NEW ZEALAND

TREATMENT RESEARCH MONOGRAPH

ALCOHOL, DRUGS AND ADDICTION

2004

ACKNOWLEDGEMENT

On behalf of colleagues at the NAC, members of TRIG and contributors to this treatment research monograph, we wish to acknowledge ALAC as the major sponsor of the Cutting Edge Conference and the resulting publications including this monograph. We also wish to express gratitude to Lisa Andrews and Meg Harvey, NAC staff, who have contributed substantially to the task of compiling the monograph.

Dr Simon Adamson
Monograph Editor

SUGGESTED CITATION

Adamson SJ (ed) (2004). New Zealand Treatment Research Monograph, Alcohol, Drugs and Addiction. Research Proceedings from the Cutting Edge Conference, September 2004.

DISCLAIMER

The views expressed in the following articles represent the views of the contributing authors and should not be attributed to either ALAC or the National Addiction Centre

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INTRODUCTION

This New Zealand Treatment Research Monograph comprises summaries of the majority of research presentations from the Cutting Edge Conference 2004, held in Palmerston North, 2-4 September 2004. This Monograph is published jointly by the Treatment Research Interest Group (TRIG), and the National Addiction Centre.

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 researchers, particularly those relatively new to such activities, and subsequently encourage the development of a critical mass of clinically-oriented researchers.

Fully one third of the papers contained within this Monograph utilise qualitative methodologies, with these six papers representing twice the number of qualitative papers published in the three previous volumes of the Monograph combined. This broadening of research methods presented at Cutting Edge, and published in the Monograph, is a welcomed trend.

A further noteworthy development in the style of papers submitted is the increasing prominence given to the identification of explicit recommendations arising from the research undertaken. Approximately half of the papers make statements about changes in current clinical practice or treatment-oriented policy recommended as a consequence of the research findings. The most explicit example of this is the paper by April Matthews, which concludes with a clear set of very sensible recommendations, at both a structural and workforce level, to enhance the ability of services to meet the needs of clients with coexisting substance and mental health problems.

The 2004 John O'Hagen prize for the best research presentation by someone aged under 35 was awarded to Ata Samu. This presentation has been summarised in this Monograph.

The 2004 Treatment Research Monograph has been distributed to the 330 registrants of Cutting Edge 2004, and in addition is available on the National Addiction Centre website (www.addiction.org.nz) where previous years' monographs are being accessed at a rate of up to 100 hits per month.

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CORRELATES OF SELF-REPORTED TREATMENT OUTCOME

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Introduction

Baseline profile of clients, and nine-month treatment outcome data from the Naturalist Treatment Outcome Project (NTOP) has been previously presented at Cutting Edge[1]. Clients presenting at the three involved services had high rates of current psychiatric comorbidity (76%), previous involvement in mental health treatment (77%) and alcohol and other drug treatment (72%), and a history of criminal conviction (69%), with 27% having been arrested in the six months prior to initiating the index treatment episode. Furthermore, only 21% were in employment, 26% were married or in cohabiting relationships, and only 28% of clients' children aged 16 or less were living with their treatment-engaged parent for three days per week or more.

Outcome was measured by looking at abstinence rates, number of using days, amount used per using day (for alcohol and cannabis only), dependence features, abuse features, employment, child custody, arrest rate, and physical and mental health. The outcome data revealed that while clients showed improvements across most measures these were at times fairly modest and varied across substances. For any one substance between 56% and 77% of clients had a goal of abstinence, while 48% identified abstinence from all substances as their goal at baseline. At the follow-up interview 20% of the sample had achieved abstinence throughout the preceding four weeks. Despite not always reaching their goals, the majority of clients perceived improvement to have been substantial.

At follow-up, clients were asked: "Compared with when you came to CADS nine months ago, how would you currently rate your drinking or drug use overall?" Responses were:

Much Worse	0%
A Little Worse	1%
About the Same	14%
A Little Better	17%
Much Better	68%

This study seeks to identify which individual components of treatment outcome are most strongly related to the above client-rated outcome. Furthermore, baseline and treatment variables will also be considered as predictors of self-rated outcome.

Method

One hundred and seven newly assessed clients were randomly recruited from CADS Christchurch (62) CADS Hamilton (43), and Te Rito Arahi (2). At baseline they participated in an extensive interview, which gathered demographic, substance use, and diagnostic data. Nine months following their initial CADS assessment 102 of these clients were successfully re-interviewed, completing an abbreviated version of the baseline interview, which also gathered basic information on treatment received. Both baseline and follow-up substance use was verified by interviewing a nominated significant other.

Self-rated outcome was collapsed into two categories: 68% rated their substance use as being "Much Better", and 32% rated themselves as anywhere from "a Little Worse" to "a Little Better". This combined category will be labelled "Equivocal Outcome" while the larger more positive outcome category will be labelled "Good Outcome".

The sample investigated for these analyses are the 93 clients who completed the follow-up interview, provided a self-rated outcome score, and were not in institutional care for more than five of the six months follow-up period.

Outcome measures were converted to change scores, so that percentage days using at follow-up was converted into change in using days by subtracting the baseline value from the follow-up value, thereby controlling for problem level at baseline. Dichotomous outcome measures such as presence of dependence features were converted into three-point scales (worse, same, better).

The association between more "objective" outcome measures and self-rated outcome were examined using univariate analysis and then all variables significant at $p<.15$ were entered into a forward conditional binary logistic regression. This process was repeated for baseline variables and then treatment variables. Finally a combined regression model was generated.

Results

"Objective" Outcome Measures and Self-Rated Outcome

The first thing to become apparent when looking at "objective" outcome measures was the strong effect of abstinence status. Of the 20 clients who were abstinent during the last four weeks of follow-up, 19 had Good Outcomes. Therefore, all subsequent analyses seek to explore the association between self-rated outcome and other measures for the n=73 who were not abstinent, 46 of whom (63%) had Good Outcomes and 27 (37%) had Equivocal Outcomes.

Univariate

Using days	t=-0.68	ns
Features of Substance Dependence (DSM-IV)	χ^2=4.40 (linear-by-linear)	p=.036
Features of Substance Abuse (DSM-IV)	χ^2=5.70 (linear-by-linear)	p=.017
Mental Health (SF-12 Mental Component Score)	t=0.46	ns
Physical Health (SF-12 Physical Component Score)	t=-0.02	ns
Social Functioning (Social Problems Questionnaire)	t=0.43	ns
Arrest in the 6 months prior to follow-up	χ^2=5.76 (linear-by-linear)	p=.016
Employment (current)	χ^2=0.18 (linear-by-linear)	ns

Regression

Using a forward conditional model for all p<.15, Cox and Snell R^2=.160. Significant variables were change in arrest status (p=.009) and change in abuse status (p=.010). Arrest during the follow-up period and improved Features of Substance Abuse scores predicted Good Outcome. This successfully categorised 67.1% of the non-abstinent sample (n=73). Including abstinence at follow-up in the model for the full sample leads to a correct classification of 73.1% of the sample (n=93).

Baseline Measures and Self-Rated Outcome

Univariate

Variables analysed were: age, gender, ethnicity, treatment goal (abstinence/not), mood, anxiety, ASPD, number of substance diagnoses, percentage of days abstinent, employment and past treatment.

All associations were p>.15 non-significant except for:

Current number of substance use disorders	t=-2.29	p=.025

Regression

Using a forward conditional model, Cox and Snell R^2=.079, with a smaller number of substance use disorders being associated with Good Outcome. This successfully categorised 66.7% of the non-abstinent sample (n=73). Including abstinence at follow-up in the model for the full sample leads to a correct classification of 72.7% of the sample (n=93).

Treatment Measures and Self-Rated Outcome

Univariate

Variables entered were: number of sessions attended, time since last session, currently at CADS, choice of treatment, sense of control over treatment, family involvement, a range of putative positive and negative factors (including employment, relationships, financial hardship, engagement in hobbies), treatment modalities undertaken (day programme, detox, residential, self-help, mental health service, mental health medications), treatment satisfaction, and perceived treatment effectiveness.

Control over treatment	t=-2.27	p=.026
Effect of CADS on the problem	t=3.26	p=.002
Treatment Satisfaction	t=-2.27	p=.026
Were you offered a choice of treatment	χ^2=2.75	p=.097
Loss of employment as a positive factor	χ^2=3.62	p=.057

Regression

Using a forward conditional model, Cox and Snell R^2=.129, with a more positive rating of the effect of CADS on their problems associated with Good Outcome. This successfully categorised 67.1% of the non-abstinent sample (n=73). Including abstinence at follow-up in the model for the full sample leads to a correct classification of 73.1% of the sample (n=93).

Combined Model

Using a forward conditional model, Cox and Snell R^2=.299, with Good Outcome associated with arrest in the six months before follow-up (p=.008), improved Features of Substance Abuse scores (p=.029), and a more positive rating of the

effect of CADS on their problems (p=.002). This successfully categorised 78.3% of the non-abstinent sample (n=73). Including abstinence at follow-up in the model for the full sample leads to a correct classification of 81.9% of the sample (n=93).

Conclusions

Attaining abstinence prior to the follow-up assessment was clearly the strongest predictor of a self-rated Good Outcome, with only one client having attained abstinence (5% of abstainers) rating themselves in the Equivocal Outcome category. Separating abstainers and non-abstainers attenuated the association between the "objective" outcome measures and self-rated outcome, but nevertheless an association remained between self-rated outcome and both features of substance dependence and substance abuse. Surprisingly, having been arrested was associated with better outcome. This may have been a chance association, as the effect largely rests on the fact that all four individuals who had not been arrested prior to treatment, but had been prior to follow-up, rated themselves as a Good Outcome. Alternately, it is possible that this experience had stimulated these individuals to follow through on changes planned at the start of treatment.

Baseline variables proved to be poor predictors of self-rated outcome. Their comparatively low level of association with an outcome measure is as would be expected given that by comparison the treatment and "objective" outcome measures are more temporally related.

Taken individually the variable categories of "objective" outcome measures, baseline variables, and treatment variables were only able to successfully categorise approximately 67% of the sample, marginally higher than the criterion of 63% (the larger of the two self-rated categories, and therefore the rate of successful categorisation if all clients were predicted to have a Good Outcome). In combination, however, a 78% successful classification rate was obtained for non-abstainers, and this was increased to 82% when abstainers were added to the model. This level of association, and the Cox and Snell R^2 showing approximately 30% of variance accounted for by the model, represents a relatively successful final model. No baseline variable was significant in the final regression model, which instead relied upon two outcome measures (arrest and substance abuse) and one treatment variable (effect of CADS on outcome).

Self-rated outcome as measured by this study can only be considered a crude measure of sense of improvement in substance use. It is also a narrowly defined measure of outcome, focussing on substance use rather than wellbeing in any more general sense. It is likely, however, that in initiating treatment, most clients would have primarily had expectations of treatment-assisted change occurring in the area of substance use and so this nevertheless remains a crucial area that would benefit from being better understood. This study found that a variety of factors were associated with a client's perception of improved functioning with respect to substance use.

References

1. Adamson SJ, Sellman JD, Huriwai T. The Naturalistic Treatment Outcome Project (NTOP): Nine month outcomes. In SJ Adamson and JD Sellman (eds). New Zealand Treatment Research Monograph, Alcohol, Drugs and Addiction. Research Proceedings from the Cutting Edge Conference, August 2003.

NATIONAL TELEPHONE SURVEY OF THE ALCOHOL AND DRUG WORKFORCE

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In 1998 the NAC (then called the National Centre for Treatment Development; NCTD) conducted a national telephone survey of the dedicated AOD workforce.[1-3] A "dedicated AOD worker" was defined as paid workers, 70% or more of whose client contact is with AOD clients. As part of the newly established National Addiction Treatment Workforce Development Programme the NAC undertook a repeat of the 1998 survey.

Method

Alcohol and drug treatment workers (ADTWs) were randomly selected from a list of approximately 800 ADTWs maintained and regularly updated by the NAC and supplemented by the membership register of the Drug and Alcohol Practitioners Association of Aotearoa New Zealand (DAPAANZ). Identified ADTWs were phoned by a clinical psychology student who had their first name, initial of last name, and workplace details only.

The intention for the 2004 survey is to interview a total of 275 ADTWs. At the time of Cutting Edge 2004 the first 150 of these interviews had been completed. The data that follows is based on this interim sample, and includes comparisons with the full sample (n=217) from the 1998 survey.

Results

The 150 completed interviews represent a 96% response rate of those contacted for interview, with six ADTWs refusing to participate.

Three significant changes between 1998 and 2004 in demographic profile were revealed. The mean age of the field increased from 42 years in 1998 to 47 years in 2004, with a halving of the proportion aged under 35 years. There is a significant reduction in the proportion of the field identifying their current drinking status as "ex-drinker". Number of years working in the AOD field increased significantly.

Table 1: Demographic Profile

		1998	2004
Gender (Female)		59.4%	57.0%
Ethnicity			
Pakeha/European		61.3%	63.8%
NZ Māori		23.5%	19.3%
Other European		10.6%	9.3%
Pacific Nation		3.7%	4.7%
Asian		0.9%	0.7%
Age			
Mean:		41.8 (9.3)	46.7 (9.2)***
Age Range	<35	23.6%	11.4%
	35-49	53.3%	51.7%
	50+	23.1%	36.9%
Drinking status:			
Non-drinker		6.5%	6.7%
Ex-drinker		35.9%	26.0%*
Current drinker		57.6%	67.3%
Years in AOD field		5.7 (5.1)	7.9 (5.8)***

*p<.05 ***p<.001

Table 2: Self-selected Professional Identity

Profession	1998	2004
Counsellor/Therapist	56.8%	51.7%
Nursing	17.4%	14.1%
Social Work	10.8%	13.4%
Psychology	7.0%	5.4%
Medicine	5.6%	3.3%
Other	2.3%	6.7%
A & D/Addiction Clinician		7.4%

The only significant difference in professional identification between interviews was the emergence of "A&D or addiction clinician" as a response.

A highly significant increase in level of highest academic qualification is evident, mostly reflecting a more than doubling of those with postgraduate qualifications and an almost 80% reduction in those with secondary only or no formal qualification. From those currently enrolled in AOD-related courses the majority (12.0%) had previously completed AOD qualifications, with the remaining 7.3% undertaking AOD qualifications for the first time. In total therefore 64.0% of the field had completed, or were currently enrolled in, AOD-related education. Combining those currently enrolled in AOD-specific and non AOD-specific education, a total of 40.7% of ADTWs were currently enrolled in formal education.

Table 3: Qualifications

	1998	2004
Highest Qualification:***		
Postgraduate	16.7%	39.3%
Tertiary	56.9%	54.7%
Secondary	20.1%	4.7%
None	6.2%	1.3%
AOD-specific Qualifications		
Completed (any tertiary)	47.4%	56.7%†
Completed (postgraduate)	2.8%	12.8%***
Currently undertaking formal AOD education		19.3%
Currently undertaking formal non-AOD education		25.5%

†p<.10, ***p<.001

Table 4: Work Setting

	1998	2004
DHB	60.6%	71.3%*
Outpatient	67.3%	76.5%†
Residential detox	7.4%	8.7%
Residential post-detox	26.3%	16.0%
North Island	71.6%	67.3%
One of five main cities	66.2%	63.3%
Identified work setting as "city"		89.3%
Hours worked per week	34.3 (10.5)	34.9 (9.7)

†p<.10 *p<.05

ADTWs were asked "How supported are you by the manager of your service to improve your treatment knowledge and skills?", with the response options of: very (54.1%), a lot (11.5%), moderately (18.9%), a little (8.1%), and not at all (7.4%). They were then asked "Can you undertake as much training as you need to do your job well?", with 65.5% responding yes. From those responding no, the primary reasons given for being unable to undertake training were funding, time or availability of leave, and high workload. To a lesser extent unsupportive management was mentioned by some.

Conclusions

Significant changes in the New Zealand AOD treatment workforce have been identified in the 2004 National Telephone Survey. The workforce has aged significantly, with a marked drop in the proportion of the workforce aged less than 35 years. This has significant implications for longer term retention and the ability to adequately cater to younger-aged clients.

The ageing of the workforce can be partly attributed to a second change since the 1998 survey was conducted: the average time spent working in the AOD field has increased significantly, indicating that in the short-term at least, retention of staff has improved.

The second welcomed change evident in the 2004 data is the substantial increase in qualification level of the workforce, with a dramatic drop in those with pre-tertiary qualifications, and a large increase in those with post-graduate qualifications, with increases in AOD-specific and other post-graduate qualifications. One domain of qualification may have decreased between 1998 and 2004 and that is the apparent reduction in the presence of ADTWs in recovery.

Finally, the high level of support for ongoing training identified by respondents was gratifying, and helps explain the finding that 40% of ADTWs were currently enrolled in formal training. Taken together these findings suggest a work environment conducive to continued increases in the qualification level and professionalism of the AOD treatment workforce.

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THE ROAD TO RECOVERY - AN ANALYSIS OF INTERMEDIATE OUTCOMES IN THE TREATMENT OF DRUG ADDICTION

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Research on treatment for drug addiction usually focuses on rigid outcome measurements such as drug use, needle sharing, health status and criminal activity.

There has been very little research about the more subtle cognitive changes that occur after treatment and which persist despite apparent relapse.

The concept of cumulative and successive cognitive changes which pave the way towards ultimate recovery from drug addiction has been little studied in New Zealand, and internationally.

This research was carried out as a summer studentship project. It was designed as a pilot study with the results being used to inform a larger study in this field. Our main aim was to identify cognitive intermediate outcomes that occurred during a current and previous treatment attempts, as described by residents of a 12-step oriented addiction treatment centre.

Methods

Suitable participants were nominated by the staff of the 12-step treatment centre. The staff were provided with the inclusion criteria - firstly, participants had to have attended at least two previous intervention episodes before starting their current program. These could include harm minimization interventions such as needle exchange and methadone therapy, detoxification treatment, counselling, positive interactions with a health professional for example a pharmacist or GP, support group attendance or attendance at another residential treatment centre. Secondly, clients with major mood or personality disorders requiring regular medication were excluded from the study. Finally all participants had to be aged 18 or older.

We designed a draft interview guide based on our literature review and the team's clinical knowledge. Two focus groups were held – one with the staff of the treatment centre and one with graduates of the treatment centre – to get their input into the interview guide and to check the appropriateness and relevance of questions. Three pilot interviews were then conducted and the interview script was reviewed and refined accordingly. The final script followed a chronological structure and generally

consisted of questions around changes participants could recall in themselves after each treatment episode or event.

Using the interview guide, semi-structured face-to-face interviews were conducted with 10 client key informers. The interviews lasted 45 to 60 minutes and were tape recorded and transcribed verbatim.

We then analysed the transcripts to identify common themes that were present in the participant's recollections of their experiences. The transcripts were analysed separately by all three researchers and then discussed together. Differences in interpretation were resolved by group consensus.

Findings

Our ten key interviewees consisted of six men and four women. Their mean age was 38 years and all identified themselves as NZ European. Their main drugs of choice were alcohol, methamphetamine, and opiates. The average number of previous intervention episodes prior to attending the 12 step program was 3.5.

Following analysis of the interviews we identified nine intermediate cognitive outcomes which occurred as a result of successive intervention episodes. These outcomes can be seen as cognitive steps paving the road to recovery from addiction. We have subjectively grouped these into four early and five late cognitive outcomes.

1. *Understanding the realities of addiction:* This included education about physical and psychological aspects of addiction, breaking down denial, accepting the idea of abstinence and rejecting the idea of occasional or casual use. An example of how one participant expressed this is: "Understanding it and knowing that I am an addict. And knowing my limits."

2. *Accepting the need to ask for help:* This was identified by all ten interviewees and included issues such as recognising that isolation can lead to relapse, realising the importance of having a good support network and learning to utilise support from friends, family, counsellors, AA or NA meetings and sponsors. For example: "Just like picking up the phone when you feel triggered. Sometimes it is really hard to do."

3. *Understanding more about themselves and accepting self responsibility:* For many participants this included reflecting on which aspects of their life may have caused them to start using drugs, coming to terms with their past and taking responsibility for their negative behaviours that have hurt themselves or others. One person expressed this as: "I learnt that a lot of my behaviour comes from my past. Accepting that things have happened to me and not denying them, not discounting myself. And finding out that it's not about my addiction; it's about what's behind my addiction, what drives my addiction."

4. *Learning strategies to avoid drug use and understanding relapse prevention:* For example: "Just being around for a while I sort of know my triggers. That's something that I have had to learn for myself. And it is always the simple things that get people stuck. It is always the basic stuff. I've learnt my triggers just through experience and by talking things through with my case manager. Just not being able to hang out with certain people, or go to certain clubs, or just go to clubs full stop." This theme is

interesting as many participants felt that more emphasis needs to be placed on relapse education and prevention.

5. Learning to relate to others: This included acquiring better interpersonal skills, learning to communicate emotions effectively and also developing a degree of tolerance when interacting with other people. One participant described this as: "To be direct when I'm talking to people. To tell people when I'm angry with them so that the resentment doesn't build up. The whole emotional thing. It's teaching me how to do those sorts of things which will hopefully enable me to take on things when I get back into the outside world. "

6. Rebuilding family relationships: This is an important outcome that often occurs later on down the road to recovery. Most participants described breakdowns in family relationships as consequence of their using or due to their isolative behaviour. Re-connecting with families involved resolving past conflict and also educating families about addiction and recovery. An example of this is: "My daughter comes every week. I think it had helped her to understand more about how I couldn't give up the drugs. It has been very hard for her. To understand why I couldn't just do this one thing for her. And it has also helped me to see how I have hurt her. It has brought us closer."

7. Gaining spiritual values: This outcome varied hugely between clients. It included aspects of Christianity, surrendering to a power greater than oneself and gaining the spiritual strength to overcome addiction. This is one participant's description of it: "God's gift to me is my life and what I do with it is my gift back to God. I guess for me, having God back in my life is really important. And I've had my friends say to me, its religion. Its not religion for me. It's about having a soul and having a conscience."

8. Increased feelings of self worth, looking to the future: This includes increased confidence and self-esteem, feeling positive about the future, setting goals and making plans. One woman expressed this as: "I place more value on myself. I believe in myself more. I don't need drugs to make me a good person or more creative person. The possibilities are so open to me now. I still love my work. And at least I have that, my self esteem. And I might even open my own business one day. You know, I have that potential."

9. A desire to help others or to contribute to society: This often included a wish to help others who are struggling with addiction or a more general desire to have a positive impact on the world. For example one participant said "I have a lot to offer myself and the world and I don't want to miss out. I have more of a sense of purpose now."

Discussion

What our findings indicate is that positive outcomes for clients are often not those routinely measured by services. Traditionally outcome measurements have focused on those issues easily measured such as consumption, injecting, crime, and health. The outcomes described in this study are not easy to quantify, but nonetheless are important aspects of treatment both to clients and treatment providers.

Success or failure cannot be determined simply by the amount of time the client has remained abstinent after leaving treatment. Rather, subtle changes, such as the ones we identified, could be used to assess the impact of treatment on the client's addictive disorder. Another important implication is that even if clients resume substance use after treatment, these cognitive changes are likely to remain. As one participant said "with each treatment there was something that went in and stayed there – a collective knowledge."

Our findings have clearly been influenced by the setting of the study – a 12-step programme as has the language used by the participants. However, we hypothesise that whilst the outcomes for this group have been couched in the language of a 12-step programme, many of these outcomes might be similar for other groups (e.g. methadone maintenance clients) whilst being expressed in another way. In the future similar projects could be carried out in the context other treatment modalities. Such findings would provide information on successful treatment outcomes from a broader perspective. The end point of future research may be refining a more subtle method of evaluating treatment outcomes and charting the progress of substance dependent individuals.

REEFER MADNESS: ADOLESCENT CANNABIS USE AND COGNITION

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Funding: Canterbury Medical Research Foundation
John Dobson Memorial Foundation

Acknowledgements

Emma Deering, Naomi Malcolm and Lee Ridout (Research Assistants)

Cannabis continues to be a drug of major concern to New Zealanders. While the incidence of methamphetamine use may be on the increase, cannabis continues to be the most popular illegal drug in this country[1]. Around 30% of people presenting to A&D services are having problems with cannabis[2]. Particular attention needs to be paid to the effects cannabis may or may not continue to have some time after the drug has been ingested, particularly in adolescent populations.

The Project on Adolescent Cannabis use and Cognition (PACC) is looking at the relationship between cannabis use and cognitive functioning in samples of clinical and community adolescents. It is also examining possible intervening variables in this relationship, such as psychiatric functioning and personality. One hundred adolescents are being recruited for interviews at baseline and for a three month follow-up. This paper considers our findings in regard to cognitive tests and cannabis use in the first 37 adolescents.

Methods

Adolescents are referred from Youth Speciality Services at Hillmorton Hospital in Christchurch and from a selection of Christchurch High Schools. Inclusion criteria are that adolescents are aged 14-18 years, without psychosis, and that there is written adolescent and parental consent. The interviews last for approximately two hours (after 12 hours cannabis abstinence) and are generally conducted at the NAC offices.

The alcohol and drug measures used are an outline of lifetime drug and alcohol use, the Timeline Followback questionnaire for use in the last month[3], and a urine sample.

Psychiatric functioning measures include: Visual Analogue Scale for Mood for present mood, Beck Depression Inventory II[4], Hamilton Depression Rating Scale[5]), Conduct Disorder and Attention Deficit Hyperactivity Disorder (ADHD) (semi structured interviews based on DSM-IV criteria), Structured Clinical Interview for the DSM-IV (SCID-I)[6], and Global Assessment of Functioning Scale, Axis 5 of the DSM-IV[7]). The study also measures personality with the Temperament and Character Inventory (TCI)[8].

The cognitive battery measures memory, attention, working memory and executive functioning using:

Cambridge Neuropsychological Test Automated Battery (*CANTAB)*
This is a range of memory and attention tasks and has been extensively used with adolescents[9]. The tests used are: Motor Screening - a training procedure and screening test for visual and movement problems; ID/ED shift - an attentional set shifting task similar to the Wisconsin Card Sorting Test)[10]; Paired Associates Learning - a form of delayed response procedure, which tests two different aspects of the ability to form visuo-spatial associations; Rapid Visual Information Processing - a test of sustained attention with a small working memory component; Spatial Span - a test of spatial memory span; and Spatial Working Memory - which requires the subject both to formulate a strategy and to remember which boxes have previously contained a counter.

Pen and Paper Cognitive Tests
These tests include: WASI – shortened version of WAIS IQ test[11]; Rey Auditory Verbal Learning Test[12] - a test of verbal declarative memory with a working memory component; Digit Span[13] - a task of attention and working memory; and Symbol Digit Modalities Test[14] - a task of sustained attention.

Findings

Tables 1 and 2 show the overall demographic and drug use (ever tried) results for the sample.

The primary analyses were correlations between days of use and quantity per episode in the past 28 days, and the major outcomes of cognitive tests. Days and quantity were highly correlated ($r=0.786$, $p<0.01$). Three of the cognitive tests had a significant relationship to cannabis use (see Table 3). These were: the IDED shift on CANTAB; the Symbol Digit Modalities Test (SDMT); and the Rey Auditory Verbal Learning Test (RAVLT). High use was associated with poorer performance on all tasks. However, since high cannabis use (days and quantity) was associated with a significantly lower IQ ($r=-0.368$, $p<0.05$; $r=-0.372$, $p<0.05$) a series of ANOVAs or T test equivalents covarying for IQ were carried out. When the lower IQ of high users is taken into account the only significant effect to remain is the delayed recall on the RAVLT.

Table 1: Clinical and Community Adolescent Demographic Results

	Clinical N=26	Community N=11
Gender	50% Male 50% Female	36% Male 64% Female
Ethnicity	69% NZ European 23% Māori	82% NZ European 9% Māori
Age	mean=16.3 (range 14.5-18.1)	mean=17.4 (range 16.6-17.6)
IQ	mean=96 (range 74-116)	mean=114 (range 99-125)

Table 2: Clinical and Community Adolescent Drug and Alcohol Use

% Ever Tried	Clinical N=26	Community N=11
Alcohol	100	72.7
Cannabis	100	36.4
Nicotine	100	45.5
Hallucinogens	76.9	0
Solvents	69.2	0
Stimulants	57.5	0
Benzodiazepines	42.3	0
Opioids	10	0
% Current Antidepressant	57.7	0

Table 3: Adolescent Cognitive Test and Cannabis Use Results

Cognitive Test	Days Use	Quantity Use
Intra Dimensional/Extra Dimensional Shift (IED)		
- Stages completed	-0.440**	-
- Total correct (adjusted)	-0.368*	
Paired Associates Learning (PAL)	-	-
Rapid Visual Information Processing (RVP)	-	-
Spatial Span (SSP)	-	-
Spatial Working Memory (SWM)	-	-
Rey Auditory Verbal Learning Test		
- Total across first five trials (A1-A5)	-0.522**	-0.420**
- Total on 20 minute recall (A7)	-0.426*	-
Digit Span	-	-
Symbol Digit Modalities Test		
- Total	-0.341*	-0.482**
- Total correct	-0.359*	-0.484**
IQ	-0.368*	-0.372*

Spearmans correlation coefficient *p<0.05, **p<0.01

IED test results

After the initial correlation a Mann Whitney U means comparison test was conducted as it was clear subjects fell into two groups: those getting to stage 7 or 9. Stage 7 is when the extra dimensional shift occurs and the subject needs to move from seeing the pink shapes as the target (or correct answer) to the white distracter shapes as correct. Subjects reaching stage 7 smoked cannabis on more days on average (Mean=11.4, SD=10.9) than those reaching stage 9 (Mean=4.2, SD=7.0; $p<0.01$).

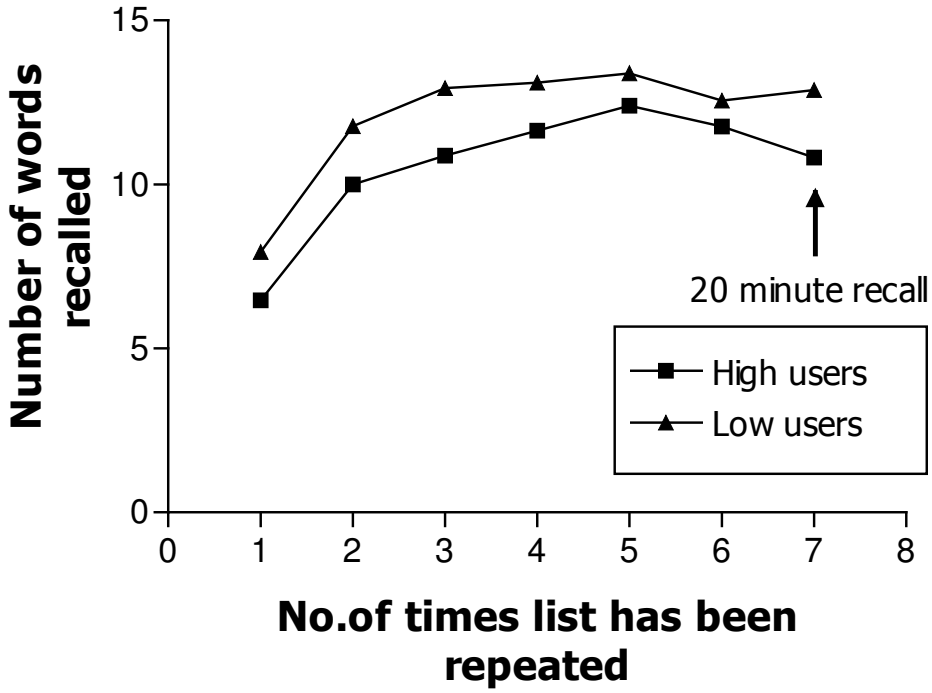
Symbol Digit Modalities Test results

The SDMT was significantly related to both days of use and quantity of use (see Table 3). However, this effect disappeared when IQ was taken into account.

Rey Auditory Verbal Learning Test results

A repeated measures ANOVA co-varying for IQ was conducted looking at cannabis use and the seven trials across the RAVLT. The results for Lists 1-5 (learning) was not significant when IQ was taken into account ($p=0.2$). For the purpose of analysis subjects were classified, according to a median split, as high users if they smoked on two or more of the past 28 days (n=19, median=11, range=2 to 28) and as low users if they smoked on one or none of the past 28 days (n=18, median=0, range=0 to 1). The distracter list was not significantly different between the two groups ($p=0.32$). The delayed recall list showed a significant difference between high and low cannabis users with high users doing more poorly (see Figure 1) and this difference was not IQ based ($p=0.045$).

Figure 1: Rey Auditory Verbal Learning Test and Cannabis Use Results



Discussion

Aspects of cognitive function are closely related to the frequency of cannabis use. However, only delayed recall was related to frequency of cannabis use independently of IQ. Consequently, cannabis may cause a reduction in IQ or may be more frequent in groups with lower IQs. It is difficult to say whether poor cognitive performance from heavy cannabis users was from cannabis use or confounding factors such as IQ. Findings are in keeping with the adult cannabis and cognition literature, particularly Solowij[15] who found heavy cannabis users to have problems with attention and memory. These results have implications for the memory of heavy cannabis users and their functioning in the school setting, as well as the information they will retain long-term from treatment sessions.

The present study has several limitation including, small numbers, debatable effects of 12 hours abstinence and several other potentially confounding factors e.g. other drug use, depression, use of antidepressants.

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GAMBLING PROBLEMS AFFECTING CLIENTS ACCESSING FOODBANKS: INTEGRATING HELP INTO A GENERIC SOCIAL SERVICE

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Anecdotal information is that many financial problems are contributed to by problem gambling.

Aims of this study were:
1. To identify the prevalence of problem gambling issues (problem gamblers themselves or those affected by another's gambling) amongst those seeking help from a social service that provides food parcels, and,
2. identify if further assistance can be provided to those affected by gambling by an on-site problem-gambling trained social worker, and willingness to accept referral to specialist services

Methods

The Salvation Army provides a substantial range of social services, including the provision of food parcels. Following training, three Auckland social service centres that provide food parcels participated in screening clients for problem gambling (Eight Screen[1]) and for those affected by another's gambling (COGS[2]). Within weeks of screening commencing, in response to very high findings of clients experiencing gambling harm, a new service model was established as an effective response. This included an Oasis trained social worker providing help (brief intervention, Motivational Interviewing, health promotion, social work and referral) on-site at the largest centre (Manukau). This new service model was also provided at a Christchurch centre.

Results

Over 9 months of screening 1,219 clients were screened in Auckland and 517 in Christchurch. Six months of the screening process included the new service model of help. Three quarters of Auckland clients and half of Christchurch clients were female. Ethnicity of Auckland clients comprised Māori (49%), Pacific (30%), Pakeha (15%) and other ethnicity (3%), with 3% missing. Christchurch ethnicity differed substantially, with Pakeha comprising 71% and Māori 22%.

Problem gambling: 13% of clients (11.4% of females, 14.7% of males) in Auckland were identified as problem gambling with an age range of 18 to 67 years. This compared with 17% of Christchurch clients problem gambling (age range 18-70 years). Over 80% of these clients had dependent children. In comparison, the

National Prevalence Survey[3] estimated 1.35% of the NZ population as clinical or sub-clinical problem gamblers. When these problem gambling clients were combined from both Christchurch and Auckland, there was no significant difference in prevalence of problem gambling between ethnic groups (p>05*).*

Affected by another's gambling: Sixty-eight percent (n=377) of clients responded that they had never been affected by another's gambling in their lives. Of the remainder, 10% were uncertain if they had been affected by gambling, 17% said they had been affected in the past, and 4.4% (n=52) were currently affected by another's gambling. One in four of these clients were themselves problem gambling.

Table 1: Current effects of another's gambling on the client (n=367)

Current effects	Number (% of effects)	
I'm uncertain	73	(16%)
I worry about it	113	(25%)
I'm nervous about it	27	(6%)
It's affecting my health	28	(6%)
It's hard to talk about it	29	(6%)
I'm concerned about my, and my family's, safety	45	(10%)
It doesn't affect me any more	132	(29%)

Help desired: When asked about help these clients wanted for the gambling effects, 47% stated they wanted help, while 53% did not want help at this stage. Sixteen percent wanted information, 9% counselling, and 17% asked for support.

Help provided: Four hundred and ten (34% of all clients) clients who were identified as affected by their own, or another's, gambling received feedback on their screen results.

One hundred and eleven (27% of these clients) received a further intervention from the on-site Oasis social worker, and 35 (9%) received a full Oasis assessment. Just 7 (2%) were referred to and attended specialist counselling services.

Conclusions

One in three clients attending these Salvation Army Social Services, usually for a food parcel, were identified as affected by their own, or another's, gambling.

Fourteen percent of clients from Auckland and Christchurch were problem gambling themselves, substantially higher than general population findings (1.35%). This may support the limited, usually anecdotal evidence, that those with less financial resources were at greater risk for gambling problems. Gambling can cause poverty. However, it appeared that in this project, clients were from larger families, and from poorer areas, and were from a population that had less resources that may have been further impoverished by their (or a family member's) gambling. The great majority of problem gamblers had dependent children, suggesting a widespread impact of gambling on these families.

Many problem gamblers responded they were themselves affected by another's gambling. Further research is needed to interpret these effects, and its implications for treatment, and it is noted that one influential study has noted problem gamblers are 19 times more likely to have a parent with a gambling problem.[4]

There was little clustering of those who were problem gambling around variables such as age (18-70 years), gender, or ethnicity, with the one commonality being poverty. Past research has identified that problem gambling risk varies with ethnicity, with Pacific and Māori being at greater risk than Pakeha. There were no differences for problem gambling risk found in this population seeking support for immediate financial difficulties, while the prevalence rate for problem gambling was high, compared with other studies. This may suggest that poverty has a strong association with gambling problems, and that poverty may be an underlying explanation between many of the differences found for risk between ethnic groups in epidemiological studies[3]. Further research would be required to confirm this, but levelling effect (albeit within a specific population) does raise this possibility.

It was noted that these clients were willing to disclose problem gambling issues, and to receive brief interventions, but preferred a 'social worker' response to specialist counselling. An example of this may be to assist with budgeting, housing, referral to a cost-free GP, and with legal representation. In many cases this may require a hands on approach by the counsellor/social worker, extending outside the counselling room. Further outcome research is required, however there has been identified a substantial need and opportunity to reduce gambling harm, through the integration of social and health services. This opportunistic intervention has modelled the approach of the recent Ministry of Health Strategic Plan[5] to provide early and brief help for those at-risk for gambling harm, through specialist and primary services. It has also identified a willingness to disclose gambling problems and to accept brief interventions, amongst a population with few resources, and often with dependent children. It has also identified a need amongst family/whanau of problem gamblers, who are poor at accessing specialist problem gambling services.

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KIA ORA, HOW CAN WE HELP YOU?
ALCOHOL AND DRUG HELPLINE WAEA AWHINA WAIPIRO WHAKAPOAUAU

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Description

The Alcohol and Drug *Help*line (0800 787 797), is a confidential information, advice and referral service for people with questions about their own or someone else's drinking or drug use. The primary aims of the Helpline are to facilitate access to treatment through referrals to services and to provide accurate information on alcohol and other drugs. Callers can also access brief interventions while those needing ongoing counselling are referred to services in the callers region. The lines are open 10am – 10pm daily except Christmas Day and Boxing Day. The Helpline is a service of the Alcohol Drug Association New Zealand.

Method

Each call is recorded on a Call Registration form. Registration forms are checked to be sure they are completed accurately; data is then entered in the Call Registration Database. Data from the database was utilised to present information about usage of the helpline including types of calls, demographics and resources sent to callers. Data were collated for the July-June financial year. All year dates below refer to the 12 month period ending in June of that year.

Findings

There has been a marked growth in calls during the life of the helpline. Over the past four years numbers have steadily risen from 10,011 (2001), to 11,019 (2002), to 12,529 (2003), with the largest increase in 2004 with 17,034 valid calls, as a consequence of a new contract with the Ministry of Health expanding the service from an Alcohol Helpline to an Alcohol and Drug Helpline in December 2002.

Table 1: Comparison of the number of alcohol-, cannabis-, and methamphetamine-related calls 2002-2004

	2002		2003		2004	
Alcohol	8645	(78.9%)	8832	(70.5%)	8107	(47.6%)
Cannabis	597	(5.4%)	1010	(8.1%)	1861	(10.9%)
Methamphetamine	0	(0%)	548	(4.4%)	1523	(9.0 %)

For 2004 alcohol-related calls comprised 47.6% of all calls to the Helpline, remaining the largest drug type category. In the same year drug-related calls comprised 38.1% of valid calls, compared to 21.1% in the preceding year.

Table 2: Resources sent to callers (2004)

Resource	No.
Concerned About Someone's Drinking	1100
Stopping Drinking	708
Alcohol General Information	692
Alcohol - Facts And Effects	685
Drinking and your Baby	685
'Had Enough' Video	592
Baby or the bottle?	568
Message in a Bottle	288
Guidelines For Drivers Over 20 (Card)	513
Women And Alcohol	480
Worried about someone's drinking?	473
Is Your Drinking OK?	438
Cutting Down	385
Maintaining The Change	224
Alcohol Helpline Information Sheet	173
Drinking For Two – Video	144
Alcohol, Drugs & Young People - An Information Guide For Parents	118
FAS/FAE Pack	116
Methamphetamine	526
Info For People Concerned About Someone's Methamphetamine Use	381
Cannabis & Your Health	370
What's The Deal On Quitting?	280
Breaking the Ice	207
Amphetamines	109
Ecstasy	109
Drugs In Focus - Adults Only	96
Guide to Quitting Marijuana	91
Heroin	84
Drugs Overview	82
Hallucinogens	73
Drugs & Driving	59
Total publications Mailed	46006

In response to the 17,034 calls 46,006 resources were posted to callers.

Table 3: Type of call: 2002-2004

Type	2002	2003	2004
Concerned about another person's drinking/drug use	2359	2792	3393
Requesting agency/service information	3303	2305	2854
Seeking support	2728	2258	1615
Wanting to stop drinking/drug use	1628	1557	1413
General information/resource request	1867	1446	1467
AA (Alcoholics Anonymous)	-	1015	1019
Effects of alcohol/drugs on health/behaviour	1071	814	835
Silent/Hang up Call	-	685	3562
Wanting to cut down drinking/drug use	611	591	347
Seeking problem screening/indication	450	556	253
Seeking assessment/intervention/treatment	461	522	509
Other	932	489	436
Inquiry/Comments about the Helpline	-	337	458
Interrupted Call	-	315	400
Requesting information for school project	257	232	296
Legal query	90	137	101
Crisis/Emergency	66	98	112
Questions about alcohol and pregnancy/FAS/FAE	210	87	75
Drink driving issues	65	70	56
Host responsibility issues	24	21	12
TOTAL	16131	16407	19273

In 2004 "concerned about another's alcohol or drug use" continued to be the highest call category with 3393 calls. This is a 21.5% increase compared to 2003.

Callers seeking support numbered 1615, a 28% decrease from last year. The latter statistic is not necessarily one to interpret negatively and could indicate that:

1. Helpliners' call coding has improved
2. Callers are aware of problems related to alcohol/drug use and ready to seek information/ intervention rather than support alone.

It should be noted that there was a 400% increase in silent/hoax calls compared to the previous year.

Table 4: Gender, Age and Ethnicity of Helpline callers compared to the Gender, Age and Ethnicity of the Person Identified with the Problem: 2003 – 2004

	Caller		Person with Problem	
	2003	2004	2003	2004
Gender				
Male	4571 (36.5%)	4970 (29.2%)	5517 (44.0%)	6227 (36.6%)
Female	6929 (55.3%)	7905 (46.5%)	3698 (29.5%)	4141 (24.3%)
Not applicable/ no data	1021 (8.1%)	4139 (24.3%)	3297 (26.3%)	6646 (39.1%)
Age				
Adult	370 (3.0%)		289 (2.3%)	Obsolete
Adult (26-59)	8312 (66.3%)	9617 (56.5%)	6304 (50.3%)	7018 (41.2%)
Adult (60 plus)	527 (4.2%)		361 (2.9%)	375 (2.2%)
Youth (19-25)	1064 (8.5%)	1404 (8.3%)	1192 (9.5%)	1782 (10.5%)
Adolescent (12-18)	646 (5.2%)	780 (4.6%)	650 (5.2%)	938 (5.5%)
Child (Under 12)	92 (0.7%)	88 (0.5%)	18 (0.1%)	16 (0.1%)
Not Applicable/No data	1451 (11.6%)	4479 (26.3%)	3642 (29.1%)	6883 (40.50%)
Ethnicity				
New Zealander/Kiwi	3253 (26.0%)	3235 (19.0%)	2610 (20.8%)	2516 (14.8%)
NZ European/Pakeha	4621 (36.9%)	6030 (35.4%)	3585 (28.6%)	4762 (28.0%)
NZ Māori	1441 (11.5%)	2011 (11.8%)	1226 (9.8%)	1818 (10.7%)
Pacific Islander	34 (0.2%)	71 (0.4%)	153 (1.3%)	219 (1.4%)
Asian	135 (1.1%)	150 (0.9%)	127 (1.0%)	169 (1.0%)
Not applicable/ no data	1117 (14.5%)	4626 (27.2%)	3919 (31.3%)	6934 (40.6%)
Didn't want to answer	279 (2.2%)	208 (1.2%)	203 (1.6%)	182 (1.1%)

More women than men call the Helpline, a pattern that is now well established. However, these gender ratios change when the person identified with a problem data was analysed, with the majority of these people being male.

The great majority of callers are adults, primarily in the 26-59 age range. Only a small number of child/adolescent callers were identified. The person with the problem follows a similar trend.

A substantial portion of callers identified as "New Zealander/Kiwi" or did not have their ethnicity recorded. New Zealand European/Pakeha were the largest group of the remainder, with significant numbers also identifying as New Zealand Māori. In contrast both Pacific Island and Asian callers appear to be under-represented. Figures for the person with the problem show a similar ethnic breakdown.

Conclusions

The Helpline has seen a large growth in calls over a three year period with a 35% increase between the 2003 and 2004 years. While drug related calls were only a small minority of calls in 2001 they have increase to 38% of all valid calls in 2004. Alcohol remains the most commonly called about substance in New Zealand.

The Helpline has responded well to increases in calls, the growing variety of drugs available on the New Zealand market, and the changing ethnic composition of New Zealand. Over the next year, the Helpline will review how it can better meet the needs of people from Māori and Pacific Island cultures.

The increase in silent/hoax calls continues to present a challenge to Helpliners prepared to deal with a wide range of situations in a sensitive manner, yet often confronted by unhelpful calls. Additionally, the Helpline is staffed by paid and unpaid workers. For volunteers that give their time freely, there are also challenges around the competing demands in their lives, with resultant pressure on availability.

The Helpline is poised to meet new needs. While the Alcohol and Drug Helpline's primary aim will always be to refer callers to services in their region, given the increasing demand on services, the Helpline will continue to develop its use of screening tools and to provide increased levels of early and brief interventions.

METHADONE MAINTENANCE: A TREATMENT OPTION FOR METHAMPHETAMINE ABUSE/DEPENDENCE? WHAT DOES IT TAKE TO ENGAGE 'P' USERS IN TREATMENT?

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The aim of this poster presentation was to explore the pathway from Methamphetamine abuse/dependence to opiate dependence. Specifically, it asked clinicians to consider whether we currently have anything to offer this client group if they were to present at an earlier time with methamphetamine dependence, and how do we engage them in treatment.

A naturalistic approach was used to analyse four clients who presented to drug and alcohol services requesting a entrance to methadone maintenance treatment program. Similar themes and pathways emerged in their histories, as they progressed from problematic "P" use, through methamphetamine dependence, to opiate dependence.

Method

Four case studies were examined, opportunistically drawn from clients who presented at CADS, Health Waikato, requesting Methadone Maintenance Treatment. Each received a comprehensive drug and alcohol assessment, were presented to the multidisciplinary team meeting, attended a medical review and were deemed suitable to commence on a methadone program. The clinical notes and interviews with clients were utilised to draw out themes and pathways from heavy methamphetamine use to opiate dependence.

Results

Patient	M.	C.	Sh.	Su.
Early initiation to drug use	17 years old	14 years old	13 years old	15 years old
Other drug use	Alcohol Tobacco Cannabis	Alcohol	Benzodiazepines	Tobacco Cannabis
Life experiences	Adoption Rejection	Rejection Betrayal	Adoption Abandon-ment	Sexual abuse Neglect
Personality Traits	Dependent	Antisocial	Antisocial	Borderline
Duration of drug use	30 yrs	20 yrs	20 yrs	4yrs
Longest abstinence	15 yrs	5yrs	1 yr	10yrs
Relapse – "P"	2000 manufacture	1998 released - jail	1998 released -jail	2000 family breakdown
Peak "P" use	2002 intensely alert	2000 "wired"	2003 "pumped"	2000 "Going crazy"

Crisis	Psychosis	"spent the inheritance"	Stabbed partner	Crime
Opiates to ameliorate	2003 "relief from anxiety, able to sleep"	2001 "helped my shyness"	2000 "levelling myself"	2001 "I can handle anything"
Opioid dependent, requesting Methadone	2004 "… never known myself without drugs, I wonder what sort of person I'll be"	2004 "…sick of being a junkie, I want to be free…"	2004 "… want to change my life for my child"	2004 "…want to reunite with my kids"

Discussion

In New Zealand, as elsewhere, the numbers of patients with methamphetamine use disorders presenting for treatment are low. The National Methamphetamine Action Plan[1] highlights the importance of supply and demand reduction and advocates for behavioural change and abstinence. It asserts that pharmacological treatments have not been shown to work. The Action Plan pays little attention to engaging problematic methamphetamine users in treatment.

Increasingly research informs us of the neurotoxicity, and possible irreversible cerebral damage, caused by this psychostimulant.[2] Service providers may do well to ask themselves what can we offer methamphetamine clients, how are clients currently managing, what does the client want, and how do we engage such clients in treatment?

'P' users who present to treatment services often do so with a history of polysubstance abuse and as such they are 'street' savvy about the use of one substance to ameliorate the effects of another. Some turn to illicit methadone in an attempt to 'self-medicate' the 'come down' or withdrawal effects of 'P'. Service providers are now hearing anecdotal reports of opioid dependence following the use of methadone for methamphetamine withdrawal and the research reflects this trend.[3] Clients now present requesting methadone maintenance treatment for their opioid dependence.

Overseas studies indicate that presentation for treatment and retention rise dramatically when pharmacological support is offered to this client group.[4,5] Prescribing oral dexamphetamine to injecting drug users had a profound effect on the behaviour of over half of the subjects in one British study, both in terms of engagement in treatment and treatment retention. Females, in particular, were retained in treatment longer.

Is methadone maintenance treatment a 'carrot' for attracting methamphetamine users into treatment? These four case studies illustrate that for some a clear pathway exists from methamphetamine use to opiate dependence, and their subsequent presentation to treatment services.

Recommendations

Service providers must examine their strategic planning with regard to methamphetamine abuse, dependence and treatment. Should we be taking a concerted health promotion approach and 'getting the message out there' of the long-term consequences of "P" use? Should we be linking more closely with harm minimisation services, such as needle syringe programs, and exploring options for assertive outreach? Should we be repeating randomised control trials of substitution therapy locally?

One thing is certain, that while we wait for treatment programs many more individuals, families and communities are exposed to the harm of this destructive 'party' drug and many will suffer serious long-term harm as result.

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CO-EXISTING ALCOHOL AND DRUG (AOD) AND MENTAL HEALTH PROBLEMS: THE SUPPORT NEEDS OF AOD PROFESSIONALS

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Acknowledgements

Thank you to ALAC who supported this research with funding and Auckland CADS for support throughout this project.

In Auckland services for clients with co-existing AOD and mental health problems are generally based on traditional parallel and sequential models. Under these service delivery models clients with co-existing disorders often struggle to access mental health and alcohol and drug services. They seldom meet the admission criteria for each system and fall through the gap.

This can result in clients not accessing either service or being accepted to one service and only one aspect of the problem is addressed, i.e., either the substance use problem or the mental health problem. There is an increasing need for AOD and mental health services to resolve this issue. An integrated model is accepted as best practice for clients with co-existing disorders. Both the AOD and mental health problems should be addressed concurrently, ideally by the same clinician or team.

New Zealand research shows there is a high prevalence rate among clients accessing AOD services of co-existing AOD and mental health problems.[1, 2] This is the norm in substance use settings, not the exception. Furthermore, the majority of these clients are unlikely to be receiving specialist mental health support or expressing concerns about their mental health status.

Studies show that health workers experience frustration, negative attitudes and feel ill-equipped to provide care for clients with co-existing alcohol disorders.[3]

There is a dearth of literature available about co-existing disorders in addiction settings. There are even fewer studies that have enquired into the support needs of AOD staff working with this client group. The majority of literature on co-existent disorders is based in psychiatric settings and focuses on clients with *severe* mental health and substance use issues.

What follows is an outline of a study, which seeks to explore the support needs of alcohol and drug professionals in Auckland working with clients presenting to their services with co-existing AOD and mental health problems.

Aims and Methods

The objectives:

1. To establish "what the needs are of alcohol and drug staff in Auckland to work with clients who have co-existent alcohol and drug and mental health problems".
2. To establish if alcohol and drug staff in Auckland have appropriate skills, knowledge and support to work with this client group.
3. To identify if there are barriers for alcohol and drug staff working with clients with co-existing AOD and mental health problems; and if barriers exist what are they e.g., knowledge, attitudes, organisational structures and service provision.

A qualitative design was chosen to meet the study objectives and a semi structured interview was developed to gain an in-depth enquiry into participants' views and experiences. Interviews were tape recorded and then transcribed. The primary mode of analysis resulted in the development of categories within a model or framework that allowed the raw data to be summarised and key themes and processes to emerge.

Findings

AOD workers acknowledged that clients with co-existing problems are the norm and recognised their responsibility to address both issues. They rated this as a highly important aspect of their clinical practice. However, because their skills related principally to AOD practice, most felt a lack of confidence in addressing mental health problems and so primarily focussed on the AOD issue.

A number of training and service needs were identified. The results strongly suggest that AOD professionals need training about co-existent problems and participants identified the need for more specialist support from *within* their own services. Suggestions included access to a psychiatrist and other specialists with both AOD and mental health knowledge.

Access to mental health services for AOD clients is experienced by the participants as difficult. Typical responses from mental health services were that abstinence from all substance use was a prerequisite before a mental health assessment could be done. Other reasons given for refusing help was the absence of an Axis I diagnosis or that the mental health problem was not severe enough. In general, AOD problems were not seen as the business of mental health services.

Poor relationships exist between the AOD and mental health services. The reasons for this include: insistence on abstinence as opposed to harm minimisation, a general lack of understanding about each others' field, language 'differences' resulting in misunderstandings, and separation of services administratively and geographically.

The results also indicate that mental health professionals have negative attitudes towards clients with AOD problems. This appears to relate to a 'moral view' that people *choose* to use substances and therefore should accept responsibility and bear the consequences.

Summary

None of the issues raised by this study are new. Over ten years ago Minkoff[4] reported on them, yet problems continue to exist.

An integrated model is the optimal approach for clients with co-existing problems. However, the persistence of parallel and sequential modes of service delivery in Auckland impedes the provision of integrated services.

Participants indicated a need for more specialist mental health resources and training within AOD and building relationships with mental health services. These initiatives were seen as an essential first step towards an integrated approach.

Training alone should not be seen as a solution. The drive towards integration must include structural reorganisation and attention to workforce development, policy revision and examination of the inherent cultures of both fields before optimal care for this client group is achieved.

Recommendations from this study

Structural

- Reconfigure AOD and mental health services to better align with each other, but at the same time maintaining the individual integrity of each field
- AOD and mental health issues are addressed simultaneously wherever the client presents. Where specialist input is required, this may be best achieved via the 'shared care approach' between the mental health and AOD services, as evidenced by the Compass programme in Birmingham[5]
- Clear referral and consultation processes and procedures should exist within the clinical pathways of both AOD and mental health services
- Clear communication pathways between services should be developed and liaison staff appointed who would maintain relationships.

Workforce

- All AOD training (undergraduate and postgraduate) must include substantial mental health content as part of the core curriculum and vice versa for mental health training
- Appropriate assessment tools and resources (such as access to a psychiatrist) must be available *within* AOD teams for professionals to be able to identify co-existing disorders and intervene appropriately
- There is a need for specialist dual diagnosis roles within AOD services. Such workers would provide specialist consultation and training to colleagues, it is not recommended that they have an exclusive dual diagnosis case load
- Where the AOD services are of sufficient size, individual dual diagnosis workers would come together to form a specialist team. As a team their principle function would be to enhance liaison and ensure quality training to both AOD and mental health services. It is not recommended that this team has a clinical caseload due to the large population it would need to serve.

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2003 National Survey of Specialist Methadone Services: Results and Implications

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In 2003 the Ministry of Health conducted a survey of Specialist Methadone Services in New Zealand. The aim of the survey was to develop a more comprehensive understanding of service provision throughout the country.

It was hoped that this information would provide a better understanding of how services are configured, as well as how they are interpreting and operationalising the *Opioid Substitution Treatment New Zealand Practice Guidelines*[1] and how collaboratively services are working to ensure co-ordinated case management. This information is crucial to the ongoing development of informed policy and practice in the delivery of opioid substitution treatment.

The survey

The data was collected by questionnaire. The questions related to service structure and delivery, including: training and support; authorisation and complaints processes; intra- and inter-area relationships; staff composition; additional and complementary services; client and waiting list numbers; self-reported strengths and areas for improvement.

The response rate was reasonable with data being received, from 15 of the 17 services that were sent questionnaires.

A summary of the data:

Some of the questions about gazettal and authorisation elicited responses that implied a degree of confusion over the terms and the processes associated with them. Although this compromises the validity of those particular data sets, it is an important finding due to its implications for future work by the Ministry of Health.

Questions related to training showed a great deal of variation in practice across the range of respondents, although all mentioned the National Opioid Treatment Training Programme (NOTTP) in relation to authorised doctors.

Most services utilised standard DHB processes in response to complaints. Almost all of the respondents described positive relationships with other (methadone) services in their region, and many also described relationships with a variety of other AOD service providers, although the nature of those relationships appeared to vary.

Forms of interaction mentioned included referral, collaboration, joint management, shared training and supervision.

Additional services for those on the programme were provided or referred to by all respondents. These services varied, including a number of physical and mental health services, as well as a number of social and support services like WINZ, ACC, CYFS, Workbridge, lawyers and budgeting advisors.

Additional services for those on the waiting list were provided or referred to by most respondents. Referrals were primarily to Community AOD Services. Two respondents mentioned low dose treatment programmes for those on the waiting list.

The most commonly mentioned service strengths were related to staff skills and team dynamics. The most commonly mentioned areas for service improvement centred around resource constraints and waiting times. Strengths at a district level included access to specialists and links with other providers. At a district level, a commonly mentioned area for improvement related to a lack of GPs motivated to accept methadone clients.

Consumer feedback on service provision was reportedly sought by the majority of respondents.

Information relating to client numbers and staff composition is presented in Table 1 below:

Table 1: Treatment Providers of Methadone Maintenance

Service	Actual places	Contracted places	Blueprint target (2003)	Actual demand for places[1]
Whangarei	155	155	223	199
Auckland[2]	956	939	1992	989
Hamilton/Thames[3]	270	255	504	273
Tauranga	106	138	291	114
Taranaki	106	112	159	120
Hawkes Bay	110	110	225	122
Wanganui	92	62	98	106
Palmerston North	173	173	245	196
Wairarapa	72	63	60	78
Wellington/Hutt[4]	395	409	400	441
Nelson/Blenheim[3]	188	153	198	214
Greymouth	39	41	47	46
Christchurch	695	694	684	775
Dunedin	285	275	271	311
Invercargill	76	65	162	82
Totals	3718	3644	5559	4066

1 Actual demand is made up of actual places plus number on the waiting list (see additional information about waiting lists in Table 2).
2 Auckland numbers include Counties Manukau and Waitemata due to a regional arrangement for service provision.
3 Thames & Hamilton are combined, as both services come under one DHB. The same is true for Nelson & Blenheim.
4 Blueprint numbers for Wellington and Hutt Valley have been combined as Hutt has been allocated places in the Blueprint, but does not currently have any due to a regional arrangement with Capital and Coast.

Table 2: Number on waiting lists and average waiting time

Service	Number waiting	Average length of wait (in weeks)	Number waiting as % (service: total NZ[1])
Whangarei	44	52	13%
Auckland	33	15	9%
Thames	0	3	0%
Hamilton	3	3	1%
Tauranga	8	8	2%
Taranaki	14	40	4%
Hawkes Bay	12	20	3%
Wanganui	14	40	4%
Palmerston North	23	48	7%
Wairarapa	6	24	2%
Wellington	46	42	13%
Blenheim	4	24	1%
Nelson	22	32	6%
Greymouth	7	52	2%
Christchurch	80	36	23%
Dunedin	26	12	7%
Invercargill	6	36	2%
		(overall average)	
Totals	348	28.6	-

[1] Total NZ includes only the data that we received, and so represents the totals of all respondents rather than all services in this ratio.
Note: Due to differing interpretations of the questions about waiting lists, some services may have included transferring clients, and transfer or processing times while others may not.

Implications

- This project has highlighted the importance of having relevant and up-to-date information accessible in policy development
- Effective and responsive monitoring and reporting practices need to be developed and implemented
- The picture is not a complete one, but gives a sense of what is happening in the sector, and highlights some areas for development
- Waiting lists and lack of General Practitioners (and in some cases Pharmacists) motivated to take methadone clients are two of the areas causing concern in the sector. These areas need to be explored and solutions worked toward
- There are significant variations in practice across the country. Delivery systems need to be reviewed to ensure consistency in the implementation of the policy that is outlined in the Practice Guidelines
- Improvement in communication and collaboration between service, DHB and Ministry is necessary if we are to work effectively toward improving outcomes.

Reference

1 Ministry of Health. Opioid Substitution Treatment: New Zealand Practice Guidelines. Wellington: Ministry of Health; February 2003.

Table 3: Reported Number and Type of FTEs[1] by Service

Service	Medical Officer	Psychologist	Nurse	Counsellor	Social Worker	Case Manager	Co-ordinator	Team Leader	Other/ Unspecified
Whangarei	1	-	-	-	-	3	1.2	0.2	-
Auckland	3.2	-	2.5	-	-	-	2	1	2.7
Thames	0.3	-	-	4.4	-	-	-	-	-
Hamilton	0.8	0.5	-	4	0.5	-	-	0.5	0.7
Tauranga	0.4	-	-	-	-	0.8	-	-	2
Taranaki	1	-	1	6	3	-	-	-	-
Hawkes Bay	0.4	-	-	2	-	-	-	-	-
Wanganui	0.3	-	0.2	-	-	-	-	-	5
Palmerston North	1.6	-	-	-	-	-	-	-	13
Wairarapa	0.05	-	-	-	-	0.6	1	-	-
Wellington	0.8	-	3.7	-	2	-	-	0.5	-
Blenheim	0.5	0.1	0.5	3	-	-	0.5	-	-
Nelson	1	0.5	1	3	-	-	0.2	-	1
Greymouth	0.1	-	-	-	-	-	-	-	1.9
Christchurch	2.4	-	11	-	2	-	-	-	1
Dunedin	1.4	1	-	9.2	-	-	0.5	-	2.6
Invercargill	0.2	-	-	-	-	-	1	-	-

Note: FTE figures do not include managerial or administrative staff. FTEs have been grouped into broad categories as the specific roles mentioned were too varied to allow easy comparison. Some FTEs were mentioned as having a number of roles. In these cases, FTEs were categorised by their primary role (or the one that was listed first where no primary role was clear). Where the specified role was not able to be categorised, the FTE was included under 'other or unspecified'. According to interpretation of the questions related to FTEs, note that some services may have included only those FTEs devoted to methadone, where others may have listed service FTEs without specifying what portion is devoted to methadone service delivery.

LIVING WITH ADDICTION - WHAT DO PARTNERS THINK?

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The aim of the current research was to examine the life experiences of individuals who are, or have been, in personal relationships with people with alcohol and drug dependencies.

Methods

Participants were recruited through an article published in the Auckland region's local community newspapers and through an information flyer that was sent out to community groups that deal with alcohol and drug issues. Participation was open to any individuals who deemed themselves to be, or have been in the past the significant other of an individual with an alcohol or drug dependency. At this current stage eleven participants have been interviewed. Table 1 shows participant demographics.

Table 1: Participant demographics

Gender		Relationship Status		Age Group	
Female	9	Current	2	18-25	1
Male	2	Divorced / Widowed	9	26-35	1
				36-45	3
				46-55	3
				56-65	2
				65 +	1

Participants were interviewed through an unstructured interview process where they were encouraged to talk freely about their life experiences as a partner or past partner of an individual with alcohol and drug dependencies. Individuals spoke about their experiences at different stages within their relationship and their feelings about what and why events happened. This included an exploration of the factors that they felt were beneficial to them within their experiences.

The qualitative analysis followed a general inductive approach that allows research findings to emerge from the common, dominant and significant themes and categories that are inherent within the raw data, which in this research is the transcripts of participants' life experiences within their relationships.

Results and Discussion

Due to the qualitative nature of this research the results and discussion sections have been combined and a summary of the key themes that have emerged is presented. A weakness of will theme emerges within the early stages of relationships. Participants reported that they blamed their partner for their drinking and drug use behaviour and saw such behaviour as a direct result of a weakness of will. The dominant feelings were those of anger and frustration towards their partner. The idea of a weakness of will emerged through an individual's analysis of their own behaviour compared with that of their partner's. They believed that their partner could give up their drinking and drug use if they committed to it.

The attribution of blame for the situation within the relationship is important. Many participants were told that their own behaviour was at fault. Their partners denied any notion of addiction and implied that any concerns over drinking and drug use were due to the fact that the participant had blown things out of proportion and that there was no real issue of addiction. Participants who accepted the blame for their spouses' behaviour focused strongly on themselves as the solution to their partners' alcohol and drug use. They believed that if they worked harder and improved themselves then their spouse would stop drinking or drug use.

This lead to viewing ones self as the solution. Many participants reported that they had spent years focusing on self-improvement. If they were only a better wife or mother etc then their spouse would stop drinking. Others reported experiences of bargaining and blackmail where they repeatedly give up their jobs, friendships, hobbies and other aspects of their life in the hope that their partner would stop drinking or drug use.

Some participants reported a strong sense of compassion, generosity and feeling of responsibility to their partner. This was evident even in the latter stages of relationships where individuals who were basically living separate lives within their relationship still reported feelings of concern and a strong desire to continuing providing the basic essentials for their addicted partner.

During the mid to latter stages of relationships participants reported the development of disease/illness understanding. For many this development resulted from their own reading on alcoholism, discussions of their partners' behaviour with others - both friends and GP's and attendance at Al-Anon meetings. This new found understanding of alcoholism as an addiction or illness brought participants a strong feeling of relief. It led to a new understanding of their situation where they no longer felt at fault or such feelings of shame. This new level of understanding created the opportunity for new roles within their relationship - those of "Carer" and "Patient". For some this lead to a new commitment to their relationship as many reported that they could not leave a "sick" person. Two types of "Carer" strategy emerged. Firstly, that of the rescuer who felt the need to support their partner through their illness and into recovery and secondly, those who saw their role as a hospice nurse responsible for providing palliative care until the passing of their patient.

Many participants early on in their relationships experienced a process of disconnectedness. This progressive and steadily increasing isolation from their family, friends and society in general was a direct result of their partner's drinking and drug

use, which lead to rudeness, unpleasantness and generally antisocial behaviour. Feelings of being undermined, weakened, an ever increasing sense of isolation, low self-esteem, self doubt and feelings of blame were reported.

All participants reported a process of reconnecting during the later stages of their relationship. This involved the active decision and commitment to reconnect themselves with society again. Individuals enrolled in education courses and sought employment opportunities. Some participants said that this was to test their own self worth. Involvement through education and employment lead to increased feelings of value, appreciation and self-esteem. Others chose to reconnect through community groups such as church and Al-Anon. Individuals credited Al-Anon attendance with the building of their personal strength allowing them to make decisions about their future lives, which for some involved leaving their relationships and for others the decision to create a focus on their own life within the relationship.

While traditionally research has been focused on the addicted individual, this research demonstrates the strong negative effects the addictive behaviour has on the partners and past partners of these individuals. It is important to extend the attention previously focused on the addicted individual to also focus on the individuals closely linked to them. The addictive behaviour has a major impact on the people emotionally linked to the individuals experiencing the addiction. This must be taken into account when dealing with families who are, or have been, affected by addiction in order to address the full impact of the addicted behaviour and heal the negative effects of drug and alcohol abuse on a broader scale.

PROMOTING DRUG TREATMENT IN SUBSTANCE DEPENDENCE: POTENTIAL FOR CONFLICT?

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The aims of the study were:

1. To elicit clinicians' views, from different professional groups, on the use of prescribed medication in the treatment of substance dependence.
2. To see if differences exist between professional groups.
3. To see what influences clinicians' views and decision making, regarding the use of medication.

The medications selected for the questionnaire have a broad evidence base for their use.

We work in a climate that demands evidence of effectiveness for interventions across a range of indicators. It has been suggested that evidence-based practice is a process by which clinical decisions are made using the best available research in conjunction with clinical expertise and client preferences.[1]

Method

A purposive sample of clinicians working within Hawkes Bay Mental Health and Addiction Services received an overview of the study and a questionnaire to complete and return. Clinicians were contacted by post or by e-mail. Thirty postal surveys were sent and approximately 100 e-mail surveys, although the number of e-mails received by potential participants is not confirmed.

Twenty-four (80%) of the postal surveys and 21 (21%) of the e-mail surveys were returned. This provided a sample of 45 clinicians.

Clinicians were asked to comment on the use of seven medications available under prescription (in New Zealand or internationally) for the treatment of substance dependence.

Following questionnaire completion, 20 of the original sample were selected for interview to establish what influences their clinical decision making regarding pharmacological treatment in substance dependence**.**

Doctors (n=15) were either working in General Practice or Psychiatry.

Nurses (n=12) were all working in the mental health or addiction field, the majority in mental health with postgraduate training.

The *Psychological Therapists* group (n=12) was the most diverse in terms of professional background and length of experience. Professional roles included Clinical Psychology, Psychotherapy, Counselling and Kaimanaaki. Though the most diverse group in background, 10 of the 12 clinicians in this group were directly involved in providing addiction services.

Other clinicians (n=6) included Occupational Therapy and Social Work and were all working in Mental Health or in Dual Diagnosis teams. Pharmacy respondents were working in the community and involved in the dispensing of the medications included in the survey, with the exception of heroin.

Findings

Clinicians were asked if they agreed or disagreed with the use of the seven pharmacological treatments. Percentage agreeing, by professional group, are displayed in Table 1.

Table 1: Percentage agreeing with the use of seven pharmacotherapies, by professional group

Profession	NRT	Benzo-diazepines	Antabuse	Naltrexone	Methadone	Anti-depressants	Heroin
Doctors	100	80	80	47	80	93	13
Nurses	92	83	92	92	92	92	33
Psychological Therapists	92	50	83	67	67	92	8
Other	100	83	100	67	83	67	17

The Psychological Therapy group appear to be less favourable than other groups towards the use of benzodiazepines, methadone and heroin.

All of the respondents who offered comment from this group had concerns about the addictive nature of benzodiazepines and felt their use should be short-term and monitored. These comments were not unlike the comments of the other groups with regard to this drug, though the other groups were not so opposed to its use.

In addition the Psychological Therapy group felt the use of psychological interventions should be practised in conjunction with pharmacology and offered evidence to support the use of such therapy.

The one respondent who offered comment and disagreed with methadone felt that working in the drug and alcohol field they had seen limited positive outcomes in the use of methadone.

Finally, the Psychological Therapy Group were strongly opposed to the use of heroin, and from their comments did not appear clear about a rationale for its use. Some of the group who disagreed with treatment were not totally closed to the idea of its use and felt that if a sustainable system was in place (similar to that of methadone) they may support its use.

The Nurse group appear more favourable of the use of prescribed heroin than any other group. None of the respondents were able to offer any evidence or research findings to support their view. Those opposed to treatment felt as other groups did, that they had inadequate experience in this area to make comment, or they felt its use had potential to inflame already existing problems related to opiate dependence.

Doctors appear less in favour of the use of naltrexone according to the table. Despite the figures it was evident from the comments that due to a lack of experience and information on its application they felt they were not able to support its use, rather than having doubts about its efficacy. This could be due to the novel status of Naltrexone in New Zealand, as it has only been in section B of the Pharmaceutical Schedule since June 1st 2004.

Within the 'Other' group of clinicians interesting comment was offered by the pharmacists suggesting that they would feel able to support the prescribing of heroin if New Zealand developed a more comprehensive health system that could support this.

Clinicians were asked to choose from a list the factor which most influenced their clinical decision-making with regard to pharmacological therapies. Their choices are displayed in Table 2.

Table 2: Factor most influencing clinician decision-making regarding pharmacotherapy

Previous Clinical Experience	33%
Research	20%
Cultural/moral/ethical reasons	18%
Local Practice	12%
High regard or disregard for a specialist service providing treatment	12%
Other	5%

Discussion

Overall the majority of clinicians in this study appeared favourable towards the use of prescribed medication in the treatment of substance dependence. Significant differences of opinion were evident between professional groups about certain medications.

In our interpretation of the results clinicians' comments were valuable in addition to their agree or disagree response. This highlighted that some of the clinicians' that disagreed actually did so because they did not have knowledge or experience in the use of a particular treatment. This was particularly evident from the doctors response to Naltrexone, as it has only recently been made available under subsidy in New Zealand.

The most influential factor in clinical decision making was previous clinical experience followed by research.

Clinicians in Hawkes Bay appear to hold differing views toward treatment and there is potential for conflict and inequality in health care delivery. This may be due to differences in professional qualification, background, experience, theoretical orientations or personal beliefs. Due to the small sample sizes within each professional group, however, it may be unwise to draw conclusions about clinicians differing views being solely due to their respective professional group.

Solutions to improve collaboration and minimise conflict could include the development of shared care protocols, and utilising standardised treatment guidelines locally based on best practice and the most up to date research.

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TREATMENT FAILURES OR SUCCESS STORIES? AN EXPLORATORY STUDY OF SHORT-TERM TREATMENT ATTENDANCE

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Many clients exit outpatient alcohol and other drug (AOD) treatment in the first weeks of service contact.[1, 2] Such short-term attendance is rarely the result of a formal discharge; rather, it usually occurs without the clinician's approval or knowledge. It is a prevailing belief in the AOD literature that these 'short-term' clients experience limited therapeutic benefit, or worse, experience deterioration in their 'condition'. As such they are classically portrayed as 'treatment failures'. However, evidence from the mental health sector challenges this portrayal. Short-term clients of outpatient mental health services have been found to experience significant therapeutic gain and clients deemed 'failures' by their respective mental health therapists frequently view their own treatment experience as a success.[3, 4] To date, the perspective of this client group has remained largely unexplored in the AOD sector. This paper presents the results of an exploratory study designed to consider the perspective of the short-term client population. Data presented include 'reasons for service exit' as stated by a short-term client group and a comparison between short- and longer-term clients on a number of service experience and outcome measures.

Methods

For a 3-month period (June-Aug 2003) clients presenting to the five Auckland CADS units for a new treatment episode were invited to participate in the study. Participation involved the completion of a brief questionnaire at the end of the first assessment appointment and a further questionnaire administered 2-months post that date (by telephone). Seventy-one percent (109/155) of clients invited to participate in the study agreed to do so and completed the initial questionnaire, of which 85% (93/109) were successfully followed-up.

Data collected from this sample were grouped and analysed according to the subsequent service attendance of each participant. Participants who had attended three or fewer appointments at the time of their discharge comprised the 'short-term'

sample (n=45). For the purposes of statistical comparison, the remaining participants were grouped into either a mid-term (4-7 appointments; n=33) or a longer-term (8+ appointments; n=31) sample based on the number of appointments they had attended at the time of their discharge.

Findings

Table 1 presents the reason for exit data as reported by short-term clients at the time of the two-month follow-up. Reason for exit data were only obtained from 22 short-term participants at this stage as the remaining clients were still planning to attend further appointments (which they subsequently did not). In the first two data columns are the number and percentage of participants who endorsed each item as a 'factor' in their decision to stop attending CADS. The second two columns present the number and percentage of participants who endorsed each item as the 'number one factor' in their decision to stop attending CADS.

Table 1: Reasons endorsed for service exit by short-term participants

Response option	Endorsed		No.1 Reason	
	n	%	n	%
Hard to attend appointments	7	32	2	9
Not happy with all or part of the service	2	9	-	-
Uncomfortable to talk about problems	1	5	-	-
Initial problem improved	17	77	12	55
Lost interest in attending the service	1	5	-	-
Service did not meet needs	3	14	1	4
Other reason	10	46	7	32

At two-months post-admission, all participants were asked to rate, on a 4-point scale (4=very satisfied to 1=very dissatisfied), their level of satisfaction with: 'Opportunities given to discuss issues of importance to you?', 'Opportunities given to discuss the type of service you wanted from CADS?', 'Opportunities given to discuss what attending CADS actually involves?', 'Amount of practical advice you were given?', 'Amount of emotional support you were given?' and 'Overall service you have received?'. Statistically significant subgroup differences were found on only two dimensions: 'Opportunities given to discuss issues of importance' (χ^2=9.46, df=2, p<0.01); and the 'Amount of emotional support given' (χ^2=7.32, df=2, p< 0.05). Short-term participants were significantly less satisfied with the opportunities given to discuss issues of importance than both their mid- and longer-term counterparts (both p <0.02). Short-term participants were also significantly less satisfied with the amount of emotional support given compared to their mid-term counterparts (p < 0.01), however, the difference between short- and longer-term participants did not reach significance on this dimension. There were no significant differences between mid- and longer-term participants in reported satisfaction on either of these two dimensions.

At two-months post-admission, all participants were also asked to think back to the original problems that brought them to the CADS service and rate (on a five-point

Likert-scale) the level of improvement at that point in time (i.e. 2-months later). Overall, the majority of short, mid, and longer-term participants rated their level of problem improvement as 'much improved' at that time (53%, 67%, 57% respectively). 'Moderate' improvement was reported by 18% (6/34) of short-term, 15% (4/27) of mid-term, and 33% (10/30) of longer-term participants. 'Slight' improvement was reported by 9% (3/34), 11% (3/27) and 7% (2/30) of each group, respectively. 'No change' was reported in 15% (5/34) of short-term, 7% (2/27) of mid-term, and 3% (1/30) of longer-term participants, and problems getting 'worse' were only reported by 6% (2/34) of the short-term group. Overall, there was no statistically significant difference between these three attendance groupings on reported level of problem improvement at two-months post-admission. These results were supported by other measures demonstrating a statistically significant reduction in participant reports of frequency of AOD consumption and levels of psychological distress (equivalent reduction irrespective of actual service attendance).

Discussion

Short-term participants overwhelmingly endorsed problem improvement as either a factor, or the number one reason, in their decision to leave treatment. This finding was supported by the outcome data. The majority of all short-term participants interviewed at follow-up rated the original problems that brought them to treatment as being either moderately or much improved. The majority of short-term participants also reported significant reductions in their frequency of AOD consumption and psychological distress at two-months post-admission. Furthermore, there were no statistically significant differences in the reported levels of outcome between short-term clients and their mid-, and longer-term peers. The service satisfaction data suggested short-term clients were equally as satisfied as their mid- and longer-term peers in terms of the overall service received, however, they may have been somewhat less satisfied with certain aspects of the service they received. The results of this study should be interpreted with some caution as a response bias may exist in terms of the reason for exit data and the outcome measurement was limited to a single-point in time.

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ONCE WERE WARRIORS, NEVER WERE DRINKERS

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The current paper is based on part of the data from a qualitative evaluation of a group of Māori men's experience of addiction and treatment. A key aim was to identify how participants related 'being Māori' to addiction and recovery. The objective was not to assess the accuracy of the relationships suggested or positions taken up, but rather to elucidate the ways in which they were developed and sustained through language. The specific focus of this paper is on the use of historical narratives of 'Māoriness' to support positions of recovery in the present, particularly, to counter the negative stereotyping of Māori in relation to substance use.

Method

In-depth interview data was gathered, both during and following treatment, from 11 Māori men attending a kaupapa Māori programme. The research was undertaken within a kaupapa Māori research framework,[1] within which data was subjected to the deconstructive techniques of discourse analysis.[2] These techniques were applied in order to identify the ways in which participants used language to position themselves as Māori, and in relation to addiction and treatment. This method is based on the assumption that 'reality' is, at least in part, socially constructed. Thus, while people may function **as if** the 'facts' which make up 'reality' are fixed, much of what is taken for granted as 'truth' is actually negotiated interpersonally within a given socio-historic context.[3] The aim of discourse analysis is to expose the ways in which people use language to support or challenge particular versions of 'reality', within particular social contexts.

Findings and Discussion

During initial interviews many participants identified a 'natural' association between 'being Māori' and addiction. In doing so they frequently referred to stereotyped images or popular portrayals of excessive substance use by Māori, for example, as seen in the film, *Once Were Warriors.*

"Māoris party up hard and have very good times, guitar parties …just drink hard out, days on end… I think a lot of Māori would drink and smoke dak."
(Whiu T2, 918-39)

"A fair percentage [of Māori] would think that's just normal, have a good night out, get drunk, fall over. I suppose [Pakeha] think that's just how they are, can't help themselves."
(Hohepa, 1611-28)

Within these narratives a connection between excessive substance use and 'being Māori' was identified as being the 'norm'. The implied contrast was that 'Pakeha' could "help themselves" in relation to drinking, such that 'being Pakeha' was not automatically associated with addiction in the same way that 'being Māori' was. Such positioning was not uncritically accepted by all participants, however, with at least one implicating broader societal factors. In this case the media was charged with perpetuating stereotyped images of inherent Māori deviance.

"On TV it's either Māori crime or skinhead. So there's like three different people. You've got the white people, the skinheads and the Māoris. Māoris are all in one group, skinheads are just a minority of white people, and then you've got the rest, the so-called norm."
(Thomas T1, 2202-19)

The foundation for the discourse cited above has been clearly evident within the narratives of early settlers, which constructed Māori as 'drunken savages'. This image was perpetuated despite evidence that alcohol-related problems in the early period of colonisation were largely an issue for Pakeha.[4] Such negative views of Māori were not, however, universally subscribed to, with at least one early traveller presenting an alternative perspective.

"Māori very often take us to task for indulging in such an extraordinary and debasing propensity [drinking alcohol], or, as they call it, 'making ourselves mad."
(Augustus Earle, 1827, in Mancal[4])

This type of narrative provided an alternative to those that constructed an inevitable link between 'being Māori' and substance use problems. Such alternatives were readily supported within a kaupapa Māori treatment programme, which enabled participants to redefine themselves within more positive narratives of 'Māoriness'. These provided a potentially central discursive resource, which enabled participants to position themselves within narratives of recovery. To a large extent such narratives drew on the absence of psychoactive substances in pre-contact Māori society, as a basis for current abstinence and associated behaviour change.

"Māori never had the problem of alcohol. It was the white man that brought the alcohol... colonization."
(Bill T1 2039)

"They never really went to an excess of drinking. ... Because on the marae there was the boundary. You couldn't do those things, you didn't want the Tohunga to come out and put the tapu on you. Because if that happened, then you lost touch with your people."
(Bill T1, 2127)

This type of discourse not only positioned Māori as substance-free, but also identified 'cultural' practices and beliefs that mitigated against substance use, at least in 'traditional' Māori settings. Such narratives also served to separate 'being Māori' from the negative impact of substance use, by locating the latter with the negative influence of colonisation and Pakeha society.

"I say that Māori have lost their boundaries ... fellas just storm in all over the show, drink their beers willy nilly. … they're just like the Pakeha. … Māori been like that too, but he's learned it from somewhere else."
(Bill T1)

In this context, dominant binaries that located Pakeha as the norm and Māori as the deviant 'other' were reversed. It is unlikely that such reversal could be easily maintained in broader social contexts where Māori continue to be negatively positioned. In certain environments, however, such as a kaupapa Māori treatment programmes, where 'being Māori' is explicitly constructed as positive, such positioning could arguably be sustained over time. This would be likely to make a significant contribution to building a foundation for more positive narratives of self.

Ultimately, through the use of discursive resources of 'tradition', participants were able to redefine themselves as Māori, in a way which linked Māoriness, 'naturally', with recovery supporting values, beliefs and practices, rather than excessive substance use. There were some limitations evident, as this located Māori culture within an historic freeze frame that did not necessarily account for the 'diverse realities' of contemporary Māori. Not all participants necessarily adhered fully to narratives of substance-free Māoriness, with some deploying this resource selectively to meet their unique needs.

"I'd say they [colonists] did bring [alcohol] here. So they caused it [alcoholism]. Dak, I don't really know how the seed got here, but the Almighty created everything. So it's a natural thing. Māoris have a natural thing, miro berries, as a hallucinogen, to see into the future."
(David 2252 – 2288)

<u>Conclusions</u>

Although there are limitations in strictly adhering to non-negotiable narratives of authenticity, predicated on substance-free Māoriness, there are likely to be benefits in supporting such discourse as individuals move from addiction into recovery. Not all Māori may take these up or sustain them over time, however, they have potential to counteract negative stereotypes that position Māori as inevitably drunk and on the deviant margins of 'normal' society. For many individuals, and whanau, the option of taking up positive narratives of Māoriness, such as those of 'traditional' abstinence, could be central to moving away from addiction.

While the current study cannot uncritically be generalised beyond the group of men who took part, the results provide important information about discursive resources likely to be useful in addiction treatment for Māori. Providing an environment in which 'being Māori' was explicitly constituted as positive allowed participants to develop alternative narratives to those available within the dominant social context, which frequently linked 'being Māori' with addiction. In contrast, the context of the treatment programme provided a venue for drawing on 'traditional' notions of Māoriness to challenge such negative narratives and reinforce recovery supporting ways of 'being Māori'. Some caution is needed, however, in terms of the utility of simply reversing dominant binaries, such that the putatively 'drunken savage' becomes the 'noble abstinent warrior'. Ultimately, such simple reversal fails to account for the complexities of both addiction and 'being Māori' in contemporary Aotearoa/New Zealand.

Implications for treatment and future research:

- Māori focused treatment programmes are likely to have an important role in helping Māori with addiction-related problems to develop more positive recovery supporting narratives of 'being Māori'
- The 'self-constructing talk', as well as the 'hard reality talk', of addiction is a useful focus for intervention, as it is likely to contribute to strengthening the "walk" of recovery
- More closely investigating the relationship between the "talk" and the "walk" of addiction would be a useful focus for future research.

No reira te whakatauaki:

Korero, te kai o te rangatira.

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TREATMENT DELIVERY THE PACIFIC WAY – AN EXPLORATION INTO DELIVERY OF ALCOHOL AND OTHER DRUGS (AOD) SERVICES FOR PACIFIC PEOPLES IN NEW ZEALAND (PADOPT I)

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This study is the first step of a three-phase project aimed to initiate the process of evaluation and improving the effectiveness of alcohol and drug treatment services for Pacific peoples.

Methods

The qualitative 'Grounded theory approach' was adopted for this study. This approach allowed for participants data to generate a theory that accounts for a pattern of behaviour deriving from the data.

Thirty-one Pacific staff from thirteen services listed in the Alcohol and Advisory Council of New Zealand (ALAC) National Directory of Alcohol and Drug Services for Pacific people were asked to participate in individual or focus group interviews. The interviews were semi-structured and explored their perceptions about service delivery practices and treatment approaches for Pacific people.

Findings

Assessment and Treatment tools, models and processes

Current assessment and treatment tools and processes highlighted a Pacific or combined Pacific/Palagi approach that was encompassed in a holistic framework (involving the spiritual, family, mental and physical aspects of an individual). This holistic approach was to be reflected in all aspects of the clinical intervention with families and significant others and recognised as an integral part of the process. Assessment forms were adapted to Pacific contexts to provide the cultural focus that was perceived to be lacking in current clinical practices. Pacific District Health Board (DHB) services used standard tools such as the Leeds Dependence Questionnaire[1] and Alcohol Use Disorders Identification Test (AUDIT)[2] on a routine basis. Commonly reported assessment frameworks for Pacific clients included the timeline, genogram/family tree and the Fonofale model.[3]

It was recognised by clinicians that Pacific New Zealand born youth clients require a specific approach. Pacific clinicians reported that Pacific youths with AOD issues were

often caught between two worlds, Palagi and Pacific, and their issues and experiences are often very different to those born in the Pacific. The suggestion here is that Pacific AOD clients associate more with youth culture than with their ethnic-specific cultures. The approach to Pacific youths was therefore more likely to be consistent with the approach to youth in general.

The need for clinicians to be transparent and clear when communicating treatment approaches was highlighted by clinicians as important for them when working with clients and family members. Clinicians suggested that these approaches needed to be interactive, visual, practical and oral more than written. These approaches were believed by clinicians to enhance client commitment to interventions.

Outcome measures

Unlike the assessment and treatment concepts, the majority of clinicians appeared puzzled by the concept of objectively 'measuring' their treatment interventions, and considered assessing the way the worker 'helps' an 'individual' as foreign. Helping people is an important value in Pacific cultures so clinicians believed the process was equally as important as the actual outcome of the intervention. They also commented that there were extraneous factors that could influence the outcome of clients' wellbeing that needed to be considered.

Key areas of outcome measures included: agency-based outcomes (measuring the effectiveness of the worker's performance with clients) and client-based outcomes (measuring the client's progress or success over time via comparison of feedback from clients, families, referrers, relevant services and any significant people associated with the client). Clinicians from Non-Governmental Organisations (NGOs) commented that funding based on outcome measures was an unfair system due to short contractual time frames. Contractual limitations also undermine the importance of rapport-building in the treatment intervention process.

Other Key Issues

Clinicians commented that the multiple roles of clinicians required multiple competency levels and that these needed to be recognised as important and integral factors in treatment interventions. However, many of these other roles, often cultural roles, are not formally recognised. These include their cultural roles within their ethnic communities and the time-consuming nature of the roles, especially for those engaged in the task of translating clinical concepts into Pacific contexts.

Education was also seen to be important not only for the service (AOD staff), by way of training, but also for those who accessed the services (clients and families), by way of education programmes.

Conclusion

This study is the first phase of a larger review of treatment interventions with Pacific clients with AOD issues in New Zealand. The study identifies a 'Pacific way' of working with Pacific clients which encompasses a holistic approach, with Pacific people with relevant skills and competencies recommended as the most appropriate AOD workers for Pacific clients.

In recognition of the New Zealand born youth population, however, the approach is suggested to be aligned with a general youth approach. However, the need to address the approach for the New Zealand born youth population requires further discussion beyond the scope of this study.

The study showed that though styles and approaches did not necessarily incorporate a specific treatment, clinicians did attempt to work in a 'Pacific' way where possible. Participants' discussion around assessment forms and assessment systems highlighted some difficulties that they had with them and suggests that there needs to be a review of current forms and systems to better capture and reflect the work that they do.

Whilst there appeared to be no difference between types of Pacific interventions offered by DHB and NGO providers there were differences in resourcing and operational systems of practise where DHB services are found to be more systematic.

A review of documentation systems (whether electronic or paper based) would be beneficial to ensure they reflect Pacific interventions and processes, ensure consistency in Pacific service delivery and enhance relationships between Pacific AOD and other services.

Ongoing clinical and cultural training for Pacific AOD workers nationwide is crucial to enhance workers skills and abilities. Whenever possible this training should be delivered by Pacific workers and clinicians. Credentialing of Pacific skills relevant to the AOD sector needs to be undertaken in order for appropriate remuneration scales to be developed and applied. There also need to be environments developed for Pacific AOD workers to obtain supervision and training skills.

Appropriate funding structures are needed to ensure that Pacific services can attract and retain skilled Pacific AOD workers, especially in the NGO sector and smaller communities.

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FACTORS AFFECTING YOUTH RETENTION IN ALCOHOL AND OTHER DRUG TREATMENT: A REVIEW OF THE LITERATURE

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Retaining patients in treatment has long been recognised as an important aspect of successful treatment outcomes in both general and mental health settings. This is especially true in the alcohol and other drug field where a number of studies have reported links between length of time in treatment and reductions in alcohol and other drug use and criminal activity, and improvements in educational achievement, employment status, and psychological well-being (1-4). Understanding the factors that contribute to retention in treatment is an important step towards ensuring the provision of better health care services.

Although retention in treatment has been identified as an important aspect of successful treatment outcome by many researchers, very little is known about the factors that contribute to treatment retention or attrition. This is especially true of treatment for adolescents with substance use problems.

Current knowledge of factors associated with adolescent treatment retention is based mainly on studies conducted with adults. Given the identified differences between adults and adolescents in regard to developmental issues, clinical presentation and history of substance use (3, 5), it is important that knowledge of adolescent

treatment retention is extended beyond replication of adult studies to examine factors that may be specifically relevant to adolescents.

The aim of this current paper is to present the first part of a larger review that is aimed at identifying factors that may be associated with adolescent retention in alcohol and drug treatment programmes. The particular focus of this review is on the research literature that has specifically focused on adolescent alcohol and drug treatment retention.

Method

A comprehensive internet search of relevant databases was conducted to identify any research that had examined retention of youth in alcohol or other drug treatment. This search revealed a limited range of studies. These included a few studies directly examining treatment retention while the other studies provided information on retention as part of their wider focus on treatment outcomes.

Results

Only eleven studies were found to meet the criteria of having examined adolescent retention in alcohol and drug treatment. Nine of these studies (1, 2, 6-12) were conducted in the United States of America.

Rigorous research designs such as randomised controlled trials are scarce. The few studies that had attempted such designs were all abandoned because of logistical issues.

Methodological Issues

The identified studies reflect a piecemeal approach to research in this area with many studies examining one-off variables. Where similar variables (e.g. age, substance use etc.) have been examined across studies, they have seldom been measured consistently. Inconsistent definitions of retention, examination of a range of treatment modalities and a lack of methodological detail have also made comprehensive evaluation both between and within studies difficult.

The minimal amount of research examining adolescent AOD treatment retention is based largely on the adult literature and has a primary focus in examining the same factors that have been found to be predictive of adult retention in AOD treatment (1, 4, 13). For the most part these factors can be divided into three main types: "fixed" client characteristics, "dynamic" client characteristics (14) and treatment characteristics (4).

"Fixed" Client Characteristics

"Fixed" client characteristics (unchangeable characteristics such as demographic and background variables) (14) are those most commonly studied. Research examining these variables has produced inconclusive findings with regards to the association between these variables and adolescent treatment retention.

Age, Gender and Ethnicity

In general studies examining age differences within adolescent samples have not found age to be significantly related to treatment retention (1, 5, 10, 13). However,

when comparisons are made between adult and adolescent samples, adults are usually found to stay longer in treatment than adolescents (2, 11). Similarly, inconclusive findings have been found with gender and ethnicity with some studies reporting no relationship (5, 6, 10, 13) and others reporting minimal relationships (11). Particularly problematic for the interpretation of results from these studies are the low numbers of females and participants of ethnic minorities that have been included in the studies.

Educational Status

Two studies found that youth who were currently enrolled in an educational or skill development programme were significantly more likely to complete treatment than those young people who were not enrolled in such programmes (1, 12). Studies measuring school achievement, however, have failed to find any relationship between this variable and treatment retention (5, 13).

Criminality

A range of studies have examined a variety of aspects of criminal history and behaviour. While some have focussed on the presence or absence of criminal history (5, 13) others have been more focussed on the level and type of criminal activity (1, 8). Given these differences in measures, findings from these studies are inconclusive especially across treatment modality, but indicators suggest that less criminal involvement is conducive to greater treatment retention especially in residential treatment settings.

Referral Source

The majority of studies conducted with adolescents suggest longer treatment retention for those who have been court-referred (2, 11). However, other studies have produced conflicting results by suggesting that internal motivation (self-referral) is associated with longer treatment retention (6). It would seem that future research that does not see these two characteristics as mutually exclusive would be beneficial in this area.

Substance Use

Many aspects of substance use have been examined including severity (1, 8, 10, 13), age at first use (6), and primary drug of choice (1, 2, 12). Similar to criminality, different relationships between these factors and treatment retention have been found in different treatment modalities and according to the different measures of substance use used.

Psychopathology/Psychological Well-Being

Evidence suggests that externalising and internalising behaviours impact on treatment retention, but the direction of these relationships is inconclusive (6, 13).

Family Relations/Family Substance Use History

Evidence is inconclusive but there is some suggestion that poorer family relations and presence of problematic family substance use involvement is related to treatment dropout (6, 8).

Peer Relations/Peer Substance Use History

Very little research has been conducted in this area, but some evidence suggests that problematic relationships with peers prior to treatment predicts shorter treatment retention (5).

"Dynamic" Client Characteristics

Although only a limited number of adolescent studies have examined "dynamic" or changing client characteristics associated with treatment retention, adult research indicates these as more relevant characteristics to examine. Research with adolescents has shown that those who were more self-motivated to engage in treatment were more likely to remain in treatment than those with less motivation (2, 6, 10). Mechanisms underlying this relationship are as yet unexamined, but provide a fruitful ground for future research.

Treatment Characteristics

The level of experience and treatment philosophy of the clinician (7, 10) are important, as are adolescents' perceptions of comfort and safety in the programme (7, 10). A more holistic approach to treatment where programmes provide services to simultaneously address problems other than those associated with substance use have also been shown to relate to longer treatment retention (7, 10).

Conclusions

Given the limited number of studies available to review and the difficulty of drawing comparisons between methodologically different studies there are not a lot of conclusions that can be drawn about factors affecting treatment retention to date. This preliminary review has, however, highlighted a number of implications for future research in this area. These include conducting studies that: have a specific focus on treatment retention rather than treatment outcome; conjointly consider treatment characteristics and fixed and dynamic client characteristics; and are based within an Aotearoa New Zealand context and be representative of Māori, Pacific and Pakeha youth.

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WHAT ABOUT POT: SMOKING HISTORY AND CANNABIS SMOKING

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Funding: The summer student stipend was kindly funded by the Asthma and Respiratory Foundation of New Zealand

Introduction

Cannabis smoking is a significant public health issue. A number of surveys in New Zealand have shown that cannabis smoking is common. In one survey[1] 20% of New Zealanders had smoked cannabis in the last year, 15% were current users, and 1 in 4 users were smoking more cannabis than they were happy with.

Both cannabis and tobacco contain a similar range of harmful chemicals. Cannabis respiratory effects include: effects on exercise tolerance, acute and chronic bronchitis, cellular dysplasia, and increased respiratory infections.[2] People may not smoke as many joints per day as nicotine cigarettes, but they have greater retention of inhaled cannabis-related chemicals, due to behaviours such as depth of inhalation, breath holding and non-filtering. Smoking a joint results in 4-5 times more chemical disposition in the lungs than one nicotine cigarette.[2]

A preliminary survey of medical records had shown that cannabis is not routinely documented[3] when taking a smoking history and patients do not usually volunteer this information unless routinely asked.

Working hypothesis

The cannabis use by clients of health services is being missed. If so, the smoking-associated health risk for these individual patients may be overlooked with the overall public health impact that population-based smoking risk will be under-documented in health statistics.

Aims

1. To examine the recording of smoking history for accuracy of tobacco and cannabis documentation.
2. To do an intervention to improve rates of asking about cannabis by health professionals.
3. To quantify any misclassification of cannabis smokers, who do not smoke tobacco, as non-smokers.

Method

Medical records were examined before and after an educational intervention directed at medical staff working at Hutt Hospital. The intervention was a lecture to medical

staff on the respiratory effects of cannabis, and suggested ways to ask, and a reminder about motivational interviewing and brief intervention. This was followed up with the ward-based teams and individual staff members, including a reminder 5 weeks later.

Post-intervention the medical records of 781 admissions to CCU and General Medicine wards were examined at Hutt Hospital from Nov 2003 to Jan 2004. These were scrutinised thoroughly, looking for documentation of smoking history during the admission.

As a control group, the medical records of 382 admissions to CCU and General Medicine wards at Hutt Hospital in September 2003 (pre-intervention) were also examined. An examination was possible of the accuracy of smoking documentation by comparing the medical records kept during admission and the smoking data written on the discharge summary. This accuracy comparison was carried out for the control group only (as not all of the post-intervention patients had been discharged from hospital by the time of the project end).

Ethical approval for this project was obtained from the Wellington Ethics Committee.

Findings

For the pre-intervention group, smoking history documentation inconsistencies were found between daily health professional notes and data in the discharge summary in (109/360) 30.3% of the medical admission records examined. Examples of these inconsistencies were: discharge summary said patient was a never-smoker, but the records showed patient to be an ex-smoker or even a current smoker (42.2% of misclassifications), or discharge summary listed smoking status as unknown, but the records documented patient as a current or ex smoker (11% of misclassifications). In some discharge summaries the patient was said to be an ex-smoker, but no details in the records were available to confirm this (14.7%).

No-one had documented smoking history for tobacco in the records for 26.7% pre and 22.5% post intervention patients. A doctor had documented smoking status in 68.9% pre and 72.3% post intervention. A nurse, but not a doctor, had documented smoking in 4.4% in each instance. These differences were not significant.

For cannabis 1.7% of patients had been asked if they used pre-intervention and 3.1% post-intervention. This difference was not significant ($p=0.18$). There was insufficient data to determine the extent of misclassification of cannabis smoking status.

Discussion

Smoking status is recognised as an important personal health risk and also a significant factor in Public Health. The New Zealand Health Strategy identified reducing smoking as the primary population health objective[4].

There are significant implications arising from smoker status misclassification. In terms of the individual who is misclassified as a non-smoker when she/he is not, there is a risk that timely and appropriate assistance may not be offered because

health practitioners will not recognise the link of smoking as a cause or contributing factor for associated personal health problems. In regard to the population at large the implication of inaccurate documentation of smoking status means that data used for public health purposes will be incorrect. This research suggests that current smoking risks in the population could be underestimated in New Zealand.

Smoker health risk misclassifications are possible if current cannabis smokers who are tobacco non-smokers are classified as non-smokers, because their cannabis use is not documented. It is very possible that cannabis smokers are not being identified because they are not being asked.

Smoker misclassifications can also occur when ex-smokers of either tobacco or cannabis are classified as non-smokers, since the health risks of smoking remain for an uncertain period of time after cessation. There is an even bigger area of uncertainty over the possible misclassification of non-smokers when these people may carry smoking-related health risks because they are passive smokers.

The results indicate that medical staff do not take care when writing up the smoking status section of discharge summaries. This discharge summary is often the only documentation relating to the admission that the patient and that the GP will receive. The results highlight the need for greater education of medical staff on the health effects of cannabis use as well as reinforcement of the (longstanding) messages about accurate documentation of tobacco use. Staff should be instructed on the importance to ask specifically about cannabis and how to use brief intervention skills.

A stronger educational intervention may have led to an increase in the number of patients asked. Nicotine smoking continues to be poorly recorded and cannabis smoking documentation is also poor. Therefore it appears very possible that smoking data used for NZ public health planning and health statistical purposes is flawed.

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MĀORI AOD MODELS: WHAT'S BEING USED IN THE ADDICTION FIELD?

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The focus of The National Strategic Framework is the enhancement of workforce development and service delivery for alcohol and other drug (AOD) problems, with an acknowledgement of Māori being at higher risk for these problems. There is also acknowledgement that co-existing disorders (e.g. gambling with alcohol and other drug problems), can complicate interventions. Following the Gambling Act (2003), with the Ministry of Health now taking responsibility for problem gambling services, the HRC felt it was important to investigate ways to address both alcohol and other drug and gambling problems in Service Delivery, particularly for Māori.

This was a qualitative research project with the following two aims:

1. To identify models and frameworks of treatment currently used by a representative sample of Māori AOD treatment providers from a range of treatment settings.
2. To identify the extent to which Māori AOD Practitioners felt that these models would apply to problem gambling treatment and to ascertain their ability and willingness to incorporate problem gambling into their current practice.

Methods

The project was structured into three phases:

1. A literature review of alcohol and other drug models, frameworks of practice, and the co-morbidity of alcohol and other drug and gambling problems, was undertaken. Meanwhile, a reference group of Māori leaders in the AOD field was identified and established and cultural supervision was undertaken to ensure a culturally safe and appropriate process was developed. A representative sample of AOD services was identified, and details of the project and invitations to participate were sent to them.
2. On acceptance, meetings were arranged and held with prospective services and/or practitioners throughout New Zealand to further inform, develop the relationship and ensure consent to further participation (only 2 out of 22 declined).
3. Structured interviews were held with practitioners to discuss their practice models, and further information was collected in regard to their view on applicability to problem gambling treatment, and their ability and motivation to provide for this in their service.

Forty-eight practitioners from twenty services in thirteen regions throughout New Zealand, from Hokianga to Invercargill, participated. These comprised five alcohol and other drug generic non-residential services, three residential services, nine 'Kaupapa Māori' services, two youth services and one tobacco cessation programme.

Findings

AOD models

The most well-known and commonly used model was Te Whare Tapa Wha, but other models commonly used were: Powhiri/Poutama, Te Wheke, Whakamana, Kahui Ao, Tatou, Dynamics of Whanaungatanga, Ma Te Wa, and Awhi. In many cases, the predominant models were used in combination with others and/or non-Māori models and concepts, to ensure comprehensive and safe practice and to match client need and understanding. There were a number of common elements inherent in the models used, for example, the process of welcome, connection, respect, support and engagement through traditional Māori process, and there was also a strong belief in the efficacy of the models for Māori. They all worked toward the goal of re-establishing mana, dignity and reconnection with Whanau and culture through a holistic view. Although similar models may be used throughout Aotearoa, some models were specific to regions, services and practitioners, and there were also differences on how Tikanga was applied in the context of practitioner's roles and the local environment.

There was a common belief in the importance of Māori values and culture as part of restoration to balanced health and also the importance of Whanau and community in this. Kaumatua and Kuia were also seen as an essential part of the process and their knowledge and role was highly valued. It was felt by some that operationalising the models takes people beyond addictive issues, toward the goal of Mauri Ora – a balance in all aspects of life, including spirituality and all relationships.

Gambling

All practitioners interviewed were aware of the harmful effects of problem gambling, such as serious financial consequences to individuals, families and communities. They were aware it was more hidden and there was more shame and stigma, and therefore those affected sought help later, often after more theft or debt is accumulated, leading to the breakdown of relationships and isolation. They also noted the rapid development of problems in comparison to alcohol and other drug use and the increasing accessibility of gambling in communities. Some practitioners such as kaiawhina, social workers and alcohol and other drug counsellors were already working indirectly with the harms caused by problem gambling. All practitioners felt that the AOD models used were broad enough to apply to problem gambling and incorporated elements as previously mentioned, that were equally as relevant to those with gambling problems.

All of those interviewed acknowledged that alcohol and other drug treatment skills were the most closely aligned with those required for treating problem gambling. They acknowledged, however, that there were differences, such as no substances involved and being more behavioural, so that they would need specialist training in this area to practice safely and effectively. All felt that Tikanga Māori models of practice could successfully blend with or run parallel with current generic problem

gambling models of practice as was the situation in the alcohol and other drug field. There was strong interest in providing assistance to problem gamblers and their Whanau/family and in acquiring the skills necessary to do this.

Although the practitioners were aware of the impact of problem gambling on the community, there was a lack of awareness about new gambling technology, the extent of the new initiatives undertaken by the Industry and the potential impact of these. There are a lot of misconceptions about gambling in the community and practitioners acknowledged the need for a community-based approach to gambling problems, including the need for accurate information, resources and interventions that are taken to the client. There is a need for health warnings to counter-balance the strong advertising messages put out by gambling providers. Although some consider they are already working with gambling issues in the community, there is little acknowledgement for the legitimacy of this role, little funding, and few resources provided.

Conclusion

The broad survey of 20 organisations and 48 counsellors provided a valid profile of Māori AOD practitioners and organisations delivering treatment using Māori frameworks and models, supported by good commitment and morale. Almost all AOD practitioners supported integration of the provision of the treatment of problem gambling in their work, which would be financially efficient, would reach more clients (particularly Māori, who are at greater risk of problem gambling) and would provide earlier identification and intervention. There are important differences in treatment models and approaches throughout Aotearoa relevant to local conditions and these should be valued and maintained. Many practitioners felt there were no ways of measuring outcomes for Māori cultural processes applied in addiction clinical roles and were unsure whether their cultural training qualifications were as valued as generic and specialist training in treatment interventions. Although there was a strong belief in the effectiveness of their practice, other than community support, referrals to organisations, and anecdotal evidence, there is no formal evidence of outcomes. Clearly, more research in this area is needed, and this project aimed to be a first stage in the process of considering outcomes, and also highlights opportunities for service and workforce development in both the AOD and gambling fields.

Footnote

This research project is comprehensively described in: Sullivan S, Penfold A, Goulding M, Cooke MA. Review of Practice Models Used by Māori Alcohol and Other Drug Practitioners in New Zealand. Health Research Council New Zealand, 2004.

INTEGRATION OF SUBSTANCE ABUSE TREATMENT INTO SCHOOLS – WOULD IT WORK?

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Introduction

Experiential and research data confirm that teenagers are one of the heavy drinking sub-populations.[1-3] Alcohol and drug prevention and treatment measures for young people range from information-providing and educational programs aimed at influencing attitudes and behaviour to residential treatment programs.

So far, schools have traditionally been regarded as the best places for delivery of alcohol and other drugs education programmes to young people. Authors are exploring the idea of offering additional types of support, through schools, for adolescents who (ab)use alcohol and other drugs. The initiative of offering certain types of alcohol and other drug interventions would also fit into the concept of "health promoting schools", which emphasise the importance of physical, mental, emotional, social and spiritual health, and see schools as parts of wider communities, which reach out and are supported by parents, local health services and other agencies.

As the first step in this research, the authors approached guidance counsellors as professionals who have good insight into the issues that young people between the ages 12 and 18 present with.

Method

A questionnaire focusing on aspects of support service-provision for young people who are (ab)using psychoactive substances was compiled and sent to guidance counsellors working at colleges in North and South Island, New Zealand. It was expected that responses would identify factors and suggest ideas about support measures that could be implemented through schools, to reduce potentially serious consequences of excessive alcohol and other drugs use. Qualitative data presented below was the result of a thematic analysis.

Results

Questionnaires were sent to 250 colleges; 130 were filled in and returned to researchers. Counsellors reported that out of all students who contact them, between 0.5 and 55% (mean=11%) want to talk about their alcohol and drug issues. When asked whether they thought the number of treatment options available in the community for young people who (ab)use psychoactive substances was satisfactory, 42% of the sample said "yes", and 58% said "no".

Table 1 shows guidance counsellors' responses to the question: Would it be a good idea to offer some forms of alcohol and drug interventions through school?

Table 1: Preferred frequency of school-based alcohol and drug intervention

Preferred Frequency	Percentage
Rarely	3%
Sometimes	30%
Often	21%
Regularly	45%

Table 2 presents guidance counsellors' opinions about who the most appropriate person(s) to offer those interventions would be (they could circle more then one option):

Table 2: Preferred provider of school-based alcohol and drug intervention

Preferred Frequency	Percentage
Alcohol and Drug Counsellor	76%
Guidance counsellor	66%
Youth worker, also trained in alcohol and drug counselling	52%
Teacher – i.e., health curriculum	50%
Others	16%

Respondents suggested the following as potential benefits of offering alcohol and other drug interventions through schools:

- Easy access to services for all young people in centralised location
- Increased understanding and knowledge about substances and understanding of addictions
- It would reach all young people in New Zealand
- The professional would become a "familiar face", would have more credibility with students than "one off" experts; it would help preserve confidentiality, as students would not have to go off site
- Professional service would be readily available – remedial and preventative; the awareness of alcohol and drug issues and education level in school would be raised; community and families could be engaged
- Teachers would have easier access to information
- Harm reduction strategy would be emphasised
- School would accept intervention rather then suspension and exclusion
- It would be easy to link in and have a planned interdisciplinary approach with other key providers, events and people - i.e., educational, school nurse, PE teachers, sports events, smoke-free events, student role models, community happenings, sports/cultural participation
- Peer and family support could be accessed

- Students would know that the school is serious about keeping them out of harm from alcohol and other drugs use
- It would help students stay clean; it would promote discussion and education and give students choices before they are hooked;
- It would create a school culture that stands up to alcohol and other drugs use and provides other social options;
- Culturally appropriate, on-site support, normalising of interventions;
- It would model relationship building;
- Could provide pressure to stop;
- More students would be aware of their destructive behaviour under the influence, less pregnancy scares;
- It would provide early intervention.

When asked about potential drawbacks of offering certain types of alcohol and other drugs interventions through schools, guidance counsellors provided the following as answers:

- Possibility of inadequately trained professional working with students
- Schools are under-resourced
- Senior management might perceive it as glamourising the "drug life style"
- "Normalises" alcohol and other drugs use behaviour
- Privacy; confidentiality; anonymity
- Could be a disaster if not handled appropriately
- Perception of a school as a "druggie" school
- Students might think it's "cool"
- Some schools think being open about drug and alcohol problems tarnishes its image; giving too much attention to problem behaviour
- None; we already do it and it works fine
- None; there are much greater risks if you do not run intervention and education programmes
- It would need to be the whole school approach, with appropriately trained professionals who are able to make connection with young people
- Time constraints
- Can't see any if there is a balance of positive activities, i.e., sports, music, drama etc alongside discussions of drug related issues.

Conclusions

The data from this initial study confirm that there is a need for additional support measures for young people who (ab)use alcohol and other drugs, to be offered by adequately trained professionals. In the light of knowledge we have about prevalence and potential consequences of drug use, and building on the positive experience of many Health Promoting Schools initiatives, we think that the idea of offering school based, limited range of alcohol and other drug interventions would be worthwhile considering. As one of participants in this study said, it would need to be a carefully planned process, that would provide professional, empathic and timely assistance to students, and would need to create an environment of care, trust and friendliness, which would encourage student involvement.

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