice, the Ministry of Health commissioned the Royal Australian and New Zealand College of Psychiatrists to develop guidance notes (Ministry of Health, 2000). This guidance document noted that mental health professionals working in partnership with family and whānau, rather than treating the patient in

isolation from their family, contributes to the improved well-being of both the individual and the whānau.

In spite of this section being included in the legislation and guidance notes being disseminated, a review of the application of section 7A was commissioned by the Ministry of Health following persistent concerns that family members were not routinely included in key decisions related to a patient's care and treatment (Ministry of Health, 2006). This review followed significant attempts to improve the involvement of families in this challenging situation including a parliamentary petition (2002/17) in 2002 requesting this Act be amended to extend the circumstances in which indefinite orders would apply. Further, in 2003 a private members Bill was proposed in parliament called the Mental Health (Compulsory Assessment and Treatment Family Involvement in Assessment and Release) Amendment Bill. At that time, the Health Select Committee, which was considering the parliamentary petition, recommended that the Ministry of Health review the application of section 7A to determine whether there had been an increase in consultation with family/whānau since the 1999 amendment and to make recommendations. This review confirmed that health professionals were, at best, inconsistent in their involvement of family and whānau in the treatment process. They often failed to utilise the knowledge and support of family members in making key decisions about someone's diagnosis and care. The review concluded that rather than introducing additional legislation, this signalled a need to change the culture of professional practice through various practice-based mechanisms, including clarification of terms such as 'consultation', case study exemplars and standardised forms which included checklists. The report also concluded that "more research is necessary to identify best practice and support family/whānau inclusion in the care and treatment of people with mental illness" (Ministry of Health, 2006, p. 10).

Given the workforce divide that was outlined in the introduction chapter, it cannot be assumed that any cultural change in this practice of family involvement when responding to mental health patients has been transferred to those working in addictions. This does signal that legislative direction is not enough in itself to give rise to practice change. Any change to legislation proposed clearly needs to be supported by several other mechanisms such as policies, practice guides and training to reinforce a change in approach or direction in service delivery.

Addiction Treatment in Aotearoa, New Zealand

This research is located at the juncture between the legal frameworks that facilitate the compulsory detention of those experiencing severe addiction for treatment and the health system, specifically the addiction treatment field providing the treatment responses. The review of the legislative process is one aspect of this arrangement, the other is to examine the treatment environment and how this contributes to the experience of those involved. A review of the development of the treatment field in New Zealand is presented in order to understand the context in which this condition is managed from a health perspective.

Historically, addiction treatment in the Western world and in New Zealand has been underpinned by the prevailing philosophy of the day surrounding alcoholism or drunkenness. For example, in 1 Corinthians 5:11-13 in the Bible stated, "*But now I have written unto you not to keep company, if any man that is called a brother be a fornicator, or covetous, or an idolater, or a railer, or a drunkard, or an extortioner; with such a one, no, not to eat...therefore put away from among yourselves that wicked person.*" From early times until the late nineteenth century, alcoholism was viewed as a moral weakness, as indicated in the Biblical quote above. In 1895, records showed that 30% of admissions to lunatic asylums were for alcoholism (Report on Mental Hospitals of the Colony for 1907, AJHR 1908, volV, H7, p1). In 1909, the Reformatory Institutions Act was passed which was designed to "make provision for the establishment and control of reformatory institutions for the reception of habitual inebriates and of fallen women".

The first facility to cater for alcoholics separately from those with mental health issues was opened by the Salvation Army on Rotoroa Island in the Hauraki Gulf in 1907. The basis of "treatment' was founded in the idea that "drunken asylums must be situated in the quiet of the countryside…there, with sympathetic nursing, rest and the imposition of regular routine, he or she might be led to recovery" (Bretherton, 1986, p. 473). The focus of treatment was on achieving abstinence and providing the necessary spiritual guidance to reform behaviour. It is clear that the legal system has been linked with addiction treatment from its inception in New Zealand. In the 1930s and 1940s, the rapid development of the field of psychiatry, as a specific field of medicine, resulted in a number of related treatment models being developed.

Most notably the disease model of addiction was posited, and Alcoholics Anonymous was formed. Alcoholics Anonymous (AA) is not a treatment per se but a support programme underpinned by the 12 steps (Appendix 2). AA was founded in America in 1935 by two men, Bill W, previously a successful Wall Street lawyer and Dr Bob, a physician. Carl Jung, the noted Swiss Psychiatrist is often credited with establishing the impetus behind this group in instructing his patient, who was continuing to drink after one year of psychotherapy, that his case was "hopeless" and his only hope would be a spiritual conversion (Finlay, 2000). This patient then went on to become the first person who was assisted by Bill W and Dr Bob, and the "12 steps" to recovery were later formed (Appendix 2). The concept of "recovery" as being synonymous with abstinence, and the discourse around this has remained consistent within the AA movement ever since.

'Recovery' is fundamentally posited within the disease model, which suggested that people with alcohol dependency (a later concept developed by the American Psychiatric Association (APA) which replaced the term alcoholic) had a chronic and life-long condition for which the 'cure' was to stop drinking. The desire to maintain strong links with the dominant medical field is evident in these early days. For example, Bill W was advised that in order for the AA Big Book to be accepted it was necessary for a medical practitioner to write the foreword supporting its publication (Finlay, 2000). This was duly done by Dr Silkwood. Because of the background of Dr Bob as a medical practitioner, they were allowed access to hospital wards to talk with potential 'members' and encourage people's participation in the programme. The emphasis on anonymity also allowed for professionals (including medical professionals) to seek support for problematic drinking behaviour without fear of recriminations, and as such AA has been afforded a high status in regards to support across many sectors. In New Zealand, AA became a formalised adjunct to the hospitalised care of alcoholics from the 1970s as a key part of continuing care in the community (Cave, Robertson, Pitama, & Huriwai, 2008).

Treatment programmes developed models that incorporated the 12 steps as part of the process of getting into long-term recovery. One such model, the Minnesota Model developed by the Hazelden Foundation in Minnesota, USA, was founded on the idea that excessive drinking was used to manage emotional pain. The corresponding treatment, therefore, was to uncover this psychological issue and develop more helpful coping strategies. This thinking has continued to pervade current treatment programmes as counsellors aim to assist dependent drinkers to gain

insight into their behaviour. In doing so this exposes the underlying 'reasons' for this compulsive behaviour in the belief that this would alleviate their need to drink. The disease model of addiction posited that alcoholism was a chronic and progressive condition that required intensive, residential treatment. This was reflected in the changes made to the clinical criteria for diagnosing the condition. Alcoholism appeared in the first versions of the Diagnostic and Statistical Manuals by the American Psychiatric Association in 1952 (as a subset of personality disorders, alongside homosexuality. In later versions, alcoholism was renamed alcohol abuse and alcohol dependency, and was characterised with physiological symptoms.

At the time the current Alcoholism and Drug Addiction Act was written in 1966, the 12 steps and Minnesota Model was the dominant model of treatment carried out in remotely located treatment facilities over relatively long periods of time. The residential treatment programme available for people under committal at that time was owned and operated by the Salvation Army, an organisation which shares the same Judeo-Christian philosophical underpinnings as that shaped our legal system.

It is interesting to note that the emphasis on the psychiatric nature of addiction, and corresponding psychotherapeutic models of treatment, has played a part in creating some distance from the mainstream medical field. This, coupled with the fact that no 'cure' or effective pharmacological intervention has been found has consistently resulted in addictions treatment being marginalised within both the wider health sector and mental health. The advent of HIV/AIDS in the Western world in the 1980s resulted in the establishment of 'needle exchange' services for the injecting drug user (IDU) community in New Zealand. This stimulated the beginning of the 'harm reduction' philosophy of treatment that focused not on stopping substance use but instead working with the person to achieve goals aimed at addressing the behaviour causing the most harm, which may or may not include ceasing alcohol or drug use. This also coincided with the development of opioid substitution therapy (OST) or methadone treatment across New Zealand in response to the influx of heroin into the country at that time (Sellman, 1996). Methadone or opioid substitution therapy treatments are typically located within hospital-based services due to requirements under the 1975 Misuse of Drugs Act (also currently under review) which stipulates that special authority from authorised medical practitioners (not General Practitioners) are able to prescribe methadone

for drug users. As such, it is interesting to note that these treatment services have, to date, been considered 'medicalised' and thus separate from the general addiction treatment field.

Harm reduction or harm minimisation philosophy, however, became increasingly prominent throughout general addiction treatment. This meant a focus less on abstinence and more on reducing substance use or the seriousness of the consequences from using. This harm reduction philosophy in conjunction with the service contracting arrangements of that time limited the length of stay of intensive treatment services and encouraged increased use of outpatient counselling services. It has led to a system designed to treat those at the less severe end of the addiction continuum. Most residential services that existed in the 1990s are closed and there are now only two longer stay facilities (one in the North Island and one in the South Island) that exists to treat those more severely affected. With respect to the ADA Act, the impact of these changes has meant that people who are experiencing alcohol-related brain injury, reversible in most cases but requires a long period of abstinence, are being placed in care environments that are inappropriate to their needs or situation (Johnston, 2010).

The government led policy of deinstitutionalisation in late 1980s and 1990s resulted in people affected by mental health and addiction disorders being treated in the community. One of the effects of this change has meant that if people with mental health and addiction problems engage in problematic behaviours, such as disorderly conduct or public indecency, they are regarded as 'criminal' and processed through the courts. This has been labelled by some as "criminalising the mentally ill" (Miller, 1997) and is somewhat supported by data that indicates a higher prevalence of those suffering substance abuse and mental illness in prisons than in the community (Leafe, 2015). One New Zealand national study often quoted, showed that 89.4% of the total prison population had a current substance abuse or dependence diagnosis, and that 35 percent of those people had received treatment for the abuse disorder since they have been in prison (Simpson, 1999). Unfortunately, there have been no further stocktakes of this issue in the prison population since this report was published. Alcohol and drug treatment courts, which are based on a model of therapeutic jurisprudence, are currently being piloted to redress this situation.

Coercion versus mandated treatment

With regard to the adoption and implementation of any legislation that allows the State to detain someone for treatment, there will be a need to balance meeting the individual rights of people and the desire for society, and those close to the person to protect them from harm. In general, it has been found that people support some form of legislation, such as this to be used as a last resort (NZLC, 2010).

A literature review undertaken by Urbanoski (2010) indicated the effectiveness of mandated treatment compared to non-mandated treatment is inconclusive and often conflicting, although many studies demonstrate court orders tend to result in longer treatment stays which are typically associated with better outcomes in relation to a reduction in substance use (Copeland & Maxwell, 2007; Klag, O'Callahan, & Creed, 2005). Other studies show that clients who undertake addiction treatment as part of legal requirements show better than or equal to short term outcomes in relation to reductions to substance use and criminal activity when compared with others (Burke & Gregoire, 2007; Kelly, Finney, & Moos, 2005; Perron & Bright, 2008). This is somewhat supported by the anomaly of Section 8 in the ADA Act, which allows for people to self-refer for a committal order. Of the admissions to Nova Lodge during 2012 the majority were section 8 committals (68%), although a significantly higher number of those under section 9 (non-voluntary committals) complete the full programme.

Some of the discrepancy in study outcomes could result from the lack of distinction between studies of mandated treatment and coercion. Mandated treatment refers to the referral source, for example, being court ordered as opposed to self-referred. Coercion of treatment refers instead to the patients' perceptions of the level of force (external or internal) imposed when they entered treatment. To suggest that self-referred clients are not coerced is incorrect as many pressures bear on those entering addiction treatments regardless of referral source (Wild, 1999). As Urbanoski (2010) noted, perceptions of coercion are linked to self-determination, a sense of autonomy and motivation. Greater autonomous motivation was found in Urbanoski's study to be associated with higher levels of confidence in treatment and lower perceived coercion, which was then associated with improved resolution of substance abuse problems. Therefore, it is important in future studies examining mandated treatment that client perceptions of coercion are taken into

account rather than assumed by virtue of their route of entry into the treatment facility. In this situation, however, because one of the criteria to be eligible to be detained under the Act is that a person has refused to undertake treatment voluntarily, it is clear that anyone under committal is both coerced and mandated for treatment.

Family and whānau involvement

There has been no research conducted to date, that focused on addiction civil commitment and family involvement. There have been several studies seeking to evaluate the legitimacy of compulsory treatment in mental health that have included interviews with significant others as key stakeholders (Mullen, Gibbs, & Dawson, 2006; Storbjörk, 2012; Wallsten, ÖStman, SjÖBerg, & Kjellin, 2008). Gibbs and Dawson (2006) conducted a New Zealand based study that specifically sought information from Maori whānau as well as patients and practitioners about their experience of the revised Mental Health Act, which allowed for compulsory community treatment orders. Unlike addiction treatment options, this allows for people to be treated in the community once they are stabilised under a mandated medication regime. There were mixed views about the favourability of community treatment orders but most family members reported that it had improved their relationships, their sense of safety around their family member and increased their hope for recovery. Wallsten et al. (2008) interviewed family members following changes to mental health law in Sweden which shifted decision making for compulsory treatment from a medical to a judicial authority. Most patients and their relatives agreed that compulsory treatment should be available when it was necessary to protect patients from harm.

Sheehan (2009) undertook a literature review of research relating to compulsory treatment in mental health that had been carried out in 2008-2009, and noted that the primary concern had been the restriction of personal liberty and how this was justified clinically and ethically. While the focus on understanding the experience of mental healthcare had led to an increase in patient centred approaches to treatment, Sheehan (2009) concluded that "the goal of research should not be to determine if compulsory treatment is right or wrong but to investigate when it can be implemented effectively and how it could be used to strengthen the therapeutic relationship" (p.585). My research seeks to move beyond legitimising the use of this last resort process, and focus on understanding what is happening for those involved.

Other studies that involve family members supporting people in compulsory treatment are focused on their level of satisfaction with the health services delivered. While the overall intention may be similar to this proposal in seeking to improve treatment experiences, these studies do not explain the underlying processes involved in this complex situation. Ridley, Hunter and Rosengard (2010) evaluated the views and experiences of carers of mental health patients in Scotland who were being treated in the community under the recently implemented Mental Health (Care & Treatment) Act 2003. Carers, who were living with, and supporting the patient who was under committal, reported feeling isolated and unsupported. They were critical of the lack of consultation and involvement in decisions made about the patient's ongoing care and medication. A South American study that reviewed the experience of patients and their families following hospitalisation for eating disorders, found they were satisfied overall with the service, even though the patient was coerced (Rojo, Barbera, Plumed, Sangüesa, & Livianos, 2009). Parents were happy with the quality of care given in the hospital, but were concerned about the lack of control measures and the poor support available upon discharge.

In summary, it does seem that a change in legislation as proposed for the review of the Alcoholism and Drug Addiction Act 1966 presents a window of opportunity to research and appreciate the experiences of those involved in the current procedure. This would help understand their reality and make positive changes for the future based on this information rather than on well-intentioned assumptions. The complexity of making decisions on behalf of another person with whom one has a personal relationship with, and balancing competing interests between the people and systems involved needs to be explored and understood. There is a lack of research in the area of compulsory treatment for addictions via a civil commitment, and specifically a lack of research that examines the actual experience of and understanding what is happening for family members going through the committal process on behalf of the person directly affected by addiction.

Chapter 3   Research Methodology

Introduction

An important feature of rigorous research is to outline the theoretical underpinnings of the study. Making explicit the theoretical assumptions of the research helps to support the choice of methodology and the methods used. This chapter outlines grounded action as the chosen research methodology underpinned by a Glaserian grounded theory. The rationale for positioning the research in Glaserian grounded theory with the addition of grounded action is examined.

This research sought to answer two questions; first, "what is happening for family and whānau in the process of seeking compulsory addiction treatment for their family member?" and further, "what can we do about addressing the problems that are identified?" In order to achieve this, a two stage process was undertaken using the development of a grounded theory to answer the first question and then a grounded action plan was developed to address the second question.

Grounded Theory Methodology

The first question this research aimed to answer was, "what is happening for family and whānau members in the civil commitment process for compulsory addiction treatment?" The aims of this study were to understand the main concern of families and whānau involved in the process of committing a family member to compulsory addiction treatment, develop a theory to explain how they resolved that concern and develop an action plan to resolve the main concerns identified. As yet, no research has focused on the experience of family, whānau or significant others involved in a civil committal process. As such, the processes by which this situation is managed by those involved is relatively unknown.

Glaser and Strauss (1967) developed grounded theory as a general inductive methodology by which to develop theory, grounded in data collected, rather than a verification of a pre-existing hypothesis. At the time this was developed, grounded theory distinguished itself from the predominant postivist paradigm, which focused on testing to validate an existing hypothesis by

instead developing theory from the data collected without a preconceived idea of what the theory may be.

The purpose of grounded theory as a methodology is to uncover hidden patterns of group behaviour and develop a theory through rigorous analysis of the emerging data (B. Glaser & Strauss, 1967). This is done through the perspective of participants rather than the researcher who must put aside preconceptions about the area under investigation (B. Glaser, 1998). In this way it is the participants who identify the problem and articulate how they resolve the problem. Glaser (1978) termed this as theoretical sensitivity; the ability of the researcher to be able to generate concepts from the data and this involves being open to the data that is present and allowing the theory to emerge from that data rather than fitting data to any preconceived hypothesis or influenced by a professional framework.. This emergence of the key components and their properties of the area under enquiry is a key feature of Glaserian grounded theory. As a practising psychologist for 20 years, much of my work has involved identifying patterns of behaviour from interviews and observation of clients as this is the basis on which to make a diagnosis of the presence and severity of a psychological condition. As such, this felt a familiar strategy, but one that I needed to consciously apply line by line data analysis to ensure the perspective of the participants had primacy, rather than any clinical interpretation I may be tempted to overlay.

An epistemology defines "the nature of the relationship between enquirer and the known, what counts as knowledge and on what basis we can make knowledge claims" (Grant & Giddings, 2002, p. 12). In this way the epistemological position underpins the methodology and theoretical assumptions of the research. It determines the question(s) being asked and gives direction to the manner in which it is investigated. As Grant and Giddings suggested, the chosen research process reflects the researcher's theoretical stance or methodology. Glaser (1998) posited that grounded theory was atheoretical on the basis that as the theory was derived from data unknown at the time of collection, it could not be assumed to fit within a known paradigm. However, other writers have since challenged this position (Annells, 1996; Charmaz, 2000).

The publication of, *Discovery of Grounded Theory* (B. Glaser & Strauss, 1967) came at a time when the positivist paradigm dominated social sciences and research in general. The language

used and the processes followed reflected the positivist terminology of the time and served to give equal rigour to this methodology. Glaser and Strauss (1967) did not make the epistemological positioning clear at this time. However, since then their respective backgrounds and influences were noted by Glaser when he later described the development of grounded theory as harnessing "the logic and rigour of quantitative methods to the rich, interpretive insights of the symbolic interactionist tradition" (B. Glaser, 2005, p. 143).

Other writers have suggested, however, that grounded theory is situated within a constructivist inquiry paradigm and that data is managed through the lens of symbolic interactionism (Annells, 1996; Charmaz, 2000; Grant & Giddings, 2002; Strauss & Corbin, 1990). Symbolic interactionism posits that the meaning we ascribe to the world and our interaction with it is derived from our social interactions with others and how we interpret meaning from those social interactions. Glaser (2002) argues that to apply symbolic interactionism as a theoretical perspective that underpins the theory development will lead to conceptual description akin to a qualitative descriptive analysis. This would contrast with the primary objective of a grounded theory, which is to develop theory from the emergence of the data itself. Instead, Glaser views symbolic interactionism as simply another data type used in a general method of this type of research process. Crotty (1998) suggested that constructivism is the way that meaningful reality is constructed, through the interactions humans have with their world, and that this meaning is then transmitted within the social context to develop a shared understanding. Researching from this position invites the researcher to be open to new or deeper meanings, and requires "we not remain straitjacketed by the conventional meanings we have been taught to associate with the object" (Crotty, 1998, p. 51).

Charmaz (2004) suggested that constructivist grounded theory is interactive in that the data is developed through interaction between the researcher and the participant. In this way a reinterpretation of meaning is a possible outcome of research. Our social life is expressed through symbols and the most common system used to transmit meaning is language. Within the context of my research, it can be seen that terms such as 'addict', 'alcoholic', and 'treatment' are constructed terms that describe people's interactions and relationships with particular objects, namely the substances which they are using. They carry with them not only a shared understanding of the quality of that interaction, but also frequently judgement and stigma directed

at the person involved. Seeing people as active agents in the process of influencing their situation, and giving new meaning to the way they interpret their environment, is an important precept in a situation such as addiction, which is characterised by powerlessness. For this reason, I agree with Glaser's assertion (2002) that the focus of the research from the participant's perception must be paramount, including their understanding of the nature of that information, knowledge and experience. This, I believe, is the rationale for Glaser's assertion of the atheoretical position of grounded theory. It is developed in its entirety from the position of the participant (including their understanding of the development of their knowledge about the subject) rather than overlayed by any theoretical bias of the researcher. However, I also agree that as the researcher, I cannot be immune to those influences and understandings myself which are shaped by my own experiences. Acknowledging this and ensuring that strategies are in place to minimise my influence over the data will assist in the development of a theory that is derived as much as possible from the data sources as Glaser originally stressed.

A further development of grounded theory was the splitting of the key authors in different directions. Strauss, who later collaborated with Juliet Corbin (Strauss & Corbin, 1990), produced further works outlining a grounded theory process that emphasised descriptive analysis and a further coding process; axial coding. Glaser (1992a) strongly rejected this as a grounded theory, and contended these changes were more akin to a descriptive analysis that 'forces' the data. Glaser has continued to develop the methodology (1998), maintaining his adherence to an objective perspective on the part of the researcher and the key features of the original writings of grounded theory.

The emphasis on giving voice to the participants of the research and ensuring that through application of the method, due consideration is given to maintaining that focus throughout the development of the theory is critical to ensuring that any solutions fit the problem as identified by the participants themselves. Glaser (1998) asserted this, and noted that "a methodology was needed that could get through and beyond conjecture and preconception to exactly identify the underlying process of what is going on so that professionals and laymen alike could intervene with confidence" (p. 4). Understanding what is going on in the situation under study is achieved through constantly asking: "what is happening in the data?" and identifying the basic psychological processes that are used by participants to manage what is happening (B. Glaser, 1978).

Providing a voice to those family members in the situation that is one focus of this research and assisting to provide possible solutions that address their main concerns is a key driver for me in undertaking this study. For these reasons classic grounded theory that is aligned to the original writings of Glaser and Strauss and the later writings of Glaser (B. Glaser, 1978, 1998) have been utilised in this research. Further to this, I was interested in ensuring that appropriate action was taken and practice changes were implemented as a result of this theory development. To achieve this, a Grounded Action approach (Simmons & Gregory, 2004) was utilised as a systematic way of developing solutions that directly address the concerns identified by family members and articulated as components of the grounded theory.

Grounded Action

Grounded Action is "grounded theory with an added action component in which actions are systematically derived from a systematically derived explanatory grounded theory" (Simmons & Gregory, 2004, p. 87). Grounded action was designed as an extension of grounded theory to facilitate the development of purposeful and practical solutions to the issues identified in the grounded theory.

Simmons and Gregory (2004) described grounded action as a systems approach because the process of developing the actions takes into account all relevant variables within the system in question. The development of an emergent grounded theory leaves the researcher with a number of related issues and problems which are described as the components of the main categories. The researcher who is interested in applying solutions to these issues must consider the factors that 'promote, inhibit and prohibit change' (Simmons & Gregory, 2004, p. 92) in order to propose solutions that will actually resolve the identified problems for the participants involved. Using the data grounded in the participant's perspective, the grounded theory allows for the development of subsequent actions that are also grounded in the real world context that can address these problems within the usual limitations of resources.

It has been my experience that research has often been used as evidence to support a particular new approach or to underpin a policy shift in health care practice. It is rarely used to systematically examine an area of practice and propose solutions that address each component in order to

achieve a significant cultural change of practice. In applying a grounded action approach, I am seeking to undertake a systematic evaluation of the issues identified in the substantive theory developed by the family members in relation to the judicial and addiction treatment systems as they are applied to those under a committal order, their families and whānau. One objective in doing this is to develop an action plan which is realistic and could be implemented over a period of time to enhance practice and improve the experiences of families who are involved in the committal process.

Key Components of Glaserian Grounded Theory & Action

In the next section, the key components of Glaserian grounded theory and grounded action development are outlined in more detail. The key components of Glaserian grounded theory development as originally outlined by Glaser and Strauss (1967) are memoing, theoretical sampling, constant comparative analysis and data saturation. Once the data was collected the following strategies involved in generating a grounded theory were utilised:

- Integrating data analysis with data collection
- Identifying concepts, through the simultaneous processes of making comparisons and asking questions about the data, and recording provisional answers to those questions using memos.
- Classifying those concepts into meaningful categories (usually referred to as 'coding')
- Proposing and testing links between categories

- Identifying and verifying conclusions

(Minichiello, Sullivan, Greenwood, & Axford, 2004, p. 631)

The process of sorting memos and concepts as above facilitates the development of a theoretical outline. Further refinement and a condensed version of this emergent theory can produce a "basic social psychological process" (BSPP). A basic social psychological process summarises the pattern of behaviour that answers the question of what is happening for the participants as they resolve the issue they are seeking to manage; Further to this, the additional processes of the grounded action including ongoing memoing were employed to develop an action plan.

Memoing

Writing memos is a key strategy in generating theory from the data collected. Glaser and Strauss, (1967) suggest writing memos on field notes, which are the researchers thoughts and ideas generated in response to the data. Memos "are the theorizing write-up of ideas about codes and their relationships as they strike the analyst while coding" (B. Glaser, 1978, p. 83). These memos can assist in developing theory as they break-up the story as told and makes it possible to rearrange and elevate the information to a conceptual form. The writing of memos is useful to track the flow of ideas and the subsequent theory generation, and provides a "memory fund" for the researcher to draw on (Glaser, 1978, p.86). The use of memoing to articulate links with various codes and categories also helps develop the theory's flow as they are sorted. The sorting process helps to confirm the relevance, fit and workability of the resulting theory. Glaser (1998) supports the use of handwritten notes as memos to capture thoughts as they occur, in a stream of consciousness, rather than use of a computer based programme that could later sort through these ideas in a structured way. The ability to shift the data into a conceptual level and link these thoughts and ideas is an important part of this process. There is a risk that a structured programme could limit the ability to conceptualise information required for a substantive theory, which is a key feature of Glaserian grounded theory development.

Ongoing memoing is an important feature of the grounded action process as ideas are captured about the connections between the theory and possible actions. Simmons and Gregory (2004, p. 102) stress the importance of memoing and the free flow of idea generation to the grounded action process in order to consider the range of components of the action plan. This includes considering for example, the political, environmental, social, legal and financial implications of ideas as well as considering the human resources required and timing of the plan.

Theoretical sampling and data saturation

Following the initial data collection and initial coding, a process based on the concept-indicator model which looks at the relationship between the codes in order to elevate the codes to a conceptual level is used. These conceptual codes or theoretical codes form the basis of the emergent theory which then are used to inform selective data collection. This is known as theoretical sampling and is used to direct the next steps of focused data collection and literature

review to support and test the theory. Theoretical sampling is central to the development of an emergent theory and has been described by Glaser and Strauss (1967) as the process by which the researcher "jointly collects, codes and analyses his data and decides what data to collect next and where to find them" (p.45). Holloway and Todres (2003) emphasised the developmental nature of grounded theory with respect to the interaction between the data collection and analysis. Theoretical sampling describes the process that the researcher uses to determine what questions need to be answered and who to ask next (Glaser 1978; 1998). The goal of an interview is not about the specific response from the individual, but rather to uncover group patterns of behaviour (Artinian, Giske, & Cone, 2009).

In this way, the theory has no preconceived framework but emerges from the data and the researcher must follow the line of inquiry that the data is indicating. The ongoing data collection is then determined by the developing core category. As more data is collected and the sampling is more sensitive to the codes and categories, the fit and relevance of the emerging theory becomes clearer and there is a point where no new data is forthcoming. This is the point of data saturation and the point at which data collection stops. There can be a tendency with new researchers to grounded theory to want a specific number of participants involved or interviews undertaken as an indicator for a sufficiently robust theory development. This is in line with the traditional quantitative approach to research which places a high value on obtaining a sufficient number of participants to justify making claims of agreeing or otherwise with the proposed hypothesis. In contrast, data collection stops in a grounded theory once saturation has been reached which occurs when no new significant information has been obtained. Theoretical saturation is achieved "by the constant comparison of incidents in the data to elicit the properties and dimensions of each category or code" (Evans, 2013, p. 41).

Glaser seemed to find a consistent problem with students not knowing when this data saturation had been achieved and recently published a book titled *"Stop. Write! Writing Grounded Theory*!" (B. Glaser, 2012). In this he emphasised that conceptual completeness is the end goal rather than ongoing descriptive coverage of the theory. He reiterated that "a substantive GT [Grounded Theory] is only a slice of what is going on and will go on, however strange it is in explaining the continuing resolving of a main concern" (B. Glaser, 2012, p. 7).

Constant comparative method

The constant comparative method refers to the simultaneous analysis of data to data, data to concepts and concepts to concepts as well as managing the ongoing collection of data until data saturation is reached that occurs in a grounded theory process (B. Glaser & Strauss, 1967). Glaser (1978) further defines the constant comparative method as when "comparison is made incident to incident, a category is generated (an index with meaning)" (p.24). As data are related to ideas that are then compared to categories the relationship between core concepts emerges. As the researcher undertakes additional interviews, the comparison of data also occurs during the interview itself whereby data is compared to previously collected data and the analysis that has been done. In this way, later interviews become more focused on these emerging categories and codes until such time as this information is saturated and no new data is added. This is not a linear process and requires the researcher to work in a complex manner of building the theory while collecting and analysing the data at the same time. This constant checking method ensures that the theory remains 'grounded' in the data from which the theory emerges however the grounded theory is an abstraction of the data rather than a descriptive record. The sorting of these categories, memos and codes to show their relationship in a conceptual way provides the foundation of the emergent theory.

Rationale for Choosing Glaserian Grounded Theory-Action

As Howell (2013) suggests, in selecting the most appropriate methodology a researcher must consider the relationship between the world of the researcher, the participants and the issue under investigation. The grounded theory methodology was selected as appropriate for this research as it sought to identify the patterns of behaviour of a group of peoplemanaging a similar situation. It was also important to the researcher that the voice of the participants informed the development of the theory and that the resulting action plan was grounded in addressing issues central to the participants. The selection of the Glaserian grounded theory approach in comparison to other grounded theories such as Strauss and Corbin's or Charmaz's constructivist methodology was influenced by my desire as a researcher to both align this work to the inductive process that Glaser posited and the additional process of grounded action as outlined by Simmons and Gregory

(2004). The application of grounded theory to affect a structured and planned change to address the issues identified was an important driver of this selection.

Research Methods

This section outlines the research methods (techniques and procedures) that I used to collect and analyse the data. The starting point for this is to introduce myself as the researcher and consider the ethical implications and confirm these considerations have been approved by an ethics committee (see the section Research Principles and Ethical Considerations). I outline my position as the researcher before introducing the participants and the sampling strategy used to recruit them for this study. The process of data collection is outlined and the analysis of the data using memoing and the constant comparative method is explained and examples are given.

Personal and professional perspectives

"*Two thirds of what you see is behind your eyes*" Chinese proverb

A key part of qualitative research is to recognise how the assumptions and preconceptions, based in the researchers' personal and professional backgrounds, may have influenced their choices of focus for research and interpretations of the data. The process of making these assumptions overt enables the researcher to put them to one side and alerts them to possible biases and influences that can be checked throughout the research process by supervisors. From a grounded theory perspective, a fundamental precept is that theory development emerges from the data (Glaser, 1998). It is in the use of this methodology which is grounded in the data collected that objectivity and research rigour in managing the data is maintained. As a researcher who has a background working in this area it would be difficult to be completely objective about this topic under investigation. In addition, the importance of memos, which are a collection of the researcher's thoughts and ideas, in the development of the emerging theory suggest that my own ways of thinking and processing of information (in relation to identifying relevance and fit) are likely to influence the theory development. I was committed to ensuring that as much as possible, the perspectives of the participants remained paramount and using their words as much as possible throughout the process to reflect this was a key way to achieve this.

As previously mentioned, my professional background is as a registered psychologist and I have managed both intensive residential and outpatient alcohol and drug treatment programmes over the past 18 years. In a previous role, as a manager of one of the gazetted institutes for those under compulsory treatment orders, I had the privilege of working with a number of people some of who were in treatment as a result of having been through the committal process. At that time, I became aware of a tension in the general treatment philosophy of the time which suggested that clients needed to be motivated to be successful in treatment and those that were committed and unhappy about being in treatment. The sometimes disruptive behaviour of those who were struggling to come to terms with being coerced into treatment resulted many times in those clients being 'discharged from the Act' or 'placed on leave' at the direction of the treatment facility. This was to the dismay of the family members who, as a last resort, undertook this committal process believing that their family member would be 'detained' in a facility and assisted to get well. I was aware that as a facility we were not always best suited to meet the needs of some of these people with complex conditions. However, I was less appreciative of the impact that our actions, as professionals, had on those family members left to support them, and without anywhere else for them to go.

In my current role as National Manager of Matua Ra<u>ki</u>, the national addictions workforce development organisation, I have the opportunity to work alongside the Ministry of Health in the current review of the Alcohol and Drug Addiction Act (1966) legislation. This has enabled me to have input into the design and structure of service delivery and workforce training needs that might be recommended. I have encouraged both clients currently under committal and family members interviewed for this research to make submissions in respect to the review of this legislation, so that there is a strong family and whānau voice represented in recommendations for change.

As a result of these previous experiences, a key assumption that I have bought into this study is that the current legislation is not particularly effective in achieving its intended aims. Thus, I anticipated that people involved in initiating this process would express a level of frustration. My experience has been in working with those who have already been through the process of auctioning a committal. I have not, been involved previously in initiating this process of committal.

I am interested to discover the issues that family members face in deciding that this option is required and what strategies are employed by family members to resolve this situation.

Research principles and ethical considerations

This research was undertaken after receiving approval from Auckland University of Technology Ethics Committee, (AUTEC **12/225**, Appendix 3), and conducted under the ethical guidance provided by AUT and my primary research supervisor, Professor Denise Wilson. AUT provided templates and advised on the preparation of the information sheets for participants (Appendix 4a), the participant's consent from (Appendix 4b), the transcriber's confidentiality form (Appendix 4c) and the advertisement to invite potential participants to take part in this research (Appendix 4d). Maintaining the ethical principles of autonomy, beneficence, non-maleficence and justice was paramount to this research (Gordon, 2002). Ensuring that the participants were in control of their part of the process and that the research achieved its intended outcomes and did no harm were principles that aligned to both my professional code of ethics as well as being consistent with the methodology of grounded theory that was selected for this research. It was made explicit to all participants that the decision to participate or not was completely theirs. Participants had the option to stop participating and withdraw from the study for a period up to two months following their interview and that their information would be deleted from the records if they choose this option. To maintain anonymity individual names or personal identifiers were not been used in any transcripts or anywhere in this thesis, or in any published results. Each participant interview was given a numerical code prior to the actual interview so that only the researcher could track the interview transcript to the participant. Given the small number of people undergoing compulsory treatment under the ADA Act each year, the demographic information relating to them and their families has been kept to an absolute minimum to avoid the possibility of being recognised. Digitally recorded interviews were deleted once they had been transcribed and checked for accuracy. I undertook to hold this data collected with great honour as taonga (treasure) and to work diligently and with integrity to analyse it accordingly and complete the work as intended.

As the researcher, I did not know the participants nor had I worked with their family member in a clinical capacity. I had not worked with this client group for several years. I was, however, familiar with the addiction treatment centres that participants referred to by virtue of my long-term

involvement with this sector. Research participants were informed about my background and that I had worked for six years (1992-1997) as a manager and clinician in a treatment facility, which worked with committed clients. They were also informed of my current role as part of the working group in the review of the current legislation. With respect to potential vulnerability, counselling was offered to participants if required. It was anticipated that this need would be mitigated largely through their opportunity to tell their experience, and to influence positive change for other family members and whānau in a similar situation in the future. This proved true, as several people commented that they had not previously had a chance to talk about their story and felt positively about doing so. Sharing my experience in this area and relationships with the people involved served to establish credibility and a right to undertake the research and ask the questions needed of the participants. In doing this, several participants expressed a relief that they did not have to explain every detail in order for me to understand their experience or certain jargonised treatment-related terms. Wilson and Neville (2009) stated that researchers who are considered to be 'insiders' are typically more trusted by participants, as they understand "the socio-cultural requirements associated with interacting with these groups" (p.77). It is in adherence to the methodology of grounded theory that objectivity is achieved and maintained.

Recruitment and participants

Glaser (1992a, 1992b) encouraged the collection of data from many dimensions and suggested that these sources of data are selected as they are required, based on the theoretical sampling of the data as you go rather than decided at the start of the research. This allows the research to explore many aspects of the area under investigation and ensures that data sources are led by previous data collected rather than predetermined by the researcher. The intention for using several sources of data in this research was to elicit the perspectives of those who have engaged and supported people through this process to ensure a thorough data collection occurred. A purposeful sampling strategy was used to identify potential participants against criteria, rather than a random selection of people (Polit & Hungler, 1999). The inclusion criteria for this study were that participants were:

- A family or whānau member (as determined by their own sense of relationship to the person) of someone who had a severe substance addiction; and

- Had supported that person through the Alcoholism and Drug Addiction Act committal process (either successfully or otherwise) at some time in the past three years.

As a result of an earlier focus group in preparation for this research, clients who were in treatment under committal had invited me to approach them for assistance to invite their family members to participate. It was acknowledged, however, that they constitute a vulnerable group and due consideration was given as to how this was appropriately managed. This was done in a voluntary way by providing these clients with information about the research and my contact details to pass on should they choose to. A brief presentation was given to the consumer forum group which was attended by people in treatment under a committal order. At this session, I gave people information about the research and provided an opportunity for people to ask me questions directly prior to leaving the contact details with them. It was made clear that the focus of the research was about the process their family members undertook, rather than about the client themselves. I have not had any involvement with providing clinical services at the treatment centre where this forum occurred. In addition, the invitation to participate was posted on the A & D Netlink which is the addiction sector key communication link.

A network sampling strategy was also used that involved using my existing networks to access additional sources of data including practitioners (Polit & Hungler, 1999). As it became clear that much of the experiences of the participants focused on their interactions and engagement with addiction practitioners and services, it was important to investigate this information from the perspective of health professionals who had experiences of utilising this Act. I conducted semi-structured interviews with four addiction practitioners. The initiating questions asked of these participants were:

- Tell me about how you see your role in ADA Act committal process.
- How do you see your obligations to the person who is coming under committal?
- How do you see your obligations to the family of that person?

In addition, court reports, where available, were accessed as these also provided transcripts of applicants' (family members') concerns outlined in court and the Judges' responses. I also had several conversations at various fora with people who shared their experiences of using or trying

to utilise this legislation and their engagement with services during that time. All of this information was also included in the data set which was analysed.

Data collection

As a classic grounded theory methodology is being utilised, Glaser's assertion that 'all is data' has been applied (B. Glaser, 2001, p. 145). Thus, the dataset used to generate the theory comprised interviews with family members and with addiction practitioners, court reports and conversations with others who had been involved in the committal process.

In response to the open invitation to take part in this study, 11 family members made contact and agreed to be interviewed. Interviews took place at various locations throughout New Zealand nearest the participants' locations. Two interviews were conducted over the phone as requested by the participants. Due to the small numbers of people entering treatment under this committal process, demographic information about the participants has been kept to a minimum and reported on collectively in this section to minimise the likelihood of any identification.

The 11 participants were from Auckland, Whitianga, Palmerston North, Wellington, Nelson, and Christchurch. Their relationships to the person undergoing the committal process were as, parents, adult children, partners, spouses and siblings. They represented 17% of those under committal at the time of the interviews (during 2012) and their ages ranged from 24 years to 75 years of age. The treatment centres that they had been involved or made contact with represented the breadth of available services and included District Health Board services, including detoxification and specialist addiction services, as well in residential and outpatient facilities, non-government and community-based organisations. Three participants had themselves previously been in treatment for their own addiction.

Data were collected from participants using unstructured interviews. Interviews were with individuals or in pairs (as determined by the participants). Each participant received an information sheet (Appendix 4a) outlining the purpose of the research. Prior to starting the interview, it was verified that each person had read the information and a further opportunity to ask any questions was offered before proceeding with the interview. Participants were then invited to sign the consent form (Appendix 4b), although many had bought a signed copy with them. General, open-

ended questions were used to initiate the interview and to encourage participants to provide their perspective of their experiences without my influence. The initiating questions included:

- Tell me about your experience of supporting your family member through the ADA Act.
- What were you most concerned about in regards to undertaking this process?
- Tell me about how this process has worked for you and your family member.

Interviews (except one at the participant's request) were recorded and transcribed. Note taking during the interview and memo writing immediately afterwards were also primary methods of data collection. Glaser (1998) supported the use of note taking after interviews in order to capture the main ideas, and believed taping can produce too much data and that subsequent transcription creates delays in the theoretical sampling of the data. However, the recorded sessions provided me an additional opportunity to undertake a line-by-line check of the information for accuracy. This gave reassurance that the data collected was the participant's information, not my interpretation of what I had heard and noted. In the spirit of reciprocity, participants were given a petrol voucher as a koha in exchange for their time and sharing their knowledge. As indicated, the interviews which were taped were transcribed by a professional transcriber who signed a non-disclosure, confidentiality agreement (Appendix 4c). The data was then analysed using an open coding process initially.

In addition to these interviews, five judicial decisions from court reports relating to hearings for committal procedures were reviewed. These contained explicit commentary from family members outlining their concerns at the time of the hearing. Semi-structured interviews with four addiction practitioners were also undertaken during the study as part of theoretical sampling after it became clear that much of the family data related to their interactions with addiction professionals. Theoretical sampling, which "is the process by which data collection is continually guided" was used as the data were collected from each participant by identifying emerging codes (B. Glaser, 1992a, p. 102). This continued throughout the study until the data were saturated and no new codes emerged.

This additional investigation served to strengthen the rigour of the theory development and provide additional information that was useful in contextualising the experiences of those

involved. The interviews were conducted until data saturation was reached, whereby no new information was forthcoming within each category (B. Glaser, 1978, 1998; B. Glaser & Strauss, 1967).

Cultural considerations

Ensuring this study was culturally safe was paramount and the research was underpinned by the framework outlined by Wilson and Neville (2009), which emphasised partnership, participation, protection and power as key concepts to consider when designing the research and collecting and managing the data. The threading of these concepts through a Glaserian grounded theory was managed firstly through the recognition of power sharing between the researcher (who was entrusted to manage the participants' shared information) and the participants who had the knowledge of their experience to share. This relationship was built on the basis of a partnership, which was founded on the understanding that the participants were the expert holders of the knowledge and the researcher was the recorder of that knowledge and entrusted with it to manage it to an agreed end. It was understood that the research outcome would be beneficial to the group, that is, family members of those affected by severe addiction.

Participation was crucial for the study and some effort to reach the small sample of people was made, particularly Māori whānau, who are affected by the ADA Act. Unfortunately, it proved too difficult to locate Māori whānau who had experience of the committal process so the actual interview data were limited to non-Māori participants. Some Māori practitioners were included, however, providing data collected via network sampling including conversations and interviews with addiction workers. It was also important to me that the lack of people under committal who identify as Māori and the difficulty in locating any whānau was not ignored but rather served as a challenge to ensure that this population was better served through appropriate interventions and professional support. Protection of the data was also a key feature and any information given was stored and managed with due respect. Completing the research and achieving the stated outcomes was, to me, the most honouring thing to do with the data entrusted to me.

Data analysis

The data were analysed simultaneously with on-going data collection. Interview data and memos recorded after interviews, were analysed using constant comparative analysis in which the interview data was compared against previous interview data for common concepts and codes. It is noted that the process of data analysis, using constant comparative analysis, while sequential overall, involved steps which occurred simultaneously and back and forth checking so it was not a linear progression of theory development. Initially all data were coded (open coding) in response to the researcher asking the questions;

- 'What is this data the study of?'
- "What category does this incident indicate?"
- "What is happening in the data?"

(B. Glaser, 1992b, p. 51).

As ideas were shown to relate to each other, substantive codes were developed. Theoretical sampling determined the direction of data collection and when no new information was forthcoming, data saturation was deemed to have occurred and data collection stopped. The relationship between related categories and codes, which conveyed participants' underlying concerns and processes for managing them, was then developed into a theoretical code. This theoretical code was then used to integrate the theory which emerged from these categories. (Breckenridge & Jones, 2009; B. Glaser, 2009; Hernandez, 2009; Moore, 2010; Roderick, 2009). The resulting theory is deemed to have rigour if the following interrelated properties are evident if the theory:

1. fits well with the area under consideration and works when applied;
2. is easily understandable and has relevance to participants and others associated with the area;
3. can be generalised across situations (eg; into mental health areas generally) ; and
4. can to continue to evolve.

(B. Glaser, 1978, 1998; B. Glaser & Strauss, 1967).

Open coding

The analysis of the data was guided by a Glaserian approach as expanded on in Rennie, Phillips and Quartaro (1988) and modelled in Wilson (2004) and McCann and Clark (2003). Open coding began by taking a line-by-line review of the interview transcripts, and the researcher's notes and memos written following the interviews and assigning codes to the information. The data, which pertains to the area under inquiry, was used to elicit open codes. This assists in the development of a substantive theory that has relevance and fit with the area in question. Participants' words were used to create in-vivo codes, which assisted in avoiding imposing the researchers' preconceptions or opinions (see Table 4 below, for example).

Table 4:

In vivo Codes and Comparative Coding

Data Excerpt	Open (In-Vivo) Codes	Data Excerpt	Comparative Codes
Ref A-B		Ref E	
We said "She's very unsafe with people, and she's really unsafe with herself".	Unsafe with herself	They [treatment centre] wouldn't talk to me and I said I need to know what's happening.	Service not talking
They said "that's not good enough grounds to do anything"	That's not enough to do anything	We'd been told there wouldn't be a bed for three months; I said "she will be dead by then, I can tell you that right now".	Nothing available
So, we tried talking with the Social Worker about the A&D Act and they said, "That's nothing to do with us that's up to you to sort out".	Tried talking (to service)	If that happens I'll be furious and he was like, "Oh well are you threatening us?"	She'll be dead
	Nothing to do with us	I said, "I'm just worried about my Mother and I won't apologise for that".	
	You need to sort it out		Worrying about [another]

During the comparative process, the codes start to be expressed using gerunds. A gerund is a noun made from a verb by adding 'ing' to the end of the word. For example, "They wouldn't talk to me" is converted to a conceptual code of "not talking". This assists with answering the question when examining the data set, "what is happening here?" When expressing the core categories of the substantive theory in this way it serves to emphasise how the participants are actively going about resolving the concerns in their situation. This can be reflected in the actual process of the research itself as I realised that as the researcher, I was discovering what was happening at the same time as the participants were articulating how they have been resolving the situation.

Memos

Memos were written throughout the process of coding in order to capture thoughts, emerging ideas and pre-understandings relating to the data, as the coding of information progressed. Many of the memos posited questions that indicated gaps in knowledge, which in turn prompted more data collection (theoretical sampling). Glaser (1998) suggested that memos are the researcher's private notes and take whatever form is necessary to capture the ideas and thoughts that will assist in the later analysis of the data, and trace the development of the theory. An example of a memo is tabled below:

Table 5: *Example of memo*

Memo #3 Withdrawal is the trigger point

There appears to be a common feature of 'withdrawal from' or loss of contact from the other person that triggers the increased level of concern for welfare in the family member. People have been living with general concerns off and on for the other persons' welfare for many years but a key feature of relapse and deterioration in someone with an addiction is withdrawal from supports.

This becomes a paradoxical situation for family members who become increasingly concerned about someone because they are withdrawing from them and then have to articulate their concern to health professionals who want details of the persons behaviour which the family cannot provide because they are not in contact. It is reported as supposition based on previous experience with the person. This leaves the family in a position where they are potentially perceived by health professionals as not particularly useful informants and concerns are easily discounted without a high level of detail which may otherwise have activated an equal level of concern in professionals.

Core category and emerging theory development

Analysis then focused on elevating the codes into categories and identification of a core category or overarching category, which linked several of the categories. McCann and Clark (2003) suggested that a category is developed by grouping or clustering the codes into a higher order concept which is identified through constant comparative analysis of the data (B. Glaser, 1965). Codes were grouped by identifying connections, relationships and shared properties through comparisons of the data in each of the data sets. Using the example from Table 1 above, one

concept that reflected the meaning of this data was identified as "*Fearing for another's life"*. These concepts became the blocks of the theory (Piantanida, Tananis, & Grubs, 2004). A basic social psychological process is a type of core category outlining the way in which people resolve a problem or concern (Wilson, 2004). One key outcome of this study was to identify the basic social process that family members used to resolve their concern regarding managing the process of supporting someone with a severe addiction. Understanding how family members resolve this concern and manage this situation will provide information to inform how people in this situation can be best supported by health professionals and the legal system.

The outline of the theory emerges from the sorting of memos and categories and organising them into conceptual relationships. I found it useful to put the memos and categories onto post-it notes in order to be able to move them around a large blank piece of paper and cluster them until I was able to verbalise these relationships in a way that made sense to me. I also found it helpful to verbalise these conceptual relationships out loud to my supervisor to ensure the theory outline had readability and logic.

Research rigour

To ensure a trustworthy theory is developed Glaser and Strauss (1967) stress the importance of the reader being able to both understand the theory and to 'see and hear' the participants voices. Credibility and rigour of the research process is measured by whether the theory is sufficiently grounded in the data. To demonstrate this, the theory needs to meet the criteria of fit, relevance and workability within the substantive area under investigation and that it can withstand being modified and reformulated (B. Glaser, 1978). A theory with fit and relevance is readily applicable to the situation and is understood by all the parties involved in the substantive area. Workability refers to the theory being meaningful and general enough to able to be applied to diverse situations within the area of research, in this case, being involved in the process of compulsory addiction treatment.

Grounded Action

It is at this point that the grounded action process begins. The substantive grounded theory developed served as the basis and rationale for the ensuing operational theory and action plan.

The first step in the generation of an operational theory is to "revisit the action problem" (Simmons & Gregory, 2004, p. 101). While the explanatory or substantive theory already developed articulates *what is happening* in the research situation the operational theory is a further step which seeks to systematically address the action problem. The operational theory can take the form of programmes, interventions, policies and incorporates the important properties of the explanatory/substantive theory. A similar process of constant comparative analysis was undertaken for the development of both theories. To take this further step, the following questions are asked of the properties and components of the explanatory/substantive theory:

- What does the explanatory theory indicate is the real problem?
- What is the desired outcome?
- What are the outcome priorities?
- What does the theory indicate about aspects of the action problem that need to be successfully addressed to bring about the desired outcomes?
- What is possible?

An ongoing process of memoing ideas generated from the properties and components of the substantive theory is used to develop the action plan. The action plan emerged from the sorting of these operational memos. An example of an operational memo grounded in the substantive theory outcome named 'being invisible' is below (Table 6):

Table 6: *Example of Grounded action memo*

MemoOPT #12 Being Invisible

Recognising family members at the outset must be reflected in revised legislation at all relevant points. Note: Mental Health Act does not specify at which points in the process family members need to be engaged or informed & leaves it open to clinical direction. The MH review shows it cannot be assumed that family members will be included if not specified.

Other barriers to recognition stated:
- No way of coding engagement – we do what gets measured. Must include relevant T code to capture as recordable activity
- Consulting rooms not big enough for family – FACT is that most whanau/family engaged are 2-3 people not large groups
- Client doesn't want them involved – nominate 1 support person and or challenge reality of involvement if they are likely to be returning home to family (they already involved)
- Training – link with memo #8/9
- Practice guides for roles – include family engagement (see ANZ Psychiatrists guide)

The final components of the grounded action is to implement the actions and put in place an evaluation and review process to ensure that what is done is effective. A key part of the implementation of an action plan for change is to measure whether the activities or policies have addressed the problems as intended. A review process allows for on-going learning and ensures that changes are able to be adjusted if necessary to stay relevant. Effective change processes in clinical practice may be useful to be reported on so they could potentially be transferable to other areas.

Summary

This chapter has outlined the grounded theory-action research process that was undertaken to develop an understanding of what is happening for families engaged in the process of seeking compulsory treatment for a family member experiencing severe addiction. This process resulted in the development of a substantive theory made up of three main components and a basic social psychological process that serve to explain how family members resolve this situation. Further analysis of this theory led to the development of an operational theory and comprehensive action plan which aims to improve the systems in which this research is located and ultimately improve

families' experiences of being in this situation in the future. The substantive theory and operational

theory are summarised in the next chapter.

Chapter 4   Research Findings

"The whole situation is sad. It's sad and its ugly and it causes a lot of distress for everybody" (mother of young woman under the ADA Act)

This chapter is in two parts. The first part explains the Glaserian grounded theory, encompassed by the basic social psychological process (BSPP) identified as *Living with it*, and each of the three main categories which form an interactive system that comprises this theory. This theory and its' components are outlined on Table 7, (see page 75) using a similar structure utilised by Wilson (2004).The basic social psychological process *'Living with it'*, provides a theoretical explanation for what is happening for families involved in the process of committing a family member to compulsory addiction treatment using the civil commitment process available through the Alcoholism and Drug Addiction Act 1966. It is acknowledged that this is a substantive grounded theory and as such is applicable to the "chosen data boundaries" of those family members who had utilised the compulsory treatment legislation to assist a person into treatment for severe addiction (B. Glaser, 2011, p. 10). A substantive grounded theory explains a "slice of what is going on" (B. Glaser, 2011, p. 11), and therefore, this theory contributes to a greater understanding of the process of how families manage this situation.

The second part of this chapter outlines the grounded action operational theory which has three key components; Recognition, Responsiveness and Resilience. The activities associated with these components form the action plan which is designed to address the issues identified by family members in the substantive theory. As a primary aim of this research was to influence practice change, a systemic approach to addressing the issues identified in the substantive theory has been undertaken and is presented as an action plan, that informs the health workforce and services involved in working with those with long-term addictions to be better equipped to assist and support families during this time. As the Alcoholism and Drug Addiction Act 1966 is currently under review, it is also hoped that this operational theory can inform this revised legislation of where inclusion of family and wider supports is critical for improved utilisation and efficacy of this revised Act.

Table 7:

Overview of Grounded Theory "Living With It"

Main Category	Focus	Concepts	Properties	Outcomes
Basic Social Psychological Process "Living with it"				
Fracturing Relationships	Wanting to be part of the solution (but seen as part of the problem)	Not communicating	• No communication • Assumptions made about process • Compromised quality of relationships • Withdrawal • Volatile relationship	Being invisible
		Prioritising wrong relationships	• No healing • Continued whānau disruption • Feel unimportant • System rhetoric	Being a Bystander
Working It Out Myself	Barriers and challenges to getting help	Making decisions	• Being conflicted, frustrated and confused • Making mistakes • No win situation • Wasting time • Finding an ally	Being strong & determined
		Taking responsibility for another person	• Lack of available support • Convincing others • No one knows what to do	
Holding my Breath	Managing the constant stress	Fearing for life of another	• Do nothing not an option • Risk of another dying • All consuming situation • Accepting they can't change it • Respite for short while • Compromising good relationships	Feeling powerless
		Keeping going	• Not knowing • Protecting self • Never ending	

Basic Social Psychological Process – 'Living with it'

…you just have to get on with it all at the end of the day you just live with it all the time, you

can't control it, it just never ends. (Mother)

The basic social psychological process (BSPP) describes the way in which family members manage and resolve the issues identified in the process of using the ADA Act (1966) to seek treatment for someone with a severe addiction. Although the Act is the mechanism by which people were seeking help and was the context for this research, this theory uncovered the primary concern for family members was 'living with it' while seeking help for the addiction affecting their family and it highlighted the lack of support available for them by health professionals. The profound lack of support from the health system meant that families had little choice and were forced into engaging a legal process to access treatment as a last resort. This process was signified by the main categories of 'fracturing relationships', 'working it out myself' and 'holding my breath'. The BSPP identified in this substantive grounded theory is '*Living with it'*.

'Living with it' is in many ways a sentiment of despair and the sense of powerlessness to effect change in someone else. It encompasses a feeling of resignation of living with *'it'*. 'It' being the addiction itself; a chronic and debilitating condition which has an enormous impact on their lives as a family/whānau. *Living with it* involves recognising that family members, in a similar but different way to those who have the addiction, also 'live with' this condition. The family members have their lives disrupted at irregular but frequent intervals such that jobs and relationships are under enormous strain and are often at risk of being lost as a result of these disruptions. Family members sometimes see the signs that the condition may be deteriorating and a need for intervention is coming, but they cannot anticipate their role in the ensuing drama and crisis that inevitably plays out.

> *It's exhausting…well we didn't have much time for each other that's for sure…and certainly didn't have much to do with friends…it has really taken over our lives (parents)*

Their role as supportive family/whānau members is in the hands of someone else to determine, until such time as it becomes clear that they feel the need to step in or face the worst case

scenario. The repetitive nature of this situation over several years is disheartening despite brief periods of respite there is little significant change in spite of people's best efforts.

> *It would be the major thing in my life really. (mother).*

A key aspect of *living with it* that was evident was that regardless of the ongoing strain and disruption to daily life, the words "living with" also suggest being present and *living*. To be 'living' is to accept the situation as it is and continue to live with this as a component of one's life. It reflects the sense of hope that the family members conveyed when telling their story. There is a sense of being ever hopeful of a more positive outcome.

'Living with' denotes a dynamic, changing and ultimately positive stance in resolving this situation for the family as a whole. It speaks of the reality of living with someone experiencing severe effects of addiction in one's life, but more so the reality that family members themselves are living with it as well. This is their experience as much as it is the person directly affected by addiction, and as such deserves specific attention rather than only being seen as part of the distanced support network of someone else. There are significant issues that impact the family as a result of living with or supporting someone who has severe alcohol addiction that are unique to being in that situation, which should be recognised by addiction treatment services more than they currently appear to be. *Living with it* reflects the participants' holding onto hope for another. At certain points in the journey, holding this hope is all that family members can do for someone who is struggling with this chronic, relapsing condition. *Living with it* is to hold the hope for another and maintain a belief in the power of people to make positive change, regardless of how bad things seem to be.

Three main categories; Fracturing relationships, Working it out myself and Holding my Breath are key components that support the basic social psychological process; Living with it. These three categories and their respective properties outline an interactive system in which each component is connected and supports the other. These categories and their properties are explored in the following section.

Category - Fracturing Relationships

I'd have to say it's like you don't count. The family doesn't count, frankly. (father)

The category, *Fracturing Relationships* explains family members engaging in a system designed to help but paradoxically having nothing to offer them. *Fracturing relationships* comprises two main concepts: *Not communicating* and *prioritising wrong relationships* and the focus for the family is wanting to be part of the solution but being seen instead as part of the problem. The concept of *Not Communicating* is comprised of the following properties:

- no communication

- assumptions being made about the process

- compromised quality of relationships

- withdrawal

- volatile relationships

The properties are explained in more detail below, but to summarise, the lack of communication about options for treatment or support allows assumptions to be made about what to do and what is available. The withdrawal from family contact by the person with the addiction is frequently a symptom that prompts the family to seek help but the lack of communication from professionals leads to them withdrawing from the health system. The quality of relationships is compromised as people become increasingly desperate to seek help which can lead to unhelpful behaviours from family members such as nagging or criticising the person with the addiction. This often leads to volatility within relationships which further compromises the quality of the relationships and increases the likelihood of withdrawal from possible support. The outcome of this for family members is *being invisible,* whereby they effectively become a bystander during the treatment of the person concerned, rather than being seen as an important source of support or participant in the ongoing recovery of the person from severe addiction.

Not communicating

Each time he came out, he came home to me. And I was none the wiser. And the last time he came out, two months ago now, I wasn't kept in the loop with the after care plan or anything...I knew I was feeling depressed and that if he started drinking it would make the situation worse for myself, but I didn't know how best to help him. (partner)

Strained and fractured relationships are a central tenet for all parties involved in this process. The quality of the relationship between the family and the person with a severe addiction is compromised prior to any action involving compulsory treatment. Fractured relationships are frequently 'volatile' as the person, when unwell, displays aggression manifested by angry outbursts and emotional stress while at other times appearing more 'normal'. There is often a degree of shame associated with relapsing into addictive use of a substance after a period of abstinence due to these associated behaviours which are often anti-social, so it is understandable that given the choice, some people entering treatment would not wish to further involve or inconvenience family members.

*I remember when I was there [*in treatment*] they said to me when I first arrived, "Is there anybody you'd like us to contact?" And I said" No". So he would have been given the same option and he would have said no. (partner)*

The very process of seeking a court order to detain someone else into treatment that they are resistant to is likely to cause further strain in an already difficult relationship. Court reports document the 'choosing of sides' of family members; those who are supporting the action being taken versus those who are supporting the person with the addiction to choose not to have treatment. Often the family member who has initiated the committal procedure is standing alone, unsupported by others in the family. For these family members standing alone in court, the fear of the person dying from their addiction has outweighed a concern about losing the relationship. There remains the hope that once in treatment and with time to get well, the opportunity for the restoration of the relationship would be available.

Once in treatment, there is a challenge with regard to balancing the right of the individual in treatment to include who they wish for support with the family's needs to have sufficient

information so they can adequately support that person. The treatment service's approach toward the 'treatment of an individual' is a barrier to useful dialogue between health professionals and family members and their ability to move past this impasse. Little or no recognition of the individual within the context of their social or familial relationships occurs, other than if the individual chooses to disclose information. Family members are often the primary initiators of the committal process, and are frequently asked to undertake this role by health professionals in treatment services.

> *We tried to discuss the ADA Act with the social worker the last time and they [social worker] said, "Oh, it's nothing to do with us. That's up to you to sort out." (mother).*

Nevertheless, once the process is underway the relationship between family members and the person undergoing the committal process is either minimised or ignored by the health professionals and services to the point that family members become, in effect, '*bystanders'* rather than active participants in the process. The quality of the information they possess, by virtue of their relationship with the person affected by addiction, is minimised to such a degree that it renders the family invisible in the treatment process.

> *We don't do family work because there's no way of recording statistics if we did family work. (addiction worker)*

> *But it's [working with the family] not part of the psychiatric orientation, which is mostly focused on the individual. (addiction worker)*

Family members, who are primary support people, consistently experience a lack of information about the committal process and the implications of taking this action. That is; the treatment pathways and/or options; information about medication and its effects; and continuing care arrangements and expectations. They feel excluded and unsupported in the role of primary support by health professionals. Due to this lack of engagement and information there is confusion about when and how to intervene, and conflict within the family frequently escalates as a result.

Some family members in this study were also in recovery from addiction themselves, so were balancing maintaining their own wellness by not getting over-involved in someone else's situation.

Others knew little about addiction other than their first-hand experience, and had no opportunity to learn or determine alternative ways of coping.

The family are subjected to this addiction for a number of years, and have witnessed the deterioration of their family member's functioning and health. The family typically only make contact and engage in help-seeking on behalf of their family member at a time when they are most concerned for the other's safety.

I had to do it because she was so unsafe. I didn't have any choice really. (daughter)

The lack of helpful responses from health professionals when they express their concerns serves to elevate their anxiety. Addiction practitioners indicate a preference for people with addictions to make contact with the service themselves as a signal of motivation to engage in the treatment process. Concerns are frequently minimised by health professionals, and rarely is support offered or adequate information given to the family member to assist them. Although no data is collected on addiction related deaths, many accidents, falls and emergency department visits are related to substance abuse and alcohol use in particular. Severe alcohol addiction has been linked to deaths caused by cancer, stomach ulcers, liver damage and other chronic conditions. Addiction is a potentially fatal condition and families are genuinely concerned about the life of their family member when they reach out for help. However, as family members increasingly express their desperation and agitation, the more professionals perceive them as part of the problem and opt to not engage with them in any meaningful way. As a result, this leads to family members disengaging from health services even further. In many cases it could be seen that the tangible activity of seeking a committal through the courts is a last resort not only of seeking assistance for the person with the addiction but also for themselves in finally being heard.

Being invisible

By the time they [the client] get to this stage they have pretty much burned their bridges and there's no family around anymore (addiction practitioner).

The outcome of this component of the category *Fracturing Relationships* is that the family experiences *Being Invisible*. While this practitioner's statement above may be true for some people, many do have families willing to be involved. The invisibility of the family from the

practitioner's perception may have occurred as a consequence of the family's previous interactions with health services. Strong messages that they are not welcome, not catered for, and that their opinion and support is not required as part of the treatment inevitably leads families to believe addiction treatment services are not places to engage for assistance.

> *I would have called 3 or 4 times, I emailed as well, I didn't get any response, no reply (Parent)*

> *It was August when she sent the forms and I heard nothing from them so I phoned not long before Christmas and said, "Well I think this is really appalling". And then I was sent another lot of forms (Sister)*

> *They [*the family*] are given the documents* [court papers] *because that is a matter of right and then they'd be told confusing information, dismissive, be dismissed, and essentially dissuaded in proceeding with it. (addiction worker).*

At present, there is no mention of family in the current ADA Act so there is no requirement to engage with or involve family or support people in the treatment process itself. The lack of visibility extends throughout the health system involved in the committal process from the Act itself through services available and the practice of health professionals.

This experience of *Being Invisible* contrasts, however, with the court system in which the application process was managed. Often people find the court process frustrating because of its adversarial nature and not conducive to addressing family concerns, but rather adds to existing conflict and relationship tensions. However, this research clearly showed that although there were some challenges for people in certain locations to access the court system, mostly due to the infrequent use of this legislation, once they were in the court system it operated as expected. In fact, the court process was such a non-issue for people that in all but one case I had to prompt with the statement, "Tell me about how the court process was for you.", to obtain information regarding this part of the process. Often positive comments were made, such as:

> *The Judge took me seriously. (father)*

> *He* [the judge] *really listened to everything we had to say and weighed it all up. (sister)*

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> *He* [the judge] *could see by looking at her that she was in a bad way and we weren't*
> *making it up. (parent)*

Instead of feeling frustrated by the adversarial nature of the court process in which you may have to state one's argument against the other person, people reported feeling heard, validated, protected and secure in the process in which everyone knew what to do and who did it. This was in sharp contrast to families' experiences of health services.

Prioritising wrong relationships

The *Prioritising of Wrong Relationships* is the other concept in the category of *Fracturing Relationships*. This concept comprises the following properties:

- No healing
- Continued family whānau disruption
- Feeling unimportant
- System rhetoric

In spite of the familiar rhetoric that 'addiction is a family disease', families themselves experience no opportunity within the treatment journey to redress or repair strained familial relationships. Only one family in this study reported being part of a discussion with the key case worker and their family member while in treatment. This discussion focused on the after-treatment care plan and how to support the person on their return home. While this is important, it still focuses the family on their role of support rather than any attempt at repairing the relationship or seeing the family members as having needs from the impact of the addiction in their own right. The exclusion of family members from the treatment process and on-going care plans suggests that health professionals are attributing a higher value to their relationship with client over the family's relationship.

> *There needs to be clinical work around the person and the family together, not keeping*
> *them separate. Because each time they go back out, they go to their families but they*
> [clinicians] *seem to think their relationship is more important with the client than the family.*
> *(Parent)*

Families experience a *prioritising of the wrong relationships* throughout the treatment process. This is reinforced by the primacy of the practitioner–client relationship in the treatment process. Practitioners' rationale for the exclusion of family in treatment included time constraints and prioritising clients' stabilisation through the withdrawal process and complying with their clients' wishes to not have family involved. Even when a client is known to be returning to live with family, it is considered optional for them to be included in ongoing treatment plans. The agents involved in the continuing treatment of this chronic condition, therefore, become reliant on the client themselves and the support they may continue to receive from the professional may only amount to one hour per week of actual contact. Even when the client is involved in self-help groups as additional support, the focus continues to be the 'self' with little or no opportunity for consideration of 'the other' and addressing any areas of relational concern that may negatively impact on long term recovery.

Without the family involved in the treatment process, there are no opportunities for resolution of conflict within the family that may have preceded the committal process or for the healing of fractured relationships. The family feel unimportant and not valued in treatment and are consequently not invested in the treatment itself, although maintain a high degree of interest in the results. Families experience continued disruption within the family whānau that remains unresolved and are instead compounded by the lack of information or resource given to them to try and address these issues themselves.

Being a bystander

For the family, *Being a Bystander* is the outcome of fracturing relationships when the prioritising of the wrong relationships continues in the treatment process. From the family's perspective, being a bystander emphasises their focus on wanting to be part of the solution but being seen as part of the problem by health professionals. Feeling unimportant and *being a bystander* to the treatment process is further compounded by practitioners' interpretations of, and attempts to, balance competing rights and risks. Respecting the right of an individual to have autonomy over medical interventions is a human right to which all adult New Zealanders are entitled (NZ Bill of Rights Act 1990). Thus, the challenge for health professionals to balance this right against the concerns of family members about safety is a difficult one.

With little support from health services, families are left to develop the best strategies for coping that they can. With a family system already in significant distress, and with little information to make better decisions, the likelihood of repeating unhelpful behaviours is high. Thus, '*living with it*' is the solution which family members employ to resolve this ongoing, chronic situation.

Category - Working It Out Myself

The second main category was identified as "*working it out myself*". This category is characterised by having to make decisions with little information, navigating complex systems (health and justice) with little support and sometimes making mistakes. The focus of this category are the barriers and challenges to getting help. There are two concepts; making decisions and taking responsibility for another person. The properties involved in the family members being in the position of *Making Decisions* are:

- Being conflicted, frustrated and confused

- Making mistakes

- Being in a no-win situation

- Wasting time

- Finding an ally

> *…she wasn't going to put herself under* [the Act] *because she wasn't going back to pick tomatoes. So I had to find out. Well what do I do now? So I rang [*treatment centre] *and they said, "No. She'll have to go to* [other treatment centre] *we won't take her back". And I said, "How do I do that?" Well you have to ring them. So I rang them and they said "No, you can't just do that because you want to put her under the Act"…They wouldn't give me any information so I rang back* [the first centre*] and they said, "Ring the courts." The courts said, "No, you don't ring us. You have to book a bed first"…so I rang* [treatment centre] *to say I need to book a bed first and they said, "Well you can't. We need a referral from somewhere first"….From who? "You need to contact the original referrer". So I rang them back and they said, "We don't do that". …It was very frustrating. (Daughter)*

The quote above was a typical scenario faced by the families in this research and demonstrates the extent of the lack of response from those in the health system. The levels of frustration from family members trying to navigate this committal process was high as a consequence of the lack of information forthcoming while at the same time being handed the responsibility of making all the decisions. Feelings of frustration were elevated as the need to undertake this course of action, which is not taken lightly, is done when the family is feeling that the person with the addiction is at risk of significant harm. Instead of the assistance they initially expected, they were confused by the lack of urgency and genuine desire to help from professionals.

> The case worker said, *"If you really think you're going ahead with this thing then you have to go and find a place for her and a bed for her. **You** have to. Somewhere that will be willing to take her"....He* [the case worker] *didn't want anything to do with the committal process and kept saying, "No I can't". But others would tell us he's the person who can get this started…(partner)*

> *No one told me I had to do an affidavit. (Parent)*

Family members are generally aware that their family system is not functioning optimally. There are issues of enmeshment, catastrophizing, and/or other unhelpful behaviours that they may exhibit as learned behaviours while living with someone with a severe addiction. However, the unwillingness of health professionals to engage with family, irrespective of some of these behaviours, in a way that facilitates an investigation into their situation, evaluates their concerns objectively, and then offers appropriate supports severely limits any opportunity to develop a positive relationship with health care workers.

Previous experiences contribute to family members having low expectations of health provider support. The event of finding someone who was willing to respond to their concerns was of such significance that the person was identified by name and gratitude expressed for their responses, however small. This person was identified by family members as an ally in the health system even if the outcome of their interaction was simply to be referred to someone else. Finding an ally seemed an important property of this category as it signalled to the family that they were not completely alone in getting something done and a sense that if they looked hard enough and kept going they would find the person that could give them what they needed. Critical information about

the necessary networks and procedures for the committal process was clearly held by a few people within the system, rather than being easily accessible for those who may need it.

> *There's a lady called* [name] *and she's been outstanding because she replies to my e-mails …she's the only one who's ever communicated with me. (son)*

> *..but then this guy* [name] *who I was talking to said no I don't work out of* [centre] *but I'll go and see the admitting lady and get back to you…and he did get back to me. (father)*

The second key concept of '*Working it out myself'* is '*taking responsibility for another'.* This was characterised by properties including; a lack of support, a need to convince others and finding out that no-one knows what to do. Being put in the position of having to take responsibility for another person who is so unwell they are unable to access help for themselves, but experiencing barriers to getting that help added further to the resolve and determination on the part of family members.

The lack of information about options for assistance or the committal process itself from treatment centres throughout the country results in family members having to take responsibility for navigating the process themselves. Even when the family is not keen to pursue a committal process, in the absence of any other option or assistance, this becomes the choice by default. Several mistakes in getting the required components in order to make the committal, and significant time delays in obtaining the correct information and access to help occurs as a consequence.

Consistently, families are presented with barriers to accessing assistance and given incorrect, inadequate information or are simply ignored. Treatment centres appear to be ill-equipped to manage situations when a person is actively unwell and engaged in relapsing behaviour. Health professionals cite a lack of belief in the committal process to achieve its aims or are philosophically opposed to the notion of committal as reasons for not offering support for this process, withholding information or dissuading families from undertaking the process. Alternative options are not offered or made available except for the suggestion to elevate mental health concerns in order to access the mental health system. Concerns are often minimised by others, including police and treatment providers.

> *…And they* [treatment worker] *said oh she hasn't finished her drinking yet…she's far too young and she can't be that bad. (parent)*

When faced with this level of interaction, the family is put in the position of having to convince others that their situation is sufficiently bad enough to require the level of intervention they are seeking. There was in general, a lack of understanding on the part of addiction practitioners that the people for whom this treatment was being sought were likely to have cognitive impairment or substance related brain damage associated with their severity of their addiction which would impede a person's ability to make a positive decision for treatment themselves. Instead, a lack of motivation was often cited as the reason for the person not wanting to engage in treatment and the reason for the treatment practitioners to not get involved. The onus was on the family member to prove their case by way of repeatedly outlining several examples of significant harm in order to convince the health professional that this person was not just choosing to reject treatment.

Unfortunately, even when practitioners conceded committal under the Act was a viable option, they did not know what to do or provide the family with accurate directions on where to find that information. Thus, the family is left to work it out themselves.

> *I know when to get involved….I know when she starts to isolate and I can't get her on the phone, or I don't see her getting down to get her booze and she's got a taxi driver bringing it to her...I get involved at that point because she hasn't got the ability to do it herself…they* [the health workers] *don't believe that. Their mind is set if she's not turning up for appointments her level of motivation is not great. (daughter)*

A feature of this category *working it out myself;* is the family member having to navigate and negotiate their way through two different complex systems; court and health, on behalf of someone else. The agents working in both these systems neither communicate with nor understand well the role that each other plays so the family, already in distress, develops a level of determination to get things done. Unfortunately, the outward expression of this determination can often be interpreted by those in the health system in a negative way as insistent, aggressive or forceful. The outcome of this, is to reinforce to the health professional that the family is indeed 'part of the problem', and thus the family itself becomes a barrier to getting help. However, from the perspective of the family this determination is underpinned by the sense that their actions are

necessary to save the life of their family member experiencing the severe effects of addiction. This leads to the third main category; *Holding my breath.*

Category - Holding My Breath

> *I sat there and had a good howl* [cry inconsolably] *when they rang and said she couldn't go in that week, because I thought I can't hang in there any longer, it's like you're holding your breath the whole time. (Father)*

The third main category in this substantive theory is *Holding my breath*. *Holding my breath* is characterised by properties including a fear of their family member dying as a result of their addiction, and therefore, doing nothing is not an option. When things are going badly and help is not forthcoming, it can become a situation that consumes much of their time and energy, negatively impacting on the quality of their other relationships. Over time, family members find ways to protect themselves emotionally and some were aware many of these strategies such as lying, getting aggressive, threatening, bribery or withdrawing from their own supports, were not ideal but worked in the immediacy of the situation. Brief periods of respite while the person was in a residential treatment programme did little to mitigate the sense of helplessness felt by family members bought about by accepting that they were not in control of making the necessary changes to improve the situation. In this way, the concepts that underpin *Holding my breath* are 'fearing for the life of another' and 'keeping going'. The focus for the family is on 'managing the constant stress' associated with supporting someone with a severe addiction. The outcome of *Holding my breath* is 'feeling powerless'.

> *I'd find myself feeling totally relaxed when she was in there and a month before she was coming out I'd start getting all revved up again. (Daughter)*

> *I'd say for at least 15 years I've known that at any time I could get a knock on the door and there's a policeman saying, you know, sorry but your son's dead. (Father)*

> *You feel responsible because the next thing you might hear is she's dead in a ditch somewhere. (Mother)*

The outcome of both the categories '*working it out myself*' and '*holding my breath*' is a paradoxical situation whereby family members are required to be strong and determined to work out this process via both court and health systems on their own, but at the same time they feel powerless to affect any actual change or action. As a result, concerned family members become hypervigilant about keeping the other person as safe as possible and watching for signs of deterioration. Sometimes this over involvement of time and energy, put pressure on other areas of their life and other relationships risked being neglected or put under significant stress. Family members had lost jobs and relationships, they had put personal plans on hold, and holidays had been indefinitely deferred because of the amount of time and attention that they felt they had to give to supporting the person with the addiction and finding them the right help.

I got to the point of thinking I can't deal with this shit; work and this stuff at home…(Mother)

Living with the chronic stress of their situation, broken by small episodes of respite while someone is in residential treatment or in a detox unit could be likened to living with people who have other chronic and deteriorating conditions that require long-term care plans and management. However, the difference is that in this situation the primary supporters are typically not given information about the care plan and there are no clear strategies or responsibilities outlined for different parties involved in the event things start to deteriorate.

In fact, treatment providers absolve themselves of on-going involvement. Health professionals are able to indicate they are no longer willing to work with a person or their service is not appropriate without making any alternate arrangements for care or more appropriate treatment, and instead direct the family to undertake this task. These types of interactions continue to keep the responsibility for the other person's care with the family who choose to or feel obligated to stay involved.

Further, it results in a lack of trust between the family and treatment providers around the family's ongoing involvement in care. There are no opportunities for family members to develop working relationships with other people involved in the person's care. Thus, the family stays waiting, albeit in the background, for the next episode to occur and for the cycle to start again, without knowing who the best agency is to ask for assistance and support. This means that even periods of sobriety

and relative wellness is simply a waiting game for family members who are 'holding their breath' until the next time the process of help seeking begins again or indeed the worst happens.

The chronic nature of this severe form of addiction means that for the family this cycle of respite and relapse feels 'never ending'. The lack of a cure and lack of certainty about what will fix a situation means that families stay stuck in 'not knowing' how to help or indeed when or if it will get better. Although the families in this study had accepted they were unable to change the situation on their own or resolve the addiction itself, they continued to hold on to the possibility of change and hence they remained committed to using any mechanism available to them such as the ADA Act, even multiple times, to allow for that possibility.

Grounded Action

The grounded action is presented here as an operational theory. Its components form an action plan, developed to address the issues raised by family members articulated as the properties in the grounded theory outlined above. Family members' involvement with the compulsory treatment process is characterised by a lack of communication and information, and increasing frustration. The family members in this study resolved this situation by adopting a sense of 'living with it". *'It'* refers to the chronic addiction that their family member is experiencing. Family's lives are also directly impacted by this condition, and the stress they experience is chronic and intense. They are living with 'it', and in some ways experience a similar stress to the individual with the addiction, as they are in effect, powerless to make any change no matter how much they want it to be different. Recovery and wellness is the desired change, but this is largely in the hands of someone else who is seriously affected by this condition. It is clear from the perspectives of family members that the lack of communication and support from health professionals are key sources of their stress when they attempt to seek appropriate treatment for their loved one. There is much that could be done within the treatment sector and within the revised legislation to improve the future experiences of families in this situation. In this section, the components of the action plan will be outlined.

Following a process of ongoing memoing using the properties of the grounded theory presented above, three areas of focus for action emerged. These areas were the categories named;

Recognition, Responsiveness and Resilience. Appropriate activities to address these categories and what they represent were then outlined using as many avenues as possible (see Table 8). In order to ensure that the activities were realistic and achievable, current resource limitations were taken into account and barriers to implementation were investigated. Solutions have been detailed which are most likely to affect a change both to the treatment system and the practice of individual workers. Details of the actions proposed are explored in the discussion chapter as specific activities were selected following a focused literature review to determine current best practice and best fit for an effective and sustainable solution to the issues identified by the families in this research.

This research provided a framework which outlined a focused approach to improving and achieving addiction services' ability to respond, recognise and support family resilience. Taking a multi-faceted approach as outlined above improves the likelihood of success of a cultural change in which family involvement in treatment becomes the norm. Promotion of a shared goal of 'family wellness' in which recovery from addiction, as understood by the persons concerned, is a cornerstone and critical to effect these changes.

As taking action to effect some positive change was a key driver for me in undertaking this research, many of the activities outlined above have been undertaken over the past 18 months. As evaluation is a key feature of a grounded action, the training conducted to date has been evaluated with regard to reviewing its utilisation in clinical practice with a view to improving the training for wider implementation. Although evaluations have been considered part of the planning for these activities, including the legislative amendments, it is acknowledged that these activities are a start in a long-term investment in culture change, the impact of which will not be fully realised for some time.

Table 8:

Grounded Action Operational Theory – Action Plan

Focus from grounded theory (Table 5)	Grounded Action - Categories	Grounded Actions - Activities to address the components identified in grounded theory
Wanting to be part of the solution (but seen as part of the problem)	**Responsiveness**	• Make visible and give clear information about using the compulsory treatment process to addiction treatment workers, mental health workers, police and emergency department workers, that includes who it is for, who to include (support and family. • Make training widely available about the process and use of compulsory treatment. • Train addiction treatment workers in specific family inclusive practice models (CRAFT, single session family interventions) to ensure first contact is positive and supportive. • Develop practice guides and provide training for addiction treatment workers in implementing the guide, which includes a family member. • Provide information in the practice guide that outlines the responsibility to share information under the Privacy Act, and address any misconceptions. • Undertake a stocktake of working with family focused training options in undergraduate training programmes, and promote this as a core component of undergraduate preparation.
Barriers & challenges to getting help	**Recognition**	• Change legislation to include family/whānau at each stage. • Introduce activity data codes in PRIMHD* to facilitate data collection of family engagement activities. • Increase the number of services involved in treating people with severe addiction that deliver culturally appropriate interventions. • Commit to utilising existing platforms to discuss family and whānau in treatment (leadership days, Cutting Edge conference, regional and national hui, newsletters), and promote services that are working well with whānau. • Establish exemplar services that work well with family and whānau and explore opportunities for them to provide training and mentoring to interns or new graduates.

Managing the constant stress	**Resilience**	• Ensure ready access to, and availability of, information tailored for families that includes:
		  • Information about addiction from a family perspective.
		  • Information about the committal process including forms, process charts, decision support, and important contact details.
		  • Support for family in their own right.
		  • Self-help support and strategies.
		• Commission treatment services to ensure that working with family members is core business.
		• Ensure addiction treatment services are open and able to work with family members, provide family/whānau focused information, counselling and wellness programmes that are specifically for family members and/or are family inclusive. Use the experience of those working in gambling treatment to support these developments.
		• Ensure addiction treatment workers include designated support persons for individual's treatment plan, and that they are made aware of support strategies and have plans and contacts for when assistance is required. Templates for this are to be included in practice guides.
		• Promote addiction treatment services working with local whānau ora services, and work with whānau ora approaches appropriately to improve family wellness

Note. *PRIMHD is the Ministry of Health national data collection system for mental health and addiction service reporting.

In this next part of this section, I have outlined some of the key activities that have already been undertaken: revision of the ADA Act legislation, treatment worker training and development of an on line information portal for family members.

Legislative review

As a member of the working party to support the drafting of a new legislation for the compulsory treatment of those severely affected by addiction, it was paramount to me that these family members' voices were included in the process, and their role recognised. The revised legislation will be the key mechanism for enacting the compulsory treatment of someone with severe addiction. Thus, the updated version needs to recognise the role of family, whānau and principal support people at each stage of the process, and specify where their involvement interfaces with the legal process and health professionals. As part of the consultation in the development of a draft Substance Addiction (Compulsory Assessment and Treatment) Bill to replace the existing ADA Act (1966), it has been strongly advocated that the role of family and whānau are reflected throughout. The Substance Addiction (Compulsory Assessment and Treatment) Bill was introduced into parliament in New Zealand in December 2015. The sections pertaining to family members and support people have been extracted and are included in Appendix 5.

 The proposed clauses include a clear definition of a relative or whānau or principal support which is very broad and encompasses relationships beyond first degree relatives and is inclusive of whomever the patient nominates as his or her support person. It was considered important that family members who are designated by the patient as support people, receive information about the criteria and process of the committal as well as sufficient information about alternative options for treatment and support if the criteria are not met in their case. This grounded theory showed that information about appropriate treatment options was consistently not provided to family members causing significant delays in getting the help needed. The onus to provide readily accessible information about addiction itself and the services available within the health system lies with health professionals rather than on the public to have to source for themselves. A clause which specifies the responsibility of health professionals to give appropriate support and information to family members who are very concerned about someone who doesn't meet the criteria for committal will be helpful to guide improved engagement practices.

It would be helpful for both the patient and support people to be advised of the patients' rights in a way that they will understand at the start of the process. This will ensure that family members are clear about what they can expect to know about the patients care and what information will remain confidential under the Privacy Act and health codes of practice. A further issue identified in this study was the lack of information provided to family members and key support people about changes to the status of the person under committal. It was difficult for family members to reconcile the effort they had expended on getting the person through the court process and into addiction treatment only to find a short while later the person had been discharged from the service to return home without their knowledge or any indication of what had happened and what to do next. Therefore, it was recommended that the practitioner responsible for the care of the patient should be required to notify the patient's designated family of any transfers or discharges from treatment facilities. In addition, any proposed ongoing care plans for the patient should be cognizant of family members and ideally they would be involved in the development of the follow up care plan. In this way, family members would be informed of agreed steps should they become concerned about the patient once they have returned home and have appropriate contact details to seek further assistance if required.

As family members and whānau are a valuable source of information about the patient/tangata whai ora and the extent of their condition, the new Act does need to provide for them to be able to be heard at each stage of the committal proceedings. Further, it is recommended that there is recognition of their role as primary supporters and advocates for the care of their family member. This will assist in mitigating the current situation whereby the relationship between the patient and the health professional is given primacy. In the circumstances presented here where patients are committed to attend treatment because they are deemed incapable of making a decision to accept treatment themselves, it seems important that the patient has the benefit of support and advocacy from someone independent from the health system.

The 1999 amendment to the Mental Health (Compulsory Assessment and Treatment) Act 1992 recognised the role of family and whānau in the process of admitting someone under compulsory mental health treatment. Section 7A of the MH (CAT) Act states:

Medical practitioner or responsible clinician to consult

(1) In this section, practitioner means—

(a) a medical practitioner conducting an assessment examination of a proposed patient under section 9; and

(b) a responsible clinician providing an assessment of, or treatment to, a patient.

(2) A practitioner must consult the family or whānau of the proposed patient or patient. This subsection is subject to subsection (3).

(3) Subsection (2) does not apply if the practitioner has reasonable grounds for deciding that consultation—

(a) is not reasonably practicable; or

(b) is not in the best interests of the proposed patient or patient.

As discussed earlier in Chapter 3, the Ministry of Health conducted a review in 2006 of this amendment, because there were concerns that clinicians were not consulting with family and whānau in the manner that was intended. The results of that review concluded that several mechanisms were required to be implemented to support this amendment to effect practice change. The legislation itself and broad guidelines alone were insufficient to create this change. While the legislation's wording is important to highlight the necessary parameters and expectations of this process, it needs to be supported by strong leadership, organisational and practice-based guides and tools that ensure this is enacted at the practice level. The practice guides, where roles and responsibilities are clearly articulated and templates and forms support standardised responses, will be developed once the draft bill has been through the processes which will set these clauses into legislation.

In learning from the amendments to the Mental Health (Compulsory Assessment and Treatment) Act 1992, which looked to recognise the role of family, it is clear that legislation itself is insufficient to produce practice change. While legislation may give a clear signal as to expectations, unless the system and practises within it are also addressed, unhelpful practices are enduring.

It is accepted that although the Substance Addiction (Compulsory Assessment and Treatment) Bill has been introduced into parliament, some changes may occur as a result of being reviewed by the Health Select Committee and public consultation. However, given the level of prior consultation, and input from the findings in this research, it is hoped that the proposed sections and clauses discussed above will be retained or further strengthened.

Workforce training

Conditions required for the translation of training and knowledge into practice have been summarised by Goldstein and Ford (2002) into three components: instructional design (e.g. learning objectives and instruction plans); trainee factors (e.g. motivation and readiness to learn); and work characteristics (e.g. opportunity to practice, workplace culture which values the training, access to resources which support the new practice). To apply this framework and build on existing strengths, partnering with a whole organisation that values this shift in practice and has sufficient spread of services and practitioners across New Zealand was needed. This then provided adequate supervision and support, and increases the likelihood of achieving generalised change. I was aware that one of the national providers of addiction treatment, and a gazetted treatment facility for clients under committal, had already implemented the Community Reinforcement Approach (CRA) model of treatment (Doherty, 1985). This treatment model was developed as CRAFT; Community Reinforcement and Family Treatment approach, so the CRA was a partial implementation of this original model without the family components. Further details of this model and others that were evaluated for this research are explored in the next chapter.

When I spoke with the Manager of the Bridge Programmes, Salvation Army about this project, they indicated an interest in expanding CRA to include the family components of the model (CRAFT), which is designed to engage treatment resistant individuals by working with their family members (personal communication, Major Mike Douglas, 15 September 2013). They explained that while this had been intended at the initial stages of implementing the CRA model some 10 years ago, it had become a low priority for their internal workforce development as other training needs superseded this plan. They had questioned at the outset whether to focus training on a dedicated 'family' worker in each team, or attempt to make working with family member's part of standard addiction treatment practice. The reliance on a single person fulfilling a role designated as a 'family worker' has been successful at periods of time but has proved to be an unsustainable approach to practice change as everyone else in the treatment team simply relies on the one person in the designated family role to work with the family. Therefore, it was decided that to achieve a cultural shift toward improving responsiveness to family members overall, it was important to train sufficient numbers of those existing staff who have the motivation and interest. These trained staff can then influence the practice of others in the team and provide sufficient

support for them to undertake this family work. This approach was seen as more likely to provide confidence for general treatment staff in working with families and demonstrate that including family improved the effectiveness of the work they were already doing with the individual experiencing addiction. Expanding on an already accepted model of practice (CRA) was seen as building on what they already had confidence doing, and therefore, was more likely to get support from the workforce within this organisation. As a workplace culture that values this training and a structure that supports the opportunities for practicing these new skills were in place, many of the features of the framework for successful transfer of training into practice exist (Goldstein & Ford, 2002).

I worked to support this organisation to undertake a national train-the-trainer programme for over 35 of their practitioner workforce, which commenced in August of 2014 and facilitated by Andy Andersen from the USA, one of the original trainers of the CRAFT model. The organisation remains committed to implementing this over the long-term and providing the necessary resources to support practitioners. This will ensure that there is an organisational culture shift to embedding expectations of being responsive to family, and an evidence-based, consistent approach to how this should be managed within the treatment environment.

A more recently developed intervention to engage families seeking assistance for a wide range of issues is the single session family intervention (Young, Weir, & Rycroft, 2012). This was found to be a quick, easy to learn and readily adaptable intervention which increased practitioners confidence in engaging with families. We have started to work with the Bouviere Centre in Victoria, Australia to bring this training to New Zealand for mental health and addiction practitioners in the near future.

Leveraging sector events and allied programmes

In order to further promote discussion and present the issue of family involvement in addiction treatment to the wider addiction sector, the addiction sector national conference committee (of which I am a member) has agreed to the theme "*it's all about family whānau*" for the national conference for addiction practitioners, Cutting Edge in 2015. It is hoped that this will give an opportunity for services to showcase working with family initiatives. It also exposes addiction practitioners to the research, which supports working with family as a contributing factor to

enhancing outcomes for individuals experiencing addiction. This research was presented at this conference, as outlined in the programme (Appendix 6). The feedback I received following the presentation of this research supported the credibility and rigour of the theory developed. One person whose wife had died several years' prior as a result of her addiction expressed his thanks at having his story told in such a way, and stated that "it was like it was his story on every slide". A woman who explained her father had also died from his addiction and had been found in terrible circumstances also gave similar feedback and stated that although she had been to several addiction conferences she had never heard family voices before and that the presentation described exactly how she and her family had found the system to deal with. Glaser and Strauss (1967) suggested that one of the ways to convey credibility of the research was to use the data in such a vivid way that people can 'see and hear' the participants as they relate to the theory. These comments received by attendees of the presentation at the Cutting Edge conference suggest that the theory has credibility and shows relevance for the addiction sector.

Addiction sector leadership days are held three times a year in Wellington, Auckland and Christchurch respectively. The attendees of these days are mostly clinical leaders and service managers as well as those in policy, primary health and criminal justice fields. This provides a great opportunity to open discussion about family in treatment, outline the barriers to doing this effectively and profiling services and programmes that are successfully implementing innovations to engage family members. As an organiser of these events, I set the theme of the most recent leadership day in Auckland on the 23rd July 2015 as *whānau ora, engaging with families* and worked in partnership with the Kotahitanga whānau ora collective to promote whānau ora and demonstrate how it works. Whānau ora is a current cross-sectorial policy action which aims to support the wellbeing of Māori whānau and calls for services to be whānau focused and build on whānau strengths (Whanau Ora Taskforce, 2010). The whānau ora framework recognises the unique position that Māori have in New Zealand and the need for all services that engage with Māori, not just kaupapa Māori services to be responsive to whānau as appropriate to the Te Ao Māori worldview. In this way, the responsibility is for all health services to develop their workforces and service delivery systems to be able to respond to whānau. It is widely appreciated that this approach would not only serve to improve the health outcomes for Māori, but also for the general population.

This event was attended by over 200 leaders in the addiction treatment and allied fields. Evaluations of this day indicated that attendees felt more informed about whānau ora and felt more confident about engaging with a whānau ora collective in their local area after the workshop. The attendees also indicated an interest in continuing to focus on 'working with families effectively' for future leadership days. This event was also profiled in the latest edition of the addiction sector newsletter, produced by Matua Ra<u>ki</u> (www.matauraki.org.nz/publications) and efforts are being made to ensure that this publication is used as a vehicle to profile and promote services that are working well with families. One of the goals in doing this is to share with others what has worked well and what mistakes were made along the way in order for others to learn and adapt these programmes and innovations to suit their local situation.

Other developments in the wider mental health and addiction sector, which will support this shift toward more family inclusive practise include the implementation of COPMIA (Children of Parents with Mental Illness and Addiction), a Ministry of Health led programme. An implementation plan is expected to be released by October 2015. This programme of activity and resource development will further encourage discussion and practice shifts beyond the individual and toward the needs of family. This programme is being adapted from the Australian developed COPMI programme, which aims to improve outcomes for children of those with mental health disorders and reduce stigma ([www.copmi.net.au)](www.copmi.net.au). One of the key amendments in the New Zealand adaptation is the explicit inclusion of children of parents with addiction, hence the addition of the A in COPMIA.

One of the barriers for working in a more considered way with family, as indicated by the addiction practitioners interviewed in this research, was the lack of ability to report any activity related to working with a family member. The lack of a mechanism to record 'working with a family member' as a legitimate activity within the treatment system seems to have resulted in a belief that this is not their business. As part of the COPMIA programme, it is expected that a new code, which does allow for work undertaken with family members to be recorded as an activity, will be introduced in 2014 into the PRIMHD national data collection system to which all services, both DHB and NGOs, record their activities. PRIMHD is the Ministry of Health's "single national mental health and addiction information collection of service activity and outcomes data for health consumers" (http://www.health.govt.nz/nz-health-statistics/national-collections-and-urveys/collections/primhd

-mental-health-data). It does seem that the old adage "what gets measured gets done" (author unknown), also applies to health services so the ability to record, and therefore, measure this as an activity which can be reported on is critical to facilitating family work.

A long term strategy of working with addiction training providers to include family inclusive practice into the core training for all undergraduate programmes for practitioners has also been tabled by myself with the addiction training provider network. This network includes all of the tertiary training providers currently offering both undergraduate and post-graduate training programmes in addictions. It does seem from this discussion that one of the goals of training the workforce to work with family and whānau in addictions treatment is to challenge the judgements made by professionals about 'who' is acceptable to be part of someone's support network. Being prepared to work with family whānau members irrespective of their current status of drug use, recovery or wellbeing on the shared goal of assisting the individual concerned is paramount. The influence of working this way to impact change on those who observe positive change in others and who are exposed to ideas and thoughts of positive change is, in my opinion, grossly underestimated and could be used to achieve a much greater impact than health carers currently experience.

One of the anomalies uncovered in this research has been the different way in which those working with gambling addiction are expected to work with family members in comparison to the alcohol and other drug treatment sector. Gambling addiction treatment in New Zealand is funded through the gambling levies via the public health system and takes a population health approach to treatment similarly to tobacco control and smoking cessation. Families and whānau are mentioned throughout the policies and practice guidelines (Ministry of Health, 2008a). For example, these gambling service requirements explicitly state that people who have been affected by the gambling of a family/whānau member are eligible for services in their own right (p.18), and specific screening tools for family members as well as details of the process of working with family members are included.

In this way, working with a family member is counted as an activity for data collection in the same category as the person with the gambling addiction, there is no distinction as they are both clients of the service. Using the platforms previously indicated, such as addiction leadership days to highlight and promote the approach that those working in the gambling area have taken to working

with families, is likely to serve to increase the level of confidence in other addiction workers to undertake these tasks.

Information website

The other key activity undertaken in preparation for the amended legislation as part of this grounded action research is the development of a website that is primarily for family members of those with addictions. The families in this study showed a high level of resilience with regard to 'living with' this condition of severe addiction. They managed to find ways to maintain positive relationships, jobs and lives, while adapting to the irregular but frequent interruptions bought about by supporting the addicted person. The lack of information available for family members to assist them with the compulsory treatment process, coupled with the challenge of finding appropriate professional support, meant that this coping was learned through trial and error. A number of families commented about the negative impact of some of these errors, which compounded the stress that everyone in the family system experienced unnecessarily. To enhance the resilience that was evident in family members involved in this study, I felt that ready access to accurate information about addiction and treatment options including compulsory treatment and the processes involved was important. Information specifically designed for family members that includes stories from family members themselves would assist in giving confidence about where to go and what works well. It would also serve to let the family know they are not alone in managing this situation as many others have been there before them. Because isolation from supports has been the result of not receiving appropriate support for these families in the past, hearing from others in a similar situation may help to reduce this isolation. It is also hoped that a consequence of imparting this level of detailed information to families will make services accountable for providing the expected level of support.

To achieve this, I worked with a national organisation, already producing some resources for the workforce to work with families, to refocus their website offerings to provide support and information directly to family members. An updated website was launched in July 2014 (www.kina.org.nz) that seeks to provide information to family members. It acknowledges family members as needing support in their own right, independent of the status of their family member in the treatment process. Providing resources to assist family members to recognise their own

levels of stress, provide some effective management strategies as well as links to supports available to them, and an online chat forum to support each other are currently under development. Several videos of the stories of family members have been filmed and uploaded to provide some shared context to the challenges that people face when supporting people with addictions. It is planned that once the updated legislation is in place, a page on this website will provide information to family members about the process of compulsory treatment, its purpose and limitations and other options that may be available to them. It will also provide contact details of services and what they provide and may include the necessary forms to initiate the process so that it is all in one place and easily accessible for both family members and the addictions workforce.

Summary of the Findings

This Glaserian grounded theory of 'living with it', has identified key elements of how family members currently manage the process of compulsory addiction treatment for a family member who has severe addiction. Further, a grounded action approach enabled the development of an action plan to address the issues of concern outlined in the grounded theory. Changes that have been proposed seek to legitimatise the role of family and whānau as partners in the treatment process as well as acknowledging they will have their own needs that health professionals need to consider. A culture shift towards the inclusion of family-focused practice is recommended and actions have been specified in the action plan to affect this change. Some significant changes have been negotiated as part of this research including the wording in the revised legislation, organisational wide training, sector engagements and events that draw attention to this issue and the establishment of an information website for family members. These activities represent a start in a culture change in the addiction treatment sector to recognise and be more responsive to family members who are affected by addiction. Other sector activities that further support this shift which are led by government agencies with resources to implement these well would suggest this change is both possible and sustainable into the future.

Chapter 5   Discussion

This grounded theory-action first explains how this group of family members experienced the civil commitment process (ADA Act 1966) to seek compulsory addiction treatment for a family member who is relapsing from chronic addiction. 'Living with it' is the basic social psychological process (BSPP) and the key solution that family members employ to resolve the concerns that were identified in the grounded theory. Second, a grounded action approach sought to take a further step in utilising the issues of concern identified in the grounded theory to develop an action plan to address these concerns in a considered and systemic way. In this chapter, I summarise the focused literature review that was undertaken after the grounded theory-action. The options for the action plan and the barriers to successful implementation of proposed plans are also examined.

The literature review was undertaken using the following library databases; Psych INFO, AUT Library commons, Scopus and Medline. The key search words varied with each area under review and included terms; family and addiction and interventions, family and chronic conditions, health/addiction and workforce and training. The timeframe criteria extended from 2000 to 2015 with the exception of key or original works still being referenced in general use.

In this section, a focused literature search was undertaken to examine more closely the role of treatment services in the addiction compulsory treatment process (ADA Act). To understand where we can go from here, we have to understand how we got to the current situation. This first part of the literature review examines how this situation, whereby family members are typically excluded from addiction treatment, has evolved. I will address the barriers to effective interventions and make recommendations to address this in order to improve the situation for families in this situation. This research has highlighted that family members are keen to have a greater role in the treatment process and to have a better understanding about how to provide appropriate assistance. Therefore, I start with clearly establishing the case for involvement of family in the treatment process by demonstrating that engagement of family members as key supports in treatment improves treatment outcomes and helps to reduce familial stress and

tension. I will argue that the system needs to have a multifaceted culture change in order to effectively respond to the needs of family in this situation, and that in doing so ultimately benefits treatment outcomes for all concerned.

Family and Whānau as Part of the Solution

The issue of non-involvement of families in mental health and addiction treatment is not unique to New Zealand. In spite of studies which demonstrate that the involvement of families in mental health treatment can improve outcomes for the person with a mental health condition as well as improve family relationships and decrease familial stress the inclusion of families in treatment in any form is rare (Dausch et al., 2012; Pharoah, Mari, Rathbone, & Wong, 2011; Spencer & Skipworth, 2007). The World Health Organisation has recognised the importance of taking into account the needs of families when developing mental health legislation. It recommended that "appropriate information about treatment and care plans to enable them to support appropriately needs to be given in a way that balances the principles of confidentiality and need to have sufficient information to care properly" (World Health Organisation, 2003, p. 39). Indeed, the amendments to the Mental Health (Compulsory Assessment and Treatment) Act 1999 in New Zealand introduced mandatory family and whānau consultation unless it was not in the interests of patients. The guidelines that accompany this Act recommend that family consultation should occur at each stage of the process under the Act. In a review of this feature of the Act, Spencer and Skipworth (2007) found that of the 270 individuals seen over a 2-month period, 66% of cases reported a family consultation had occurred. They reported that a range of clinicians' views about the involvement of family was expressed. The views of family members as to whether they believed they had been consulted in this study were not included in this study. One study that sought this feedback was undertaken by Ewertzon, Lutzen, Svensson and Andershed (2010) who surveyed 70 families involved in psychiatric care in Sweden. The majority of participants reported a negative approach from professionals and a lack of cooperation. They conveyed a sense of powerlessness and social isolation in the care that was provided, which the researchers concluded were indications of alienation. Feelings of powerlessness were expressed even more by those families receiving compulsory care, something that is similarly echoed by participants in this study.

A report prepared for the Families Commission (Moriarty, Stubbe, Bradford, & Tapper, 2010) sought to identify the issues for families living with addiction in New Zealand. Families interviewed for this report felt underserved by health providers in seeking help for their family member with an addiction and increased levels of stress. Family members indicated they had experienced gaps in accessibility and timeliness in services and issues of confidentiality was often used as a reason by health professionals for not being helpful or providing information they felt was important. The impact of not getting the help they needed when they needed it included low self-esteem, a lack of confidence in help seeking, becoming comfortable with dysfunction and social withdrawal. When protective factors, such as work and positive relationships, are compromised over long periods of time there is an increased risk of stress-related illness occurring (R. Glaser & Kiecolt-Glaser, 2005; Jaremka, Lindgren, & Kiecolt-Glaser, 2013). Many of these impacts are not dissimilar to the properties outlined in this grounded theory.

Several studies have demonstrated that early engagement for affected individuals in addiction treatment is significantly associated with increased retention, improved therapeutic relationships, and reduction in the addictive behaviour (Dowling & Cosic, 2010; Fiorentine et al., 1999; Villano et al., 2002). Poor family and whānau relationships has been shown to increase levels of motivation to seek treatment for drug dependency and also negatively impacts on long-term post treatment outcomes (Griffith et al., 1998). Where families are involved in the early engagement of health treatment, such as parents of children hospitalised for emotional disturbances, research has shown that repeat admissions rates was positively correlated to the level of engagement and satisfaction of the parents in earlier admissions (Brinkmeyer et al., 2004). This suggests that success in treatment could be highly influenced by the manner in which a person under a civil commitment for compulsory treatment is engaged in the process of treatment, and the manner in which significant others are similarly engaged in the process.

In this grounded action research, the practitioners that did respond actively to either their own concerns or those raised by family members, incurred negative comments from colleagues who suggested they were behaving outside of their professional boundaries, and 'enabling' or 'rescuing' the person by seeking help on their behalf. I noted that those practitioners who responded in a more helpful way in spite of experiencing negative feedback from colleagues had

a background in social work training, although their current roles were not defined as social workers.

Family members in this current study, who made contact with health services to seek advice or assistance reported being met repeatedly with no information or assistance forthcoming. It often took several attempts to engage with health professionals over a number of relapse episodes of the addiction, before the family member came across an 'ally' in the treatment arena who was prepared to listen, support, give accurate advice or talk confidently about options available in their situation. Such allies became a key contact person whom they relied upon for ongoing information and support. Families expressed their gratitude for even the smallest of helpful activities they encountered. These activities included, for example, acknowledging e-mail queries, referral to other services, taking time to listen fully to their concern, acknowledging they were not sure about a response but would attempt to find out and then following up. None of these activities would be deemed overly onerous or impacting severely on the workload of a practitioner and rather, would be typically viewed as 'business as usual' activities.

Tambuyzer and Van Audenhove (2013, p. 676) defined service user and family carer involvement in care as "involvement in decision making and active participation in a range of activities (for example; planning, evaluation, care, research, training, recruitment) starting from the expertise by experience of the person in collaboration with and as equal partners of professionals" (p. 676). Their study reviewed key mental health care stakeholders' perceptions (patients, professionals and family members) in relation to how important they each were to the treatment process and how this was reflected in practice. They found that treatment providers perceived family carer involvement as less important and less practised than service user involvement. Troubled relationships between family carers and service users, practical constraints and the social isolation of service users were cited as factors contributing to this lack of involvement in treatment from the perspective of treatment providers. Each party though, agreed that providers were ill-equipped to support the involvement of family in care plans and treatment activities. The authors concluded that integrating the values of involvement and partnership in practice required a culture shift and skill development on the part of all participants in the treatment process. This supports the findings of the review of the amendment to the Mental Health Compulsory Assessment and Treatment Act (Ministry of Health, 2006), which found that clinicians used similar rationale for not

involving family and whānau in treatment, and they similarly concluded a culture change was required to effect a change in this practice.

Possible levels of family involvement in addiction treatment could be seen on a continuum of practice from no involvement to an integrated family therapy approach (see Figure 2).
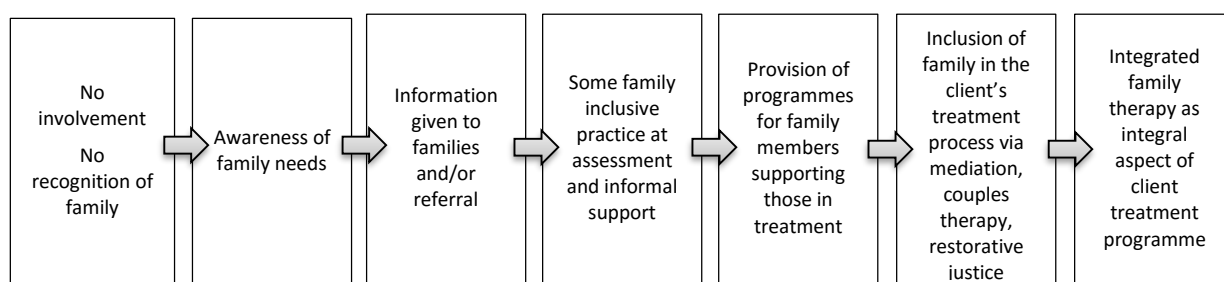

Figure 2. Continuum of family inclusive practice in addiction treatment
(Copello, Templeton, & Powell, 2009)

The experiences of the families in this study who are managing their situation by 'living with it' suggests they are living with it with very little, if any, support from addiction treatment providers. Families reported responses from treatment services across the country that ranged from being turned away and the minimisation of concerns expressed to being given non-specific instructions to seek what they needed elsewhere. Based on the continuum of family inclusive practice (Figure 2), it would seem that services gave families responses that are situated at the lower end of this spectrum.

Due to the inaction from health services, family members of those severely affected by substance addiction are typically the applicants of committal proceedings under the ADA Act. Judicial decisions involving the ADA Act which were reviewed for the research in this thesis showed clearly the difficult position that family members are in when they take this course of action (NZFLR, 2008a, 2008b). As an example of the conflict within a family which occurs when initiating this committal process the following court report states; "J's position is that he believes that this order must be made to preserve his brother's welfare, if not his life. L's position is that she wants to help her brother P but is loathe to be part of any detention of him against his will" (NZFLR, 2008a). Family and whānau not only have to risk the relationship with the person of concern but also navigate complex and powerful systems (health and justice) to achieve an outcome that

arguably is not as effective as that which they were anticipating. Coroner Ian Smith (2014) reported on a death from alcohol dependency which he attributed in part to the person's family finding the process of the ADA Act too difficult to access and get the help that was needed. An Australian study about young people with problematic substance use and their families showed the funding models of current treatment delivery, which is focused on individual treatment, limited the opportunities for services to respond in a flexible way that includes family or whānau. This report recommends that targeted funding to support families dealing with addiction was critical to improve the outcomes of treatment (Frye, Dawe, Harnett, Kowalenko, & Harlen, 2008). A recent UK drug policy commission report also concluded that research had shown that the involvement of families in treatment for addiction positively influenced the course and outcomes of the interventions, engagement of the individual in treatment and reduced the likelihood of relapse (Copello et al., 2009). Further, they add that attention given to offering family members support in their own right can assist in reducing the stress related harms that commonly result from trying to manage this long-term chronic condition.

It is my contention that the consequences of our treatment system continuing to fail to respond adequately can be costly and potentially fatal and improvements to this situation for families is deserving of attention. These are the very people that the addiction treatment system was initially set up to treat and support, and evidence supports the value in family members being involved in the treatment process both to support the individual and in their own right (Copello & Templeton, 2012).

Overcoming Barriers

As a result of the process of developing the grounded action plan for this research I have focused on potential barriers that currently prevent the system responding to family members and have proposed solutions to address these barriers. These barriers include the dominant philosophy of treatment, systemic barriers and workforce issues. These will be examined further in this next section with respect to addiction treatment specifically.

Practice Paradigm vs Rhetoric

Interestingly, in reviewing the history of the development of addiction treatment (Chapter 2), family involvement was recognised in the early writings of the 12 step movement as a critical feature of success in treatment. Chapters in the original writings of Alcoholics Anonymous were written by the wife of one of the movement's founders about her experiences, for example; *Lois Remembers* http://www.al-anon.org.nz/node/21. The subsequent emergence of Al-Anon support groups recognised of the needs of family members (http://www.al-anon.org.nz/).

In a study of participants in a New Zealand addiction treatment programme, Schafer (2011) found that all participants had experienced forms of family disruption as a result of child custody issues, loss of employment, depression and or abusive behaviour. Many participants had also experienced strained relationships as a result of accidents and criminal offending related to their addiction, financial stress and dishonesty. Similarly, Barnettt and Barnes (2010) found that people with mental illness described the tension and discrimination within the family unit. Key features of strained family relationships from their perspective included anger directed towards them, the tendency for others to assume authority when they were unwell, social exclusion, fear, and wanting to change their behaviour, especially in regard to living conditions.

There is no denying that being in any type of relationship with someone who is experiencing severe addiction is going to be stressful. The chronic and progressive nature of this condition and the often unpredictable patterns of recovery and relapse results in disruptive and distressing periods for all those involved. As such, we understand that this level of chronic stress can cause stress-related illnesses, including mental health conditions such as depression and anxiety in family members. Addiction workers talk about 'addiction is a family disease' and there is a growing body of research as noted above that supports family involvement in the treatment process, so how do we move beyond rhetoric and develop family inclusive services? Identifying the practices that limit family involvement is the first step. Using the compulsory addiction treatment process under the ADA Act which is the context of this research, the next sections will challenge the use of commonly held practices that have the unintended consequence of making it more difficult for families to access support.

Diagnostic criteria not translated into practice

The impetus for many family members in this study, to initiate the committal process is their concerns about the 'withdrawal' and loss of contact with their family member, regardless of the quality of contact within that relationship. Withdrawal of contact is an indicator that things have deteriorated and relapse into addictive substance use has likely occurred. In addition, people with severe addiction who have had on-going relationships with addiction treatment services typically disengage from that service when they become unwell and relapse into addictive behaviour. The manifestation of relapse appears similar for families and services, although the different interpretations and attributions given to withdrawal of contact create a paradox for families.

Withdrawal of contact is a sign for families that a person is becoming increasingly unwell and typical responses result in active help-seeking. Services, on the other hand, frequently attribute this behaviour to a decline in motivation for treatment. Thus, as reported by the practitioners in this study, the outcome of disengagement from a treatment service is a lack of obligation from health care workers to take action. While this may be an appropriate action for those with less severe forms of addiction, for the group that would be considered severe enough for committal, this action represents a lack of understanding about the likely impact of addiction on cognitive functioning and decision making.

Withdrawal from social networks feature as a key criteria (refer to criteria 6,7,9 on the table on page 4) for the diagnosis of an alcohol-use disorder in the Diagnostic and Statistical Manual 5 (DSM 5) (American Psychiatric Association, 2013a). Therefore, evidence of withdrawal from family should be considered as an indicator of relapse into addictive behaviour rather than a 'lack of motivation' to continue with treatment. For many people with addictions, the lack of engagement with supports at a time when relapse occurs may be symptomatic of the shame they feel as well as a reluctance to be an on-going burden to those around them or admit that things have gone wrong (personal communications, addictions consumer leadership group, 5 July 2013). For those with severe addictions, the above is true with the additional component of the loss of capacity to make decisions about treatment seeking due to significant brain dysfunction. By asserting non-contact is a lack of motivation it suggests that this behaviour is intentional and a choice that one is making. On the contrary, I would suggest that the unplanned disengagement from both family

and treatment support is likely to be a signal of relapse and the non-contact is a result of the lack of decision making capacity to do so caused by the addiction itself – not a motivational issue. The lack of recognition of this feature and the absence of concern about the potential seriousness of this situation by health professionals suggests a knowledge gap, and perhaps a sanitised view of severe addiction and relative appropriate treatment needs.

The addiction practitioners interviewed for this research, and subsequent conversations with addiction workers and training providers, have highlighted the change in training environments of addiction treatment professionals in the past decade. Previously, the vast majority of addiction workers received their initial training in intensive treatment environments, including residential programmes in which people lived at the facility for a period of time to undergo daily programmes.

Some of these residential programmes, which no longer exist, also doubled as 'dry tanks' where people would go for short periods of time to 'dry out'. This function is now typically performed by the NZ Police whereby heavily intoxicated people will be held in the police cells over night to 'sober up'. The inclusion of watch house nurses located in some areas to work alongside the Police to provide the medical intervention sometimes required during the detoxification process indicates the potential seriousness of these events (Paulin & Carswell, 2010). The impact of this early exposure of workers to the process and seriousness of substance withdrawal, particularly from alcohol, as well as observing the duration of time required to regain mental capacity, resulted in workers who understood that this was a potentially dangerous situation that sometimes required immediate intervention.

Over the past two decades, most residential addiction treatment facilities have been closed and community-based outpatient services are now the predominant mode of treatment. In addition, the training for addiction practitioners is now provided by tertiary institutions and is academically focused rather than practice-based. While there is a practice component this is typically one paper among many in a degree programme, and a placement is more often conducted in a community-based setting. Further to this, there is a high level of ascription to the belief that one can only treat people who are motivated to receive it. This level of motivation is equated with people who initiate the treatment engagement themselves and comply with all the practitioners' and facility's expectations to meet the desired goals for change. The high numbers on waiting lists for services

across the country mean that anyone who does not meet these 'motivational' criteria can be considered unsuitable for treatment and moved to the back of the queue or, in the case of those who are considered disruptive, declined from accessing services in the future. These actions by services are further reinforced by the incentives within the health system.

One of the current key performance indicators (KPIs) that services are required to collect data on and report to their funders is wait list times (Ministry of Health, 2014a). The national target set is to ensure that 85% of all referrals are seen within 3 weeks of contact and 95% within 8 weeks. This goal offers a perverse incentive to services to focus on the throughput of clients entering the system rather than on engagement and effective management of a chronic condition. In this way, services are geared towards moving people off wait lists and through the system there is no incentive to work with more complex or hard to engage clients.

The unintended outcome of this shift in training environment and exposure to people experiencing withdrawal form substance use is an addiction treatment workforce that is predominately only exposed to and who work with people who appear motivated, compliant and are sufficiently sober to engage and think clearly. They have little appreciation of and lack an understanding about the consequences of severe addiction, including the reality of withdrawal from substances and the impact on brain function and the lack of capacity to think clearly and make rational decisions. In other words, they lack the necessary empathy with the family member who is faced with this serious situation and respond within their own frame of reference which is actually a much sanitised view of addiction. This was confirmed when I facilitated a training workshop for experienced addiction practitioners on the cognitive effects of addiction as part of the Dapaanz School of Addiction in 2013. Participants repeatedly voiced that they had no idea that clients' challenging behaviour they encountered was likely to be a result of brain dysfunction caused by the addiction itself. This in conjunction with a system that measures the throughput as a key indicator of success means there is little incentive for services to work with those who take longer to engage or are more complex and will require more intensive, longer term interventions. The international literature indicates this situation is similar in other jurisdictions where mental health and addiction health professionals are ill equipped to identify and treat people with alcohol related brain injury (Brighton, Traynor, Moxham, & Curtis, 2013). This results in people with severe effects of addiction are placed in inappropriate environments for care such as rest homes or remain

untreated as they do not cope with demands of traditional treatment services. This means families are left coping with supporting someone with this condition in isolation of professional support. Even when mechanisms such as the ADA Act exist to support this group of people, it is families that are left to use these tools as health professionals show little appreciation of the utility of the Act or realise the treatment options available do not address the needs of this group well.

Addressing confidentiality and balancing needs

Respecting the confidentiality of their client was a consistently reported reason for professionals' non-engagement with family members in this study. The Privacy Act 1993 was cited as the reason not to disclose any information pertaining to the treatment being received by a person to their family members. This was true for families in this study even in situations when people had absconded from a treatment centre while under compulsory treatment, whereby the treatment centre staff would not disclose this status to concerned family members. Solomon, Molinaro, Mannion and Cantwell confirmed this was a common issue amongst health staff, particularly administrative staff who were often fielding calls from concerned family members, and concluded that it stemmed from the confusion about confidentiality and the limits of confidentiality. They found that a brief half-day training programme based on case studies and examples of what was acceptable to say to balance needs of maintaining confidentiality of the patient and the family concerns was beneficial. Such training improved staff attitudes about talking with family members and their confidence in dealing with these situations. However, Solomon et al., (2012), noted that annual training was necessary to sustain these improvements.

It is important that practitioners understand the Privacy Act 1993 and its parameters as it applies to their work with clients, and to avoid using it as an excuse to not actively engage with third parties who are supporting their clients' wellness. From the family's perspective, this tendency of professionals to use the Privacy Act to avoid engaging with them, is a way of the practitioner giving precedence and priority to their own practitioner-client relationship at the expense of the family's relationship with the client. Practitioners elevating their own relationship with their clients while excluding family members with whom their client is living with, conveys an erroneous message that treatment is of no importance or consequence to the family.

Implications for Māori

One of the unrealised goals of this research was to identify what was happening for Māori whānau during this process of compulsory treatment for severe addiction. None of the people interviewed for this research identified as Māori and none of the current cohort of people in treatment under an ADA Act committal order identified as Māori. As outlined earlier in this research, Māori are, however, are at least three times more likely to experience a substance use disorder in their lifetime (Baxter, 2008). In addition, statistics also indicate Māori have a significantly higher incidence of apprehensions by Police while intoxicated than non-Māori (Stevenson, 2009). New Zealand population health reports do show that Māori have a shorter life expectancy and experience more ill-health related conditions that could be substance related compared to non-Māori (Ministry of Health, 2010b). This may explain in part why Māori who have serious addiction issues may be more likely to be seen in the criminal justice system or other parts of the health system rather than in addiction treatment via the ADA Act. However, I do not think it accounts for all who may need this level of intervention.

Given the experience of those that were interviewed and the substantive theory generated which included properties of, not communicating, frustration, confusion and lack of available support, it is somewhat unsurprising that Māori whānau, who often feel that health services do not meet their needs do not feature prominently in this picture (Wilson, 2004). Appropriately addressing the needs of Māori who experience the severe effects of addiction and their whānau needs to be a critical consideration for future planning of services.

Although this was not addressed in the course of this research, I facilitated the establishment of a Māori advisory group to advise the Ministry of Health on appropriate and culturally inclusive wording on the draft legislation. As such, several features of the revised legislation do seek to ensure that the compulsory treatment of Māori who are in need of this intervention, is more appropriate and culturally respectful than previously. This includes the option to have courts convened on a marae, and that provision of culturally appropriate services is considered and provided.

The recognition and role of the family and whānau is also indicated with regard to reporting to and being informed of care and treatment plans. The importance of this being written into the

legislation is that it removes the ability for those implementing the Act to have the 'option' to include, or not include, these features if it does not fit current practice. The proposed legislation requires that these features are present in managing this situation, and therefore, practice and guidelines must reflect these requirements. The Bill (Appendix 5) includes a key objective of invoking this Act will be "mana enhancing". This is the first time such a reference has been made in health legislation in New Zealand and hopefully is the first of many which seek to realise the importance of reflecting the aspirations of all New Zealanders.

Workforce Issues

The predominant philosophy and associated models of treatment as outlined in Chapter 1 have dictated the focus of training of the addiction treatment workforce. A model of care that is focused on diagnosing a condition and treating the individual with the condition has resulted in a workforce focused on and trained to work primarily with individuals. To demonstrate this, Table 9 below summarises the professions that make up the addiction workforce in New Zealand and where they work.

Table 9.
Specialist AOD Workforce 2011

1500 specialist staff
50% work in DHB services
52% Addiction Practitioners/Counsellors (60% in NGOs)
16% Nurses (90% in DHBs)
66% had Dapaanz membership
86% of those registered under HPCA work in DHBs

Source: (National Committee of Addiction Treatment, *www.ncat.org.nz, 2013)*

A recent stocktake of the mental health and addiction workforces reported a total specialist addiction workforce of 1,832 of which 30% were in clinical addiction, co-existing practitioner or counsellor roles, 17.2% were nurses, 16% were support workers, 4.9% social workers, 2.5%

psychologists and 4.7% in other medical professional roles (Te Pou, in print). These statistics show that the majority of the addiction treatment workforce are trained in counselling or nursing.

As discussed in Chapter 2, there is a declared divide between the medical paradigm predominant in mental health service provision and the psychosocial paradigm, typically associated with the addiction treatment system. The genesis of counselling as a specific form of practice and the various subsequent schools of practice that have been generated have their origins in psychiatry. Although psychology and counselling practises have evolved in response to the perceived shortcomings of the medical paradigm to address the psycho-social aspects of a condition, there are significant features of the delivery of these modes of health care that maintain a close alignment to medical practice.

A closer examination of the usual method of delivery of addiction treatment positions it more closely to the medical model of treatment than is commonly realised. Addiction treatment is predominately based on individualised assessment and care, and involves appointments initiated by the individual which are scheduled with a key person and held in an office/clinic environment. Typically the rooms that appointments are conducted in are not large enough to host more than 2-3 people. Although improvements are being made to assessment procedures, many are still done on the basis of self-reported information alone without any consultation or verification of information from other sources. While addiction practitioners and counsellors are trained to undertake different tasks from a different philosophical basis to medicine, arguably the experience of the service received from the perspective of the service user is not dissimilar from visiting a general practitioner. The individualised approach to assessment and treatment with the professional (clinician) and client results in an expert-help seeker relationship developing that typically excludes other players in the help seeker's life. Even when others are included, it is generally done in order to support the treatment plan. The implication is that supporting the treatment plan to keep the individual concerned in sobriety will improve family relationships in itself. Although information pertaining to the client reported stress in his or her familial relationships is collected by the practitioner at the time of the assessment, little appears to occur to address this information.

The lack of attention to identifying and addressing relationship and communication issues within the family context seems to fall short of the intended goal of improving psycho-social health overall. A possible assumption that discussing communication strategies in a group setting, a typical therapeutic mode of delivery, as a proxy for one's family, continues to rely on the perception of only one person in the actual relationship. Because of the predominant training of group therapy facilitators is in counselling, the actual therapy conducted is individual focused therapy in a group setting. It is difficult to see how treatment to address relationship issues can be effective if only one party of the relationship is included in the treatment. Addiction counsellors and practitioners, as reported to myself, typically do not have training, confidence or competence in family therapy, working with couples or addressing family conflict so this aspect of a person's well-being is not addressed well, if at all in treatment. This seems to be a gap in training which impacts the ability of the clinician to meet desired outcomes of treatment which adds unnecessary stress to an already fragile system of family functioning.

There have been some models of practice that have recently been developed to address this issue and encourage services to be more family inclusive. The next section will review some of the evidence base that currently exists for these models and indicate where they may be applicable to the New Zealand addiction treatment context.

Effective Models of Family Inclusive Practice

The Community Reinforcement and Family Training model of treatment (CRAFT) was developed to enhance the role of families through psychoeducation and family therapy as part of a coordinated model of community based treatment (Doherty, 1985). The CRAFT model was designed to engage treatment resistant individuals by working with family members. In this model, the treatment service is open to working exclusively with family members irrespective of whether the person with the addiction is a client of the service. The focus of attention continues to be the addiction itself and working individually with the family member, at least, initially. The experience of family members who received this intervention was one of feeling included in the process and validation of their stressful experiences of addiction. This is in contrast to the family members in this study who were not given opportunities to engage in helping themselves or openly discuss

their experiences with treatment staff. It is of note that the Salvation Army Bridge programmes, one of the two providers of treatment for people under compulsory addiction treatment adopted this as the primary model of treatment over 10 years ago. However, to date only the CRA (community reinforcement) components of this model had actually been put into practice and the family training components were still on the agenda to be introduced for the future (personal communication, Major Mike Douglas, 13 September 2014). Major Douglas explained this was largely a result of the training backgrounds of their staff being addiction practitioners in general who do not have the skills or confidence to work with the often contentious family dynamics that occur when families are included. This is not unique to the Salvation Army, and Figure 5 shows the activities of the addiction workforce during 2011-2012 (www.health.govt.nz/PRIMHDdata,). The number of family and whānau contacts are just marginally higher than General Practitioner engagement with methadone clients, a new initiative.

Frampton, Wahl and Cappiello (2010, p. 53) describe patient and family involvement as "a complex multifaceted and dynamic concept which evolves in the context of a true partnership". They argue true patient centred care extends the role of family members beyond the "bounds of visitation and support". Their study involved the introduction of a family initiated rapid response team (FIRRT) whereby family members could initiate a rapid response from health professionals when they were concerned about the deterioration in the mental or physical health of their loved one. This response would be coded by the professional team, which would indicate the level of care required. This was in recognition that it was the family who knew the patient best and would be more likely to notice deteriorating health before health professionals and could activate care earlier, hopefully avoiding more intensive and costly services.
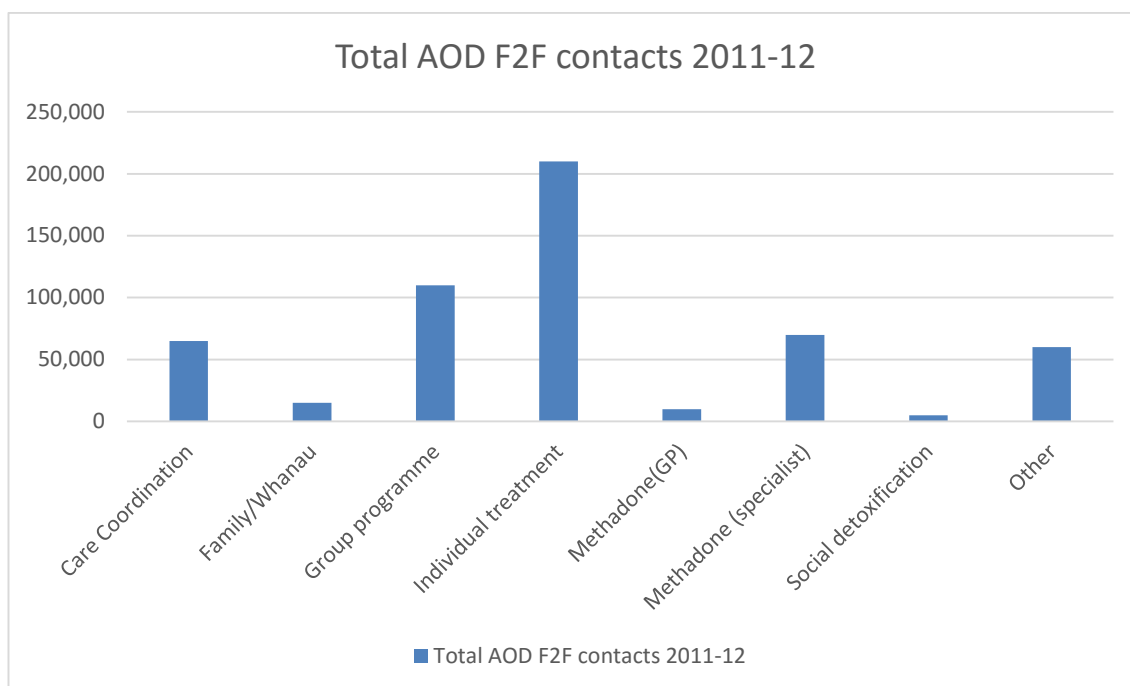
Figure 3. Alcohol and other drugs face to face contacts for 2011-2012

Source: Ministry of Health (2012) – PRIMHD data

The key barriers found when implementing such a programme was the nursing staff fearing an increased burden and workload, and a lack of consistency in communicating with patients. Subsequently they introduced specific staff training and support and developed standardised guidelines with supporting documents to facilitate a consistent approach. The results demonstrated patients returned home from hospital visits sooner and family members reported feeling more confident as they had training on how to effectively support and care for their family member at home. They also had an expectation that they would have the support and back up of professional's when needed.

In a similar but extended programme, Dausch et al. (2012) developed a framework for a family friendly agency in which either the level of clinical instability of the consumer OR the distress of the family can initiate and direct the level of service required. The services available included couples' counselling for relationship distress, even when the mental health of the consumer is not the primary motivator for treatment. In this way, the family stays engaged with the service for appropriate levels of support when required and the frequency of admissions for mental health concerns from the consumer was significantly reduced.

Couples therapy, based on addiction and intimate relationships being reciprocally related that can negatively or positively impacts the other, has been shown to be more cost effective than individual counselling (Klostermann, Kelley, & Mignone, 2011). This notion of a reciprocal relationship between the addiction and the quality of family relationships is supported by evidence that relatives of those with addiction issues show higher levels of both physical and psychological symptoms, and they make more use of health services compared with non-relatives. These symptoms decrease significantly when the addiction issue improves (Copello, Templeton, Krishnan, Orford, & Velleman, 2000). Copello et al. (2000) developed a 5-step intervention based on stress coping models for use in primary care settings for family members of those affected by problematic substance use. The attitudes of professionals and their motivation for working with family members improved after training and taking part in this programme.

More recently, the Bouviere Centre in Victoria, Australia has developed the single session Therapy approach which seeks to utilise the first contact from anyone seeking help (individual or family members) to engage and provide support and information (Young et al., 2012). The aim is to provide responsive services that give people what they seek at the time they seek it. This is in contrast to the service centric way of offering 'what we do to only the people we do it to'. This model also accepts that many people will only engage once with a particular service, and therefore, seeks to make the most of that opportunity. The review of the Victorian state-wide implementation of this model in social services showed that clients of the services reported satisfaction with getting focused assistance when they needed it. The use of this model for family sessions was shown to provide a basic structure to a session, encouraged active collaboration in the planning of treatment and allows for prioritising family members concerns. Young et al., (2012) reported the single session model provided a family inclusive way of working and increased the confidence of those practitioners to work with families without becoming a family therapist.

To achieve the desired cultural change to create a treatment system that is inclusive of family and whānau, it is likely to be more effective to build on existing structures and areas of work in which workers are confident and work to gradually shift the culture, rather than oppose the existing culture (Carroll & Quijada, 2004). It was clear in this research that addiction workers' failure to respond to family members appropriately was not due to a lack of goodwill, but rather a lack of training and confidence about working with family members and a lack of knowledge about the

committal process itself. One of the key functions of training is to effect practice change. Some consideration has been given in the workforce development literature over the past several years to examining the effective transfer of training into practice. Holton, Bates, and Ruona (2000) suggest that training transfer involves "the application, generalizability and maintenance of new knowledge and skills" (p. 334). Therefore, in order to ensure that training assists in the desired cultural shift and change in practice, consideration needs to be given to the ability of the trainees to apply their new knowledge within their respective work environments and what is required to support them to do this. To this end, training in and of itself is insufficient to affect the level of change required. Development and implementation of service guides, practical resources, and the provision of supervision and mentoring will contribute to the sustainability of the practice changes.

Whānau ora

Whānau ora, meaning 'wellbeing of the extended family" (Boulton & Gifford, 2014, p. 1), is a well-established approach in health care and social services in New Zealand. Whānau ora is a philosophy, a practice model and an outcome which focuses on the improvement of wellbeing of the family whānau, underpinned by Māori cultural values from the perspective of the family whānau rather than any one individual. It recognises the collective worldview of Māori whereby the whānau (the family including extended family members) is at the centre of the social structure. From this perspective, a person's wellness is related to the wellness of their whānau across several domains including physical health, emotional health, spiritual, social, educational and employment status. As such, whānau ora as a way of working crosses the governmental department divides of health, social development and justice.

Boulton and Gifford (2014) interviewed Māori whānau to determine the general understanding of what whānau ora meant to them. They found that achieving whānau ora for these families meant having balance across physical, mental and spiritual wellbeing. A sense of community, living by shared values and a sense of duty to care for members of the whānau were critical to achieving whānau ora. For some in this study, whānau ora was a future state and an aspirational goal. For these whānau, working towards wellness with the goal of ensuring a positive future for their children and grandchildren was the key driver. A focus on developing potential, taking

opportunities and looking forward was also considered achieving whānau ora but as a part of a longer journey beyond themselves rather than a destination in itself. The reality for many whānau who have experienced intergenerational poverty, unemployment, violence, addiction and being disenfranchised from their culture is that it will take time, support and resources to achieve wellness in all these domains.

In addition, Boulton and Gifford (2014) analysed the correlation of whānau understanding of whānau ora against the policy goals of whānau ora as articulated by the Taskforce on Whānau-centred Initiatives. The results of their analysis showed that whānau ora is multi-dimensional and there are many understandings of what whānau ora is. It was clear that even for families who had limited knowledge of te ao Māori (Māori worldview), access to services that reflected alignment to Māori tikanga (cultural practices) and used te reo (Māori language) was very important. Providing services that focus on an individual and only one part of the individual (such as their physical health or social wellbeing or education) in a "one size fits all" approach is not appropriate or relevant to Māori and indeed are not likely to achieve any long term change for Māori whānau. While it may be useful to have aspirational policy goals such as "whānau self-management", it needs to be considered in the context of many whānau who may not be currently in a position to achieve this and are likely to take considerable time and resources to get there. This is important because the success of the whānau ora policy will determine its ongoing funding support, and this success is reliant on an understanding that positive change for some families will be resource intensive and take considerably longer to achieve than our current systems tend to allow (Kidd, Gibbons, Lawrenson, & Johnstone, 2010).

As Māori make up over 30% of the consumers of addiction services (Te Pou, in print), whānau ora as a policy and practice needs to be duly considered in service design and appropriate engagement of Māori. In the population of those experiencing severe addiction that is under consideration in this research, this is even more so as appropriate interventions provided earlier in the life course of a condition is going to be more effective at establishing long-term management strategies and supports. This was emphasised in a study undertaken which sought to discover how Māori whānau experienced the health care system when one of their tāne (men) had a diagnosis of cancer or other chronic diseases (Kidd, Gibbons, Kara, Blundell, & Berryman, 2013). The men and their whānau reported their success in working towards whānau ora was linked to

the "dignity of being proudly Māori, the quality of interpersonal relationships with health providers and the acceptance of unique whānau needs" irrespective of whether the service was Māori specific or mainstream (Kidd et al., 2013, p. 136).

Service providers who understood and valued the importance of being Māori were likely to be seen by the men and their families as caring and the families felt hopeful, valued and engaged in the treatment process. An important feature for Māori wellness that was highlighted in the study by Kidd et al.,(2013) is whakamā. They defined whakamā as "an illness that effects ones' physical, mental and spiritual dimensions and is characterised by unresponsiveness and withdrawal" (p. 136). Less severe whakamā is often experienced as shame and embarrassment. For the families in their study, they experienced whakamā particularly when there was a lack of information about what was happening and when health care professionals were rude or impersonal. The men experienced whakamā also when thinking about their previous actions or behaviours that had contributed to their current condition. They explain that a consequence of whakamā is withdrawal of social interaction due to loss of mana (pride). The participants in their study responded to whakamā in a range of actions from not wanting to appear to be 'a nuisance' to the health care provider, anger at the 'cold' environment of non-Māori health services to completely disengaging from the service. This may help to explain why there were no Māori evident in the population being investigated in my research. It is likely that Māori with severe addiction will also be experiencing a high level of whakamā because of the severity of their addiction, the resulting behaviours associated with this condition and the disruption it has caused in the lives of their whānau. Whakamā, is compounded with the lack of information and engagement they and their whānau would receive from health services, as reported by other families interviewed for this research. A likely outcome of this is the complete disengagement and lack of trust in health services.

All providers in the health and social service systems, both Māori-specific and non-Māori need to be responsive to Māori. For addiction services specifically, the challenge is to address the aspects of their service delivery that contributes to Maori experiencing whakamā, as well as ensuring that attention is given to identifying and healing whakamā in their Māori clients and their whānau. As described above, addressing this starts with the service and staff valuing the te ao Māori worldview including the involvement of whānau members in the treatment as appropriate and

being genuine and respectful in their interactions with Māori whānau. As such, attention to working from a whānau ora perspective and how this works in practice is a priority for upskilling the addictions workforce and improving services for Māori.

Families living with other chronic conditions

This literature review also examined if there were learnings from families that were living with other chronic conditions that could be applied to support families living with addiction. A recent thesis which outlined a study of families managing chronic illness of a family member identified 'struggling' as a core feature across multiple domains both interpersonally and between relationships in the family (Perkins, 2012). Although the families in my research also experienced struggles and stresses as a result of the impact of the addiction of their family member, their level of resilience and ability to find coping strategies to live with this situation was more evident. I would argue that focussing attention on enhancing that inherent resilience would be more effective to improving a sense of wellbeing than an increased level of awareness of the struggling aspects of their situation as Perkins suggests.

Another grounded theory study examined how parents were managing living with children who had hard to treat ADHD (attention hyperactivity disorder) and found the core category was also 'struggling' (Brinchman & Sollie, 2014). Similar to my research they also found that while parents sought help the actual engagement with helping services was as problematic as the relationships they had with their teenage children. The parents often found themselves in the position of having to argue and advocate for services for their children, and as a result the strategies of the parents included nagging, arguing, fighting and writing letters. Also similar to my study, these parents sometimes found an ally, someone in the system they could trust and who would communicate with them in a respectful way. The key features of the interactions with these trusted professionals which the parents valued were flexibility, discretion and continuity. These parents were seeking support which was compassionate and flexible and professionals who offered practical assistance as well as listening to them.

The implications for addiction services and practitioners are to appreciate that the nagging, arguing and more aggressive behaviours from family members that may have previously resulted

in a lack of desire to engage with them are likely to be a manifestation of the lack of support they have been receiving. Being prepared to listen with compassion may be the first opportunity that family members have been given to tell their story and be heard. Having rigid rules and criteria for service access creates unnecessary barriers that family members find frustrating and limits their opportunities to seek help. A good example of this is addiction services that require the individual with the addiction to self-refer and will not accept third party referrals from family members. For families and individuals who are experiencing the effects of severe addiction this is less likely to occur and contact with family should instead be seen as a way to encourage those who are hard to reach or who have disengaged to re-establish treatment relationships.

Having flexible services which are responsive to the individual, their family within the context of their culture and situation is critical for improving the effectiveness of services. As discussed earlier in Chapter 1, early engagement in treatment increases the duration of time spent engaged in treatment which in turn increases the effectiveness of treatment overall. Any opportunity to engage must be seen by health practitioners as perhaps the *only* opportunity, and therefore, treated with the importance that this would warrant by giving information, advice and support

A psychosocial, structured programme; Mastering Each New Direction (MEND) has been developed as a way to assist families manage the stress of coping with a child who has a chronic illness (Distelberg, Williams-Reade, Tapanes, Montgomery, & Pandit, 2014). It is based on a family systems approach and involves individual and family therapy as well as peer family group sessions. In addition, a focus on supporting the development of the child's peer group is important as children with long-term conditions frequently miss school and typically have less opportunity to develop healthy peer relationships. One of the goals in both peer family groups and peer child groups is to develop a shared language that describes common themes and experiences. The process over a period of several weeks looks to engage families and the child in the treatment process, provide a platform for them to openly discuss their stresses and experiences, identify unhelpful coping strategies and work on supporting each other as a family to develop new coping skills. The programme was found to be effective in reducing the negative impacts of the illness on the family system and the child across several dimensions including attendance at school, confidence and peer relationships. In fact, the Health Related Quality of Life (HRQoL) scores of

the children in this pilot programme cohort were improved after completing the programme to the level of those normal functioning families.

The implications of this programme for addiction treatment services are to consider making room for facilitated family group sessions that educate family members about the process of treatment, develop a shared language and exposure to healthy ways of coping. To some extent, this is occurring in several services. However, this research suggests this offering tends to be highly reliant on the individual practitioner who has a special interest in working with families and as such is an unsustainable and ad hoc approach to having a family inclusive programme. I would argue that having family groups and offerings for family members in their own right, and that therapy and counselling should be a core component of all addiction treatment services irrespective of whether the family member with the addiction is an active client of that service or not.

Arestedt, Perrson & Benzein (2014) undertook a recent study which sought to understand the meaning of living as a family coping with chronic illness. In this study a number of family members were interviewed about how they experienced living as a family with chronic illness. The results indicated that families who are living with chronic illness are challenged by changing family functioning, roles and communication. The families developed new, slower rhythms in life which, like the families in my study, included limiting or reducing activities. There was also more attention to being in the present rather than too focussed on an unknown future. The role changes typically involved adult children taking care of chronically ill parents and in a number of cases involved them living with the chronically ill family member so having frequent daily contact with each other. Arestedt et al., (2014) described the families in their study as moving towards wellbeing and co-creating a new way of living with a chronic illness with each other. They suggest that health workers who adopt a family inclusive approach to working with people with chronic illnesses can leverage this process by supporting the family in developing their new ways of living as well as highlight the resources that exist within the family.

The relevance of the Arestedt et al.'s (2014) study for families living with chronic addiction such as in my study is that practitioners are made aware that families are engaging in this process of co-creating a new way of living with the condition whether or not the health system is involved.

The benefit of health workers being open to being involved in this process as part of this new network for both the individual and their family is that everyone develops an appreciation of the strengths and limitations of the new way of living. Acknowledgment of the work of the family in doing this by health practitioners is likely to reposition the family as the primary care support network for the individual, with health practitioners supporting them to achieve this new way of functioning. This is in contrast to the current way of working which was highlighted in my research whereby the addiction practitioner takes the lead support role and the holder of expert information while the family is relegated to a lesser role in the background.

Family Involvement in Self-Management of Chronic Conditions

A small but growing body of literature has focused attention on the role and efficacy of family member's support of those living with chronic illnesses. One such study found that family attempts at support were more common for those with low health literacy and although some of these attempts were perceived negatively by patients as nagging or criticising, most patients were glad family members were interested in their care. They also found that women tended to react to family involvement in their care with more frustration, guilt and confusion (Rosland, Heisler, Choi, Silveira, & Piette, 2010). This has important implications for health professionals when asking *if* the patient wants family involved in their care programmes. The answer to this question is often 'no', which may be more a reflection of these feelings of guilt and frustration at the situation rather than a statement that is interrelated by the professional as meaning there is no one available or interested. Instead, I would recommend that a standard question of "*who* would you like to be involved" be asked of clients and patients. This has the effect of assuming that others will be involved in this care programme, not just the health professional, while still giving the patient the control over who is nominated as the key support person. It is also important that the health professional recognise that family involvement may not always be seen positively by patients and clients and this should be acknowledged and managed accordingly.

A study that examined family and friends support for self-care interventions for those experiencing depression found that general emotional support such as listening and involvement in self-care activities such as encouraging exercise or being invited out for dinner as well as direct support for therapeutic tools were seen as helpful by the person who had depression (Sussman et al., 2014).

Practitioners may find it useful to discover activities that the family enjoys doing together or can be encouraged to do to support overall wellness may help the client adhere to the treatment regimes. Walker et al. (2014) found for those with epilepsy in their study, family support was important for general wellbeing but did not necessarily impact on seizure control. The importance of taking a holistic approach to wellbeing and utilising family support in helping people maintain a level of wellness within the context of their chronic condition cannot be overlooked. Treatment that only focuses on symptom management and elimination of relapses for addiction fails to treat the whole person and in doing so may miss significant aspects of life which are meaningful for an overall sense of wellness irrespective of the presence or otherwise of the chronic condition.

Limitations of the Theory

As with any research, the reader is cautioned with regard to the limitations of this study. As noted earlier a key limitation is the lack of Māori involvement. Whānau is a central tenet in te ao Māori (Māori world view). The findings of this study demonstrate a low level of active involvement of whānau in addiction treatment and further investigation as to the reasons for this occurring is recommended.

The addiction treatment centres that cater for this relatively small group of people who are in treatment under a committal order, also provide the same programmes to people who are not under a committal. As the treatment itself and the workforces involved are not exclusive to this group of people, some generalisations of the findings are able to be drawn. However, this should be done with caution as it is acknowledged that the people who are experiencing sufficiently severe symptoms to warrant a committal order, are more likely to present with increased complexity and potential challenges due to cognitive impairment that impact on their treatment experience.

Further, this research examined the experiences of those who have successfully navigated the system through which their affected family member has been committed for treatment via the ADA Act. There will be many other families who, perhaps as a result of the response from addiction professionals, who did not know about how this Act works, have not pursued this process and their concerns and experiences are not captured here. Understanding the concerns

of those who are supporting people not eligible or unable to access this type of 'last resort' option could be useful with regard to understanding the support they require and where they access support.

This research has indicated a need for additional research that can add further insight into the role of family as supporters and co-creators of effective treatment in those with long term health care needs and how this benefits patients. It also highlights the need for urgent development of diagnostic tools which support the identification of substance related brain injury and effective treatment programmes. Further research into effective models of care for chronic illness in a health system designed to treat acute conditions may assist in the development of tailored systems to work in conjunction with existing models more effectively. The other area for future consideration would be to investigate where Māori who have severe addiction are. As they are not being seen in addiction treatment services under a committal order, there is an assumption that they may be in other parts of the health system due to health complications resulting from their drinking or in the justice system due to offending behaviour while intoxicated or indeed being looked after by whānau without significant input from professionals at all. Having this information would be helpful in order to design culturally appropriate supports and ensure that equitable access to those supports was in place.

Conclusion

This grounded action research firstly used a Glaserian grounded theory to describe the process by which family members of those with severe addictions manage their situation as *living with it*. Living with it has three main categories; fracturing relationships, working it out myself and holding my breath. The properties of each of these categories were analysed further to develop an action plan which aims to resolve the main concerns that this theory highlighted. The grounded action plan was focused on three key areas that emerged from the analysis of the properties; Recognition, Responsiveness and Resilience. As most of the areas of concern stemmed from the family member's poor engagement with treatment services this is reflected in the action plan activities which are primarily aimed at improving the level of service that families receive in the future.

This research is located in the junction of the civil legal system and the addiction treatment system. As such, the recommendations for improving the experiences for family and whānau who are living with the impact of severe addiction are two-fold. In the first instance, recognising the critical role of family and whānau have as primary support people to those requiring the highest level of intervention. At present, in the current Alcoholism and Drug Addiction Act 1966, there is no mention of family and no requirements to include family in either the court or treatment process that follows. Despite family members being required to initiate and start the assessment for compulsory treatment, once this process is underway, professionals effectively take over. In many situations they actively exclude family from engaging in, or being informed about, the progress or status changes of their family member. This research has highlighted the high levels of chronic stress that this situation creates for family members and that the lack of recognition in addiction services, and in particular, for those seeking support for hard to engage people is contributing to this high level of stress. This leaves family members who are *living with it* to develop coping strategies for their own lives and as bystanders in the involvement in treatment of their family member.

Translating the desired culture change to observable behaviours and events is one of the critical success factors for organisational culture change (C. Dawson, 2010). There are three main ways which have been recommended some of which have been implemented as part of this research to achieve a positive cultural change across the addiction treatment sector to respond more effectively to families and whānau. Firstly, recognising that family and whānau have a legitimate role within the compulsory addiction treatment legislation and within the addiction treatment process itself. Secondly, with regard to the need for the treatment workforce to improve their responsiveness to family members when they make contact for support and information. And thirdly, by supporting the resilience in family and whānau through offering treatment support and information to address their own concerns related to their experience of living with the impact of severe addiction. An evaluation of these activities is recommended once the revised Compulsory Treatment Act is enacted so that effectiveness of these interventions can be determined.

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Appendices

Appendix 1: APA Permission to use DSM 5 criteria (E-mail)

From: Cecilia Stoute [mailto:CStoute@psych.org]
Sent: Thursday, 5 February 2015 8:59 a.m.
To: Vanessa Caldwell
Subject: RE: Request to Obtain Permission from APA/APP. Permission Request Reference ID: PL645

Dear Ms. Caldwell,

Permission is granted for use of the material as outlined in the request below for use in your dissertation only. Permission is granted under the following conditions:

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Appendix 2: The Twelve Steps of Alcoholics Anonymous

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

Sourced from http://www.aa.org.au/members/twelve-steps.php

Appendix 3: AUTEC Ethics approval letter

AUT
UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

M E M O R A N D U M
Auckland University of Technology Ethics Committee (AUTEC)

To:	Denise Wilson
From:	Rosemary Godbold, Executive Secretary, AUTEC
Date:	25 September 2012
Subject:	Ethics Application Number **12/225 The involvement of family and whanau members in the civil commitment process for compulsory addiction treatment.**

Dear Denise

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC) at their meeting on 27 August 2012 and I have approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement by AUTEC at its meeting on 8 October 2012.

Your ethics application is approved for a period of three years until 25 September 2015.

I advise that as part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/research/research-ethics/ethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 25 September 2015;

- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/research/research-ethics/ethics. This report is to be submitted either when the approval expires on 25 September 2015 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact me by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 6902. Alternatively you may contact your AUTEC Faculty Representative (a list with contact details may be found in the Ethics Knowledge Base at http://www.aut.ac.nz/research/research-ethics/ethics).

On behalf of AUTEC and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Dr Rosemary Godbold
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Vanessa Caldwell vanessa.caldwell@matuaraki.org.nz

Participant Information Sheet

AUT
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TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

Date Information Sheet Produced:

25 September 2012

Project Title

Involvement of family and whānau in committing a family member to compulsory addiction treatment.

An Invitation

Kia ora, my name is Vanessa Caldwell and I am completing a Doctor of Health Science degree at AUT university in the Faculty of Environmental Health Science in the Taupua Waiora Centre for Māori Health Research.

I invite you to take part in a study which seeks to explain what is happening for family and whānau of people who are experiencing the severe effects of substance addiction during the process of civil commitment for compulsory addiction treatment.

Participation in this study is voluntary and you may withdraw at any time prior to the completion of data collection on 31 January 2013.

What is the purpose of this research?

The aim of this research is to develop a greater understanding of what is happening for family and whānau involved in the use of the civil commitment process for a member of their family to get compulsory addiction treatment. The Alcoholism and Drug Addiction Act (1966) is currently under review and it is hoped that understanding what happens for family and whānau trying to utilise this last resort mechanism for assistance will help inform the new legislation from this perspective.

How was I identified and why am I being invited to participate in this research?

People who are family or whānau members or significant others of those who have experienced severe effects of addiction and who have used or tried to use the Alcoholism and Drug Addiction Act (1966) to obtain treatment for their family member have been invited to participate in this research.

You may have been invited to take part by your family member who is under a committal following a presentation they attended about this research. Your participation or otherwise in this research will not affect their treatment programme in any way and is completely independent of the treatment facility. Your family member has been made aware the focus of this research is on YOUR experience as a family member during the process of obtaining a committal not on detailing their behaviour.

What will happen in this research?

If you agree to participate in this research it will involve detailing some of your experiences leading up to and during the process of the committal procedure in an interview with the researcher. This will take approximately 1 hour.

Once the data from all interviews is analysed by the researcher, a thesis will be written and submitted to AUT in application for completion of the Doctor of Health Science degree. This information may also be used to inform the development of resources to support family and whānau in similar circumstances in the future.

What are the benefits?

Your participation in this research will assist in providing a greater understanding about what is happening for family and whānau during this civil commitment process. Information will potentially assist in informing the development of appropriate support resources for other family and whānau facing a similar situation in the future. It will also contribute to the researcher in completing the Doctor of Health Science qualification.

Declaration of researcher interests

The primary researcher, Vanessa Caldwell, is also involved in a working party that is reviewing the Alcoholism and Drug Addiction Act (1966) as part of her work role with Matua Ra<u>ki</u>, the addictions workforce development centre. This involves supporting the Ministry of Health to draft a revised legislation and ensure that the addiction treatment sector is well prepared for the implementation of this revised Act. It is hoped that information collected in this research will assist in the development of appropriate support resources for other family members facing similar situations in the future.

Potential discomfort & risks

Should you feel distressed or discomfort following the interview and discussing your experiences, you may wish to talk with a counsellor. This service will be made available to you free of charge.

If you need to access counselling services you will need to:
- Contact AUT counselling centres at WB219 or AS104 or phone **09 921 9992 City Campus** or **09 921 9998 North Shore campus** to make an appointment.
- Let the receptionist know that you are a research participant and provide your contact details so they can confirm this.
- AUT has a Counsellor for Maori within the AUT Counselling Team and you may consider this an option.
- More information about the counsellors and the option of online counselling on the following website:

    http://www.aut.ac.nz/students/student_services/health_counselling_and_ wellbeing

Limits of confidentiality

Illegal Activities: Please be aware that if you talk about any involvement in any illegal activity while you are engaged in the research, I may be obligated to disclose this information if requested to do so by the police. You are advised to think carefully about talking about any involvement you may have had in illegal activities.

How will my privacy be protected?

The confidentially of the information you provide to the researcher will be maintained. Interviews will be recorded and transcribed by a third party who will sign a confidentially

agreement. No individual identifiers will be used in the collection of data so no individual can be identified.

The focus in this study is on identifying group patterns of behaviour of people experiencing a similar situation so notes taken will not be relating to your own individual experience but common concepts identified as those shared with others.

All records (consent forms and research notes) will be held in securely locked cabinets or password protected electronic files by the researcher for a period of 6 years as per AUTEC protocols.

What are the costs of participating in this research?

Participation in this research will involve approximately 1 hour of you time for an initial interview with the researcher and to be available for brief follow up interviews if necessary. The interviews for this research will occur over the period between September and December 2012 and will occur at a convenient location for you as agreed with the researcher.

What opportunity do I have to consider this invitation?

The invitation to participate in this research is open until December 2012 or until such time as sufficient participants have agreed to take part.

How do I agree to participate in this research?

If you wish to participate in this research please read and sign the consent form which can be obtained from the researcher, Vanessa Caldwell. This consent form can be e-mailed or posted out to you.

Will I receive feedback on the results of this research?

A summary of the research findings will be made available to you on completion of this research. When you agree to participate in the research you will be asked if you wish to receive a copy of this summary and how you would like to receive it (e-mail or post).

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, *Associate Professor Denise Wilson,* dlwilson@aut.ac.nz, 90 921 9999 ext 7392

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Dr Rosemary Godbold, *rosemary.godbold@aut.ac.nz* , 921 9999 ext 6902.

Whom do I contact for further information about this research?

Researcher Contact Details:

Please contact me for further information or if you have any further questions.

Vanessa Caldwell, Vanessa.Caldwell@matuaraki.org.nz, 04 381 6477

Project Supervisor Contact Details:

Associate Professor Denise Wilson, dlwilson@aut.ac.nz, 90 921 9999 ext 7392

Consent Form

Project title: **Involvement of family and whānau in the civil commitment process of compulsory addiction treatment**

Project Supervisor: **Associate Professor Denise Wilson**

Researcher: **Vanessa Caldwell**

○ I have read and understood the information provided about this research project in the Information Sheet dated 25 September 2012.

○ I have had an opportunity to ask questions and to have them answered.

○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.

○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.

○ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.

○ I agree to take part in this research.

○ I wish to receive a copy of the report from the research (please tick one): Yes○ No○

Participant's signature :..……………………………

Participant's name :..…………………….………….

Participant's Contact Details (if appropriate):

………………………………………………………………………………………………..

………………………………………………………………………………………………..

………………………………………………………………………………………………..

………………………………………………………………………………………………..

Date:

Approved by the Auckland University of Technology Ethics Committee on 25 September 2012, AUTEC Reference number 12/225

Note: The Participant should retain a copy of this form.

Appendix 4c: Approved Confidentiality Agreement

Confidentiality Agreement

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Project title: *Involvement of family and whānau in the civil commitment process for compulsory addiction treatment*

Project Supervisor: **Associate Professor Denise Wilson**

Researcher: **Vanessa Caldwell**

○   I understand that all the material I will be asked to transcribe is confidential.
○   I understand that the contents of the tapes or recordings can only be discussed with the researchers.
○   I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature:
....…………………………………………………

Transcriber's name:
....…………………………………………………

Transcriber's Contact Details (if appropriate):
………………………………………………………………………………………..
………………………………………………………………………………………..
………………………………………………………………………………………..
………………………………………………………………………………………..
Date:

Project Supervisor's Contact Details:

Associate Professor Denise Wilson
dlwilson@aut.ac.nz, 90 921 9999 ext 7392

Approved by the Auckland University of Technology Ethics Committee on 25 September 2012 AUTEC Reference number 12/225
Note: The Transcriber should retain a copy of this form.

Appendix 4d: Approved Advertisement

AUT
UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU   **INVITATION TO PARTICIPATE IN RESEARCH**

Involvement of family and whānau in compulsory addiction treatment.

The Alcoholism & Drug Addiction Act (1966) which provides for compulsory addiction treatment to those experiencing severe effects of addiction is under review.

If you are a family or whānau member who has utilised or tried to use this existing legislation to assist your family member to get treatment, you are invited to participate in a doctoral project which aims to develop an understanding of what happens for family and whānau in this situation.   It is anticipated that information provided will assist in developing appropriate support resources for families facing similar situations in the future.

For more information please contact the researcher, Vanessa Caldwell 027 703 8855 or via e-mail Vanessa.caldwell@matuaraki.org.nz.

This research has been approved by the Auckland University of Technology Ethics Committee on 25 September 2012 AUTEC Reference number 12/225

Appendix 5: Substance Addiction (Compulsory Assessment & Treatment) Bill clauses relating to family and support people (as tabled in NZ Parliament 08 December 2015.

Part 1 clause 4   Definitions

principal caregiver in relation to any patient,means the friend of the patient or the member of the patient's family group or whanau who is most evidently and directly concerned with the oversight of the patient's care and welfare

principal support person, in relation to any patient, means any of the following:
> (a) the patient's principal caregiver:
> (b) the patient's nominated person:
> (c) the patient's welfare guardian:

relative, in relation to any person, includes—
> (a) a person who is married to, or in a civil union or a de facto relationship with, that person; or
> (b) a person who is married to, or in a civil union or a de facto relationship with, a person who is connected by blood relationship to that person

Part 2 clause 16 (2d) Arrangements for specialist assessments

(d) ensuring that the purpose of the assessment and the requirements of the notice given under **paragraph (c)** are explained to the patient in the presence of a member of the patient's family, or a caregiver of the patient or anyone else concerned with the welfare of the patient:

Part 2 clause 23 If certificate not signed, advice must be given

(2) The approved specialist must, if he or she considers it appropriate, give advice on alternative options available for treating the person—
> (a) to the person; and
> (b) to the principal caregiver, if any, of the person.

Part 2 clause 27 Information to be given to others

(1) As soon as practicable after an approved specialist certifies that a patient meets the criteria for compulsory treatment, the Director of Area Addiction Services must give a copy of that certificate and a written statement of the patient's legal rights and other entitlements under this Act to each of the following:
> (a) the applicant who applied under **section 11**:
> (b) every principal support person of the patient:
> (c) the medical practitioner who usually attends the patient:
> (d) the district inspector.

Part 2 clause 28 Detention and treatment in treatment centre

(2) In giving the direction, the responsible clinician must take into account each of the following:
> (a) the wishes and preferences of the patient; and

(b) the views of the patient's principal support persons.

(3) Before or on admission to a treatment centre, the Director of Area Addiction Services must ensure that—
>   (a) a notice is given to the patient that specifies the treatment centre and requires the patient to attend at the place and time specified in the notice for the purpose of the patient's admission to the treatment centre:
>   (b) all reasonable steps are taken to notify every principal support person of the patient of the name, location, and contact details of the treatment centre in which the patient is detained:

Part 2 clause 33 Principles governing exercise of power over all patients

Every person and every court that exercises, or proposes to exercise, a power conferred by or under this Act in respect of a patient must be guided by the following principles:
>   (a) where compulsion is necessary, the level of coercion used on patients should always be the least restrictive possible to enable effective treatment; and
>   (b) the views of the patient and a principal support person should be ascertained and taken into account before the power is exercised, unless it is not reasonably practicable or in the best interests of the patient to do so; and
>   (c) interferences with the rights of patients should be kept to a minimum; and
>   (d) the interests of patients should remain at the centre of any decision-making; and
>   (e) the power should be exercised with—
>>   (i) proper recognition of the importance and significance to the patient of the person's ties with his or her family, whanau, hapu, iwi, and family group; and
>>   (ii) proper recognition of the contribution those ties make to the patient's wellbeing; and
>>   (iii) proper respect for the patient's cultural and ethnic identity, language, and religious or ethical beliefs.

Part 2 clause 40 Transfer to another treatment centre

(2) Before ordering the transfer of a patient to another treatment centre, the responsible clinician   must take into account each of the following:
>   (a) the wishes and preferences of the patient:
>   (b) the views of every principal support person of the patient

Part 2 clause 43 Discharge and other planning

(3) In preparing the plan, the responsible clinician must take all reasonably practicable steps to ensure that the following persons are consulted:
>   (a) the patient:
>   (b) every principal support person of the patient:
>   (c) any agency involved in providing relevant services to the patient.

(4) The responsible clinician must take all reasonably practicable steps to provide the patient and every principal support person of the patient with appropriate information about follow-up care.

Part 2 clause 47 Principal support persons to be informed of events affecting patient

(1) If any of the events described in **subsection (2)** occur in relation to a patient, the patient's responsible clinician must take all reasonably practicable steps to notify every principal support
person of the patient of the event.
(2) The events are—
>   (a) the patient leaves the treatment centre without permission or fails to return when the period of leave ends:
>   (b) the patient is discharged from the treatment centre:
>   (c) the patient is transferred to another treatment centre:
>   (d) an application is made to extend the currency of the patient's compulsory treatment order.

(3) The responsible clinician must give the notice as soon as practicable after becoming aware the event has occurred.
(4) If the patient is transferred to another treatment centre, the responsible clinician must also state in the notice the name, address, and contact details of that other treatment centre.

Part 2 clause 62 Parents and others to be informed of decisions

(1) Where any person takes any action, or makes any decision, under this Act that significantly affects any child or young person, that person must ensure that, wherever practicable, the following persons are informed, as soon as practicable, of that action or decision and of the reasons for it:
>   (a) every person who is a parent or guardian of, or a person having the care of, the child or young person:
>   (b) the child or young person.

(2) It is not necessary to inform a child or young person of any action or decision if—
>   (a) the child or young person is incapable of understanding it; or
>   (b) it is plainly not in the child's or young person's interests to be so informed.

(3) The information required by **subsection (1)** to be given to any person must be given—
>   (a) orally and, where practicable, in writing; and
>   (b) where practicable, in a manner and in language that the person understands.

Part 2 clause 69 Persons entitled to be heard in proceedings

(1) The following persons may appear and be heard at every hearing of an application:
>   (a) the patient:
>   (b) every principal support person of the patient:
>   (c) if the patient is a child or young person, each parent or guardian of the child or young person:
>   (d) any lawyer of the patient:
>   (e) the person who applied to have the patient assessed:
>   (f) the medical practitioner who usually attended the patient immediately before the patient was required to undergo compulsory treatment:
>   (g) the Director of Area Addiction Services:
>   (h) the responsible district inspector:
>   (i) any other person the court considers should be entitled to appear and be heard because of that person's interest in the welfare of the patient.

Appendix 6: Cutting Edge 2015 Conference Programme

Cutting Edge 2015 Programme
(Subject to change)

Wednesday 2 September 2015

Please see cuttingedge.org.nz for details
    Maori Hui: 9.00am – 4.00pm, Whakatū Marae, Nelson
    Drua Pacific Fono: From 9.30am, Waimea room, Rutherford Hotel
    Field Trips – details on website

Registration desk opens 4pm – 6pm

Thursday 3 September 2015

7.30am	Registration and Information desk opens please be seated in main auditorium by 8.45am
9.00am	MAITAI ROOMS **Mihi Whakatau and Welcome by Claire Aitken (dapaanz chairperson)**
9.30am	MAITAI ROOMS **Culture, Mobility and Diversity – Challenges in providing services for the whānau and family of today** *Len Cook* Families Commissioner *Chairperson: Eileen Varley*
10.00am	Morning tea – EXHIBITION GALLERIES
10.30am	MAITAI ROOMS **Working Against Violence in the Family and Community** *Henare O'Keefe* *Chairperson: Moe Milne*
11.15am	MAITAI ROOMS **What's it Like for a Child Growing Up in a Household Where Alcohol and Other Substance Use has a Significant Impact on the Family Environment?** *Michael Bird* Chair, NSAD *Chairperson: Vanessa Caldwell*
11.45am	MAITAI ROOMS **Its All About Whānau** A facilitated discussion for both panel and conference delegates on improving outcomes for families Panel: *Henare O'Keefe, Te Puea Winiata, Graeme Watson, Robert Steenhuisen & Michael Bird* *Facilitator: Claire Aitken*

12.30pm – 2.00pm	Lunch - EXHIBITION GALLERIES Poster Session (30 mins) – MAITAI ROOMS Energize – NEAR REGISTRATION DESK

1.00pm – 1.45pm	The Nurses Meeting Co-ordinated by DANA – HEAPHY ROOM	Jacob Le: Vietnamese peer support model in a recovery house - WAIMEA ROOM	Co-exisiting Problems Practitioners Meeting – WAIRUA ROOM
2.00pm	**WAIMEA ROOM** **Aotearoa New Zealand has been a Leader in LGBT Rights and Marriage Equality** *Kathryn Leafe* CEO CareNZ *Chairperson: Susanna Galea*	**HEAPHY ROOM** **Living with it: Family involvement in compulsory treatment for severe addiction** *Vanessa Caldwell* Matua Raki *Chairperson: Ian MacEwan*	**MAITAI ROOMS** **Focusing On The 'A' In COPMIA: Supporting family and whānau to thrive** *Anna Nelson*, Matua Raki & *Dr Bronwyn Dunnachie*, The Werry Centre *Chairperson: Tohi Tohiariki*
2.30pm	**WAIMEA ROOM** **Can We Work Together? Yes we can! Specialist AOD work within Primary Care to support family/whanau** *Anne Bateman & Jessica Stevens* Odyssey Auckland *Chairperson: Susanna Galea*	**MAITAI ROOMS** Open facilitated discussion on ***It's All About Whānau*** *Facilitator: Saveatama Eroni Clarke*	
3.00pm	Afternoon tea - EXHIBITION GALLERIES		
3.30pm	**MAITAI ROOMS** **Improving Outcomes for Substance Misusing Families: An overview of the Parents Under Pressure program** *Professor Sharon Dawe* School of Applied Psychology, Griffith University *Chairperson: Sue Paton*		
4.15pm	**MAITAI ROOMS** **Family Work in the Australian AOD Sector: A decade of progress or not?** *Dr Stefan Greunert* Chief Executive Officer, Odyssey House Victoria *Chairperson: Debbie Sutton*		
5.00pm	**MAITAI ROOMS** Wrap up for day one		
5.15pm – 6pm	Family Advisors' Meeting WAIMEA ROOM		
From 7.00pm	**MAITAI ROOMS** Cutting Edge Dinner & Awards –Rutherford Hotel BRING YOUR TICKET WITH YOU		

Friday 4 September 2015

Time					
8.00am	Registration and Information Desk Opens				
8.30am	 Hui / Fono Feedback				
9.00am	MAITAI ROOMS *Sosopo le va:* **Negotiating boundaries in** *talanoa* **research with Pasifika families** *Dr Byron Malaela Sotiata Seiuli* School of Psychology, University of Waikato *Chairperson: Philip Siataga*				
9.45am	MAITAI ROOMS **An Unexpected Journey** *George Hickton* *Chairperson: Raine Berry*				
10.30am	Morning tea - EXHIBITION GALLERIES				
11.00am- 12.30pm	Stream 1 *Chairperson: Ben Birks Ang*	Stream 2 Chairperson: Selina Elkington	Stream 3 *Chairperson: Anna Nelson*	Stream 4 *Chairperson: Susanna Galea*	Stream 5 *Chairperson: Layla Lyndon-Tonga*
	HEAPHY ROOM	WAIMEA ROOM	WAIRAU ROOM	MAITAI ROOM 2	MAITAI ROOM 1
	Bridging the Gap Between Patients and Their Families *Sarah Redfearn, Sheila Doshi & Debbie Oranje*	**Silent Siege: The experiences of parents of problematic illicit drug users** *Rachael Butler*	**OST Services and the Importance of Friends, Family and Whānau** *NAOTP and Matua Raki colleagues*	**Critical Success Factors in Kaupapa Māori AOD Residential Treatment: Māori youth perspectives** *Mino'aka Kapuaahiwalani - Fitzsimmons*	**Multi-venue Exclusion – A new tool for addiction and mental health practitioners** *Eru Loach, Anaru Haumaha & Sean Sullivan*
	Growing Stronger, Together: Enhancing resiliency within families affected by mental illness and/ or addiction *Debby Sutton & Farah Elnashi*	**Meaningful engagements and community building in the digital age: How Kina uses the internet to reach addiction affected family members** *Nathan Frost*	**Connections: The recovery of hope and a sense of belonging** *Suzy Morrison*	**Alcohol Law Reform: It's all about whānau** *Doug Sellman*	**Gambling as a Visible Spiritual Injury – Know me to know you to heal your injured heart: Samoan and Tongan therapeutic healers with affected church-goers** *Ben Langi*
	Changing Patterns of Opioid use in New Zealand and the Role of Relationships in	**"I'm Not the One With the Problem"** **The journey of working with**	**Adoption: Negotiating an Identity in 'No-man's Land'** *Dr Denise Blake*	**What Families need to know about the Gamblers Brain** *Ritchie Stewart*	**Whanau/Families in Recovery-Free from Violence, Alcohol and other drugs. Couples in**

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	this: Consumer and clinician perspectives *Klare Braye*	**whanau in a group setting** *Araluen Clarke*			**Recovery – Making a difference in the world for whānau/families** *Ngaakete Andrews & Shelley Baizer*
12.30pm – 1.20pm	Lunch - EXHIBITION GALLERIES Energize – NEAR REGISTRATION DESK				
	NA meeting - HEAPHY ROOM		AA meeting – WAIRAU ROOM	Consumers 'Mix n Mingle' - WAIMEA ROOM	
1.20pm-2.05pm	MAITAI ROOMS **Quality of Caregiving in Substance Abusing Mothers: The news is far from all bad** *Professor Sharon Dawe* School of Applied Psychology, Griffith University *Chairperson: Sue Paton*				
2.05pm-2.50pm	MAITAI ROOMS **A New Frontier for Recovery: How the internet provides unique healing opportunities for addicts** *Lotta Dann* 'Living Sober' *Chairperson: Suzy Morrison*				
2.50pm – 3.00pm	MAITAI ROOMS Launch of the Waitemata DHB Pregnancy & Parenting Service Process Evaluation *Cath Edmondson & Marijke Cederman* Health Promotion Agency / Waitemata DHB *Chairpersons: Moe Milne & Dallas Hibbs*				
3.00pm-3.30pm	MAITAI ROOMS Closing Panel – Audience participation **It's All About Whānau** *Professor Sharon Dawe, George Hickton, Michael Bird, Kathryn Leafe, Dr Stefan Greunert, Dr Byron Malaela Sotiata Seiuli & Lotta Dann* *Facilitators: Moe Milne & Dallas Hibbs*				
3.30 – 4pm	MAITAI ROOMS Whakamutunga & Closing by Eileen Varley (conference convenor)				