Addiction Treatment Research NEWS

NEWSLETTER OF THE ADDICTION TREATMENT RESEARCH INTEREST GROUP

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EDITORIAL

This latest edition of the ATRN taps at the heart of some of the most pressing issues currently facing addiction workers and researchers. Raising these issues in this newsletter appears very apt at the time when ATRIG has just expanded its membership to include DAPAANZ members. Starting in 2011, ATRN will be increasing publication to four times a year and those of you who are DAPAANZ members will receive a copy of ATRN with your DAPAANZ newsletter. ATRIG only members will continue to receive their electronic newsletter but with a bonus extra issue per year. We are hopeful that combining the newsletters will allow addiction clinicians much better access to up to date NZ addiction research and will also encourage you to have a voice in the addiction research scene. The ATRN provides a great opportunity for experienced and novice researchers alike to discuss their current and upcoming research. For many in the NZ addiction research field it has provided the first opportunity to share their findings more publically. So for those of you who have done, or are currently doing, great research but haven't yet shared your findings publically, think of the ATRN as a great place to start. I look forward to hearing from anyone interested in writing a brief article for future editions of the ATRN.

In the current issue the two major foci are the annual Cutting Edge conference and some of the very real challenges that are presented to clinicians and researchers in terms of providing integrated and individualised care to clients. These issues are discussed in relation to the new treatment competencies in the addiction field that have been aligned across AOD, problem gambling and smoking cessation, and in the MOH initiative to ensure integrated services delivery for co-existing mental health and addiction problems. These are challenges that we face right here, right now in the addiction field and are issues that many of you are likely to be dealing with on a daily basis. The authors in this edition have shared their views, now you have an opportunity to share your views with the field. If you would like to have your own say about any issues raised in the ATRN please don't hesitate to write a letter to me, the editor, for publication in the next edition of ATRN.

Many thanks to the authors of the articles in this edition. I know you all have very busy lives and I really do appreciate the time you have given up to contribute to this newsletter. Thanks also go to Lisa Andrews for the ongoing time and patience she gives to formatting this publication.

Happy reading and writing!

Ria Schroder
ATRN Editor

ABACUS REPORT

Adolescent addiction risk: gambling on the Internet

It has become appallingly obvious that our technology has exceeded our humanity. ~Albert Einstein

With the advent of new treatment competencies aligned across AOD, problem gambling (PG), and smoking cessation (SC), a generic foundation competency will require practitioners to respond with age appropriate protocols and effective responses to young people. Specialised resources already exist for young people in AOD (CADS Altered High), PG (Gambling Problem Helpline's InYerFace), and SC (Smokefree Schools). Nevertheless, the new draft competencies propose that all addiction treatment practitioners in the three workforces have a basic level of competence when working with young people. This raises a number of questions, including:

- What age range are 'young people'?
- Relatively few adolescents seek help for problem gambling: what evidence exists for additional resource needs?

Age range

In mental health, the age range for children and adolescents is often described as 0-19 years of age[1], while the WHO and Ministry of Health (MOH) identify adolescents into cohorts (early adolescence 10-13, middle adolescence 14-15, and late adolescence/young adult 16-19)[2,3]. Youth and young people is defined by the MOH as 15-24 years[3], and in problem gambling treatment contracts, competency is expected to apply to treatment of clients from 15 years of age. Supporting this older range is the relatively recent findings using MRI scanning that although much of the grey matter of the central nervous system is formed by approximately 12 years of age, full connection of the mid-brain to the frontal lobes (i.e. maturity) is not completed until mid-twenties[4]. By contrast, use of technology and social networking through the Internet has been embraced by youth, often by early adolescence, notwithstanding (poorly enforced) age restrictions.

Young people participate in addictive behaviours

Public influence has contributed to reductions in the numbers of young people (ages 14-15 years) being regular tobacco smokers, down two-thirds since 1999[5]. But this may be the only good news in the three addiction categories, with alcohol products appearing to be on another track. Ready to drink 'alcopops', not available until 10-15 years ago, are considered to be specifically marketed at young people, with 14-17 and 18-24 year age cohorts being their largest consumers[6]. Gambling problems for young people may have a similar trend to alcohol.

There is a range of research from overseas, and more limited research from NZ, indicating that the risk of problem gambling behaviour for young people is substantially higher than for adults[7]. This is not reflected in their accessing of treatment services, with approximately 4% of problem gambling clients accessing the Gambling Problem Helpline in any year being aged 20 years or less, however then correcting to 14% of calls under 25 years (then aligned with population cohort proportion)[8]. One could interpret this in a number of ways, including casting doubt upon the accuracy of PG prevalence research for young people under 20 years. Yet in health issues young people appear to be less likely to access health services for a range of reasons, with NZ research suggesting that this may be due to a range of concerns, including not wanting to 'make a fuss', being too scared, worried about parents finding out, and confidentiality concerns[3].

In the case of gambling, new and exciting opportunities are arising for young people to participate that were not available in the past. This age group are adept at the use of technology, and the Internet has embraced gambling as a favourite son with more than 2,500 gambling sites currently accessible.

In particular, gambling is provided, and indeed prompted, through the social networking sites such as Facebook, MySpace, Bebo and Twitter, with poker being the mode of growth. Texas Hold 'Em is now rebranded as Zynga Poker, providing a range of practice sites where free gambling is offered. Initial chips are free, with top-ups purchased at low prices. Live gambling occurs with other players at speeds unable to be matched in real life games. Players converse during games by emailing facilities (or now can connect with voice through earphones), can send virtual drinks, flowers and gifts to other players, moving up to higher stakes games as they seek greater excitement. However, as games can have minimum bets of several million virtual dollars, replacing losses can cost considerable sums of real money. Also, prompts are regularly given to join money gambling sites, with similar initial free stakes. Free sites are clear gateways to electronic gambling for money for the young. In the USA, males aged 18-22 years using online sites for gambling increased from 4.4% of this cohort in 2008 to 16% in 2010, and younger high-school students (aged 14-17years) increased from 2.7% to 6.2% during this period[9]. The conclusion reached by the researchers was that payment restrictions on Internet gambling sites were no longer a barrier to young people. Another researcher, Professor Derevensky, (2008) identified 33% of underage Canadian youth had tried online poker for free, and 8% had gambled for money.[10]

Youth will not tolerate delays or poor graphics. What may explain the growth in participation in these gaming sites is that the free software is now being effectively run alongside far more powerful hardware, with access to faster broadband, now both at affordable prices. In NZ, broadband usage by those accessing the Internet increased from 67% in 2007 to 82% in 2010[11]. We may posit that the level of problem gambling for young people is set to rise in the near future.

Accessibility, prompt reinforcement, and continuous modes of gambling are highly correlated with problem gambling[7]. There is every possibility that as young people increase participation in internet gambling, their prevalence of problem gambling will increase substantially. PG treatment specialists, in meeting the MOH's requirement of 'knowledge and understanding of young people's issues'[3], may need an up-to-date working knowledge of technology-based problem gambling modes. The draft competencies call for the PG treatment workforce to have a basic level of competence to work with young people, and awareness around the technology-driven nature of new gambling that has particular attraction to youth, will ensure that the workforce does not lose touch with this rapidly developing new face of gambling.

Sean Sullivan
ABACUS

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THE 15TH CUTTING EDGE CONFERENCE, 2010

Cutting Edge this year was held on 23rd-24th September at the Rendezvous Hotel, Auckland. The theme was 3D: Development, Diversity, Direction for a new decade. We were warmly welcomed by Matt Maihi from Orakei Marae at the Powhiri, which was followed by Hon. Dr. Jonathan Coleman's opening address. There were a number of inspiring and moving speakers and some excellent posters. International keynote speakers included Dr Richard Velleman, a leading researcher on co-existing problems and the impact of problematic substance use and mental health distress on family members, including children, and Dr Robert Williams from the USA, whose most recent work has made him an international expert on Gambling. This brief article only allows that I cover those that most provoked my imagination and stimulated my thoughts-but that is not to say the others didn't. You can out find more about those that aren't mentioned here (and more about those that are by visiting http://www.cuttingedge2010.org.nz/)

The first rousing keynote speaker was Ross Bell, the executive Director of the NZ Drug Foundation. His dazzling multi-media supported speech (using well tried and tested propaganda techniques for good) gave us all a very clear message about the damage the 'war on drugs' and associated criminalisation of drug users has caused to individuals, families, communities and societies around the world. While there is no doubt that the use of drugs can cause social and health concerns for those that use them, and significant others in their lives, Mr Bell pulled no punches about the fact that drug control laws, and the criminalisation of drug users probably causes much more destruction, especially where it is used to support human rights violations. So, the message was clear, and the evidence is clear. Drug control laws and the criminalisation of drug users is harmful and does not decrease the demand for drugs. The war on drugs is not working 'right here, right now' (Fatboy Slim? Surely The Chemical Brothers would have been more apt Ross) and when the time comes early next year we will all be writing our submissions to the Select Committee about the review of the Misuse of Drugs Act, thanks to the good work of Mr Bell and his colleagues at the NZ Drug Foundation.

Before lunch on day one I attended one of the concurrent sessions by Majors Ian and Lynette Hutson about their ongoing work and partnership with the Notorious Chapter of the Mongrel Mob. Their humble and honest account of this 'cutting edge' work they have been doing with those from this chapter of the Mongrel Mob who have been identified as having problematic substance use, was really awe inspiring. The Salvation Army have for a long time been a solid and dependable provider of abstinence based services throughout Aotearoa and their ability to be able to work in the way they highlighted with this group of consumers should be congratulated. As they said it was about taking 'a service to a system' not removing people from their systems-however 'dysfunctional' or challenging these may appear to be. The ability they had to see the similarities between the Salvation Army and the Mongrel Mob (for example they both have patches) enabled this partnership to flourish, in what were often very difficult circumstances. The media scrutiny that the programme came under and the clear anxiety and stress that it caused came second to providing an appropriate, flexible, whānau orientated, 'healing and restorative' journey for this group of people in order that they might choose a different path for their futures, a path of wellness.

On the afternoon of day one Dr Grant Christie provided an entertaining overview of the importance of brief interventions with young people. He talked about his ongoing work with The Werry Centre and Matua Raki in promoting his Substances and Choices Scale-Brief Intervention (SACS-BI) to a variety of health and social care professionals (CAMHS and CYF's workers). This screening and brief intervention tool developed for use in New Zealand with our young people, has an excellent evidence base for use with a diverse variety of young people in both specialist youth alcohol and other drug services, as well as in the community setting (for example schools). Dr Christie remains an excellent advocate for adolescents and reminds us of the need to offer appropriate and flexible services to our young people.

Later on, on day one Professor Dennis Gray from the National Drug Research Institute along with Associate Professor Ted Wilkes from Curtin University discussed addressing indigenous AOD issues from an Australian perspective. While there are certainly many differences between Australia and New Zealand when its comes to addressing these issues (for example in Australia there are over 500 different languages and tribes), there are also obvious similarities (devastation and damage caused by colonisation) and there were certainly some thought provoking ideas addressed in

this presentation that would certainly be relevant, indeed important for us to think about. The most obvious of these for me is the need for a Complementary Māori National Drug (and alcohol) Strategy and Action Plan to complement current strategies. When we know that Māori are over represented in statistics for problematic substance use and under-represented when it comes to accessing services to address these issues we clearly need to be doing a number of things differently. Following Australia's lead here and developing a complementary strategy and action plan seems like an extremely crucial thing for the entire AOD sector to advocate for, coupled with continuing support for innovative grass root kaupapa Māori initiatives to support whānau.

Finally I'd like to make special mention of the presentation by members of the Mana Arahi team (Matua Raki's Rawiri McKinney and WelTec's Bronwyn Jones, and Matt Renata and their students (Aorere College's Jonathan Phillips, Hoko Fiavaai and Ofa Laiseni) which presented an overview of Mana Arahi to the audience. Mana Arahi is an online year 13 'introduction to the addictions' course comprising 14 unit standards. Mana Arahi is a collaboration between Weltec and Matua Raki that has seen this first group of successful students (12 in all) through the pilot programme aimed at getting more young, high achieving students to think about a career in the addiction sector.

I left the conference, as I do each time I attend, with a feeling of immense pride in the work that the addiction sector are undertaking to meet the needs of consumers who we are all here to service. While we may still have a long way to go, we must not forget how far we have come.

Anna Nelson
Programme Manager
Matua Raki

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

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

ATRIG's objectives are:

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

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

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MESSAGE FROM THE CHAIRPERSON

I hope that many of you took the opportunity to attend this year's 15th Cutting Edge Conference held in Auckland in September. It was a wonderful event hosted by DAPAANZ and sponsored by ALAC and the Ministry of Health. I understand that nearly 400 practitioners, consumers, researchers, workforce developers, policy makers and interested parties attended what proved to be an excellent line-up of keynote speakers, presenters and posters.

Ross Bell provided an amazing, and entertaining insight in to the impact, (or lack of it) of the global war on drugs and challenged us to consider other ways of developing 'healthy drug laws'. Dr Richard Vellerman from the UK highlighted the importance of supporting the families, as well as the clients, affected by coexisting substance and mental health problems and proposed some interventions that he had shown to be effective. Dr Robert Williams from Canada explored strategies around minimising harm from internet gambling and Pulotu Bruce Levi provided an insight in to maintaining a Pasifika identity within mainstream services. In addition to these keynotes there was a great array of presentations looking at effective treatment interventions. To identify just a few: Dr Paul Quigley and Moira Gilmour's work with the CCDHB Emergency Department highlighted to me the time it can take to put together, implement and see the effectiveness of a strategy. Matua Raki's Mana Arahi students offered insight from a young person's perspective on how we can develop an initiative to build on the workforce; Peter Thorburn updated us on the realities and availability of mephodrone whilst Emma Clare drew on the clinical implications and guideline development for benzodiazepine prescribing.

It was Emma's research and presentation which included a literature review, key informant interviews, in depth interviews with Wellington Psychiatrists and a national psychiatrist survey that saw her awarded the Young Researchers Award. This award has been re instigated this year, supported by the Addiction Treatment Research Interest Group to provide an incentive and recognition of the work that goes in to preparing and presenting a piece of research in poster or presentation format. As a result of Emma's work important implications for clinical practice, guideline development and resourcing needs were highlighted. It was evident that although most prescribing was in concordance with guidelines, concerns were raised that benzodiazepines are frequently prescribed, that short-term prescriptions are not reviewed appropriately, and some long-term treatment is inappropriate. Furthermore benzodiazepine use may inhibit the effects of Cognitive Behaviour Therapy and survey respondents suggested a low availability of psychological therapies adversely influencing benzodiazepine prescribing rates.

The other event of note at Cutting Edge for ATRIG members was of course the ATRIG AGM. This in practice is a time of official reports from executive members, financial statement approval and executive election processes. Whilst this process did occur, I must confess that without the formal guidance of our esteemed secretary, Lindsay Atkins, the discussion jumped fairly rapidly to general business topics. We reviewed the role of ATRIG to the workforce and clarified the collaborative relationship that is being developed with DAPAANZ. This is leading to a structure of membership and newsletter distribution that will incorporate much of the clinical workforce and ultimately lead to a wider audience of addiction treatment. We also highlighted the Young researcher Award and the possibility that it might be reframed with a focus on a 'new and emerging researcher' rather than solely on age. We explored initiatives for sharing research ideas, the use of Mahara, an online platform for special interest groups currently being administered through Matua Raki being one of them. We also discussed the development of a regular Research Symposium, as was initiated by University of Auckland earlier in the year. Whilst we recognise that addiction research remains a small focus of interest amongst the addictions workforce it was encouraging to see so many attendees and so much interest at the AGM.

Klare Braye
ATRIG Chairperson

ADDICTIONS RESEARCH AT THE UNIVERSITY OF AUCKLAND, FACULTY OF MEDICAL AND HEALTH SCIENCES

A number of researchers within the Faculty are active in the addictions field. Below is a summary of some of the recent activity, and includes completed projects, projects on the go, and ones just in the planning stages.

Alcohol

Alcohol research has been a focus for a number of us in the last while. Professor Ross McCormick has recently published his paper: The Research Translation problem: Alcohol screening and brief intervention in primary care – real world evidence supports theory in Drugs: Education Prevention and Policy (1). The research aimed to show how the well known theoretical constructs about screening and brief intervention for problem use of alcohol translate into primary health care action, and was focused on work undertaken in New Zealand, Newcastle (UK) and Catalonia (Spain). The researchers' description of their country's work to implement brief interventions in primary health care was compared and contrasted and common themes found about how to promote clinical activity based on research findings. For more information contact Ross on: r.mcormick@auckland.ac.nz

Recent research has also been completed by Janie Sheridan and Ross McCormick exploring the rates of risky drinking amongst community pharmacy customers, and whether or not this population feels it would be appropriate for community pharmacists to undertake screening and brief intervention. This is based on feasibility studies already undertaken in the UK and recommendations in the UK that trained pharmacists could become involved in this work. The study found risky drinking to be prevalent in this population, thus indicating a potential role for pharmacists. Although risky drinkers were less positive about the pharmacists' role, overall the feedback was generally positive. A paper based on this study is currently under peer review. It is hoped that in the future services may be set up in certain pharmacies in New Zealand and evaluations of outcomes undertaken. For more information contact Janie on: j.sheridan@auckland.ac.nz

Other alcohol related research is being undertaken by two PhD students. The first, Theresa Boyes, is exploring issues around undergraduate drinking culture, focussing on the perspectives of students who live in university residences. To date prevalence data on risky drinking have been collected, and pilot focus groups have been undertaken. This research is likely to provide an insight into student views and offer opportunities to develop interventions to reduce risky drinking. Theresa is supervised by Ross McCormick, Ann McKillop and Natalie Walker. For more information contact Theresa on: t.riley@auckland.ac.nz

Another exciting PhD is being undertaken by Karen Renner. She is exploring the potential for modification of drinking behaviour through the use of participant designed, self generated text messages via mobile phones. In the study, the intervention group will have access to the text messaging function while the control group will have access to a simple web site with safety messages. The intervention group will be able to design and schedule messages to be sent to their mobile phone at times when they intend to be drinking. They will be able to change these messages and delivery times whenever they wish to. Outcome measures include changes in unintended consequences and drinking (AUDIT-C). Karen is supervised by Ross McCormick and Natalie Walker. For more information contact Karen on: karen.renner@gmail.com

Families

Rachael Butler has recently successfully completed her Masters degree in which she explored the accounts of parents whose child had formed a problematic relationship with illegal substances, in particular focusing on how relationships within the family had been impacted.

Unstructured interviews with ten parents were conducted. Parents' accounts reveal that their social world was severely impacted by their child's drug problem. This was, in part, due to the varying responses of different family members to the addiction. Participants expressed a lack of agency in relation to what was unfolding within the family as they felt under siege from the drug user's behaviour. Despite this, they expressed a commitment to maintaining a

connection with their addicted child, although some had renegotiated the nature of the relationship. Participants' accounts revealed the broader implications of what it meant to have an addicted child. For some, this was associated with failed parenting and resulted in parents seeking to keep the drug use hidden via a range of tactics. This self-imposed silencing meant that parents were further isolated, as they actively withdrew from family and other social networks in an attempt to keep the transgression concealed. For more information contact Rachael on: r.butler@auckland.ac.nz

Tobacco research

Our Clinical Trial Research Unit has recently completed a number of tobacco-related research. The first was a phase III, single blind, randomised, cross-over trial of the effects of three novel nicotine replacement therapies (NRT), a pouch, mouth spray and lozenge, on the relief of tobacco withdrawal symptoms . This study assessed the withdrawal relief potential and acceptability of three new faster acting NRT in comparison with standard NRT gum and placebo. The study was funded by NicoNovum (Sweden), who have received a confidential report detailing the study findings. Two key publications have arisen from this study (2, 3).

A second study has evaluated the pharmacokinetics, tobacco withdrawal relief and acceptability of an electronic inhaled nicotine delivery device - the Ruyan e-Cigarette (WIRED). The study explored the effect of an electronic cigarette on cravings and withdrawal, acceptability and nicotine delivery compared with nicotine inhalator, placebo electronic cigarette and tobacco cigarette using a randomised cross over trial design and included 48 participants. The study was funded by SBT Holdings Limited Beijing and Hong Kong, via Health New Zealand Ltd (4).

A third study has investigated the effect of using NRT (patches or gum) for two weeks before the quit date, on 6-month abstinence rates (n=1,100). Recruitment was via Quitline and used a randomised controlled trial design, and was funded by the HRC (5).

Other studies are currently underway and include a randomised trial of reduced nicotine cigarettes to aid smoking cessation, funded by the HRC, which aims to assess if a short course of denicotinised cigarettes in combination with NRT can increase 6-month abstinence rates. The CASCAID trial is a single-blind randomised controlled non-inferiority clinical trial to evaluate the efficacy and safety of cytisine compared to usual care (NRT plus behavioural support) as a treatment for people who wish to stop smoking. For more information, please contact Natalie Walker on: n.walker@auckland.ac.nz

Reflective practice

Dr Robin Shepherd is currently running a project called: 'Where is the GPS? Navigating the waters of co-morbidity treatment as part of workforce development. A reflective journey. This project is being undertaken with postgraduate students who are undertaking the Co-Existing Disorders Paper: Theory and Practice II. Students are writing a reflective journal and the research will be drawing themes from the journals to explore the bridge between theory and practice amongst both mental health and substance abuse practitioners and their academic work. Two similar studies, one exploring whether reflective practice addresses cultural issues in the addiction field amongst Samoan students in higher education and the other exploring whether Reflective practice in Addiction Studies promotes deeper learning and destigmatising myths about addictions are both underway. For more information please contact Robin on: rm.shepherd@auckland.ac.nz

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I'VE BEEN READING …

I've been reading 'Te Ariari o te Oranga, the Assessment and Management of People with Co-existing Mental Health and Substance Use Problems (CEP) 2010'. This comprehensive Ministry of Health (MOH) document penned by Dr Fraser Todd is a clinical framework for health professionals working in both mental health and addiction services, aimed at enhancing the care provided for clients. It is supported by another document, 'Integrated Solutions - Service Delivery for Co-existing Mental Health and Addiction Problems' which aims to guide funders, planners and providers in the implementation of better CEP capable mental health and addiction services.

Why did I read them? Well, I was recently invited to a workshop run by the MOH to launch the current CEP initiative and was given them. As I lugged the volumes back to work after a pleasant day in the shadow of Maungakiekie I had two thoughts. The first was 'What a fantastic resource… hasn't Fraser done a great job.' The second was 'What a pity all the people who need to read this, won't.'

As someone with some interest in promoting better CEP practice in mental health and addiction services (mainly in youth) I fear that the culture shift required to enhance CEP practice across our health services will not occur via guidelines alone. Although Te Ariari o te Oranga will be a great support to the *CEP-aware* who are wanting to enhance their practice, the best use of it for the *CEP-oblivious* may be as a club to beat them into submission (albeit the evidence for clubbing people with large paper reports leading to lasting behaviour change is anecdotal at best). Really we need to understand better why mental health and addiction workers are so hesitant to do their job.

One reason is related to the ever increasing evidence base for the interventions we provide. What CEP promotes and what consumers want from services is care provided for them as individuals; they do not want to be viewed as simply having a series of problems able to be treated or otherwise. However services and workers increasingly see ourselves as having expertise in specific areas, say CBT or Motivational Interviewing or medication management, which then dictates what we to offer clients. In doing this we inadvertently devalue the experiential and humanistic qualities that most clinicians attracted to the helping professions bring to their therapeutic interactions.

We also fail to recognise the universality of most of our therapeutic endeavours. The low confidence with regard to 'training' or 'competence' in addiction work that mental health workers routinely report (and vice versa) is at odds with the practical reality that mental health and addiction workers all do much the same thing. We all work motivationally, do 'goal plans' or complete 'relapse prevention plans'; indeed the difference in a relapse prevention for psychosis compared to alcohol dependence is no greater than the difference between a plan for psychosis and mood disorder. The problem is with workers perceiving that specific treatments are special or difficult or requiring a different skill set from the one they already have.

But it is not just these blindspots that lead us to compartmentalise our practice and reduce our clients to sets of problems. Pressing workloads combined with complexity and risk in clients leads to prioritisation in not only client management plans, but also clinician caseloads and service delivery. When a busy clinician perceives that there is more work required than time allocated to do it, they understandably concentrate on those areas they feel confident and competent in and look to farm other tasks out to workers and services around them. This could be described as the de-integration (or disintegration) of care. Understandably consumers seldom want this, no more than shoppers are likely to request to zigzag across town for their groceries rather than go to the supermarket.

In recent months my service has been struggling with workload and has been investigating ways to manage demand better. To this end I have also been reading 'The 7 Helpful Habits of Effective CAMHS and The Choice and Partnership Approach (CAPA)". This manual by Steve Kingsbury and Ann York stemmed from steps taken to manage long waiting times (up to 2 years) in Child and Adolescent Mental Health Services (CAMHS) in the UK. The 7 Helpful Habits outline strategies that overstretched services can adopt to manage demand and flow better. CAPA is essentially a sophisticated triage system that works to fairly share out a scarce resource across communities. It aims to balance what can be provided by mental health and addiction services against the needs and expectations of consumers.

For our service the '7 Helpful Habits' was a useful tool, helping us understand the issues related to demand and flow better and providing strategies and ideas to address bottlenecks and stress points. We will be more prepared next time the end of year rush hits on account of it. CAPA, we were less enthusiastic about. Its implementation requires significant changes to triage and assessment systems and involves a series of assessment steps (Choice then Partnership) that usually necessitate the handing of care from one clinician to another, surely a recipe for consumer frustration and disengagement.

On the face of it CAPA is a sensible system that would work well for clients with clear, demarcated problems that respond to time-limited evidenced-based treatments. However for those people who are precontemplative, unmotivated, lack insight, or have complex or numerous disorders that fail to meet 'severity criteria' (in other words CEP clients), CAPA seems a potential recipe for exclusion. CAPA defends itself against this drawback with somewhat idealistic claims about the flexibility of the system and how the skill of a clinician can protect and lead to engagement of the unmotivated. However we already know from experience that systems under pressure are seldom flexible, rather clinicians revert to type and concentrate on what they feel most confident doing. CAPA seems at high risk of being misused, driven by what services perceive (rightly or wrongly) they can provide rather than by consumer's needs.

This is where the two documents I've been reading appear to neutralise each other. I fear that the CEP initiatives spelled out in Te Ariari o te Oranga are at risk of being undermined by the Choice and Partnership Approach, something I understand the MOH may consider implementing beyond CAMHS. Although there is no denying that resources need to be managed and distributed fairly, CAPA risks creating process (rather than people) dominated services. Compartmentalising people's problems and then matching them to what services can provide, as occurs with CAPA, may discourage integrated care (or CEP) and inadvertently make us to forget about treating our clients as individuals. I am sure the two documents could happily co-occur exist in an ideal mental health and addiction world but the pragmatist in me is not convinced that that place exists.

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MEMBERSHIP/RENEWAL FORM

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

Membership in ATRIG entitles you to the following:

- three issues of the Addiction Treatment Research News via email
- membership in the ATRN email discussion group

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The objectives of ATRIG are:

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

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I support the objectives of ATRIG and wish to be a member of ATRIG for the 2011 calendar year. I understand membership fee is $20.

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