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Dr Simon Adamson and Assoc Prof Doug Sellman
Monograph Editors

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TABLE OF CONTENTS

INTRODUCTION

This New Zealand treatment research monograph comprises summaries of the majority of research presentations from the Cutting Edge Conference 2003, held in Waitangi, 28-30 August.

With this being the third successive year in which the monograph has been produced it is time to state with confidence that this has become a significant publication for anyone interested in treatment-oriented research in the alcohol, drugs and addiction field in New Zealand. The monograph provides a permanent written record of valuable and interesting research conducted in the New Zealand alcohol, drug and addiction field, which in many cases will not be formally published elsewhere. The monograph is widely available, having been disseminated to all Cutting Edge 2003 registrants and being available as a pdf document that may be downloaded from the National Addiction Centre website (www.addiction.org.nz), from which previous editions of the monograph also remain available. This monograph was the vision of members of the Treatment Research Interest Group (TRIG), and the National Addiction Centre prior to Cutting Edge 2001. This vision has proved itself to have been well-founded.

These papers have not been formally peer-reviewed, but instead have undergone a process of critical editorial comment and correction. At this stage of the development of the alcohol, drugs and addiction research field within New Zealand it is considered important to be inclusive, in order to encourage and support young (and not so young) researchers and subsequently encourage the development of a critical mass of clinically-oriented researchers. In time, it is hoped that this may lead to the emergence of a peer-reviewed journal. Approximately half of the papers included in this edition of the monograph arise from PhD work, with the remainder including several Masters level students. This is a clear indication of the increasing vitality of the alcohol, drug and addiction research community within New Zealand.

While this edition of the monograph contains a wide array of papers, attention should be drawn to several themes present. Firstly, this year two papers report on the results of qualitative research, with only one such paper having appeared in the preceding two years monographs. While this methodology presents challenges in distilling work down to a concise size suitable for the monograph it is hoped that the presence of the papers signals the potential for such work to continue to be presented at Cutting Edge and represented in future monographs. One of these qualitative pieces, by Robert Steenhuisen, also represents another important theme, that of the consumer/client voice. Both this paper and that of Daryle Deering explicitly reflect a client perspective of the treatment process, while Justin Pulford's paper also describes research attempting to capture the views of clients in relation to their treatment experience. Other themes across papers are those examining treatment retention/exit (three papers), methadone maintenance (six papers), adolescent/young adult populations (four papers), gambling (two papers), and treatment outcome (four papers).

The 2003 John Dobson Memorial prize for the best opioid presentation went to Alistair Dunn, while the John O'Hagan prize for the best presentation by someone

aged under 35 years went to Grant Christie. Both presentations are summarised in this edition of the Treatment Research Monograph.

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THE NATURALISTIC TREATMENT OUTCOME PROJECT (NTOP): NINE MONTH OUTCOMES

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The three aims of this study were:

1. To describe the type and range of clients presenting at outpatient services in NZ
2. To measure a multi-dimensional outcome for a representative outpatient sample
3. To identify clinical predictors (client and treatment variables) of treatment outcome.

The baseline profile of clients in this sample were described in greater detail in the 2001 Treatment Research Monograph[1]. Particularly of note was the high rate of psychiatric comorbidity, with 77.1% of the sample diagnosed with an axis II anxiety or mood disorder.

Methods

One hundred and seven randomly selected clients were recruited from CADS Christchurch and CADS Hamilton and were interviewed within the first two months following initiation of the index treatment episode. All participants consented to be recontacted for follow-up nine months after the date of their initial CADS assessment, and 102 were successfully recontacted, a follow-up rate of 95%.

Outcome measures adopted were:

- Continued substance use, percentage days using, amount used per using day (alcohol and cannabis only)
- Presence of symptoms of substance abuse and dependence (DSM-IV) using the Composite International Diagnostic Interview (CIDI)
- Physical Health and Mental Health (SF-12)
- Social Functioning: Social Problems Questionnaire (SPQ), employment, child custody, arrest in past six months
- Self-rated improvement from baseline

All outcome measures except self-rated improvement were also employed at baseline to allow objective comparison of change from baseline to follow-up.

Results

Table 1 shows changes in using pattern and symptoms of abuse and dependence for all substances aggregated, and for the three most commonly used substances

individually. Significant improvements were found across all categories for the "all substances" aggregate and for stimulants. There was no change in average number of drinks consumed on drinking days, nor was the reduction in percentage meeting one or more symptom of alcohol dependence significant. In contrast, there was a significant reduction in amount of cannabis smoked on using days, but no significant change for abstinence rate, dependence or abuse criteria met.

Table 1: Substance Use

Substance	Outcome Measure				
	Using	Using Days	Amount	Dependence	Abuse
Any Substance					
Baseline	97.9%	67.1%	-	85.4%	80.7%
Follow-up	88.7%*	50.0%***	-	69.7%**	52.3%***
Alcohol					
Baseline	93.8%	35.8%	15.6[a]	61.8%	61.1%
Follow-up	82.4%*	22.9%***	15.1	55.1%	41.1%**
Cannabis					
Baseline	60.3%	60.8%	3.3[b]	38.2%	30.8%
Follow-up	58.1%	48.2%**	2.0***	30.3%	23.1%
Stimulants					
Baseline	26.5%	14.7%	-	18.0%	19.8%
Follow-up	17.1%*	3.7%**	-	10.1%*	4.4%***

*p<.05, **p<.01, ***p<.001
[a]Alcohol amount quantified as standard drinks (10gm pure ethanol)
[b]Cannabis amount quantified as "typical joints = average sized containing half and half head and leaf"

Table 2 shows changes in health and social functioning scores, with significant improvements evident in SF-12 Mental Health, SPQ scores, arrest rates and employment. There was no significant change for SF-12 Physical Health or percentage of children aged 16 or less currently in custody of the patient.

Table 2: Health and Social Functioning

	Baseline		Follow-up	
Health	Mean	(SD)	Mean	(SD)
SF12 Physical	45.4	(6.5)	45.9	(6.1)
SF12 Mental	38.3	(8.3)	41.7	(6.1)***
Social Functioning				
Social Problems	11.9	(7.2)	9.7	(6.8)**
Arrested	28.6%		11.0%***	
Employed	25.1%		42.1%*	
Child custody	27.5%		31.8%	

*p<.05, **p<.01, ***p.001

Finally, participants were asked "Compared with when you came to CADS nine months ago, how would you currently rate your drinking or drug use overall?" The responses were: Much worse (0%), A little worse (1.2%), About the same (13.8%), A little better (17.2%), Much better (67.8%).

Conclusions

In conclusion, these data demonstrate that outcome can be defined in a number of ways. Clients showed improvements across most measures, but these were usually modest. There was evidence that outcome differed across substances, so that for example reduction in cannabis use occurred because of fewer smoking days and smaller amounts per smoking day, but not due to participants becoming abstinent. For alcohol, reduction occurred as a result of participants becoming abstinent, or drinking less frequently, but not by drinking less on drinking days.

The high rate of stimulant use in the sample supports contemporary concern at the rising prominence of this class of drugs. Comfort can be taken in the findings, however, that substantial improvements were found across all four outcome domains for stimulant users.

Despite most objective measures only improving modestly, participants perceived that improvement had been substantial. This data can be equally interpreted as a strong endorsement of current treatment as delivered, or could be seen as highlighting the absence of more substantial improvements. It is proposed that on entering treatment this client group may have had fairly modest expectations of change, which were largely met. Furthermore, given that improvement may often occur with multiple treatment episodes, and be aided by self-directed change between treatment episodes, the magnitude of improvements shown here should be considered as adequate.

Reference

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DO ADOLESCENTS ATTENDING OUTPATIENT SUBSTANCE USE SERVICES DIFFER FROM THOSE ATTENDING OUTPATIENT PSYCHIATRIC SERVICES?

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Introduction

Substance use is not only widespread in New Zealand adolescents[1] but it has a significant impact on their health[2]. Substance use treatment services for youth in New Zealand are poorly established and evidence to guide their future development is scarce. RADS 'Altered High' Youth Service is unique, offering as its core business, primary substance abuse treatment to young people. Describing and comparing the self-reported problems of adolescents attending 'Altered High' Youth Service with adolescents attending a community mental health service will enable a better understanding of this unique population and inform service development for 'Altered High' and other youth substance use services in New Zealand in the future.

Method

A self-report questionnaire, the Drug Use Screening Inventory-Revised[3] or DUSI-R, was administered to a cross-section of adolescents presenting to Waitemata DHB youth services, namely 'Altered High', 'Tupu' and 'Te Atea Marino' and Marinoto North (adolescent mental health services.) Ethical approval was granted by the Auckland Ethics Committee. Consent was obtained in writing from participants.

The sample included all 14 - 18 years olds attending a treatment session at the respective services. Excluded were those who were unwell, intoxicated or low IQ. Non-participants' demographics and reasons for non-participation were recorded. A sample size of 130 (65 in each group) was calculated as having sufficient power to show a significant difference in the mean scores between the two groups.

The DUSI-R is a validated self-report questionnaire that is designed for adolescents and is in the public domain.[3] It screens and quantifies severity of disturbance in 10 domains of psychosocial functioning including: drug and alcohol use, behaviour, health, psychiatric symptoms, social competence, family system, school performance, work adjustment, peer relationships, and leisure and recreation (+ total problems.) Completed DUSI questionnaires were collated and the de-identified data was scored, recorded and analysed using an SPSS data-base. Descriptive statistics were used to describe the characteristics of the two populations. The differences between the groups' mean scores across each domain were compared.

Results

Demographics

149 clients were approached and 131 agreed to participate. There was no significant difference in the gender or age of the participants in each group, although the substance use group had significantly more Mäori and Pacific Island participants.

Substance use

Alcohol use was high across both services with 13% from each service using alcohol more than 20 times over the last month. Cannabis use was significantly higher in those attending the substance use service with 75% having used cannabis in the last month and 30% more than 20 times. This compared to only 33% in the mental health service with 13% using heavily (more than 20 times). Tobacco use was significantly higher in those participants attending the substance use service. Not unsurprisingly smokers used frequently (over 20 times a week). Amphetamine use, currently a concern in New Zealand, was less common. Sixteen percent of those attending substance use services reported some use in the last month, but only 4% had used more than twice.

Most of those attending the substance use service reported that cannabis was both preferred (61.2%) and the most problematic (46.3%) substance for them. Alcohol (34.3%) was the next most problematic substance followed by amphetamine (4.5%). A large proportion of those attending the mental health service answered that the 'most problematic' (39.1%) and 'preferred' (26.6%) questions were not applicable to them. Most identified alcohol as their preferred (37.5%) and most problematic (39.1%) substance. Only 9.4% of participants identified cannabis as the most problematic substance. The differences in responses to these questions between the two services were significant.

DUSI-R domain scores

The DUSI is a self-report questionnaire consisting of 150 YES/NO questions. These questions address issues across 10 domains of psychosocial functioning. The percentage of positive responses to questions in each domain yields 10 separate 'Problem Density' percentage scores and all questions are summed to provide a 'Absolute Problem Density' score or total problems. Adolescents attending substance use services reported significantly more problems with substance use, performance at school and peer relationships than those attending mental health services. There was no statistically significant difference in reported psychiatric symptoms, behavioural problems, social competency, health problems, family problems, difficulties in work functioning or troubles with leisure and recreation time nor total problems between the two groups.

Conclusions

The population presenting to adolescent substance use services predominantly reported problems with cannabis use, whereas mental health service participants' main concerns were with alcohol use. Those attending substance use services reported a similar complexity of problems and the same or higher levels of morbidity as adolescents attending mental health services. These results suggest that youth substance use services attract young people with high needs and as such complement youth mental health services. Future development of substance use services for young people will need to be sophisticated to cater for the complexity of this population's presentation.

Many thanks to the staff of RADS ('Altered High', Te Atea Marino, Tupu) and Marinoto North CAMHS, who kindly gave their time to collect the data for the above study.

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METHADONE PRESCRIBING IN NEW ZEALAND: A NATIONAL SURVEY

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Methadone has been prescribed for opiate dependence in New Zealand since the early 1970s. Since then, numbers in treatment have risen from 219 in 1979 to an estimate of over 3000 in 1999[1]. Methadone maintenance treatment is recognised as an integral part of the harm reduction approach to treating drug misuse.

Current national data on methadone prescribing are not able to give accurate figures on daily doses, take-away doses or even to distinguish between prescriptions for dependence and those for pain relief[2].

Methods

A national survey was conducted in February 2003, with the aim of presenting a 'snapshot' of methadone prescribing patterns in New Zealand. Doctors were asked to provide information on the methadone prescription for each opiate-dependent patient covering the most days in February 2003. The details requested were:

- age and gender of patient
- date that the current treatment episode started
- whether split doses (a daily dose taken in two or more portions) were prescribed
- methadone daily dose in mg
- whether the patient was on a maintenance or reduction regime
- whether the methadone was dispensed at a clinic or community pharmacy
- days on which doses were consumed under supervision
- number of take-away doses per week

Questionnaires were initially piloted with staff at methadone treatment services to establish the feasibility of collecting data and to ensure that instructions were clear and unambiguous. The intention was then to send out a survey questionnaire to all doctors in New Zealand gazetted or authorised to prescribe methadone. Methadone services were contacted first by phone or email to establish willingness to participate and to nominate a key contact person. This person was then asked how many clients were seen by the service and how many GPs were authorised by the service. Questionnaires were then sent directly to the services and prepacked questionnaires were also forwarded on to authorised GPs by the services.

Results

Nineteen major methadone services were involved in the survey. The total reported number of patients was 4185, ranging between 29 and 958 at each service. A total of 372 GPs were authorised by services to prescribe methadone and this group was reported to be prescribing for 24% of patients.

Responses were received from 12 services and 164 GPs, giving data on prescriptions for 2200 patients. This amounts to just over half of the total reported number of patients. The average age of patients receiving methadone was 37 and 58% of patients were male.

The overall mean daily dose was 85.8mg and the median was 85.0mg. These values fall right in the middle of the dose range of 60 to 120mg, recommended in the National Protocol for Methadone Treatment in New Zealand[3], which was current at the time this survey was carried out. Split doses were prescribed for 5% of patients and this group had a significantly higher mean daily dose.

Maintenance doses were prescribed for 92% of patients. The mean number of supervised doses per week was 3.8, with the most common dosing regimen involving three supervised doses and four take-away doses per week. The maximum number of days between supervised doses gives an indication of the maximum number of take-away doses given to a patient at any one time. The mean of this value was 2.1 days, suggesting that prescribing practices are fairly safe in New Zealand. Considerable variations in prescribing patterns were also noted between different regions and between GPs and specialists.

Discussion

While these are only provisional results, it has been possible with this study to present data on prescriptions for 2200 patients. This is over half the population receiving methadone for opioid dependence in New Zealand.

A major limitation of this study was that some whole services were unable to respond. Some questions were also misunderstood by a number of respondents, particularly when we asked for the 'date this treatment episode started'. Problems with misunderstanding were mainly seen with GP respondents and may have been avoided if questionnaires had been piloted with GPs as well as methadone service staff.

A full report on this study will be completed shortly. This will be sent out to all services involved in the study, along with a feedback form to assess the study's methodology.

This study will provide useful baseline data against which to measure any changes in practice in future research. New guidelines on methadone treatment were released by the Ministry of Health earlier this year and a repeat of this study is planned for 2004 to assess what impact the new guidelines have had on prescribing patterns.

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CLIENT SATISFACTION WITH METHADONE TREATMENT USING THE TREATMENT PERCEPTIONS QUESTIONNAIRE (TPQ)

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Introduction

Client satisfaction is one aspect of measuring quality of care and treatment outcome, and is complementary to clinical measures of outcome. Measures of client satisfaction can provide an indication of the extent to which interventions are perceived to meet individual client's treatment needs and wants[1] and can also indicate, in general terms, whether clients feel positive or negative about interventions and care received[2].

The Treatment Perceptions Questionnaire (TPQ) is an instrument developed in the United Kingdom by Marsden et al[1] to measure client satisfaction with substance use treatment. In developing the TPQ, the authors incorporated specific issues that were identified in qualitative studies to be related to satisfaction with substance use treatment services. These included therapeutic relationships with staff, individual treatment goals, how the service operates and having enough time in treatment to deal with issues.

The TPQ is a 10-item scale consisting of five items concerned with the nature and extent of relationships with staff and five items concerned with how the intervention programme operates, including rules and regulations. The total TPQ score is 40 and each item is scored on a scale of 0 – 4 (0 = strongly disagree; 4 = strongly agree). Negatively worded items are reverse scored (i.e. 0 = strongly agree; 4 = strongly disagree). Higher scores indicate higher levels of satisfaction. The aim of this study was to ascertain clients' perceptions of methadone treatment using the TPQ.

Method

The data for this study were collected as part of a research programme evaluating methadone maintenance treatment. Participants comprised two randomly selected samples of Mäori (n = 29) and non-Mäori (n = 64) recruited from the Christchurch Methadone Treatment Programme (MTP) of the Canterbury District Health Board.

The TPQ was administered to participants in a face to face interview in a setting of the participant's choice by either the first author (DD) or the research interviewer (MH), or by phone (two participants). The interviewers emphasised their independence from the MTP, participant anonymity and the confidentiality of information provided. Participants were interviewed between January 2002 and April 2003 and compensated $20 for travel/time.

Results

The average age of participants was 37 years (SD=7.8; range 23-56 years); 55% were male; 31% identified as New Zealand Mäori, 66% as New Zealand European/Pakeha and 3% as other (Samoan, Cook Island Mäori and Irish). Thirty-two percent of participants were in a relationship; 31% were employed/full time student and 19% received a Domestic Purposes Benefit, indicating full-time parenting status. Sixty-eight percent of participants had been on the MTP for more than four years (range one month – 20 years), and for 55% of participants, their current daily dose of methadone was 60mgs methadone or more. Over half (55%) the participants planned to remain at the same dose of methadone, 30% were reducing their dose, 51% were increasing and 8% of participants had completed withdrawal.

In terms of reported drug use in the previous month: 14% of participants reported injecting drugs (4% more frequently than weekly); 27% reported use of benzodiazepines (8% more than weekly use of non-prescribed benzodiazepines); 69% reported use of cannabis (55% more than weekly use); 8% of male participants reported drinking above the New Zealand guidelines for responsible drinking of 21 standard drinks per week for males[3]. No females reported drinking above the guidelines for females of 14 standard drinks per week. Five percent of participants reported use of other non-injecting drug use during the previous month (stimulants, inhalants, hallucinogens) and 86% of participants reported daily use of nicotine.

Overall, while in general participant's felt positive about the MTP (mean score 22.7, SD = 8.6), similar to the finding reported by Marsden et al[1] from the UK oral methadone programme sample (mean score 22.6, SD = 7.7), comments and responses to individual items provided more detailed information. For example, in relation to the item… *The staff have not always understood the kind of help I want…* comments and item scores (mean score 1.8, SD = 1.5) indicated a range of responses, with key factors being attributes of the clinical case-manager and continuity of staff. In relation to the item… *I have been well informed about decisions about my treatment*…(mean score 2.5, SD = 1.5) comments identified the importance of being informed about methadone treatment and about changing clinical case-managers and changing rules and regulations. Likewise, in relation to the item…*I have not liked some of the treatment rules or regulations…*(mean score 1.3, SD = 1.4) comments identified the need for rules and regulations, but also individual flexibility eg in terms of "take away" policies to accommodate people in employment and; highlighted the negative impact of a rigid cannabis use restriction policy.

No differences in TPQ scores were found in relation to socio-demographic variables, treatment variables or types of drug use.

Treatment implications

Treatment implications indicated by participant comments were reflective of research findings in relation to components of effective treatment programmes[4,5].

Important staff factors included

- The therapeutic relationship between the client and clinical case-manager/ counsellor or doctor as a central core component of methadone treatment.
- Continuity of staff
- Staff competencies (skills, knowledge and attitudes)
- Valued consumer input
- Flexible, individualized clinical case-management

Important programme factors included

- Adequate resources and accessibility
- Not underestimating the impact of changing rules and philosophies for long-term clients on their quality of life
- Flexible response to people who are working, parenting
- Ability to meet different levels of therapeutic need
- Striking a balance between a bureaucratic approach and an individualised therapeutic approach particularly for treatment programmes with large numbers of clients.

Conclusions

The TPQ elicited important information on key aspects of MTPs and the total TPQ score was similar to the total score obtained from a UK community MTP sample by Marsden et al[1]. Results support the importance of using standardised measures to systematically obtain clients perceptions of treatment provided. This is particularly so for a client group for whom treatment is long-term and that is vulnerable to changing treatment philosophies and service delivery through changing policies and procedures. Obtaining client comments as well as item ratings is recommended, in order to identify common themes and trends.

In administering the TPQ, care needs to be taken with the negatively worded items to ensure accuracy of ratings. How the TPQ is best administered requires consultation with consumer advisors and may vary from service to service. Clients need to feel safe to provide honest feedback and to feel their views are being heard and taken into account by staff. The challenge for alcohol and drug service providers is to find ways of using measures such as the TPQ within day-to-day practice and to actively use feedback to continue to develop services in partnership with consumers.

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PATIENTS LEAVING METHADONE MAINTENANCE TREATMENT (MMT): AN AUDIT OF THE WELLINGTON OPIOID TREATMENT SERVICE (OTS)

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Over the last decade, there has been considerable emphasis given to the retention of clients in MMT. However, an objective of MMT is eventual withdrawal (National Protocol 2002), but this has been an under-evaluated area in recent years. In 2001 a paper by Lenne et al.[1] examined the issue of suitability to withdraw from MMT and suggested a number of operation criteria that could be helpful in predicting a favourable outcome. This audit examined their criteria for patients voluntarily exiting MMT, as well as the reasons and rates of withdrawal.

Method

A retrospective audit of all patients' files discharged January 2002 to April 2003 was undertaken, and an audit-tool database completed. The Wellington OTS had approximately 410 patients during the study period, with 95 being General Practitioner prescribed by authorisation.

Results

Over the 16 months, 87 patients (about 20%) were discharged. From this group one died (during induction), 20 transferred to another clinic, 32 were involuntarily discharged and 34 completed a voluntary discharge (albeit 7 left the programme abruptly).

Involuntary Discharge

From the sample of 32, there were 16 who were imprisoned and withdrawn according to the prison protocol (5 mg/day reduction to 25 mg – then 2.5 mg reduction per day). The other 16 were discharged for diversion (10), violence and behavioural issues (2), problematic IV drug use (1) and continued other drug use (3). The majority (56%) of these were withdrawn on a schedule of the above "prison-protocol". Four were withdrawn more gradually and three abruptly discontinued the programme during their countdown.

Voluntary Discharge

There were 22 females in these 34 clients. The mean age at discharge was 34 years (range 22 – 53). The duration of this MMT period was 67 months (range 5 – 170 months). Nine were GP prescribed.

Regarding other co-morbidities, it was found, at discharge, that 8 had cannabis dependency, but none were benzodiazepine dependent. Four were considered to be alcohol abusers, two Cyclizine users and five amphetamine users. Five were treated

for depression and 29 (85%) had positive hepatitis C serology. At discharge 19 were medication free, 9 were on ancillary detoxification medication and one was on naltrexone.

Over the three months preceding discharge, 19 of the 34 were considered to have no illicit opioid use. Fifteen of the sample were known to use opioids or other drugs IV once or more per week.

The mean dose of methadone prior to dose-reduction was 86 mg (range: 20 – 185). The duration of reduction was a mean of 13 months (range 5 – 45 months).

The rate of reduction was most commonly 1 – 5 mg/week in 20 patients (59%). Three had a rapid withdrawal using the prison regimen, four withdrew at a rate of 5 mg or more decrement per week, and seven ceased the programme abruptly (immediate discontinuation).

Two patients switched to Kapanol to complete withdrawal, and one underwent rapid detoxification under anaesthesia (Australia).

The reasons noted for wishing to withdraw most commonly were: "readiness to be methadone free" (21), social pressures and stigma (11), and programme "restrictions" (15).

During the managed withdrawal 23 patients had case-management or other A & D support. Three had inpatient detoxification and eight went to a residential treatment programme. Twelve (including the seven abrupt leavers) had no recognised support during the withdrawal. The decision to withdraw was strongly supported by Clinicians in 19 of these 34, clinicians expressed ambivalence in 5 cases, and did not support withdrawal in a further 7.

With reference to the "operational criteria" described by Lenne et al, the following analysis for such criteria was met among these 34 clients:

Criteria	*Number*	
1. Opioid Abstinent	19	(55%)
2. No polydrug abuse	24	(70.5%)
3. No significant psycho-social issues	23	(67.6%)
4. No medical/psych condition complicating withdrawal	33	(97%)
5. Pregnant/breastfeeding	0	
6. In MMT > 6 months	33	(97%)

It was found that 18 (53%) met all of the criteria.

Conclusions

Our principal observations from this audit include that many more patients than generally appreciated exited this MMT programme. However, approximately 50% are involuntary discharges due to imprisonment or breach of programme compliance/safety issues, and a further 20% "jumped-off" the programme.

It was noted that of those who cooperated with a voluntary withdrawal programme, there is a preponderance of women (66%). We were reassured that there were only low levels of benzodiazepine use/dependence. Over one half of these clients had strong Clinician support for the withdrawal, which was predominantly a gradual withdrawal over more than one year.

Encouragingly, 18 of the 34 voluntary discharges met all of the proposed operational criteria, which to our knowledge is the first analysis of this approach. It would be worthwhile to establish whether these 18 had positive long-term outcomes, but this audit did not seek to undertake longer-term outcomes and follow-up.

Finally, the stated reasons for wishing to leave MMT are salutary. It may be that clinicians underestimate the restrictions placed on clients by programme conditions (pharmacy, clinic visits, urine drug screens and interference with employment). Also, despite the advances in promotion and acceptance of MMT (by health professionals and the public) there is much perception of stigma by clients, their friends and families.

Despite the agenda to retain patients in MMT, and an awareness of the relapsing nature of drug dependency, many clients express a goal of being methadone free. The challenge for clinicians is how best to identify those with the more secure prognosis for success, and how best to support them. This audit offers preliminary information about current practice.

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TOBACCO PREVALENCE RATES IN A GROUP OF ADOLESCENT PSYCHIATRIC OUTPATIENTS

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Background

International smoking prevalence rates among patients with mental health problems (55-90%) are considerably higher than among the general population (30%). While an association has been established between smoking and some psychiatric disorders in adults, similar investigations in adolescent populations have been minimal. Studies conducted in the late 1970's and early 1980's of adolescents reported links between tobacco use and neuroticism, neurotic symptoms, poor coping strategies and low self-esteem. Subsequent research indicated that adolescents with symptoms of anxiety and depression are at higher risk for smoking initiation and the later development of nicotine dependence than non-symptomatic adolescents. Recent investigations suggest that smoking rates among adolescents in New Zealand and elsewhere with mental health problems are estimated to be in the region of 30-60%. While daily smoking among the wider community of 14-19 year olds in New Zealand is estimated to be in the region of 11-20%, the specific rate in adolescent mental health populations has not been well identified. To date few studies have focused on a relationship between psychiatric disorders and smoking among adolescents and what has been reported involves the examination of medical records, primarily in inpatient units, rather than surveying actual prevalence rates from face to face interviews.

Objective

The aim of this study was to ascertain the smoking prevalence rates among adolescent psychiatric outpatients and to investigate the potential factors and mechanisms underlying a possible association between smoking and mental health disorders. In order to do this four key questions were explored:

1. What is the pattern of tobacco use including prevalence of nicotine dependence in a clinical sample of adolescents?
2. What is the relationship between nicotine dependence and demographics?
3. What is the relationship between nicotine dependence and other substance use disorders?
4. What is the relationship between nicotine dependence and other psychiatric disorders?

Method

Face to face interviews were conducted with 90 patients (13-18 years) who underwent an intake assessment at the Youth Specialty Service, an adolescent

outpatient mental health service in Christchurch during a four month period (June to September 1998). A 14-item questionnaire was administered to ascertain past and present smoking status, age of first use and opinions on smoking. Additional information was gathered from a systematic search of each patient's clinical file to determine demographic information, referral agent, psychiatric diagnosis, number of treatment sessions, duration with service and success or otherwise of treatment.

Results

The rate of current smoking was 45.5%, with the mean age of first use being 11.7 years. Identified in the sample, of the 41 smokers were significantly more were Mäori than non-Mäori (17.5% and 82.5% respectively, $p<0.02$) and more females than males were nicotine dependent (65.9% and 34.1%, $p<0.05$). There was a chart diagnosis of nicotine dependence for 15.6% of the sample, significantly more smokers than non-smokers meet the criteria for conduct disorder (29.3% and 12.8% receptively, $p<0.05$), cannabis (36.6% and 2.1% receptively, $p<0.001$) and alcohol (34.1% and 6.4% receptively, $p<0.001$) use disorder (either dependence or abuse), however no difference was detected between groups in relation to depressive and anxiety symptoms.

Conclusions

The results from this sample indicate that smoking is highly prevalent in adolescents with psychiatric problems, but nicotine dependence is under diagnosed. This research suggests that young people with mental health problems are almost three times more likely to smoke than adolescents in comparably aged community samples. Age of first use is earlier and regular smokers younger in psychiatric adolescent populations than their general population counterparts. While this study supports other general and adolescent population studies, whereby female smoking rates are higher than their male counterparts, these differences appeared even larger in this study with almost twice as many female as male adolescent outpatients reporting regular smoking. The general theme running through previous studies is of adolescent smoking linked to a pattern of deviant behaviour including externalising behaviours and substance misuse and/or smokers with depressive and anxiety symptoms continuing to smoke (self-medicate) in order to cope with their distress. As conduct disorder, cannabis and alcohol disorders were highly co-morbid with tobacco smoking and depression was not, these findings suggest that depressive and anxiety symptoms in adolescents are not as strongly related to nicotine dependence as substance use and externalising behaviour disorders.

Implications

Neglecting the investigation of tobacco use in adolescent psychiatric populations has a number of implications including the potential to mask the diagnosis of some psychiatric disorders, influencing treatment outcomes and losing a vital opportunity to administer effective cessation interventions. Furthermore, screening for tobacco smoking in psychiatrically disordered adolescents may provide an opportunity for clinicians to explore other drug taking behaviour. Given that adolescents with psychiatric disorders have a unique set of problems that may contribute to the limited success of standard interventions, it is highly likely that specialised programmes incorporating effective prevention and cessation practises need to be tailored. Age appropriate prevention programmes and treatment interventions aimed

at high risk adolescents are particularly important as early onset of smoking may be a significant indicator of future substance abuse. Understanding gender differences related to smoking is vital in the development and subsequent implementation of cessation programmes and research is required to identify the issues associated with smoking among psychiatrically disordered girls.

MINIMAL METHADONE TREATMENT: A PILOT METHADONE TREATMENT DEVELOPED BY NORTHLAND A&D SERVICE AND DELIVERED BY GENERAL PRACTITIONERS

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Background

Perhaps the greatest problem facing those working in the field of methadone maintenance treatment (MMT) in New Zealand is that of waiting lists for treatment. Delay in starting treatment is contrary to the harm reduction principles on which MMT is founded and exposes clients to significant on-going harm[1,2]. Given that funding for MMT programmes is likely to be constrained in the foreseeable future, new approaches are required outside of existing services. One such approach is the use of *"Interim"* or *"Low Threshold"* treatment. This treatment is characterised by rapid admission into methadone treatment, but with the provision of only minimal ancillary services and has already been proposed in N.Z.[3,4]. These methods of MMT delivery have been found to be safe and effective in the United States[5,6] and the Netherlands[7-11].

A number of issues arise in relation to the feasibility of low dose methadone prescribing by GPs, as opposed to A&D services. Few GPs are interested or adequately trained in prescribing methadone, and evidence from Australia and the UK highlight pitfalls in GP prescribing practices[12,13]. Ethical dilemmas could also arise if a client cannot afford to continue paying fees for treatment and the GP considered stopping treatment. There has been no research to examine the feasibility or efficacy of such treatment in the New Zealand setting. The aim of this research is to provide such evidence and to simultaneously alleviate the plight of those on the Whangarei MMT waiting list.

Methods

A prospective cohort study design was used to assess the effects of providing minimal methadone to MMT waiting list clients. Given the strong likelihood of benefit it was considered unethical to randomise patients to no treatment (i.e. remaining on waiting list). Outcomes were measured by using the Methadone Treatment Index (MTI see below) at three-monthly intervals, with treatment continuing until the patient was admitted to the MMT programme.

- *Subject Selection* - patients were selected from the MMT waiting list, and as such had all been previously assessed by the A&D service, including urine drug screen (UDS) and MTI
- *GP Role* - initiates and manages patients in the private sector
  - must have appropriate training
  - authorised to prescribe by A&D service
- *A&D Service role* – no direct input or monitoring involved other than managing MMT waiting list

- *Methadone Regime* - NO TAKEAWAYS
  - max starting dose 20 mg , increased 10mg per week prn
  - max dose 60mg
  - no benzodiazepines prescribed
- *Outcome Measure*
  The "Methadone Treatment Index" (MTI)[14] is a questionnaire comprising three sections that covers drug use (Degree of Drug Use Index = DDI), social and behavioural functioning, and general health. Each section has a possible score of 50, with lower scores indicating better outcomes. The MTI is done as part of the initial A&D assessment for placement on MMT and provides the baseline pre-treatment level, reflecting the initial level of drug use and dysfunction in the patient's life. The GP repeats the MTI three-monthly until the patient enters conventional MMT.

Results

From the eight patients who started on minimal methadone, five are currently still receiving minimal treatment, one has successfully withdrawn off opiates altogether, one is now in prison, and one has transferred to conventional MMT. Seven of these eight patients had completed a three-month repeat MTI. Table 1 shows change in MTI total scores and DDI subtotal scores at baseline and at the first three-month follow-up appointment for seven patients.

Table 1: MTI total and DDI subtotal scores: baseline and three-months follow-up, n=7

			MTI total		DDI	
Age	Gender	Methadone Dose	Pretreatment	Three months	Pretreatment	Three months
35	M	60mg	62	22	23	6
38	F	15mg	55	23	20	1
23	M	60mg	66	55	30	16
31	M	60mg	52	29	12	4
45	M	60mg	70	59	28	19
37	M	50mg	51	13	19	1
31	M	60mg	52	31	8	1
Mean score			58.3 (7.7)	33.1 (17.3)	20.0 (8.0)	6.9 (7.6)

Analysis of MTI scores showed that the data were not normally distributed, hence non-parametric Wilcoxon Signed Rank test was used. There was a highly significant fall in scores after treatment, with $p = 0.018$ for both DDI and total MTI scores. In all cases there was a reduction in both MTI total and DDI scores.

Summary

Minimal methadone treatment is an evidence-based initiative to alleviate the plight of those on MMT waiting lists. Lack of interested and adequately trained GPs is a limiting factor if treatment is to be provided in the private sector. The results of this

pilot study show clinically significant gains in harm reduction were achieved, based on MTI scores.

Acknowledgement

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PROJECT ON ADOLESCENT CANNABIS USE AND COGNITION: INTERIM RESULTS

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Introduction

Cannabis is a drug that receives a lot of attention in the popular media, being both extolled and demonised. The present study aims to investigate the non-acute effects of cannabis on adolescent cognition. This report is an examination of results to date as of Cutting Edge 2003.

In Australia 39% of the general population have tried cannabis, in New Zealand this number is closer to 50%. Youth presenting for treatment are doing so primarily for alcohol and cannabis difficulties. The relationship between adolescent cannabis use and outcomes remains unclear, despite the fact that by the age of 21 years 70% of adolescents will have tried cannabis. The 2003 Parliament Committee Report on public health strategies related to cannabis acknowledged, "The results indicate that a significant proportion of New Zealanders have used cannabis at a young, formative age."

Cannabis is known to be a drug with acute cognitive effects (memory loss, time distortion) and subtle long-term cognitive effects (difficulties focussing, sustaining and shifting attention). What is not known is the long-term effect cannabis is having on adolescent cognition, where the brain is still maturing. The cognitive deficits from cannabis have been shown to significantly effect the frontal lobes. While the human brain has reached 95% of its full volume by age 5 years, it is still maturing until late adolescence and the frontal lobes are an area particularly late to advance. There is already evidence that alcohol has a distinct effect on maturing adolescent rat brains.

For adolescents this is a concern. In the first instance, adolescents are in an accelerated phase of life in developing cognitive abilities and expanding their knowledge-base through education. Secondly, concerning for adolescents is the finding that cognitive deficits from cannabis in adults may not be entirely reversible or reversible for all individuals. Consequently, the Project on Adolescent Cannabis and Cognition (PACC nee PYCANS) is aimed at exploring the relationship between adolescent cannabis use and cognition whilst considering a number of intervening variables that may effect this relationship.

Method

The study is interviewing 120 adolescents – 80 from a clinical setting (Youth Speciality Services, Hillmorton Hospital, Christchurch) and 40 from two local Secondary Schools. Each adolescent is interviewed twice, once at baseline and then at a 3-6 month follow-up. To date most interviews have been conducted at the NAC offices, though adolescents are offered a range of options of venue. The study measures adolescent drug use as well as mood, psychiatric functioning, personality, general functioning and demographics. As well as using traditional pen and paper cognitive tests we are utilising a computer package developed in the United Kingdom (CANTAB). Through interactive tasks CANTAB measures cognitive functioning and is able to distinguish very subtle deficits. The cognitive measures are primarily measuring frontal lobe functions related to attention and memory, as well as a premorbid measure of intelligence.

Data collection has been underway for a year and 19 initial interviews have been done. The following results are from this sample.

Results

The sample is comprised 47% male and 53% female. Sixty three percent are NZ European and 26% identify themselves as Mäori. The mean age is 16 years 3 months, with age ranging from 14 years 7 months to 18 years 1 month.

One hundred percent of the sample had tried alcohol, cannabis and nicotine. These three drugs were also the most common to have been used in the last month (84%, 84%, and 89% respectively). Hallucinogens had been tried by 79%, solvents by 74%, stimulants by 58%, benzodiazepines by 53%, and opioids by 32%. Use in the last month was more common for solvents and hallucinogens (15% and 10%). Additionally, opioids (5%) and stimulants (5%) had been used in the last month, benzodiazepines had not.

The level of cannabis use was, as expected, high. Only 2 adolescents had not used more than 5 times within a month at some time. The average age for first use of cannabis was 12 years (the range being from 5 years to 15 years). The age of heaviest use was later, ranging from 11 years to 16 years with an average of 14 years.

Cannabis use was quantified by dividing days into four six-hour blocks (e.g. 6am-12pm and thus 28 blocks in a week). Use in the past month ranged from 0 to 56 blocks, with a mean of 10. Three adolescents hadn't used in the last month, though the majority had used on at least 4 occasions in the past month. Two had used every

day in the last month. In terms of recency, in current users most had used within the last 5 days.

The average IQ of these adolescents was 99 (the general population average is 100), with a range of 77 to 122. For the Digit Span (memory) task the maximum score possible is 28. The adolescents in this sample had scores ranging from 8 to 21 with an average of 13. In the Rey Auditory Verbal Learning Test (a task of verbal declarative memory with a working memory component) the number of words to learn is 15. The present sample recall on the fifth trial ranged from 5 to 15 with an average of 12. On the interference trial (after hearing a distraction list) recall ranged from 8 to 15 with an average of 12. Reporting of the CANTAB results is beyond the scope of this presentation and paper.

Depression and drug disorders were the most common psychiatric disorders with 57% having experienced past depression or a drug disorder, while 21% were currently depressed and 36% had a current drug disorder. Ten percent of the adolescents had a past eating disorder, though none were currently experiencing one. The incidence of alcohol disorders (abuse and dependence) was also high with 31% experiencing a current disorder and 31% a past disorder. Finally, 21% had experienced an anxiety disorder in the past and 26% had one currently. Anxiety disorders included panic disorder, agoraphobia, social phobia, post traumatic stress disorder, and generalised anxiety disorder.

No clear conclusions can be drawn at this time. There continues to be the wide range of cognitive ability and drug use seen in the case studies presented last year in this Monograph. At present there is no obvious relationship between cannabis use and cognitive functioning. This is, however, to be expected with such small numbers.

WEB-BASED SCREENING AND BRIEF INTERVENTION (E-SBI) FOR HAZARDOUS DRINKING: A DOUBLE-BLIND RANDOMISED CONTROLLED TRIAL

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The e-SBI instrument can be viewed at http://ipru.otago.ac.nz/sbi1demo

Despite strong evidence of its efficacy in reducing hazardous drinking, screening and brief intervention (SBI) is not yet routine in primary healthcare in any country. Various problems have been highlighted regarding its implementation in healthcare systems, not least of which is a reluctance of some doctors to proactively discuss alcohol with their patients. Research conducted with tertiary students, a group with a high prevalence of hazardous drinking, suggested that they would be unlikely to engage in a discussion about their drinking with a healthcare professional, which was not self-initiated[1]. That research showed that web-based assessment and personalised motivational feedback (known generically as electronic screening and brief intervention, e-SBI) would be more acceptable to students[2].

e-SBI has certain advantages over practitioner-delivered SBI: it involves little or no clinician time, it can be conducted anonymously, and it can be accessed without limitations of distance. Additionally, e-SBI may be less threatening to hazardous drinkers, than a face-to-face intervention. The aim of this study was to determine the efficacy of e-SBI in reducing hazardous drinking among tertiary students.

Methods

Users (aged 17-26 years) of the Student Health Service were invited to complete web-based screening. Individuals scoring 8+ on the AUDIT and reporting >4/6 standard drinks (females/males) on 1+ occasions in the preceding 4 weeks, were eligible to participate. Participants and research staff were unaware of group allocation during intervention and follow-up (i.e. it was a double-blind study).

Intervention consisted of on-line self-assessment and personalised feedback. This included a summary of recent consumption, risk status, consumption relative to

recommended upper limits, an estimate of their peek blood alcohol concentration and comparisons with national and university norms.

Participants completed a six-week assessment by clicking a hyperlink to the site, sent to their e-mail address. A posted questionnaire was used for six-month follow-up.

Outcome measures:

1. Frequency of drinking: drinking days in preceding 2 weeks;
2. Typical occasion quantity: drinks per typical drinking occasion;
3. Total volume: drinks consumed in the preceding 2 weeks;
4. Frequency of very heavy episodes: occasions where >80g/120g ethanol (females/males) was consumed;
5. Personal, social, sexual, and legal consequences: items endorsed on the Alcohol Problems Scale
6. Consequences related to academic performance: a score on the Academic Role Expectations and Alcohol Scale

Analysis

Outcomes 1-5 were analysed using negative binomial regression for panel data. For outcome 6 we used linear regression analysis for panel data, after log transformation. Models adjusted for baseline differences by including the AUDIT score, and included terms for group assignment, follow-up assessment, and their interaction, using the *xtnbreg* procedure in STATA. The interaction term tested for differences in the intervention effect between the two follow-up assessments.

Results

One hundred and twelve students were eligible, of which 104 consented to follow-up and were randomly assigned to intervention (n=51) and control (n=53) groups. At baseline, mean AUDIT scores (SD) were 16.6 (6.0) and 16.6 (5.7) respectively. Assessments were completed by 83 participants (42 intervention, 41 control) at six weeks, and 94 participants (47 intervention, 47 control) at six months.

Estimates of the effect of the intervention are presented in Table 1, as the ratio of the geometric mean of the intervention group to that of the control group. At six weeks, relative to controls, the intervention group reported lower total consumption, and fewer heavy episodes and alcohol-related problems. For quantity consumed per typical occasion, both groups reported reductions at six months relative to six weeks (ratio = 0.75; 95% CI: 0.71 to 0.91). At six months personal and academic problems remained lower, even though reductions in consumption were no longer significant.

Effect sizes were computed for an aggregate of alcohol consumption measures and for alcohol-related problems. These are presented in the lower part of Table 1.

Table 1: Six-week and six-month intervention effects, based on random effects models

Outcome	***Ratio of geometric means**** *Intervention/Control*	*(95% CI)*	*p*
1. Frequency of drinking			
6 weeks	0.80	(0.63 to 1.02)	0.08
6 months	0.84	(0.67 to 1.06)	0.15
2. Typical occasion quantity			
6 weeks	0.84	(0.68 to 1.04)	0.11
6 months	1.02	(0.81 to 1.27)	0.89
3. Total consumption			
6 weeks	0.74	(0.56 to 0.96)	0.03
6 months	0.90	(0.70 to 1.18)	0.46
4. Frequency of very episodic heavy drinking			
6 weeks	0.63	(0.42 to 0.94)	0.02
6 months	0.85	(0.59 to 1.22)	0.38
5. Personal, social, sexual, and legal consequences of episodic heavy drinking			
6 weeks	0.70	(0.54 to 0.91)	0.01
6 months	0.76	(0.60 to 0.97)	0.03
6. Consequences related to tertiary student role expectations			
6 weeks	0.74	(0.53 to 1.03)	0.07
6 months	0.72	(0.51 to 1.02)	0.06
Summary effect sizes** (95% CIs)	6 weeks	6 months	
Consumption measures (outcomes 1-4)	0.40	0.15	
Alcohol-related problems (outcomes 5-6)	0.45	0.44	

* The exponent of the arithmetic mean of the log-transformed data.

** Positive values for effect sizes indicate better outcome for brief intervention compared with control.

Discussion

At six weeks, the intervention resulted in reductions of 26% in total consumption, 37% in very heavy episodes, and 30% in alcohol-related personal, sexual, and legal problems. At six months, there were reductions of 24% in alcohol-related personal, sexual, and legal problems and 28% in consequences related to academic role expectations. For typical occasion consumption, the groups were similar at six months, the controls apparently reducing their consumption subsequent to six-week assessment.

It is possible that intervention group members underreported their drinking, having been provided with personalised feedback at an earlier stage. If underreporting occurred to a greater extent than among controls, the efficacy of the intervention would be overstated. For self-reported alcohol consumption, the likelihood of under-reporting is reduced when assessment procedures minimise the potential cost of an honest response. In this study participants were assured of confidentiality, no names were used and judgmental language was avoided.

As was shown in a meta-analysis conducted by Moyer et al.[3], $\leq$ 3 month effect sizes (and 95% CIs) for interventions targeting individuals not seeking treatment, were 0.67 (0.39 to 0.95) for alcohol consumption and 0.30 (0.08 to 0.52) for measures of alcohol-related problems. The e-SBI effect sizes fall within the confidence intervals for the Moyer et al. estimates.

For 3-6 month outcomes, Moyer et al. estimated effect sizes of 0.16 (0.10 to 0.22) for alcohol consumption and 0.14 (0.08 to 0.21) for alcohol-related problems. e-SBI effect sizes suggest similarly modest impacts on consumption, but larger decrements in alcohol-related problems. It can therefore be concluded that, in the short to medium term, for university students, e-SBI performed as well as practitioner-delivered brief interventions have in non-student populations.

A strength of the study was the naturalistic setting. Previous trials with tertiary students have occurred in artificial conditions, e.g. psychology classes or with highly self-selected participants, such that results may generalize poorly to settings in which SBI could be delivered in a sustainable manner. e-SBI shows promise for reducing hazardous drinking among tertiary students. The authors are presently seeking to replicate the findings in a larger trial and to investigate the application of e-SBI in other groups of drinkers.

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THE PHENOMENOLOGY OF PATHOLOGICAL GAMBLING AND OTHER BEHAVIOURAL ADDICTIONS

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Introduction

Pathological gambling (PG) first appeared in the DSM III in 1980 as an Impulse Control Disorder (ICD). Since then, its conceptualisation has remained in evolution. It has also been variously considered as an obsessive compulsive spectrum disorder and an addictive disorder. Understandably, the course and direction of research were influenced by researchers' perspective of the disorder, and vice versa. Even though phenomenologically, PG resembles an addictive disorder, there has been little research in this direction. More recently, the concept of addictive disorders has been expanded to include addictive behaviours involving everyday activities, and it may be difficult to define when an excessive behaviour becomes pathological. In this study, we attempted to explore the relationship between PG and some of these behaviours, including: pathological buying, pathological internet use, excessive video game playing, excessive exercising, pathological eating behaviour, compulsive sexual behaviour and excessive telephone talking.

Aims

In this study, we conceptualise gambling as an addictive behavior and PG as primarily an addictive disorder as defined by the DSM-IV criteria adopted from similar criteria for substance dependence. The specific aims of the study were to:

1. Ascertain if DSM-IV PG criteria correlated with the dependence criteria
2. Determine rates of co-existing addictive behaviours as defined by the Behavioural Addiction Questionnaire (BAQ)
3. Explore rates of psychiatric comorbidity

Methodology

This was a prospective descriptive study consisting of a 2-hour face-to-face interview with the participants, who were recruited from two problem gambling counselling centres in Christchurch. People who scored 5 or more on South Oaks Gambling Screen and DSM-IV PG criteria were included. Approval from the Ethics Committee and informed consent from patients were sought before the study began. During the interview, participants completed the research protocol comprising: Demographic data, Gambling Behavioural Questionnaire, BAQ, Scheduled Clinical Interview for DSM-IV Axis I disorders (SCID) version II for the identification of psychiatric disorders; and questionnaires about general, social functioning. The BAQ was adopted from the SCID, where the dependence criteria for substance use disorders were adapted for use on persons presenting with PG and other addictive behaviours.

Individuals who satisfied 3 or more criteria out of 7 would be deemed to have an addictive disorder for that particular behaviour/activity.

Results

Out of the 39 participants recruited, 15 were males and 24 were females. The mean age was 45.9 years. Seventy-nine percent were New Zealand Pakeha and 13% Mäori. Forty-four percent were in a relationship. The mean number of years of formal education was 12 and only 54% were working. The average income was $23,205 per person per annum before tax. Seventy two percent were in debt, averaging $30,939. The mean score on the Global Assessment Functioning (GAF) scale was 66.2, thus the participants were experiencing moderate difficulties in their socio-occupational function or relationship with others. More than half of the participants were severely dissatisfied with their finances and relationship status. Most sought help through the phone book and helpline, and 85% received funded personal counselling. The main presenting problems were debt and family or marital difficulties. Eleven percent presented for counselling unwillingly.

The mean age of onset of their gambling was 33.9 years old and the mean duration of problem gambling was 11.3 years. The three most common modes of gambling were machines outside casino (90%), machines in casino (90%) and lotto (87%). Men tended to engage with lotto and machines, and females mainly with machines. The mean scores for SOGS and DSM-IV criteria were 11.6 and 8 respectively. All of them satisfied the dependence criteria and there was a high correlation between the PG and the dependence diagnoses.

Eighty two percent of participants had a lifetime prevalence of psychiatric disorders, including: major depression (69.2%), panic and phobic disorders (36.3%), generalised anxiety disorders (33.3%), alcohol & drug use disorders (33.3%), post-traumatic stress disorders and eating disorders (both 23%). The mean number of psychiatric disorders suffered over their lifetime was 3.5. Fifty four percent of participants had other behavioural addictions including pathological eating (33%), excessive electronic games playing (22%), pathological buying and exercising behaviours (both 11%). The mean number of behavioural addiction was 2.2. In the family history, the percentages of participants with family members with alcohol-related problems, psychiatric disorders, gambling problems and other behavioural addictions were 70%, 65%, 47% and 30% respectively.

Discussion

The sample consisted of a group of severe pathological gamblers. The age, mean SOGS scores and debt level corresponded with those of a community sample of pathological gamblers seeking help, though females were over-represented in the current sample. A number of findings provided the basis for conceptualising PG as an addictive disorder:

1. High rates of gambling, alcohol, drug problems in the family history
2. Its association with other co-existing addictive disorders and behavioural addictions
3. The high correlation between those satisfying the DSM-IV PG criteria and the corresponding criteria in the dependence disorder

The results were in support of possible genetic factors between PG with other addictive behaviours and common underlying vulnerability factors between PG and alcohol dependence. The association of PG with other addictive behaviours is a relatively new and understudied area and more research could be done in future in this regard. More significantly, the rate of psychiatric comorbidity was high and in comparison with other studies, there were similar rates for depressive illnesses, but a much lower rate for bipolar illnesses, higher rates of anxiety disorders and an association with eating disorders.

Conclusions

Despite the limitation of a small sample size, the results are compelling and pertinent to the notion that PG could be suitably conceptualised as an addictive disorder. The high rates of comorbid psychiatric disorders implies that active incorporation of assessment and diagnosis of these disorders should occur in the total management and treatment of PG, including, if necessary, psychiatric referrals and medication trials. Lastly, treatment should also address issues relating to the associated behavioural addictions.

BENZODIAZEPINE PRESCRIPTION IN WELLINGTON OPIOID TREATMENT SERVICES

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Objective

This file review set out to explore & quantify the prescription of Benzodiazepines (BZD) for those receiving treatment at Wellington Opioid Treatment Services (OTS). We had experienced difficulties in managing those prescribed BZDs and were keen to explore the size of the problem to inform our resource allocation.

Method

Every current file held at OTS was submitted to a 10-minute limited review using a specially devised audit tool. The tool comprised of a series of structured questions to cover details of BZD prescription – type, dose, duration & rationale. All psychiatric diagnoses were derived from the clinical file also. BZD doses were converted to Diazepam Dose Equivalents (DDE) using Ashton's scale. If the file indicated current BZD prescription, then further details were sought, including: (i) methadone dose prescribed; (ii) nature & extent of other drug use; (iii) state of physical & psychiatric health. The time limit of each review was designed to allow straight forward collation of BZD details (given their ready accessibility on a prescribing cover sheet), whilst the other information was taken from correspondence, discharge summaries and other predominantly typed assessments. GP prescribed methadone patients were not included.

Results

Two hundred and sixty nine (100% as checked against a patient register) of OTS files were subjected to the review. 50 clients (18.5%) were receiving a prescription of BZD, mean age 39yrs (range 25-49), of which 26 (52%) were female. Mean DDE was 25mg (range 2-80, but with upper range skewed by 2 Clonazepam prescriptions converting to high DDE), with a mean DDE of 21mg for females and 29.5mg for males. BZD dose followed a largely direct linear relationship to methadone dose (mean for BZD group 133mg, range 0-360mg). The relationship between age and BZD dose was direct and inverse, with mean DDE of 34mg for 25-29yrs falling incrementally to 17mg for 45-50yrs. The duration of BZD prescription was over 2 yrs in 41 subjects (82%), and had been static for 38 (76%) over the previous 2 months. Rationale for prescription was recorded in 17 case notes (34%), with commonest reasons being Treatment of Dependence, Harm Reduction and Methadone Withdrawal (13, 3, 2 cases respectively).

Forty-four subjects (88%) were recorded as using other drugs including 39 Cannabis (mean DDE 25mg); 4 Nicotine (mean DDE 29mg); 7 Alcohol (mean DDE 39mg); 6

Cyclizine (mean DDE 26mg); 6 Amphetamines (mean DDE 28mg), with the 6 (12%) not using other drugs having a mean DDE of 16mg. Twenty-four (48%) had a record of physical illness. Thirty-eight (76%) were Hepatitis C positive (DDE 23mg), 9 (18%) core antibody positive for Hepatitis B, with Deep Vein Thrombosis, Chronic Pain, Hypothyroidism, Arthritis, Seizures and CORD being present in 2 (4%) of subjects each. Mean DDE for those with a medical diagnosis other than Hep C was 27mg. Thirty-five (70%) had a record of psychiatric disorder and a mean DDE of 29mg: Depression in 21 subjects (mean DDE 24mg); Anxiety in 11 (mean DDE 30mg); PTSD in 5 (mean DDE 27mg); and Antisocial Personality Disorder/Prominent Traits in 4 (mean DDE 49mg). All subjects had at least one complicating factor of Other Drug Use, Physical or Psychiatric illness.

Conclusions

The results suggest that the majority of those prescribed BZD through OTS were comparatively stable in their BZD use in terms of longevity of treatment and stability of dose. Similarly, the dose generally did not seem excessive for a tolerant population. Although treatment rationales were poorly recorded, prescription appeared most likely to be for BZD Dependence, if only as a secondary (iatrogenic) effect of a different original rationale.

Comorbid psychiatric disorder appeared over-represented compared to the literature suggesting rates of around 50% in methadone prescribed populations. This may indicate BZD treatment (ill advised or otherwise) of psychiatric disorder, especially depression. Alternatively this may suggest that this is a multiply disordered group, with perhaps the presence of two disorders increasing the likelihood of a third (or more, given the finding that all subjects had at least one complicating factor).

Clients using alcohol or suffering from ASPD/Traits were prescribed larger BZD doses, although numbers were small. We were unclear why this was the case in those using alcohol, which would appear to be a relative contra-indication to BZD prescription. In those with antisocial functioning, the higher BZD dose was skewed by Clonazepam prescription. In addition, case review indicated that the prescription was a considered and monitored component of (predominantly harm reduction) treatment, and did not appear to result from coercion or deception on the part of the client.

The literature suggests that it is a minority (possibly 30%) who develop BZD dependence after prolonged prescription and that withdrawal over comparatively short periods would generally be successful. We felt that extrapolation of these findings to a methadone prescribed group was likely to be flawed, given that the population has been selected as having a vulnerability to addiction.

Pragmatically, this audit suggested that we should consider whether we re-directed our (finite) resources. There was a danger we were using BZD prescription as a marker for greater input, arising not least from our underlying belief that most BZD prescription was inherently misguided. Whilst this belief may or may not have changed, we reconsidered whether to focus on other more pressing problems. Indeed, we questioned whether we should target our resources more on capturing those using erratic, illicit BZDs, some of whom might benefit from stabilization on prescribed BZDs before further management. This study suggested to us that those prescribed both methadone and benzodiazepines were likely to suffer multiple

difficulties, but that the BZD prescription *per se* appeared a relatively stable process. In the light of this, we questioned whether withdrawal of BZD prescription should be a primary treatment target in this group.

PACIFIC CLIENTS AT CADS – RESULTS OF 460 SCREENING ASSESSMENTS

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Introduction

There is very little quantitative clinical data available on Pacific clients receiving counselling from community alcohol and drug services. After 4 years of data collection at the Auckland *CADS* service (Community Alcohol and Drug Services), sufficient data on Pacific clients is now available (N=460) for some preliminary analysis.

The data analysed here came from the standard *CADS* brief screening package, which includes the *AUDIT* (Alcohol Use Disorders Identification Test), *LDQ* (Leeds Dependence Questionnaire), *SDS* (Severity of Dependence Scale), and Level of Use and Mode of Use questions. Over 8,000 packages have been completed so far.

Methods

In the following discussion, problems are defined with reference to both dependence and use. Alcohol use is defined as problematic if the *AUDIT* score is 13 or higher, or if the *LDQ* score is 10 or higher. For other drugs, the problem criteria are as follows:

Drug	**SDS score**		**Level of Use**
Cannabis	3 or higher	OR	Daily or more frequently
Opiates	4 or higher	OR	Weekly or more frequently
Amphetamines	4 or higher	OR	Weekly or more frequently
Benzodiazepines	7 or higher	OR	Weekly or more frequently
Other	4 or higher	OR	Weekly or more frequently

Some of the potential biases in the screening results for Pacific clients must also be taken into account. Possible factors include the cultural background of the person completing the screen (whether client or counsellor) – how well are specific cultural/language issues dealt with? There is also the question of how clients came through the general *CADS* triage process – was *Tupu*, the Pacific team, involved?

And if *Tupu* was involved, were there any issues arising from differences between clients and counsellors – for example, younger clinicians seeing older, more senior, clients. Finally, there may be issues associated with the non-completion of screens by some Pacific clients.

Results

Looking at the demographics of Pacific clients, the average Pacific client is younger – 22% are under 20 years old compared with 13% for other New Zealanders. This may reflect the fact that 60-70% of the Pacific population in New Zealand is New Zealand-born. There are also fewer female clients – 28% versus 35%. All analyses in this paper are age-sex weighted as appropriate to take these differences into account. It must also be recognised that the category "Pacific" covers a diverse range of people – for example, different ethnicities and New Zealand born versus Pacific born.

The first comparison examines the overall pattern of problems (for those with a recorded problem). The most prominent difference is that the group "Alcohol only" is much larger for Pacific clients, as shown in Table 1.

Table 1: Main Problems (where possible to identify)

Problem substance/s	Ethnicity				Significance
	Pacific Nation		Other New Zealanders		
	Count	Col %	Count	Col %	
Alcohol use only	198	51.4%	2197	35.1%	<0.001
Alcohol and cannabis use only	81	21.0%	902	14.4%	<0.001
Cannabis use only	49	12.7%	988	15.8%	NS
Alcohol, cannabis, and others	19	4.9%	482	7.7%	<0.05
Opiate use only	6	1.6%	295	4.7%	<0.01
Other combinations	32	8.3%	1399	22.3%	<0.001
Total	385	100.0%	6264	100.0%	

Looking at problem levels for each drug separately, displayed in Table 2, the dominance of alcohol is highlighted, most strongly for Pacific clients.

Table 2: Problem Level for Each Drug

Substance		Ethnicity				Significance
		Pacific Nation		Other New Zealanders		
		Count	Col %	Count	Col %	
Alcohol	Problem use	312	68.6%	3938	54.1%	<0.001
	No problem	143	31.4%	3340	45.9%	
Cannabis	Problem use	164	36.4%	3045	42.1%	<0.05
	No problem	286	63.6%	4195	57.9%	
Opiates	Problem use	12	2.6%	867	12.0%	<0.001
	No problem	442	97.4%	6359	88.0%	
Benzodiazepines	Problem use	6	1.3%	328	4.5%	<0.01
	No problem	447	98.7%	6912	95.5%	
Amphetamines	Problem use	32	7.0%	1260	17.4%	<0.001
	No problem	422	93.0%	5994	82.6%	
Other drugs	Problem use	25	5.5%	499	6.9%	NS
	No problem	429	94.5%	6771	93.1%	

Taking gender into account, it is interesting to note that cannabis is a problem for nearly half of female Pacific clients (Table 3).

Pacific clients report fewer problems with amphetamines than other clients (Pacific 7.0% versus non-Pacific 17.4%; χ=32.622, df=1, p<0.001), especially in the case of female clients (Female Pacific 3.9% versus other Female New Zealanders 20.8%; χ=21.653, df=1, p<0.001).

Table 3: Substance Use Problem by Gender and Ethnicity

Substance		Ethnicity							
		Pacific Nation				Other New Zealanders			
		Gender				Gender			
		Male		Female		Male		Female	
		Count	Col %	Count	Col %	Count	Col %	Count	Col %
Cannabis	Problem	108	33.2%	56	44.8%	2338	44.9%	707	34.8%
	No problem	217	66.8%	69	55.2%	2868	55.1%	1327	65.2%
Amphetamine	Problem	27	8.3%	5	3.9%	836	16.0%	424	20.8%
	No Problem	299	91.7%	123	96.1%	4380	84.0%	1614	79.2%

As might be expected, cannabis is a bigger problem for younger Pacific clients than it is for older Pacific clients (Table 4). Surprisingly, however, it is a larger problem for

female Pacific clients under 30 years old than for male Pacific clients under 30 (60.3% versus 41.0%, χ=7.515, df=1, p<0.01).

Table 4: Age, Gender and Cannabis Problems - Pacific Nation Clients

Main age groups		Gender			
		Male		Female	
		Count	Col %	Count	Col %
Under 20	Problem use	34	52.3%	25	75.8%
	No problem	31	47.7%	8	24.2%
20-29	Problem use	43	35.0%	16	45.7%
	No problem	80	65.0%	19	54.3%
30-39	Problem use	30	30.6%	12	27.3%
	No problem	68	69.4%	32	72.7%
40+	Problem use	1	2.6%	3	23.1%
	No problem	38	97.4%	10	76.9%

Over half of Pacific male clients have alcohol as their only problem, in contrast to one third of other New Zealand male clients (Pacific 55.4% versus other New Zealanders 33.6%; χ=54.484, df=1, p<0.001).

Table 5: Alcohol-Only as Main Problem by Gender

Alcohol as only problem	Ethnicity							
	Pacific Nation				Other New Zealanders			
	Gender				Gender			
	Male		Female		Male		Female	
Yes	153	55.4%	45	41.3%	1505	33.6%	693	38.8%
No	123	44.6%	64	58.7%	2972	66.4%	1094	61.2%

Older male Pacific clients are more likely to present with alcohol as their only problem than younger male Pacific clients.

Table 6: Alcohol-Only as Main Problem by Ethnicity in Males

Main age groups	Alcohol as only Problem	Ethnicity			
		Pacific Nation		Non-Pacific Nation	
		Count	Col %	Count	Col %
Under 20	Yes	18	34.0%	145	17.5%
	No	35	66.0%	681	82.5%
20-29	Yes	53	51.0%	471	27.4%
	No	51	49.0%	1250	72.6%
30-39	Yes	52	59.1%	529	37.8%
	No	36	40.9%	871	62.2%
40+	Yes	30	96.8%[1]	360	67.8%
	No	1	3.2%	171	32.2%

Conclusion

Client problems are not always the same as those receiving media attention. For Pacific clients at least, alcohol (and cannabis) are still the core business for alcohol and drug treatment agencies. Just over two-thirds of Pacific Nations clients present with an alcohol problem (as identified by the AUDIT or LDQ) and just over one-third present with a cannabis problem. Over a quarter present with a combination of the two. Just over half have alcohol as their only alcohol or drug problem, a trend which increases for Pacific males as we look at older clients. Opiate and amphetamine problems are relatively low for Pacific Nation clients, especially when compared with other New Zealanders (Opiates – Pacific 2.6% versus Other New Zealanders 12.0%; Amphetamines – Pacific 7.0% versus Other New Zealanders 17.4%).

This leads to the general observation that findings about alcohol and drug problems in the community as a whole may not apply to Pacific clients – indeed, in some cases, general patterns can be reversed. For example, in the population as a whole, a higher proportion of male clients present with cannabis problems than is true for females. For Pacific Nation clients, however, the opposite is the case and for under 30 year old clients the difference in pattern is considerable (Female Pacific 60.3% versus 41.0%). As another example, in the population as a whole, more females present with amphetamine problems than males whereas in Pacific populations the pattern is sharply reversed (Male 8.3% versus Female 3.9%).

The findings in this paper will hopefully support the continued development of services for Pacific clients, and enable policy-makers, funders, managers, and clinicians to remain responsive to their particular needs.

[1] This analysis excludes clients without a main drug problem recorded, which is why the % of 40+ male Pacific clients with alcohol as their only problem is higher than the % of 40+ male Pacific clients with alcohol as a problem (taken out of all 40+ male Pacific clients whether or not it was possible to determine a main problem).

DROPPING OUT OR DROPPING IN? AN EXPLORATORY STUDY OF OUTPATIENT ALCOHOL AND DRUG SERVICE UTILISATION

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A recent investigation of service use in the 5 Auckland Community Alcohol & Drug Services (CADS) identified that most new clients left the service 'unexpectedly' after brief periods of contact (1-5 appointments). In these cases, the clients had scheduled a further appointment, were expected to attend by their clinician, and for some unexplored reason, failed to do so. In light of these findings a review of the A&D outpatient service utilisation research literature was conducted in order to determine the extent of these patterns elsewhere and to identify an appropriate service response. This review identified the following:

1. This pattern of service use is well documented and 'normative' in a range of A&D outpatient services and is consistently perceived as a 'problem' in need of a remedy. These clients are typically referred to as treatment 'dropouts'.

2. Research attempts to inform a suitable service response have largely focused on improving client retention. To date, reliable predictors of service retention or reliable strategies to improve retention have not been clearly identified.

3. Promising research efforts pertaining to the same 'service use problem' conducted in non-A&D services have not been acknowledged or replicated in the A&D research literature (see below).

4. Research in the mental health sector (where the same service use pattern is prevalent) has found that many of the brief contact/unexpected exit population are actually leaving at a time consistent with *their* original expectations and after achieving *their* treatment goals. However, the expectations and goals of this population are frequently divergent from those of their treatment providers and therefore go unnoticed. Thus, rather than 'dropping out', these clients are often 'dropping in' – that is – entering treatment with short-term intentions. Researchers in the mental health field have argued that, rather than attempting to increase retention, more efficient and effective service provision would result from tailoring treatment services to the short-term attendance expectations of this client group.

In the A&D outpatient service use literature the client perspective has been largely neglected. Therefore, it remains possible that many clients enter outpatient A&D treatment with short-term intentions and that these intentions are being obscured and/or ignored due to divergent expectations of treatment providers.

Furthermore, despite theoretical and empirical support, the possibility of aligning treatment provision with client attendance expectations (as has been argued in the mental health field) has not been tested, nor even advanced, in the A&D literature.

To make up for this short-coming in part, this study explores the possibility that the brief contact/unexpected exit population might be entering outpatient A&D treatment with short-term intentions and that their exit may be 'unexpected' because these intentions are divergent to staff expectations. It should be noted that this is one part of a larger study into 'client service use and expectations' that is designed to inform an alternative response (i.e. other than efforts to increase retention) to the brief contact/unexpected exit population. It should also be noted that all relevant data had not been collected at the time of this presentation.

Methods:

Client attendance estimates:

For a 3-month period (June-Aug 2003) the majority of clients (some exclusions) presenting to the 5 Auckland CADS units for a new treatment episode were invited to participate in the study. Attendance estimates were obtained at the end of the first appointment via a survey question asking participants to select – from a range of options – the number of appointments (at the rate of 1 per week) they were likely to attend. At the time of this presentation 139 clients had been invited to participate in this study of which 71% (n = 98) agreed.

Staff attendance perspective:

An anonymous survey was also sent to all CADS staff members that asked them, among other things, to estimate the average number of appointments attended by their clients and the average number of appointments they would consider appropriate for the majority of their clients. Thirty-four out of thirty-nine (87%) staff completed this survey.

Results:

Forty-one percent of clients stated they were 'unsure' about the number of appointments they might attend. Only 30% of those who did provide an answer estimated they would attend 5 or fewer appointments. A further 32% estimated they would attend between 6 – 10 appointments, 17% between 11-20, and 21% 21+ appointments. When these estimates were compared with expected service use trends (based on past service use data), chi-square analysis suggested these clients were significantly overestimating the number of appointments they were likely to attend ($p < 0.01$).

When asked to estimate the mean number of appointments attended by their clients, only 29% of staff provided an estimate in the 1-5 appointment range. Twenty-nine percent estimated between 6-10 appointments and 42% estimated between 11-20 (service mean approx. 4 appointments). Chi-square analysis revealed no significant difference between the percentage of staff who estimated mean attendance in the 1-5 appointment range and the percentage of clients who expected to attend 1-5 appointments. When asked to identify the number of appointments they would consider appropriate for their clients, only 13% (3/24) of staff selected the '1-5 appointment' option. Chi-square analysis found this to be significantly lower than the

30% of clients who estimated they would attend 1-5 appointments and the 65% of clients (based on past trends) who actually attend 1-5 appointments ($p < 0.05$, $p < 0.01$ respectively).

Discussion:

Only a minority of participants entered treatment with clear short-term intentions. A large proportion were either 'unsure' about future attendance or were seemingly overestimating their likely attendance (based on past trends - comparisons with actual attendance will be made once data is available). The results of the staff survey indicate that most staff believe their own clients attend more appointments than the service average and that brief periods of attendance are not sufficient. In terms of possible staff/client perspective divergence, both groups seem to be overestimating actual service attendance (so both groups appear divergent to reality rather than each other). However, it should be noted that significantly more clients plan to attend a minimal number of appointments than what staff think is appropriate. At this preliminary stage, the results suggest the brief contact population do not enter treatment with clear 'drop-in' intentions. However, this does not mean that they are necessarily dropping out either. They may in fact be leaving after achieving their goals; they were either just unsure about how long this would take or it is taking less time than expected. The wider study will be exploring the reasons behind service exit for this population and the results will be reported at future conferences.

OUTCOMES FROM A CLIENT PERSPECTIVE – HUA ORANGA

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Changes in health status in a sample of people on methadone maintenance treatment (MMT) in Christchurch were investigated using several different methods. Improvements in health are major objectives of the national methadone guidelines and are also important goals for many patients themselves. Opioid dependent people frequently have poor health status, with the most common problem being hepatitis C virus infection. Heavy drug use, tobacco smoking, respiratory problems, teeth problems, infections and injuries all contribute to poor health status.

Methods

A random sample of 85 injecting drug users was interviewed and followed up over an average 18 month period. The sample comprised 51 non-Mäori and 34 Mäori patients. Changes in health were investigated using self-reports of drug use, symptoms, and ratings using the Short Form 36 (SF-36) and Hua Oranga. The SF-36 has been shown elsewhere to be a useful tool for monitoring changes in health among opioid dependent people[1,2]. Hua Oranga is a tool for measuring health outcomes from a Mäori perspective that was recently proposed by Kingi and Durie[3]. It comprises 16 questions that aim to identify changes in the four aspects of Te Whare Tapa Wha: Wairua (Spiritual); Hinengaro (Mental health); Tinana (Physical health); and Whanau (Family health).

Minor modifications were made to Hua Oranga to enable it to be administered to both Mäori and non-Mäori, in order to see if Mäori patients were progressing better or worse than non-Mäori. This study was part of a larger economic evaluation of MMT[4].

Results

After a mean time of 57 months on MMT, there was a large reduction reported in the use of opioids and benzodiazipines. The majority of participants reported improved health, but 89% had laboratory test results showing a history of hepatitis C infection. SF-36 ratings showed that participants mean scores on all SF-36 scales reflected significantly worse health compared with New Zealand population norms. SF-36 scales measure health on eight dimensions of physical functioning, role functioning

(physical), pain, general health, vitality, social functioning, role functioning (emotional), and mental health.

Comparisons with patients starting MMT in Auckland showed that mean SF-36 scores for participants who had been on MMT in Christchurch were significantly improved in comparison (Paton-Simpson, personal communication.) This indicated that stabilisation on MMT was accompanied by improvements in physical health. Further investigation revealed that differences in health were moderated by health problems requiring receipt of prescribed medication for physical or psychiatric conditions. Participants taking such medication had significantly worse SF-36 scores than people who did not require medication.

Hua Oranga scores also indicated moderate improvements in the four aspects of Mäori Health – Wairua, Whanau, Hinengaro and Tinana. The only score that showed a significant ethnic difference was that for Hinengaro, where Mäori men experienced a significantly greater improvement than non-Mäori men. For all other aspects of Mäori Health, there were no significant differences between Mäori and non-Mäori.

Participants who were taking prescribed medication for psychiatric problems also had significantly worse scores on scales for Tinana, and Whanau Health and for the Hua Oranga total score. However, there were no significant differences in mean Hua Oranga scores according to medication taken for medical problems.

Correlation analysis was used to investigate the validity of Hua Oranga scales in comparison with SF-36 scales. Statistically significant correlations were found between: Whanau Health and Social Functioning ($p<.01$); Whanau Health and Mental Health ($p<.001$); Hinengaro Health and Mental Health ($p<.05$); Hua Oranga total score and Social Functioning ($p<.01$); Hua Oranga total score and Mental Health ($p<.01$).

These results indicated the Hua Oranga scales with the highest validity appeared to be Whanau and Hinengaro. There were no statistically significant correlations between scores for Tinana Health and the SF-36 physical health scales or between Wairua Health and Vitality. Significant relationships between these scales should be expected unless they are purporting to measure different aspects of health.

Principal components analysis was used in order to investigate the statistical evidence as to whether the four dimensions of Te Whare Tapa Wha appeared to exist in the data. Varimax rotation indicated the existence of four main factors that explained 68% of the variance. The first three factors were related to Hinengaro, Whanau and Wairua Health and each factor accounted for more than 19% of the variance. The fourth factor – Tinana – was the weakest and accounted for only 9.8% of the variance. There were two Hua Oranga questions that did not appear to discriminate between any of these four factors. These items were (a) goal setting and (b) thinking, feeling and acting in a positive manner.

The principal components analysis provided statistical evidence that supports the existence of the four dimensions of Mäori Health that Hua Oranga aims to measure. However, correlation analysis indicated that the expected correlations did not exist

between some items of Hua Oranga and the SF-36. In particular, neither the Tinana scale nor the Wairua scale were correlated with the expected dimensions of the SF-36.

General conclusions

In summary, the results indicated that people who were on MMT demonstrated large reductions in the use of both illicit opioids and benzodiazipines. Significant improvements in health were associated with stabilisation on MMT. The main factors that were associated with variations in health were the existence of health problems requiring taking of medication for physical or psychiatric conditions. The SF-36 is a useful instrument that is sufficiently sensitive to monitor changes in the health of opioid dependent people. Hua Oranga is a potentially useful tool for investigating aspects of Mäori Health. There was statistical evidence that supported the existence of the four dimensions of Te Whare Tapa Wha. However, further development of Hua Oranga is recommended, particularly of the scales for Tinana and Wairua.

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CONSUMER EXPERIENCES AND BRIEF INTERVENTIONS

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Introduction

CADS are funded to provide specialist alcohol and drug counselling services for people in the wider Auckland region. Services are provided on an outpatient basis and are mainly delivered in an individual counselling format. Over two thirds of all consumers entering CADS meet DSM-IV criteria to identify severe substance problems[1]. In addition, many consumers experience high levels of psychopathology. Seventy-nine percent of consumers presenting to a CADS unit exceeded the positive "caseness" threshold when administered the Brief Symptom Inventory[2]. This rose to eighty-eight percent when the analysis was restricted to consumers presenting for the first time. Mood and anxiety disorders are most commonly reported.

Despite these presentations, CADS provides mainly brief interventions to the greater majority of consumers. The majority of all new clients, regardless of the CADS clinical pathway, exit the service having received six or fewer face-to-face sessions. Around sixty percent do so without a formal discharge session[2].

Objective

To conceptualise what factors influenced brief service utilisation from a consumer's perspective.

Methodology

Grounded Theory is a qualitative methodology that was developed for the purpose of studying social phenomena in their natural environments. Qualitative research was defined as research based on an interpretative and naturalistic approach to the subject matter[3]. Multiple perspectives from participants were systematically sought during the research process and further refined during the analysis. Its aim was theory building, which was conceptualised as identifying plausible relationships between concepts and clusters of concepts[4].

In February 2003 thirty former CADS consumers were approached by mail with a request to participate in an interview with one of the researchers. All consumers had been formally discharged from the service in November and December 2002 and had had no further contact. No financial incentives for participation were offered. Four consumers responded and were interviewed.

The interviews formed the raw data for the analysis. The participants' clinical file was not reviewed. Two interviews were conducted in the consumer's home, one in the researcher's office and one in a restaurant. Interviews lasted for up to two hours and were based around four central themes: what did they know about CADS prior to

attending, what were their expectations of CADS, how they decided to attend CADS, and how they decided to disengage from CADS. At the end of the interview they were given an opportunity to make any comments in regards to their contact with CADS that had not been covered.

Two project participants reviewed the final draft of this project. Their comments were included in this text.

Findings

The consumers who participated in this project had significant problems with their alcohol and drug use, or were effected in a major way by the alcohol and drug use of a family member. They attended between one and five sessions during their last treatment episode. Their experiences provided a framework for beginning to conceptualise brief interactions from a consumer perspective.

Four categories emerged in the analysis of the text. Linked together they form the help-seeking experience of the participants broken into four stages: "making up my mind to contact CADS", "stepping into uncertainty", "finding what I am looking for", and "leaving CADS".

Category one: "Making up my mind to contact CADS"

The process of "making up my mind to contact CADS" was made over a period of time during which problems started to exceed the resources of the consumer and their families. These pressures gradually build up and commonly resulted in significant emotional distress. Behavioural patterns were often longstanding and thus both consumers as well as significant others took a long time to identify the problem, or to formulate it as an alcohol and drug problem.

There was a significant amount of emotional energy tied up with making the decision to seek help. The emotional charge was related to the intensity of the problem and the possible consequences of making changes. The decision to contact CADS was linked to previous unsuccessful attempts of changing alcohol and drug using behaviour.

The next step in the decision-making process was to decide where to seek help. This involved talking to a wide range of professionals, some helpful, some not. This included familiar professionals (for example a General Practitioner), people recommended by others, organisations that publicly advertise, or coincidental conversations with professionals they met in the course of contact with agencies.

The decision regarding whom to contact had a direct effect on what kind of assistance was offered. The match between what was offered and the participants' own ideas of what seemed to make sense influenced the decision to engage in help-seeking behaviour. The decision to seek help was further reinforced or discouraged if the content and context of the first session met the participant's expectations. However, this was an ambiguous process as the participants' expectations were often vague.

The decision-making was an ongoing process, not made definitively at a specific moment, but continuously re-evaluated against new information and experiences. As

searching continued for the participants while they attended CADS, responses by other professionals and the opinions of friends and family influenced the decision to attend CADS positively as well as negatively.

Participants described a strong link between the personality of the counsellor and their preparedness to be frank and open with the counsellor.

Category two: "Stepping into uncertainty"
The participants had limited or no understanding of the kind of services that were provided by CADS or any of the other agencies. This was particularly true for the first time they contacted the services.

Participants described the move to contact CADS as a big step. The process of making first contact with helping organisations was confusing, especially when it involved many people and agencies. This meant that in the lead-up to the appointment participants had to make their own assumptions about what they would gain from contacting CADS. They tended to make assumptions about what counselling could do for them and how it could solve their problems. A male participant described his experience:

> Male participant: "Life had become so painful that I needed a way out and I kind of.... I felt there was something in CADS that might be able to help me. Maybe someone could magically come and take away all my problems..... but that didn't happen..... (laughs). I am not sure about my expectations I don't think I ever really wanted to give up drugs, but I definitely wanted to minimise the pain in my life.... Not that going to CADS ever sorted out any of the pain in my life I don't think."

The participants who attended CADS previously were more aware of how "the system" worked. Awareness of the process of talking to a counsellor reduced tensions, but did not resolve them.

After the initial assessment, uncertainty could persist about what the counselling process would entail. The waiting list added to further delays in addressing the problems. This created uncertainty about the usefulness of the counselling process.

Category three: "Finding what I am looking for"
In "finding what I am looking for" participants defined what they hoped to find from counselling at CADS.

Participants described their internal images of counsellors and how they would recognise a suitable counsellor. These internal images were often incomplete and they relied mainly on an intuition. In particular, the counsellor's ability to ensure a sense of safety and intimacy was essential.

Participants used deliberate strategies to rate their counsellor for usefulness.

> Interviewer: What were you expecting when you turned up for the assessment?

Female participant: "I was a bit surprised actually. I felt not intimidated, but a bit confronted. But I guess that they needed to assess where I was at so that they knew what path to put me on. And to see whether I was any danger to myself. Because they were pretty explicit like to begin with. It was quite embarrassing admitting the state of my problem - like when he asked me how much I drank - my god - it was almost too embarrassing. Having him (the counsellor who completed the triage assessment) as an alcoholic at that stage was good because imagine admitting to someone who is not an alcoholic that you drink so much. But at least an alcoholic can relate to that."

They had difficulties in formulating what they wanted from counselling. This needed to be stated with the help of the counsellor asking the "right questions": Participants had an expectation that the counsellor would intuitively "know" what needed to be talked about in the session. They wanted to be asked the "right questions". These were based on the professional experience that effective counsellors needed to have. When the "right questions" were asked the session was experienced as helpful: When not, the clients felt disappointed. In this manner the interaction between the participants and their counsellors partly shaped the decision to continue with the counselling.

Asking the "right questions" communicated to the participants that the counsellor understood their world. These questions could be confrontational. The participants assessed these questions by their impact on how they felt during and at the end of the sessions.

Asking the "right questions" included asking them in the "right kind of way". One participant described how he contrasted various styles between counsellors and how he responded to them:

Male participant: "My last counsellor was more of the good type counsellor.... He actually set it up as it was and wouldn't 'powder-coat' it."

Interviewer: "He wouldn't what?"

Male participant: "He wouldn't powder coat it, you know. Like he wouldn't make it all nice and fluffy and try and tell you something, but skirt around the issue. He was just like "I don't know whether you realise this - but are you actually an addict!."

Interviewer: "That didn't turn you off?"

Male participant: "No"

Interviewer: "What was good about that?"

Male participant: "I probably wasn't happy about hearing it at the time but it was a simple case of knowing it. And I can see it for what it is now."

CADS services are free of charge to the consumer. While on one level this facilitates direct access to the participants, it also defined the relationship on a "take it or leave

it" basis for the participants. This would become problematic when the participant was not happy with the direction of the counselling. One participant described her response when she was not satisfied:

> Female participant: "I always used to say - if you get something for free you can't really expect it be as good as if you paid for it - and I kept thinking about that when I was looking at my counsellor. Thinking oh well - you know - maybe it was difficult for him too - he had a set way of doing things - a pattern - and I was pushing for something else I suppose."

Participants dealt with multiple agencies and professionals, so they were sensitive to the fact that if they did not present their information in the "right kind of way" they would not receive a service or end up with the wrong service.

Category Four: "Leaving CADS"

Only one participant terminated his contact with CADS by mutual agreement between him and his counsellor after two sessions. He had come to CADS with a specific question, and once the answer to that question had been provided he no longer needed the service and was referred to another service.

The other participants described the process of "leaving CADS" as a string of unrelated events that ended up with no longer attending CADS, rather than a well-considered rational decision not to attend. Difficulties in scheduling the appointments discouraged them from attending, although this was not the key reason for disengaging. Two found what they were looking for somewhere else.

One participant's life kept disintegrating. Consequently, he could not make it to the sessions, and decided that there was nothing in it for him. Once he disengaged he found it difficult to return, until his circumstance became so bad that he felt compelled to try again.

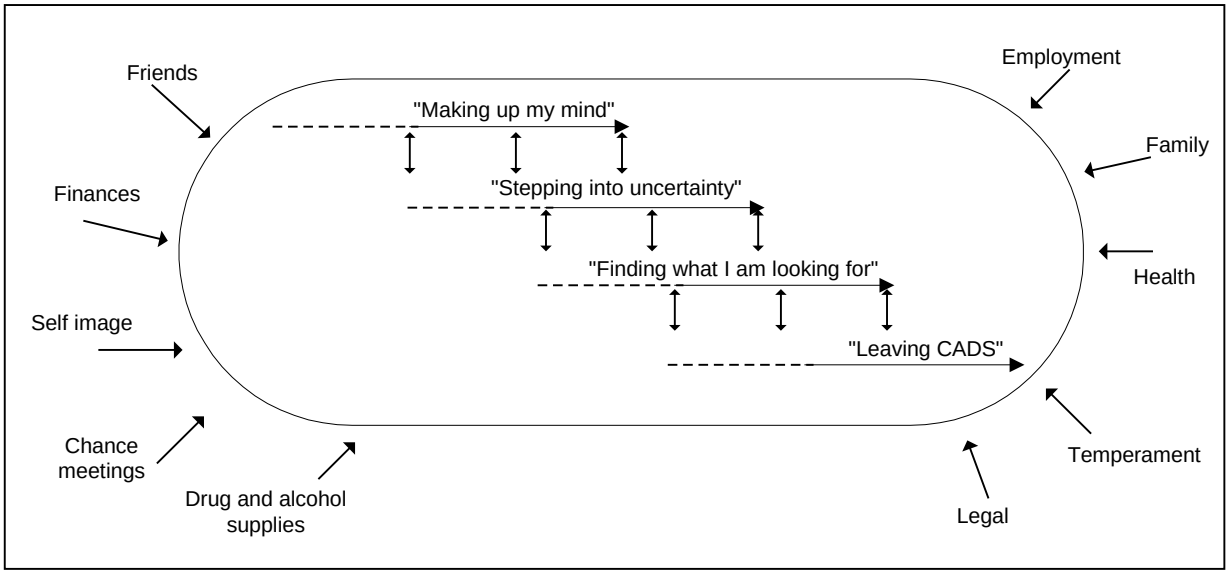
By the time that one participant was talking to the CADS counsellor her situation had significantly improved. She had not taken alcohol for over two months. As with the others, family and work events got in the way of making the appointments and once an appointment is missed or cancelled it was difficult to pick up the thread of the counselling process.

The decision to stop attending CADS was similar to the decision to come in the first place. It was not a final decision, but a process including both positions: wanting to stop and wanting to continue. What happened was determined by external circumstances that impacted on the participants (could not make the appointment because of family commitments, found help elsewhere, busy with the children, etc.) and their perceived usefulness of the CADS contact.

<u>Conclusion</u>

The four categories together formed the processes that together shape help-seeking behaviour. They are summarised in Figure 1.

Figure 1: help seeking behaviour



Each stage in the process is represented by a horizontal arrow and interacts with the others. Together they can be conceptualised as the experience of help-seeking from a consumer perspective.

In order to move from one stage of the process to the next the consumer had to make a decision to continue with the help seeking process (or not), and adjusted behaviour accordingly (vertical arrows).

To move from "Making up my mind" to "Stepping into uncertainty" required a high level of problem awareness and psychological stress. Moving to "Finding what I am looking for" was influenced by limited knowledge of what help was available, a certain determination to find out and cope with confusion, making assumptions of the counselling process, and putting up with waiting lists and agency procedures. The move further to "Finding what I am looking for" was effected by the internal image that the participants had of the counselling process as it unfolded. "Leaving CADS" was influenced by how the participants felt about the counselling process moment to moment and what benefits they saw for themselves. At each step in this process, external demands from family, employment, law enforcement agencies and others provided the context and interacted with "Help seeking behaviour".

The central finding of this project was that the decision to participate in treatment is dynamic and continuously evaluated. It was influenced by the participants' beliefs and goals, constraints in personal circumstances (e.g. time, finances), and experiences in treatment, all of which were influenced by family, friends, treatment settings, counsellors, and wider social and cultural forces. From the participants' perspective the essence of a good interview is to feel relaxed, to be able to talk freely about experiences to a counsellor, who they can trust, who is interested in them, who has expert understanding of their experiences, and who is able to guide them through a process of finding solutions that make sense to them. The perceived usefulness of the counselling relationship increased when counselling was easily and immediately available.

The implications for counsellors are that they need to consider that each contact with the consumer may be the last one and that they have limited influence on the consumer's decision to attend the next session. An empathetic problem-solving style, with expert knowledge about alcohol and drugs and the consumer's social context, and providing immediate opportunities when the consumer wants to engage appear the best strategies.

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WHAT'S UP DOC? A PROJECT TO HELP GP PATIENTS AFFECTED BY PROBLEM GAMBLING

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Funding: Problem Gambling Committee

Problem gambling appears to be a growing phenomenon in New Zealand, with numbers seeking help from specialist counselling services increasing in 2002 by 21% over the previous year. Those accessing services because of their own gambling appear to be experiencing late-stage symptoms of pathological gambling. Those affected by another's gambling comprised less that 15% of the services. With a growing participation in gambling by society identified by the Department of Internal Affairs, providing earlier interventions, together with opportunities for families of the problem gambler to access help, may be an important goal for future resourcing of those affected by gambling.

The Manukau Health Resources Trust, an Auckland Primary Health Organisation (PHO), was funded by the Problem Gambling Committee to identify whether General Practitioners could provide interventions for patients affected by their own or another's gambling problems. The PHO contracted the Goodfellow Unit to provide the research and required training, who in turn contracted Abacus to lead that research. At the time of this paper, 649 of an intended 3,000 patients aged 16 years or over had participated.

Methods

GPs were trained to provide brief interventions for their patients, provided with resources, and contacted on a regular basis by the researcher for support. The training programme was approved by the RNZCGP (GP College) for CME Practice Review Activity points (re-registration requirements). In addition, GPs received a small financial contribution for each patient screened and a further sum for providing an intervention. A two-page questionnaire was offered to all patients in each practice over a one-month period. The questionnaire contained a request for demographic information, a two-question depression screen, the EIGHT gambling screen (eight questions), and the COGS screen (three questions) for those affected by another's gambling. Patients were asked if they saw a GP as suitable to provide help for gambling problems. GPs provided appropriate interventions indicated by screen responses, then the questionnaire was passed to the researcher with the patient anonymity maintained. GPs participated in focus groups after one month to provide feedback on the project.

Results

A pilot (N=180) found 28% of patients were experiencing moderate or greater depression, 17% of patients were positives on the COGS, and 5% positive on the Eight Screen. Half of the COGS-positive patients were depression positive also, while two-thirds of EIGHT screen problem gamblers were also depressed. Reasons for presenting to their GP did not provide an indicator for the use of any of the screens.

After screening of 649 patients, 14% of patients identified that they may have been affected by another's gambling. Forty percent of these patients didn't know for sure (not uncommon with a behaviour with few clear symptoms), just over 50% responded that the effects were in the past, and 9% stated the effects were current. In specifying the effects, almost 40% responded that it didn't affect them any more, with 20% being uncertain of the effect, and 26% worried about it (other selected effects chosen were less than 5% each). In responding to a question to identify any assistance they would like, over 70% elected 'nothing at this time', while 13% sought information, 6% to talk in confidence, and 8% sought help or support. Whereas one-third responded that they did not see a GP as a suitable person to provide help for problem gambling, the majority were either approving of GPs (18%) in this role, or were still undecided (46%). Although 28% of patients were depressed, it was noted that 70% of those who responded that 'it didn't affect me any more' were depressed.

Just over 6% of patients were identified as problem gamblers by the EIGHT Screen. Almost 60% of these patients were depressed. There was a high overlap between the screens with 40% also being affected by another's problem gambling. Support for a GP providing help was higher amongst this group with less than one in four not seeing a GP as suitable in this role, although 50% were still undecided. Highest ethnic groups represented amongst EIGHT Screen positives (as a percentage of patients in these ethnic groups) were Pacific people, Chinese, and a catch-all group of 'other', followed by Mäori and Indian, with the lowest group being Pakeha.

In the focus groups, GPs to date have expressed surprise at both the numbers of patients identified by the screens as depressed and/or affected by gambling. Some have indicated that it has 'made sense' of problems for some long term patients, while others have noted the increased time required to provide interventions for issues in addition to those the patient has presented for.

Conclusion

The advantage of potentially providing a substantial increase in resources for those affected by gambling with over 3,000 GPs nationwide is an important goal. Patients appear willing to disclose emotional and behavioural problems to their GP, although significantly, large percentages remain uncertain as to their GP's role around providing problem gambling help. GPs in turn are concerned with time management difficulties. However, with the provision of appropriate training to provide brief interventions by GPs, acceptance of problem gambling by patients (and some GPs) as a health problem, the potential identified by the study to date appears both substantial and important. The passing of the responsibility for management of problem gambling to the Ministry of Health by the Health Act 2003 may be the catalyst for further development of this resource.

EXPLORING THE USE OF SPIRITUALITY IN ALCOHOL AND DRUG TREATMENT: PRELIMINARY FINDINGS

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Introduction

Although there is not a lot of research available from the western academic world regarding the use of spirituality in alcohol and drug treatment services, there is a recent growing trend in the counselling field generally, and within the alcohol and drug treatment field specifically, to extend our knowledge in this area. Within New Zealand, only three conference presentations were found on the topic of spirituality in alcohol and drug treatment[1-3]. With this lack of empirical information, it seemed important to document the experiences of clinicians working with clients.

This summary describes the research component of a workshop presented with Gail Payne, ALAC Southern Regional Manager, titled "Working from the Heart: The Place of Spirituality in Treatment".

Research Design

The broad aims of this research were to investigate how spirituality is included in treatment, the range of models used, and whether we can improve the service offered to clients. This research is also intended to promote the inclusion of spirituality by increasing awareness of it, as well as identifying training needs of staff.

The principles and techniques of Grounded Theory (GT) have been used for the methodology. GT is inductive, that is, it aims to deepen knowledge about social phenomena and to develop theory in relation to this rather than deductively testing the accuracy of theory. The techniques aim to develop theory out of differing social perspectives rather than establishing an "objective truth". It is therefore important to minimise the imposition of researcher's preconceptions on the data and so the data collection determines the on-going method rather than the reverse.

To date, four focus groups and two individual interviews have been completed. The participants have been staff from spiritually based, mainstream treatment programmes (12 alcohol & drug clinicians and 5 spiritual advisors). The findings that are summarised below are preliminary and are only descriptive (the first stage of a GT approach to data analysis).

The reporting of qualitative research is notoriously difficult to do concisely due to its narrative nature. The preliminary findings that are presented below represent just a brief overview of some of the issues that have arisen so far.

Findings

Defining Spirituality

All research participants felt that spirituality is different to religion. Spirituality can be accessed through religious practice however, participants said that not all religious people are spiritual and not all spiritual people are religious. One participant said quite strongly that "religion is nothing to do with alcohol and drugs [treatment], whereas spirituality is everything to do with alcohol and drugs [treatment]."

Participants saw spirituality as a very personal experience: because of its subjective and intangible nature they found it hard to define. Participants felt that spirituality is within everyone, but people are not always aware of it. Spirituality was described as the experience of connection. This could be feeling connected to one's self (specifically one's feelings, dreams, love, energy, and creativity) or transcending one's self by connecting with something greater than self, such as other people or nature.

Spirituality was also associated with finding meaning in life. And participants mentioned that there are spiritual qualities that people can aspire to that include: honesty, compassion, respect, acceptance, and love.

The Influences of Spirituality in Treatment

From the data there seems to be four main influences on how spirituality is used in alcohol and drug treatments. These influences are: the clients' perspective; the clinical staffs' personal and professional beliefs; the spiritual advisors' philosophy and training; and the organisational philosophy and culture. These influences will now be explored in more depth except for the clients' influence as clients have not currently been interviewed.

Organisational Philosophy

The research participants felt it was easier to address spirituality with clients while working for a spirituality based treatment programme compared to working for a secular service. However, some staff felt that although there were no written guidelines and they had never felt judged by other staff, there was a certain type of spirituality that was acceptable within the organisational culture and alternative spiritualities were not openly discussed.

At times staff felt uncomfortable about their services' policies and practices. For example, they were concerned when it was compulsory for clients to participate in specific spiritual frameworks, such as a particular religion or the 12-step programme. Clinicians and spiritual advisors assisted clients to work within these policies by encouraging clients to keep an open mind as well as affirming their personal choices about their spiritual journey.

Spiritual Specialists

Within these spiritually based programmes, clients' spiritual issues were primarily addressed by specialists, such as chaplains and spiritual advisors.

The role of spiritual guidance was seen as distinct from counselling and several specialists felt that these roles should not be mixed together. For example, spiritual specialists will often participate in group activities along with clients and take on a peer role rather than an expert role. This is quite different to the boundaries that counsellors usually adhere to in their work with clients.

The spiritual specialists ran regular spirituality groups for clients and offered individual support when clients wanted prayer, advice or when unresolved spiritual issues were blocking therapy. Occasionally the specialists also provided guidance for staff when it was requested. Both the spiritual specialist staff and the counsellors ensured that continuity of care was maintained when clients were referred between them.

Alcohol and Drug Clinicians

The counselling staff were employed as secular staff within spiritual programmes. This left many of them unclear about what expectations the organisation had of them in terms of their beliefs and roles. As this was rarely discussed in the employment setting it was never clarified.

All the research participants talked about their own spiritual journeys, how their beliefs had developed and how their current work settings continued this process. The spiritual beliefs of the clinical staff did not always match the spiritual frameworks used by the organisation. Staff developed individual ways to relate to the religious aspects and/or 12-step frameworks used in the programmes. For example, to be congruent some staff identified which aspects of the programmes they felt comfortable with and integrated them into their personal lives.

All clinical staff spoken to valued acceptance of diverse beliefs and were concerned about any dogmatic approach. They felt that using spiritual frameworks was helpful but that they should not be presented as exclusive or as the "only way".

Clinical staff thought their role was to assist clients by allowing spiritual issues to be heard, facilitating a spiritual journey, and to refer on where necessary. The inclusion of spiritual practices in their clinical work could be overt or covert. The covert spiritual practices were referred to as a "way of being". This involved: developing positive relationships with clients; promoting spiritual qualities; and creating a warm, safe and open atmosphere. The more overt spiritual "strategies" included: covering spirituality in the clients' assessment process; taking clients on outings to specific places; sharing their own spiritual experiences; assisting clients to do the 12-step programme; and using prayer/ karakia when appropriate.

Training for Clinicians

Currently clinical staff have little guidance or training on including spirituality in a counselling context. Some research participants were unsure that training is necessary or that it is even possible to teach the spiritual "way of being".
However, without training, staff only have their own spiritual experiences to inform them. They are also reliant on their employer's approach to spirituality in treatment (or lack of this). This can result in a lack of confidence in how to include spirituality in a counselling role and could potentially be unsafe for clients if clinicians don't know what's appropriate.

Research participants strongly felt that any training had to be experiential to promote trainees' spiritual development so that their practice would be congruent with their personal lives. Counsellor training could include topics such as: working with diverse spiritualities; how to facilitate clients' spiritual development; ethical and safe practice, such as working with dually diagnosed clients; 12-step facilitation; and using other spiritually based strategies and tools.

Conclusion

The clinicians who participated in this research came from diverse spiritual perspectives and yet they all valued the opportunity to discuss this in relation to the clients they work with. There are clearly some issues that need to be explored further such as, how alcohol and drug counsellors can use spirituality appropriately in their role within the current treatment frameworks. It is hoped that these preliminary findings will promote discussion among service providers to help resolve some of these issues. Further analysis of these data is planned, followed by additional data collection so that theory can be developed. For example, it would be useful to compare these data with the experiences of staff from other types of alcohol and drug services.

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AUTHORS INDEX