

NEW ZEALAND

**ADDICTION TREATMENT
RESEARCH MONOGRAPH**

2006

ACKNOWLEDGEMENT

On behalf of ATRIG and contributors to this Monograph, we wish to thank the Cutting Edge organising committee for providing a budget for the production of this Addiction Treatment Research Monograph. We also wish to express gratitude to Lisa Andrews and Lindsay Stringer, NAC staff, who have contributed substantially to the task of compiling the monograph.

Dr Simon J. Adamson
Dr Ria Schroder
Monograph Editors

SUGGESTED CITATION

Adamson SJ & Schroder R (eds) (2006). New Zealand Addiction Treatment Research Monograph. Research Proceedings from the Cutting Edge Conference, September 2006.

TABLE OF CONTENTS

| | |
|---|----|
| Acknowledgement | i |
| Suggested Citation | ii |
| Introduction | |
| Simon J. Adamson, Ria Schroder | v |
| Five-Year Treatment Outcome for Motivational Enhancement Therapy for Mild to Moderate Alcohol Dependence | |
| Simon J. Adamson, J. Douglas Sellman | 1 |
| Social Phobia in an Outpatient Alcohol and Drug Treatment Sample | |
| Simon J. Adamson, J. Douglas Sellman, Paul Robertson..... | 4 |
| Le Ala: A Stocktake Of Pacific Alcohol and Drug Services and Programmes | |
| Magila Annandale, Ta’i Richard, Moana Solomona, Cluny Macpherson..... | 7 |
| Narcotics Anonymous: “Making Our Recovery Count” | |
| Aotearoa NZ Regional Service Committee, Narcotics Anonymous..... | 10 |
| Opioid Dependent Patients: Specific Nursing Strategies for Their Acute Pain Management | |
| Peter Athanasos, Charlotte de Crespigny..... | 15 |
| Findings from a Cross-Sectional Longitudinal Study of Methadone Maintenance Treatment in a New Zealand Clinical Setting and Implications for Service Delivery and Research | |
| Daryle Deering, J. Douglas Sellman, Simon J. Adamson, Tuari Potiki, Jaki Horn, Chris Frampton..... | 20 |
| HIV, HCV and HBV Seroprevalence and Associated Risk Factors Among Needle Exchange Attendees in New Zealand 2004 | |
| Charles Henderson | 25 |
| Whole Team Training - Building Dual Diagnosis Capacity in Mental Health Teams | |
| Megan Jones..... | 31 |
| An Investigation into the Health Needs of Pacific Youth Living within the Waitemata District Health Board District | |
| Natalie Leger..... | 35 |
| Long Term Treatment Attendance: Clinical and Managerial Issues | |
| Justin Pulford, Wolfgang Theuerkauf | 40 |

| | |
|--|-----------|
| The Good, The Bad and The Ugly: Agency Perspectives on Student Placements | |
| Deirdre Richardson..... | 43 |
| Fetal Alcohol Syndrome: New Zealand Birth Mothers' Experiences | |
| Jenny Salmon | 48 |
| What Makes Them Stay, What Makes Them Go? Factors Associated with the Retention of Youth in AOD Treatment Programmes in Aotearoa, New Zealand | |
| Ria Schroder, J. Douglas Sellman | 53 |
| A New Zealand One-Stop Shop? Development of the Specialist Problem Gambling Treatment Workforce | |
| Sean Sullivan | 57 |
| The CADS/ABACUS Problem Gambling Screening Project: Gambling Problems Commonly Co-Exist in AOD Clients | |
| Sean Sullivan, Robert Steenhuisen | 60 |
| Young Voices - Young People Speak About Their Substance Use | |
| Mirjana Vilke | 63 |
| Authors Index..... | 67 |

INTRODUCTION

Dear Readers

The Addiction Treatment Research Monograph seeks to represent the array of research presentations given at the annual Cutting Edge conference and to date has attracted submissions from the majority of research presenters. This inevitably leads to a variety of research techniques, examining a wide range of issues for a variety of treatment populations and this year is no exception.

In addition to a number of papers examining issues within clinical settings, there are several taking a wider view of the AOD field, including a needs analysis (Natalie Ledger), an examination of the experiences of mothers of fetal alcohol syndrome children (Jenny Salmon), perspectives on student training (Deirdre Richardson) and two papers examining workforce development issues (Megan Jones and Sean Sullivan).

Two prizes for research presentations are awarded annually at Cutting Edge conferences. These are the John O'Hagan prize for the best research presentation by someone aged under 35 and the John Dobson Memorial prize for the best opioid presentation.

In 2006 the John O'Hagan prize was awarded to two presentations. Marewa King received the prize on behalf of Te Rangihaeata Oranga, Napier, who gave a presentation titled "It Only Takes Three Seconds" a theatre workshop developed by and for youth audiences to talk about gambling. The other recipient, Dr Ria Schroder, co-editor of this Monograph and Research Fellow at the National Addiction Centre, presented a paper reporting on interim data from an ambitious study investigating factors associated with treatment retention for youth in alcohol and other drug treatment. This paper is represented in this Monograph.

The John Dobson Memorial prize for best opioid presentation was awarded to Charles Henderson, national manager of Needle Exchange NZ (NENZ). Charles gave a keynote presentation which centred on findings from a recent national survey of users of NENZ services. This was a widely commented upon presentation which to some marked the coming of age of needle exchange in New Zealand, signalling as it did the acceptance of the harm reduction philosophy as a bedrock value and demonstrating the successes achieved by NENZ.

Dr Simon J. Adamson
Monograph Editor
Chair, Addiction Treatment Research
Interest Group
Senior Lecturer and Deputy
Director (Research),
National Addiction Centre

Dr Ria Schroder
Monograph Editor
Editor, Addiction Treatment Research
News
Research Fellow,
National Addiction Centre

FIVE-YEAR TREATMENT OUTCOME FOR MOTIVATIONAL ENHANCEMENT THERAPY FOR MILD TO MODERATE ALCOHOL DEPENDENCE

**Simon J. Adamson
J. Douglas Sellman
National Addiction Centre
Christchurch School of Medicine and Health Sciences
University of Otago
New Zealand**

Funding: The Alcohol Advisory Council of New Zealand

Contact: *simon.adamson@otago.ac.nz*

This paper reports five year outcomes for a sample of patients with mild to moderate alcohol dependence participating in a randomised controlled trial of the effectiveness of four sessions of manualised Motivational Enhancement Therapy (MET). At six months follow-up we demonstrated that MET was more effective than four sessions of a control psychotherapy (Non-Directive Reflective Listening) and than brief feedback alone¹.

Despite the large amount of research conducted in the area of motivational interviewing, few studies have applied this treatment to an alcohol dependent sample, more commonly targeting hazardous drinking populations. Of those studies treating alcohol dependent patients, none have published outcome data beyond three years².

This study was the first to demonstrate the effectiveness of MET in an alcohol dependent sample when compared to another treatment of equal duration. Patients attended a further follow-up five years after receiving treatment to enable us to examine whether or not the treatment superiority of MET would be sustained over such a period.

Methods

One hundred and twenty-five patients with a primary diagnosis of mild-moderate alcohol dependence were assessed and then attended a 15 minute feedback appointment where individualised feedback from the assessment, education about national drinking guidelines, a comparison of the patient's drinking in relation to those guidelines, clear advice to cut down to within those guidelines or abstain and written material supporting such change was given. This meeting was concluded when patients were randomised to one of three treatment options: Motivational Enhancement Therapy (MET), Non-Directive Reflective Listening (NDRL) and No Further Counselling (NFC).

At six month follow-up 110 patients were reinterviewed and drinking status data were obtained from significant others for a further 12 patients. The primary outcome

measure was Unequivocal Heavy Drinking (UHD) defined as drinking ten or more standard drinks on six or more occasions in the past six months. Of the 110 patients reinterviewed at six months, 100 patients gave consent to be recontacted for a brief five year follow-up interview, of whom 77 (70%) were successfully interviewed.

Results

The 77 patients successfully followed up at five years were compared to the 45 patients last contacted at six month follow-up (i.e. not able to be followed up at five years). The five year follow-up sample were found to be older, more educated, had less comorbid substance dependence, less comorbid depression/anxiety, attended more of their scheduled treatment appointments and drank less often at six months. They were not different for other demographics, baseline drinking and Global Assessment Scale (GAS) scores and treatment allocation, while there was a trend for more UHD and lower GAS at six months.

For the sample as a whole the proportion that were drinking at the UHD level reduced from 88% at baseline to 51% at six months and 25% at five years.

As reported above, a significant difference between groups had previously been found at six months. In order to determine the impact of a reduction in sample size to n=77 six months outcome data were reanalysed for the 77 subjects followed up at six months. The rate of Unequivocal Heavy Drinking remained lower for the MET group (33%) than for NDRL (62%) or NFC (59%). While this difference was no longer statistically significant ($\chi^2=3.44$, $p=.063$) the trend clearly remains, so that it is reasonable to assert that even with a reduced sample of n=77 there is still, broadly speaking, a short-term treatment effect to be explored further at five years follow-up.

Table 1 displays the full range of drinking categories by treatment group, showing that there was no significant difference in outcome at five years.

Table 1: Outcome at Five Years by Treatment Group (n=77)

| | MET (n=27) | NDRL (n=21) | NFC (n=29) | χ^2 | p |
|---|---------------|----------------|---------------|----------|------|
| % broke abstinence | 78 | 76 | 73 | 0.03 | .867 |
| % exceeded national guidelines at least once | 59 | 62 | 66 | 0.23 | .631 |
| % exceeded national guidelines six or more times | 44 | 52 | 48 | 0.08 | .782 |
| % drank 10+ standard drinks at least once | 33 | 38 | 52 | 1.94 | .164 |
| % drank 10+ standard drinks six or more times (UHD) | 22 | 19 | 31 | 0.60 | .440 |

Sample attrition was dealt with using a technique called Last Observation Carried Forward (LOCF) analysis. Using this method six month outcome data were used as a

proxy for five year outcome for those not followed up at five years. This method tends to provide a conservative estimate of treatment gains. Examining UHD at five years and using LOCF it is apparent that the finding of no significant difference between groups is not simply a product of reduced sample size ($\chi^2=0.74$, $p=.692$).

Discussion

Our clinical trial demonstrated that MET shows significant advantage over both a control psychotherapy (NDRL) and brief feedback alone (NFC) at six months. Drinking status continued to improve between six months and five years. However, treatment outcome did not differ by treatment condition at five years. This negative finding was not the result of follow-up attrition.

When it was decided to undertake a five year follow-up of our sample this was done with the expectation that we would not find a difference at five years. This is because of what has been termed "therapeutic half life", the notion that treatment typically has a period of maximum effect with its influence eventually waning in the absence of ongoing doses. MET is a brief intervention for a complex problem and we would therefore have been surprised to have found that the difference achieved at six months was sustained at five years.

Why did we undertake this follow-up if we did not expect to find a difference? Firstly, it is unwise in science to assume you already know the answer to something, as it is often surprising experimental results which lead to important advances. Secondly, this study represents more than just an examination of the effectiveness of MET relative to two other interventions. It also provides the opportunity to examine longer-term outcome for a sample of alcohol dependent patients who attended treatment at a typical outpatient service and for whom extensive descriptive and early outcome data were already available. The continued improvement of the sample post-treatment was particularly heartening.

References

1. Sellman JD, Sullivan PF, Dore GM, Adamson SJ, MacEwan I. A randomized controlled trial of motivational enhancement therapy (MET) for alcohol dependence. *Journal of Studies on Alcohol* 2001;62(3):389-396.
2. Project MATCH Research Group. Matching alcoholism treatments to client heterogeneity: Project MATCH three-year drinking outcomes. *Alcoholism: Clinical & Experimental Research*. 1998;22:1300-11.

SOCIAL PHOBIA IN AN OUTPATIENT ALCOHOL AND DRUG TREATMENT SAMPLE

**Simon J. Adamson
J. Douglas Sellman
Paul Robertson
National Addiction Centre
Christchurch School of Medicine and Health Sciences
University of Otago
New Zealand**

Funding: The Alcohol Advisory Council of New Zealand

Contact: *simon.adamson@otago.ac.nz*

A review of studies examining rates of social phobia (SP) in clinical alcoholic samples reported prevalence typically in the range of 10 to 20%¹. The naturalistic alcohol and drug treatment sample from which the current data is drawn reported a lifetime rate of 37% and past six months rate of 31%².

SP typically has an earlier onset age than substance use disorder (SUD), suggesting the direction of causality primarily working from SP to SUDs³. Evidence that rates of not only SP but also most other co-existing psychiatric conditions are significantly elevated in those with alcohol use disorders suggests a general, rather than diagnosis-specific, mechanism⁴.

In the only published trial of concurrent alcoholism and SP treatment for this population, patients were randomised to either CBT for alcoholism or CBT for both conditions currently⁵. The combined treatment group fared worse on drinking-related measures three months post treatment, while there were no differences between the two for SP symptoms.

Most published studies have looked at SP in alcohol use disorder populations rather than broader SUD groups, despite evidence that SP rates are similar, if not higher, in this more broadly defined clinical group. Furthermore, there is generally a failure to distinguish the impact of SP per se versus a more generalised effect of a broader range of co-existing conditions.

Given the high rate of SP identified in our sample, and the limitations of the literature as described above, the purpose of this paper was to identify differences between SP and non-SP patients with a SUD and to clarify whether these differences were associated with the diagnosis of SP or were common to the broader group with other co-existing conditions.

Methods

A random sample of 105 patients completing an initial assessment at two outpatient alcohol and drug treatment services were assessed and agreed to a nine-month

follow-up interview. This follow-up interview was completed for 102 (97%) of the initial sample. At baseline the Composite International Diagnostic Interview (CIDI) was administered. In order to examine the clinical profile and treatment outcome of patients with a co-existing diagnosis of social phobia this group was compared to two others within the follow-up sample as follows: current diagnoses (past six months) at baseline were used to separate the sample into those with social phobia (SP, 32%), other current co-existing disorders (CD, 39%), and those with no current psychiatric diagnosis other than a substance use disorder (NCD, 28%).

The question posed in this paper is:

“do SUD treatment clients with co-existing SP differ from non-SP SUD treatment clients?”

If any differences do emerge then the companion question is:

“are these differences associated with SP per se or are they the consequence of having a co-existing condition?”

To answer these two questions the SP group was first compared to the NCD group and if a difference occurred the SP group were then compared to CD group to see if the difference persisted. In this way, the CD group acted as a psychopathology control group. The three groups were compared on demographic, current clinical and past treatment utilization variables at baseline, while follow-up data were used to compare the groups on treatment outcome and treatment utilisation.

Results

Table 1: Pairwise comparisons

| | SP (n=33) | CD (n=40) | NCD (n=29) | 3-way <i>p</i> |
|--------------------------------------|-------------|--------------|-------------|----------------|
| Demographics | | | | |
| Years of education | 10.1 (2.0) | 10.4 (1.4) | 11.4 (2.8)* | .040 |
| Baseline Clinical Variables | | | | |
| Amphetamine dependence | 9% | 23% | 0% | .014 |
| No. of current substance dependences | 1.21 (1.08) | 1.63 (1.41) | 0.86 (0.64) | .023 |
| % days using | 57.1 (34.0) | 72.6 (31.4)* | 69.2 (33.4) | .120 |
| % days using cannabis (n=57) | 43.3 (43.1) | 63.6 (41.4) | 70.1 (35.5) | .125 |
| Current ASPD | 18% | 30% | 7% | .056 |
| Treatment Utilisation | | | | |
| Mental Health inpatient | 21% | 30% | 10% | .146 |
| Mental health medication | 70% | 68% | 41%* | .040 |
| Prescribed antidepressants | 61% | 60% | 27%* | .029 |
| Prescribed anxiolytics | 30% | 13% | 10% | .066 |
| Treatment Outcome | | | | |
| SF12 Mental Component ¹ | 40.2 (6.5) | 41.0 (6.6) | 43.9 (6.1)* | .096 |
| Index Treatment Utilisation | | | | |
| Prescribed MH medication | 64% | 45% | 36% | .080 |

Notes: ¹ANOVA controlling for baseline value (uncontrolled outcome values shown)

**p*<.05, pairwise comparison with SP group (conducted for all 3-way *p*<.15)

Rates of current co-existing conditions other than social phobia for the SP/CD groups respectively were: major depressive disorder 54%/38%, bipolar disorder 15%/23%, any mood disorder 79%/70%, PTSD 21%/50%, panic disorder 45%/8%, agoraphobia 45%/15%, and ASPD 18%/30%. In total, 70% of the CD group met criteria for at least one anxiety disorder.

Table 1 shows only those variables with a three-way comparison p value of less than .15, the criterion for investigation of two way comparisons. In addition to these 12 variables, a further 46 variables were not significant to this level.

Discussion

The current study confirmed that SP is common in SUD treatment settings. The SP group did not differ from either group in a systematic way. Overall, few differences emerged between SP and either CD or NCD, with only five of the 58 variables producing such differences. Where differences were evident they typically showed SP to be similar to CD, with both worse than NCD, or SP being intermediate between the two.

This pattern suggests that the impact of SP may be one best considered as a general psychopathology effect or that, in fact, such an effect was largely caused by other comorbidity and that to some extent SP may have acted as a moderating factor, reducing the negative consequences of SUD;

Despite the relatively small sample size, these findings suggest that in SUD treatment settings, patients with co-existing SP do not represent a distinctly high needs or at risk group. It should be noted, however, that the current study lacked the power to detect more subtle differences that may nevertheless have been of clinical significance.

References

1. Lepine JP, Pelissolo A. Social phobia and alcoholism: a complex relationship. *Journal of Affective Disorders* 1998;50:S23-S28.
2. Adamson SJ, Todd FC, Sellman JD, Huriwai T, Porter J. Co-existing psychiatric disorder in a New Zealand outpatient alcohol and other drug clinical population. *Australian and New Zealand Journal of Psychiatry* 2006;40:164-170.
3. Morris EP, Stewart SH, Ham LS. The relationship between social anxiety disorder and alcohol use disorder: a critical review. *Clinical Psychology Review* 2005;25:734-760.
4. Burns L, Teesson, M. Alcohol use disorder comorbid with anxiety, depression and drug use disorders. Results from the Australian National Survey of Mental Health and Well-Being (NSMHWB). *Drug and Alcohol Review* 2002;68:299-307.
5. Randall CL, Thomas S, Thevos AK. Concurrent alcoholism and social anxiety disorder: a first step toward developing effective treatments. *Alcoholism: Clinical and Experimental Research* 2001;25(2):210-220.

LE ALA: A STOCKTAKE OF PACIFIC ALCOHOL AND DRUG SERVICES AND PROGRAMMES

Magila Annandale *
Ta'i Richard *
Moana Solomon #
Cluny Macpherson

* **Fresh, Wellington**

Taimane Consultancy Ltd – Whitireia Polytechnic, Wellington

Funding: Health Research Council of New Zealand (HRC), Alcohol Advisory Council of New Zealand (ALAC) and Accident Compensation Corporation (ACC)

Contact: *magila@freshnz.com*

Currently, limited information exists about the efficacy of alcohol and drug interventions targeting Pacific peoples¹. While Pacific peoples are more likely to be non-drinkers, those that do drink often exhibit greater excessive drinking behaviour than others, especially Pacific males². This study is part of Le Ala, a research project aimed at developing and implementing effective alcohol-related harm prevention strategies for Pacific communities. It follows a comprehensive literature review undertaken as part of Le Ala and complements the suite of studies on Pacific treatment services commissioned by the Alcohol Advisory Council (ALAC).

The purpose of the stocktake of Pacific alcohol and other drug (AOD) services and programmes is to inform the Le Ala project by providing evidence of prevention interventions and services that are considered effective in addressing alcohol use and related risk-taking behaviours within Pacific populations. This is a necessary precursor to Le Ala's attempt to devise innovative prevention strategies to reduce alcohol misuse among Pacific communities in New Zealand.

Methods

A short document review was undertaken as part of this study. Information was sourced from a literature review entitled "*Alcohol Community Interventions and Services for Pacific Peoples*" which has been produced as part of Le Ala. Additional publications were also reviewed. These were obtained through bibliographic searches of various databases including Medline, Embase, Cinahl and Psycinfo, the Cochrane Database of Systematic Reviews as well as other internet sources.

In addition, information was gathered at community fono (meetings) with Pacific alcohol and drug health professionals, researchers, service managers, funders and planners and key sector leaders in Auckland, Christchurch and Wellington. Fono participants were asked to identify those whom they thought were at risk of alcohol-related harm as well as interventions they felt were working or would work best for

Pacific peoples. This was followed by in-depth, key informant interviews with Pacific alcohol and drug service providers nationwide to identify the types of services and programmes they provide and the effectiveness of these services and programmes. The primary modes of data collection were via note-taking and self-report questionnaires. Findings from the document review, fono and interviews were collated, analysed and organised into themes to form the basis of a report.

Findings

The findings revealed a lack of information regarding Pacific drug and alcohol services, especially the effectiveness of these services and programmes. Overseas studies on alcohol and drug prevention interventions targeting Hispanic communities in North America with similar socio-cultural and economic characteristics and similar migration histories to Pacific peoples in New Zealand, describe family and religion as significant elements of effective prevention strategies for reducing alcohol related-harm in these communities, a notion supported by the participants of this study.

Family, the church and increasing cultural diversity within Pacific communities were identified as important features to consider when developing alcohol and other drug prevention initiatives for Pacific peoples. Prevention approaches that take into consideration these aspects of people's lives appear to work best for ethnic communities. There is some suggestion that school-based interventions for Pacific youth are promising. However, the lack of evaluation of these approaches warrants some caution. In addition, with a high number of Pacific school leavers, other youth strategies will need to be considered for this sub-group.

Pacific populations are young, multi-cultural and ethnically diverse. Over sixty percent of Pacific peoples are New Zealand born. Young Pacific males from low socio-economic communities were described as most at risk of engaging in alcohol misuse. The media, sports drinking culture, peer pressure and cultural dissonance were identified as some of the contributing factors for this type of behaviour. Cook Islands and Niuean youth were more likely to engage in alcohol consumption than their other Pacific peers. Prevention strategies need to consider this portion of the Pacific populace.

Pacific alcohol and drug services, who work mostly with Pacific peoples, utilise an eclectic mix of Pacific and mainstream treatment interventions. Often, the Pacific models of care are adapted from mainstream models. It is difficult, however, to determine how effective they are without formal evaluations. Gaps in the Pacific alcohol and drug workforce in areas ranging from clinical, health management, organisational development to health promotion were evident with the majority of providers who participated in this study. These workforce shortfalls impact on the ability of providers to perform a range of activities, such as the evaluation of existing programmes, that would otherwise enable them to develop and deliver quality, wide-ranging and evidence-based programmes. Lack of resources and current funding approaches were also described as barriers for delivering effective and appropriate services.

Conclusion

There is a lack of information in most areas of Pacific alcohol and drug services and interventions. The majority of Pacific alcohol and drug services focus on treatment interventions, with limited attention given to prevention work. This is because government funding of alcohol and drug services is targeted at the three percent of the population with substantial to severe alcohol-related problems. International research shows that prevention strategies that involve the community appear to be more effective in reducing alcohol and drug use among ethnic groups that share similar characteristics to Pacific communities.

Pacific alcohol and drug services deliver a variety of intervention programmes with seemingly varying degrees of success. According to alcohol and drug practitioners, there are a range of variables that may define those within Pacific populations who are at risk. Further research is needed to determine those who are high risk among Pacific communities. There are also cultural factors which may discourage Pacific people from presenting for treatment. Further research is required to establish what these factors are and how these disincentives can be overcome.

A range of tailored intervention approaches is likely to create more positive outcomes for Pacific populations. This finding is supported by overseas studies involving similar ethnic groups. To be effective, interventions must take into consideration holistic approaches to health and encompass culturally diverse views. Family and parental support featured strongly in literature about effective approaches for cultural communities. Although abstinence approaches may work for some, inclusive approaches are likely to be more socially appropriate and practical.

Workforce capacity and capability is an issue that has a major impact on the viability and sustainability of Pacific alcohol and drug services. The lack of suitably qualified and experienced Pacific staff, coupled with insufficient financial resources, hinders the extent of Pacific alcohol and drug services, as well as the ability of these services to effectively trial and develop evidence based prevention strategies.

Further research in the area of Pacific alcohol and drugs is critical. Overseas research indicates that the existence of a credible, substantive body of knowledge is necessary in order to effectively address alcohol and drug issues facing ethnic communities. This study aims to contribute to building this body of knowledge.

References

1. Matangi-Karsten H, Warren H, Robinson G, Wheeler A. An overview of Pacific workers' treatment interventions with Pacific clients with alcohol and drug issues in Aotearoa – New Zealand (PADOPT). Auckland: ALAC, CRRC & WDHB, 2003.
2. Alcohol Advisory Council of New Zealand (ALAC). Pacific people more likely to be non-drinkers [Press Release]. Wellington: ALAC, Nov 17, 2005.

NARCOTICS ANONYMOUS: "MAKING OUR RECOVERY COUNT"

**Aotearoa NZ Regional Service Committee
Narcotics Anonymous
Auckland**

Contact: *pr@nzna.org*

What is Narcotics Anonymous?

Narcotics Anonymous (NA) was founded in the USA in 1953 and in 2005 had more than 34,500 weekly meetings registered worldwide. NA started in New Zealand in 1982 and today there are over 85 meetings held each week. NA is a non-profit organisation that costs nothing to join (the only requirement for membership is the desire to stop using drugs) and is not affiliated with any organisation or institution. That is, NA does not speak for any other organisation, nor does it lend its name or sanction, promote or endorse any cause or organisation and has no opinion on issues or material outside of NA. This includes having no opinion on addiction treatment methods, methadone, other 12 step fellowships, government policy, society, religion or spiritual beliefs. However, NA does cooperate with a wide range of other organisations to provide information to help groups understand NA and to refer people to NA in the most effective way. NA has a public relations policy of attracting members to recovery but it does not promote itself as "the best", "quickest", etc. way to get or maintain abstinence from drugs. Literature (books, audio CDs, etc.) is available in 55 languages.

NA makes no distinctions between addictive drugs (including alcohol) and published material is available regarding the use of medically prescribed drugs taken in accordance with the directions of a medical practitioner who is aware of the member's past drug addiction. Recovery in the NA context means abstinence from addictive drugs, attending meetings and working the NA program in daily life. The NA programme is based on the therapeutic value of one addict helping another and is spiritual but not religious. No religious path or group is endorsed and NA is established in countries with diverse religious beliefs including Christian, Muslim, Hindu, Buddhism, etc. The core of the NA programme is the twelve steps (a set of guidelines outlining a practical approach to recovery) based on the principles of honesty, willingness and open mindedness.

This paper presents the results of a survey of NA members attending meetings in 2004. It does not present any comparisons with any other organisations, methods or approaches in the alcohol and drug addiction recovery or treatment field. It was not designed to estimate the overall proportion of addicts in the population nor the proportion of addicts that have attended NA meetings or the proportion of addicts that get or remain drug free without attending NA.

The 2004 Aotearoa NZ NA survey

The survey aimed for a census of all members attending meetings in a typical week (12-18 November 2004). Meetings happen every day, across the whole country and 95% of all meetings volunteered to take part in the survey. Three-quarters of the members in these meetings filled out paper questionnaires (roughly two-thirds of all members). The overall number of questionnaires received was 475.

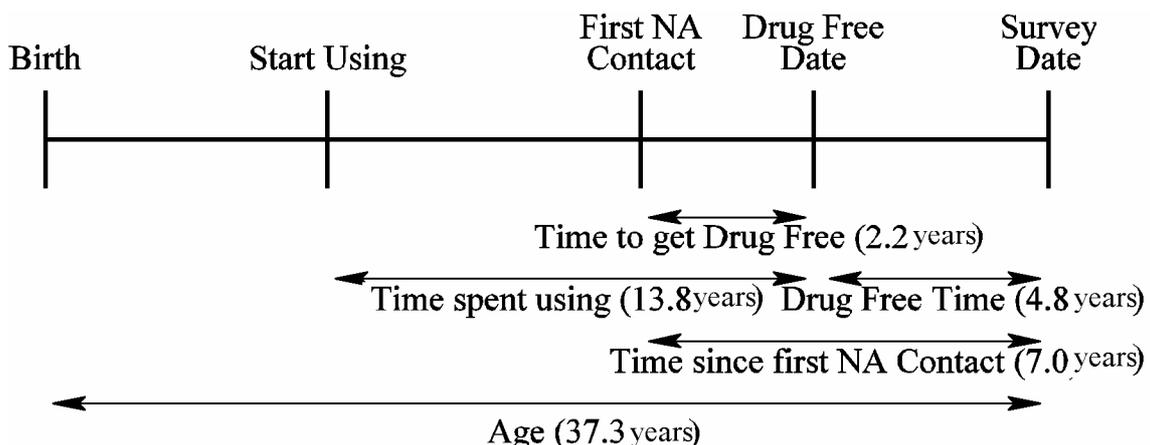
It was estimated that between 550-850 members attend meetings regularly. Compared with the general population, NA has a younger population (mean age =37 years compared to mean age =44 years for all New Zealanders aged 15 and over), has more Māori (16-21% compared to 13.5%) and fewer females (42% compared to 52%). Roughly 50% of younger NA members are female; the proportion is less among older members.

Presented below is a sample of the key results from the survey.

Past drug use

Half (50%) of the addicts were 17 years old or younger when they started using drugs, had spent two or more years after their first contact with NA before achieving abstinence from drugs and had been abstinent for at least five years. Over half of the addicts in NA were either clean or had stopped using drugs at their first meeting and are currently drug free. Figure 1 shows the 'drug use' timeline for the addict who has all the average (mean) characteristics. There were no significant differences between males and females in terms of drug of choice and drug of most use.

Figure 1: 'Drug use' timeline for the average addict in NA



The length of time free from drugs was related to age, being in employment, having a higher education, an NA sponsor and working the 12 steps of NA.

As shown in Table 1, almost one in five participants indicated that there was no one drug that they used most often and just under a third had no single drug of choice. The drug of choice was age-related (with older members more likely to use opiates and younger members to use methamphetamines or cannabis). From this data it can be conjectured that many addicts use whatever drug is available.

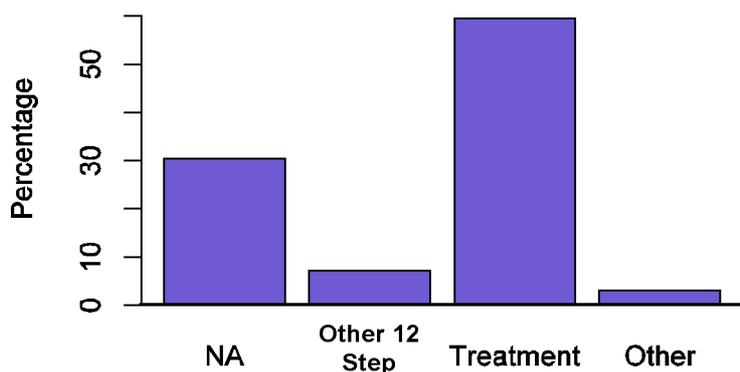
Table 1: Past drug use

| Drug | Most often used | Of choice |
|---------------------------|------------------------|------------------|
| No single drug identified | 19% | 29% |
| Alcohol | 21% | 12% |
| Cannabis | 24% | 18% |
| Opiates | 21% | 24% |
| Methamphetamine | 7% | 8% |
| Other drug | 8% | 9% |
| Total | 100% | 100% |

Getting free from drugs and getting to NA

Figure 2 indicates that most members reported becoming abstinent from drugs in treatment centres (roughly 60%) or through a twelve-step fellowship (AA for members with very long clean time and NA for newer members reflecting the age of each fellowship).

Figure 2: Where members became free from drugs



Treatment (37%) and NA contact or advertisement (34%) were most commonly given as the greatest influence to attend NA. Of the members that gave treatment as their greatest influence to attend NA, 80% became free from drugs in treatment.

Recovery in NA: Changes over time

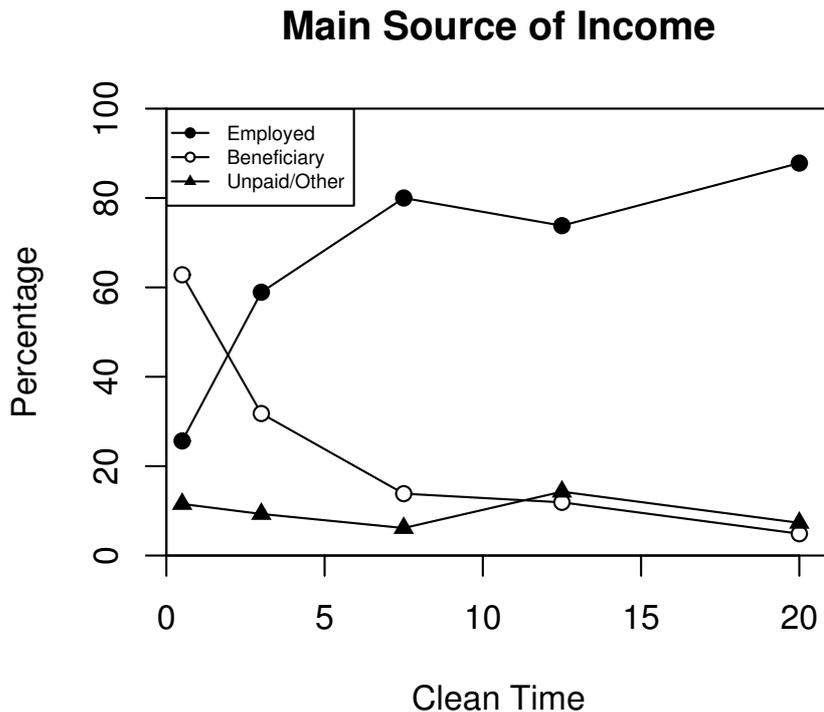
In NA terms this is multifaceted, involving getting and staying free from drugs, getting and staying healthy, becoming more independent, maintaining good relationships and becoming a productive member of society. The goal of recovery is to repair the damage caused by drug addiction in all areas of life and to become a healthy person in a holistic way.

Addicts were asked about their occupation, education level and source of income before and after becoming free from drugs. There was a decrease in addicts in unskilled occupations (from 15% to 6%) and an increase in those in managerial/professional occupations (from 14% to 23%) and students (from 0% to 7%). Almost a third (28%) increased their educational qualification (38% of those

who had 'No' or 'School qualifications only') and 27% increased their educational status by two or more levels.

As shown in Figure 3, the proportion of beneficiaries dropped from 63% of addicts in the first year drug free to 11% after five years and the proportion employed increased from just over 20% to 60%.

Figure 3



As members stayed clean there was reduced dependency on other addiction support services (70% in first year to less than 20% after 5 years clean time). This was age related (with older members less likely to need other addiction support than younger members). There was also reduced criminal drug related behaviour.

The health status of members improved markedly. Over a third of addicts (35%) had a physical medical condition when they came to NA (most commonly Hepatitis C) but only 8% were diagnosed with one afterwards. 23% of addicts had a current physical condition but 13% of those who were diagnosed with a physical condition no longer experienced the symptoms. 34% of addicts had a mental condition when they came to NA (most commonly depression) but only 11% developed one afterwards. 26% had a current mental condition but 28% of those who were diagnosed with a mental condition no longer experienced the symptoms. Overall 29% with an existing condition (physical and/or mental) when they came to NA no longer experienced the symptoms. This trend towards less problematic mental and physical health suggests that there may be reduced dependence by addicts attending NA on health services.

Conclusion

The survey results show that addicts can become and remain drug free, sometimes for decades, in NA. The changes in lifestyle for addicts in NA are more far-reaching than just stopping using drugs. There are also changes in occupation, education level and income. There is reduced drug related criminal behaviour and reduced dependency on other addiction and general health services. That is, NA offers a viable programme for the sustained recovery of many addicts.

OPIOID DEPENDENT PATIENTS: SPECIFIC NURSING STRATEGIES FOR THEIR ACUTE PAIN MANAGEMENT

Peter Athanasos *
Charlotte de Crespigny #

- * Discipline of Nursing, Discipline of Pharmacology, University of Adelaide & Drug and Alcohol Nurses of Australasia (DANA)**
- # Drug and Alcohol Services SA & Drug and Alcohol Nurses of Australasia (DANA)**

Funding: National Institute of Health (USA) Grant No. 1 RO1 DA 13706-2

Contact: *peter.athanasos@adelaide.edu.au*

The two aims of this study were:

1. To describe in an experimental context, the antinociceptive and respiratory depressant effects of very high plasma concentrations of morphine in methadone and buprenorphine subjects.
2. To describe how this research informs individualised nursing assessment and management of acute pain in the context of hyperalgesia and opioid cross-tolerance in opioid dependent patients.

Patients maintained on opioids for the treatment of opioid dependence (addiction) and who present to clinics and general wards with pain conditions are a particular challenge to the treating nurse. In addition to their medical complications, including serious illnesses, injuries, infectious diseases such as hepatitis or human immunodeficiency virus or associated psychiatric conditions such as depression, anxiety or personality disorder, they may also suffer from disorders of hyperalgesia (greater sensitivity to pain)¹ and cross-tolerance to the antinociceptive effects of clinically used² and very high plasma morphine concentrations³ (Figures 1 and 2).

Methods

Three groups of subjects were recruited. Eighteen methadone maintained subjects (12 men and 6 women), 24 to 45 years (mean 33) and weight 48 to 101 (mean 70) kg, stratified according to dose, with 6 subjects in each of the dose ranges of 11-45, 46-80 and 81-115 mg per day. Twelve buprenorphine maintained subjects (7 men and 5 women), 24 to 42 years (mean 35), weighing 49 to 97 (mean 71) kg, stratified according to dose with three subjects in each of the dose ranges of 2 to 8 mg, 9 to 15 mg and 16 to 22 mg per day. Ten control subjects (5 men and 5 women), 21 to 41 (mean 31) years and weighing 59 to 102 (mean 80) kg were also selected.

The study was double blind placebo controlled. Subjects were tested on two occasions, at least five days apart; once with morphine and once with saline placebo. The order of administration was randomised. Methadone and buprenorphine maintenance subjects were administered 55 mg of morphine IV infusion (plasma

morphine steady state concentrations; methadone subjects mean 180 ng per ml, buprenorphine subjects mean 136 ng/ml) and control subjects were administered 12 mg of morphine IV infusion (plasma morphine steady state concentration mean 23 ng/ml) on one occasion.

The experimental pain measurement was the cold pressor which has been described previously¹. It involves the immersion of the non-dominant arm in 0.5 to 1.5°C water and is measured in seconds. The pain marker was pain tolerance, the maximum time the patient was able to keep their arm in the water. Respiratory responses were also measured. Testing commenced approximately 20 hours after the opioid maintained subjects' last methadone or buprenorphine dose and their next dose was given one hour after cessation of infusions.

Results

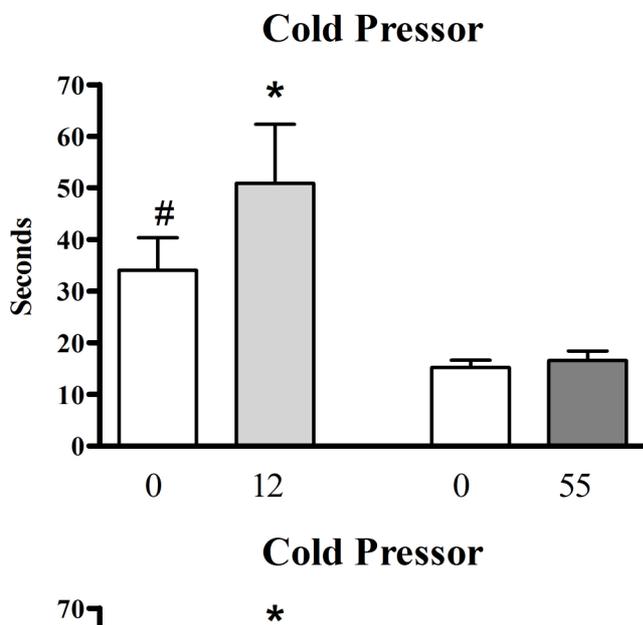
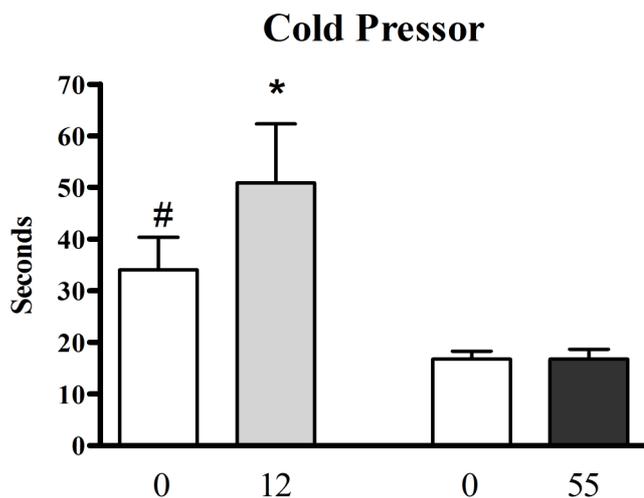
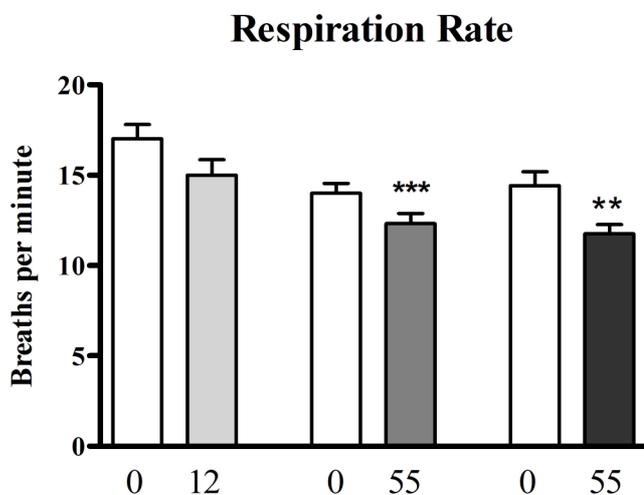


Figure 1. Cold pressor pain tolerance responses of control subjects at baseline (white bars) and plasma morphine steady state (light grey bars), and methadone subjects at baseline (white bars) and plasma morphine steady state (dark grey bars). # P<0.05 between control and methadone subjects at respective baselines, *P<0.05 for control subjects between baseline and plasma morphine steady state.



Cold Pressor

Figure 2. Cold pressor pain tolerance responses of control subjects at baseline (white bars) and plasma morphine steady state (light grey bars), and buprenorphine subjects at baseline (white bars) and plasma morphine steady state (black bars). # P<0.05 between control and buprenorphine subjects at respective baselines, *P<0.05 for control subjects between baseline and plasma morphine steady state.



Respiration Rate

Figure 3. Respiration rates of control subjects at baseline (white bars) and plasma morphine steady state (light grey bars), methadone subjects at baseline (white bars) and plasma morphine steady state (dark grey bars), and buprenorphine subjects at baseline (white bars) and plasma morphine steady state (black bars). ** P<0.01 *** P<0.001 between treatments.

There were no significant changes in pain response or respiration rate between treatments on the saline placebo administration days.

Very high doses of morphine (55 mg) failed to provide antinociception for either methadone or buprenorphine maintained subjects. This high dose of morphine is nearly five times the 12 mg dose shown to be effective in controls using the same methods. While it had little antinociceptive effect in methadone and buprenorphine maintained subjects, 55 mg of morphine significantly decreased respiration rate, but only by an average of 2 to 3 breaths per minute. Power analysis indicated that a statistically significant antinociceptive effect is likely to be obtained with a sample size of eighty methadone participants. However, with a mean increase of 1.4 s in the cold pressor test, this would not be clinically relevant. The study confirmed that methadone and buprenorphine subjects are hyperalgesic in the cold pressor test.

This research highlights the complicated nature of the management of severe acute pain in patients maintained on opioids for the treatment of opioid dependence. Opioids remain the "gold standard" of treatment for acute severe pain. The factors of hyperalgesia and opioid antinociceptive cross-tolerance compound the general level of misunderstanding of the area for treating pain clinicians⁴ and have implications for assessment and treatment.

Treatment should begin with the accurate assessment of the intensity, type and cause of pain (acute vs. chronic), underlying medical condition (surgery, dental, trauma etc) and identification of the drug of choice (opioid, stimulant or alcohol).

Once the drug is identified it is important to ascertain the daily use and the time and amount of last use. From this information an assessment should be made of the risk of withdrawal and an estimation of the level of tolerance and dependence. Consideration should be given to the fact that the patient may be a poly-drug user. If they are on maintenance pharmacotherapy for the treatment of opioid dependence, the clinician should access collateral verification and ensure the availability of the next dose. If they are not, the clinician may need to consider the option of initiation on to maintenance pharmacotherapy to prevent withdrawal.

For opioid tolerant patients receiving maintenance pharmacotherapy, it is essential that therapy continues to address the patient's baseline opioid dosing requirement and that the pain be assessed, monitored and treated aggressively⁴. The conditions of hyperalgesia and opioid cross-tolerance may necessitate doses larger than clinically used to promote pain relief. Under-treatment of pain can lead to patient distress, poor healing, premature or late discharge and, importantly, decreased responsiveness of opioid analgesics and further difficulties in subsequent pain control⁵. Communication of this to the patient, and effective multidisciplinary team management, will greatly reduce their level of anxiety and distress. Effective questioning of the patient should focus on what has worked for them in the past, what relieves their pain and anxiety and what promotes their psychological comfort? Treatment of their medical condition in this context should optimise the process of physical and psychological recovery. Importantly, rather than exacerbate their opioid dependence, effective pain management will enhance their continuance and commitment to their opioid pharmacotherapy treatment regime.

Conclusions

The evidence suggests that patients maintained on opioids for the treatment of opioid dependency may be hyperalgesic and cross-tolerant to the antinociceptive effects of opioids. The most important consideration must always be to assess, monitor and effectively treat the pain. Once the pain is dealt with and the patient is comfortable, initiation or continuation of the treatment of their opioid dependency issues will be maximised.

References

1. Doherty M, White JM, Somogyi AA, Bochner F, Ali R, Ling W. Hyperalgesic responses in methadone maintenance patients. *Pain* 2001a;90(1-2):91-6.
2. Doherty M, Somogyi AA, White JM, Bochner F, Beare CH, Menelaou A, et al. Methadone maintenance patients are cross-tolerant to the antinociceptive effects of morphine. *Pain* 2001b;93(2):155-63.
3. Athanasos P, Smith CS, White JM, Somogyi AA, Bochner F, Ling W. Methadone maintenance patients are cross-tolerant to the antinociceptive effects of very high plasma morphine concentrations. *Pain* 2006;120:267-275.
4. Mitra S, Sinatra RS. Perioperative management of acute pain in the opioid-dependent patient. *Anesthesiology* 2004;101(1):212-27.
5. Alford DP, Compton P, Samet JH. Acute pain management for patients receiving maintenance methadone or buprenorphine therapy. *Ann Intern Med* 2006;144(2):127-34.

FINDINGS FROM A CROSS-SECTIONAL LONGITUDINAL STUDY OF METHADONE MAINTENANCE TREATMENT IN A NEW ZEALAND CLINICAL SETTING AND IMPLICATIONS FOR SERVICE DELIVERY AND RESEARCH

Daryle Deering *
J. Douglas Sellman *
Simon J. Adamson *
Tuari Potiki #
Jaki Horn ^
Chris Frampton °

- * **National Addiction Centre (Aotearoa New Zealand), Department of Psychological Medicine, Christchurch School of Medicine & Health Sciences, University of Otago**
- # **Alcohol Advisory Council of New Zealand**
- ^ **Respiratory Outreach, Christchurch Hospital, Canterbury District Health Board**
- ° **Department of Psychological Medicine, Christchurch School of Medicine & Health Sciences, University of Otago**

Funding: Health Research Council and National Addiction Centre

Contact: *daryle.deering@otago.ac.nz*

The New Zealand Opioid Substitution Practice Guidelines¹ provide the clinical and regulatory framework for MMT. As in other countries, they are underpinned by a harm reduction approach and specify individual treatment and broader public health objectives, which contribute to the tensions inherent in providing MMT in every day practice.² This paper presents key findings from a cross-sectional, longitudinal follow-up study of clients established on MMT in a New Zealand clinical setting.

Method

Participants were recruited from the Christchurch Methadone Programme. The sample of 107 participants (56 men and 51 women) comprised representative samples of 35 Māori and 72 non-Māori. Ninety-three (87%) participants were followed up, on average, 23 months later (range 3-43 months). Research interviewers independent of the service conducted interviews in a setting of the participant's choice.

Outcome measures:

1. Degree of Drug Use Index (DDI)³
2. SF-36 Health Survey⁴
3. Injecting Risk Questionnaire⁵
4. Treatment Perceptions Questionnaire⁶

Results

Socio-demographic characteristics

The average age of participants was 35 years (sd 7.3, range 20-56) and almost a quarter (24.3%) were older than 40 years. Just over half (50.5%) were parenting dependent children, 22.4% were engaged in part-time or full-time work, 19.6% were full-time parents and 2.8% were full-time students. Over half (53.3%) were receiving a sickness or invalid's benefit. Paired comparisons for the 93 participants who completed follow-up found few overall changes between the two interviews. Of note, was that at follow-up significantly more participants were receiving an invalid's benefit compared to interview one (33.3% versus 21.4%) and when asked about employment, over three-quarters (77.4%) expressed an interest in undertaking a course or gaining employment.

Health status

While there was considerable variation in SF-36 Health Survey scores, on average, the MMT participants had significantly poorer self-assessed health compared to New Zealand norms. Also, in contrast to national SF-36 survey findings, within the overall MMT sample there were no significant ethnicity or gender differences, which suggest that factors within the MMT participant group over-rode New Zealand population ethnic and gender score differences. This notion was supported by the finding that the participant group had similar scores to an Auckland MMT group (personal communication with Dr G Paton-Simpson). In the month prior to interview one, just over a third of the participants (33.6%) had taken medications for a physical health problem and the same proportion for a mental health problem (33.6%), with significantly more women than men taking medications for a mental health problem. Higher frequency of benzodiazepine use was significantly associated with poorer social functioning and mental health (SF-36). Paired comparisons found few significant changes in SF-36 scores between interview one and follow-up. While over 70.0% of clients at follow-up said they had hepatitis, the majority said they had not participated in a health consultation about potential treatment and Māori participants were significantly less likely than non-Māori to have discussed hepatitis with their general practitioner in the previous year.

Recent substance use

At interview one the most commonly reported substances used by participants in the previous four weeks were nicotine (90.7% daily), cannabis (56.0% more than weekly, 35.5% daily), alcohol (36.4%, 5.6% above ALAC guidelines⁷), non-injected benzodiazepines (19.6% more than weekly, 10.3% daily) and opioids (18.7%, 10.3% more than weekly). Compared to Māori, significantly more non-Māori participants consumed alcohol and, compared to men, women reported significantly more frequent use of benzodiazepines. Overall, 28.0% of participants reported injecting drug use (13.1% more than weekly), primarily opioid use. Use of injected benzodiazepines and stimulants was low. Participants who were parents were significantly less likely to report injecting substance use. Paired comparisons showed that significantly fewer participants reported injecting substance use at follow-up, with a corresponding decrease in opioid use. Although numbers were small, of concern was that just over half of those who reported injecting drug use at follow-up, said they had directly or indirectly shared injecting equipment (7/13), albeit infrequently. Paired comparisons also showed a significant reduction in the number of participants who reported recent benzodiazepine use at follow-up (18.3% versus

30.1%), with 10.8% reporting use at both interviews. Cannabis and nicotine use remained high and alcohol use above ALAC Guidelines remained low (seven non-Māori men at follow-up).

Methadone treatment related characteristics

The benefits most commonly sought by more than 70.0% of participants at admission were to reduce drug use, improve health and for family/children reasons. This was the first admission for just over half (52.3%). 89.7% had received MMT for more than one year and 27.0% for more than four years, in keeping with New Zealand's high retention rate. At interview one the average methadone dose was 74.7 mg, within the range of effective therapeutic doses. However, about 30.0% of participants considered their methadone dose to be inadequate (mainly a little too low). During the course of the study, one female participant died and of the 93 participants followed up, ten non-Māori left MMT of whom three returned, one went to prison and one to a therapeutic community. Four of the remaining five reported no recent use of opioids. Of the 86 participants receiving methadone at follow-up, almost two-thirds (61.6%) said their dose was stable, a third (32.6%) decreasing and 5.0% increasing.

Participants' perceptions of MMT

Employed participants scored significantly higher on the TPQ (more satisfied) than unemployed participants. Higher methadone doses and frequency of benzodiazepine use were associated with lower treatment satisfaction. Higher participant self-ratings of progress were associated with higher satisfaction scores. Māori participants rated their progress significantly lower than non-Māori participants. The TPQ item on rules and regulations elicited the most negative ratings and associated comments referred to perceived rigidity of rules, negative sanctions for non-opioid substance use and lack of an individualised treatment response. Ratings and associated comments on the Staff Perception items highlighted the importance of the quality of therapeutic relationships and staff continuity, consistent with the international literature.

Summary and implications for MMT provision

The overall findings from this study reflect the effectiveness of MMT in reducing illicit opioid use and injecting drug use over time, within the context of continuous treatment and therapeutic methadone doses. The majority of participants were parenting dependent children and many, primarily women, were single parents. Results quantified high levels of nicotine and cannabis use, as well as some problematic injecting drug use (largely opioid use), benzodiazepine and alcohol use. Many participants suffered from physical and mental health problems and less than a quarter were employed, reflecting the impact of opioid dependence, in association with high risk health behaviours and ageing on participants' health and role functioning. Gender and ethnicity findings support the need for attention to the treatment needs of women and meeting the cultural needs of Māori as integral components of addiction treatment. Important feedback was gathered on aspects of MMT service provision, which indicated the high value placed by participants on individualised treatment. In addition, feedback strongly endorsed routinely seeking client feedback on MMT and consumer participation in service development and evaluation at local and national levels.

Within the context of long term MMT and consistent with findings from other New Zealand studies,^{2, 8, 9, 10} the findings from this study strongly support the need to separate the stabilisation phase of MMT from the continuing care phase. Within a continuing care model¹¹ the focus is on client centred care, health-related outcomes and routine monitoring to ensure MMT is responsive to individual client's changing needs. While monitoring of substance use and high risk behaviours is important, individualised client goals focused on wellness and client self management within a family and whanau treatment approach should assume a high priority. In this context local and national key service performance indicators should be developed. While the client pathway should continue to be based on a partnership between primary care and secondary specialist services, a wellness focused system of care should incorporate cultural and peer-based interventions and creative and flexible staffing to allow MMT to be delivered in the most appropriate settings (primary care, specialist service, NGO). Taking into account the chronic health needs of this client group, staff mix should include nurse practitioners and family focused addiction nurse specialists, working in collaboration with other team members, general practitioners, Māori health providers and specialist medical staff, pharmacists and peer-based needle and syringe exchange programmes.

References

1. Ministry of Health. Opioid substitution treatment New Zealand practice guidelines. Wellington: Ministry of Health, 2003.
2. Townshend PL, Sellman JD, Coverdale JH. A preventative ethics approach to methadone maintenance programmes. *New Zealand Bioethics Journal* October 2001;7-13.
3. Deering DE, Sellman JD, Adamson SJ, Horn J, Frampton MA. Development of a brief treatment instrument for routine clinical use with methadone maintenance treatment clients: The Methadone Treatment Index (MTI) (in press).
4. Ware JE, Snow KK, Kosinski, M, Gandek B. SF-36 health survey. Manual and interpretation guide. Boston, MA: The Health Institute, 1993.
5. Stimson GV, Jones S, Chalmers C, Sullivan D. A short questionnaire (IRQ) to assess injecting risk behaviour. *Addiction* 1998;93:337-347.
6. Marsden J, Stewart D, Gossop M, Rolfe A, Bacchus L, Griffiths P, Clarke K, Strang J. Assessing client satisfaction with treatment for substance use problems and the development of the Treatment Perceptions Questionnaire (TPQ). *Addiction Research* 2000;8:455-70.
7. MacEwan I. Upper limits for responsible drinking. ALAC Report of the Working Party on Upper Limits for Responsible Drinking. Wellington: Alcohol Advisory Council of New Zealand, 1995.
8. Sheridan J, Wheeler A, Walters C. Health problems and help-seeking activities of methadone maintenance clients at Auckland Methadone Service (AMS): potential for community pharmacy service expansion? *Harm Reduction Journal* 2005;2:online pp. 1-7.
9. Sheerin IG, Green FT, Sellman JD. What is the cost-effectiveness of hepatitis C treatment for injecting drug users on methadone maintenance treatment in New Zealand. *Drug and Alcohol Review* 2004;23:261-272.
10. Goodyear-Smith F, Gohns A, Butler R, Sheridan J, Wheeler A. Methadone Maintenance Treatment: Barriers to, and incentives for, the transfer of opioid

dependent people from secondary care to primary health care, Mental Health Commission, 2005.

11. McClellan AT. Have we evaluated addiction treatment correctly? Implications from a chronic care perspective. *Addiction* 2002;97:249-252.

HIV, HCV AND HBV SEROPREVALENCE AND ASSOCIATED RISK FACTORS AMONG NEEDLE EXCHANGE ATTENDEES IN NEW ZEALAND 2004

Charles Henderson

Needle Exchange New Zealand / Needle Exchange Services Trust

**From Cutting Edge 2006 keynote plenary session – Maximising the NZ
Needle Exchange Programme: Moving Harm Reduction Forward**

Contact: *charles@needle.co.nz*

Background

Injecting drug users (IDU) are at risk of blood-borne virus infections, including Human Immunodeficiency Virus [HIV], hepatitis B [HBV] and hepatitis C [HCV]. In some countries, like Australia, there have been regular behavioural and seroprevalence surveys conducted annually for many years. This has not been the case in New Zealand, where only two previous surveys of this type have been funded (by the Ministry of Health) and carried out in 1997 and 1998.

These studies were performed in collaboration with Australia in 1997 and 1998, and collected data from Auckland, Wellington, Nelson and Christchurch. Data were collected from a single page anonymous questionnaire and blood spot samples. The results showed low rates of HIV (around 1%), but much higher rates of HCV, at between 50% and 60%. HCV prevalence was related to people's age, how long they had been injecting, as well as sharing equipment and imprisonment. Prevalence estimates of immunity to HBV in previous surveys were based on self report.

In 2004 the Ministry contracted Needle Exchange NZ to carry out another seroprevalence survey. The study team included the National Manager of NENZ/NEST, research staff from the Department of Public Health & General Practice at the University of Otago and peer fieldworkers at the participating dedicated exchanges. Analysis of blood samples was carried out by Canterbury Health Laboratories.

Aim

We aimed to provide up-to-date seroprevalence data about HIV, hepatitis B and hepatitis C among attendees at needle exchanges and to describe their risk behaviours associated with blood-borne virus infection. Importantly, we wanted to be able to make comparisons with the results of the two previous surveys to assess changes in seroprevalence and IDU behaviours over time and gain some idea of the impact of needle exchange.

Tracking the prevalence of risk behaviors and the prevalence of blood-borne virus infection among IDU is necessary to provide policy and planning direction and to assess the extent to which harm reduction strategies and service delivery in NZ NEP have been successful.

A secondary aim of this study was to compare the results of laboratory tests on dried blood spots to venous blood samples [VBS] to see how accurate dried blood spots

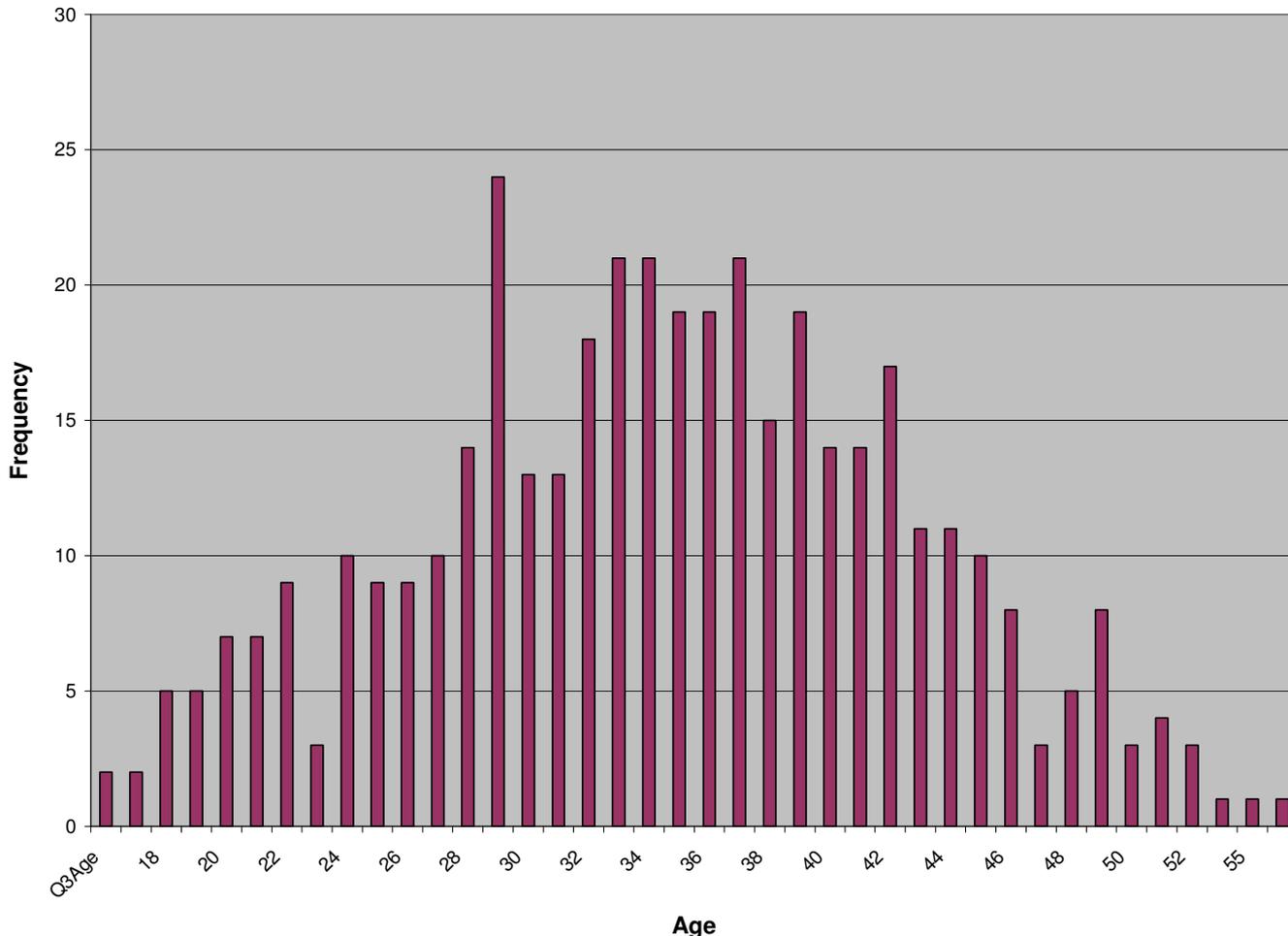
[DBS] are. This also enabled an accurate seroprevalence for HBV in this population and supports evaluation of methodology and sample gathering i.e. a difficult population to engage in research oriented activities when they had just come to the outlet with very much other considerations/ desires in mind! The comparisons of the results of the DBS & VBS testing are not discussed in this paper, suffice that it was a worthwhile secondary spin-off in demonstrating robust methodology.

Methods

Selected survey sites were Auckland, Hamilton, Mount Maunganui, Palmerston North, Wellington, Nelson, Christchurch, Timaru and Dunedin. We endeavoured to include both metropolitan and provincial sites but did not include any of the part-time or more recently established services, largely because of resource constraints. A total of nine sites were involved, compared to only four in 1997 and three in 1998.

- All IDU clients attending the participating NEP over a two week period mid-November 2004 were invited to participate.
- Each completed a one page anonymous questionnaire based on the one used in the previous surveys.
- Fingerprick blood samples were taken in all sites, as well as venous blood samples from participants in Christchurch and Wellington, so that HBV seroprevalence could be measured.

Age distribution



Results

Demographics

Four hundred and twelve people completed questionnaires, 63.4% of whom were male, 36.1% female and 0.5% transexual. The average age of participants was 35.7 (range 18-58). Most of the sample identified as European, with 13.7% identifying Māori and 2.1% Pacific ethnicity.

Blood borne viruses

There was little change in the rates of blood borne viruses, as depicted in Table 2. HIV rates were consistent over the three studies, occurring in 1% of blood samples (four positive results, one confirmed by Western Blot), half of which had been reported by participants in questionnaires.

HCV rates were 70% but once the age of respondents was taken into account these results were consistent with the previous studies. Many participants were unaware that they were HCV positive, or aware they had been tested but were unaware what those test results meant. HCV was strongly associated with the age of participants and the length of time they had been injecting. HCV was also associated with imprisonment and methadone treatment and males had a higher rate of infection than females. Very few people had ever received treatment for HCV.

HBV status was analysed for the participants providing venous blood samples and showed that 61% of these participants were not immune to HBV.

DBS tests compared favorably with venous samples for HCV but may have resulted in two false positives for HIV.

Drug use behaviour

On average, respondents had started injecting drugs at age 20 and had been injecting for 15 years with varying frequency. Fourteen percent of respondents had been on a methadone programme previously and the majority (65%) of respondents indicated that opioid dependence featured strongly in their lives. The drugs most frequently injected were morphine, homebake, methadone, Ritalin/amphetamines and benzodiazepines and injecting took place most commonly in people's own homes or in the home of a friend. Respondents could nominate more than one drug that they had injected over the last month so the list of drugs is not mutually exclusive. The majority of respondents (61.4%) had also received other treatment for drug use, most commonly counseling, rehabilitation, detox, residential treatment, or group therapy at some point in time.

A new needle and syringe was used all of the time by half of respondents and most of the time by another 40% of people. The sharing of other equipment (such as spoons, filters, water, and tourniquets) occurred in 40% of participants.

Sexual behaviours

Sixty-three percent of respondents had had sex in the previous month, only a quarter of whom reported using a condom the last time they had sex. People were less likely to use condoms with their regular sex partners but also often did not use condoms with casual and new sex partners. Twenty-six respondents had been paid for sex in

the last month, most of whom had used condoms the last time they were paid for sex.

Other risk factors

The majority of respondents had tattoos (71%) and body piercings (63.1%). Forty-five percent of respondents had been imprisoned at some stage in their lives, almost a quarter of whom had been imprisoned in the last year. Of these respondents, 40% injected whilst in prison.

Discussion

Table 1 shows how the population recruited in this study compares to those participating in previous seroprevalence surveys. The age of participants is the most significantly different factor, which will have influenced results for the duration of injecting, condom usage (as more will be in permanent relationships so are likely to use condoms less) and HCV prevalence. It is not clear why this occurred, but it is possible that it was caused by the inclusion of more rural needle exchange programmes which are likely to have an older clientele.

The proportions of Māori and Pacific respondents are in line with the national statistics gained from the Census. However, its not clear if these groups are represented proportionally in IDU in general. The “other category” was mainly people identifying as New Zealanders rather than an unexpected increase in an ethnic group.

There is little difference between the surveys on other demographic factors.

Table 1: Comparison of gender, age, ethnicity and sexual orientation of respondents in the 1997, 1998 and 2004 serosurveys

| Demographic | Kemp & MacDonald 1999 (performed 1997) | Unpublished Kemp Study (performed 1998) | BBV Questionnaire Results 2004 |
|-------------------------|---|--|---------------------------------------|
| Number of testing sites | 4 | 3 | 9 |
| Number of participants | 223 | 302 | 412 |
| <i>Gender</i> | | | |
| Males | 66% | 66% | 63.4% |
| Females | 33% | 33% | 36.1% |
| Transgender | 1% | 1% | 0.5% |
| Mean age (range) | 29 (18-50) | 29 (16-52) | 35 (18-58) |
| <i>Ethnicity</i> | | | |
| European | | 84% | 73.9% |
| Māori | 9% | 12% | 13.7% |
| Pacific | 7% | 1% | 2.1% |
| Other | | 2% | 10.3% |

Although HCV rates initially appear much higher than those in previous studies, this is accounted for by the older age group. Table 2 demonstrates that the HCV rates for

those under 25 are about the same as they were previously. This result is also consistent with other studies that have been done outside of needle exchanges.

The HIV results show that HIV has been contained within IDU, with the NEP most likely greatly contributing to this.

HBV rates are compared for the self reported data only, as laboratory tests were not available from previous studies. The high rates of those at risk shown in self report (table 2) and by laboratory tests makes a case for a vaccination programme for HBV in IDU.

Table 2: Blood Borne Virus Results

| | Kemp & MacDonald 1999 (performed 1997) | Unpublished Kemp Study (performed 1998) | 2004 Results |
|------------------------|---|--|---------------------|
| HIV positive -total | 0.9% | 1% | 0.3% |
| HCV antibody -total | 53% | 45% | 70% |
| HCV antibody -under 25 | 40% | 32% | 38% |
| No HBV infection | - | 62% ¹ | 50.4% ¹ |
| HBV vaccination | 33% ¹ | 30% ¹ | 34.4% ¹ |

¹ Self report

There is evidence for significant improvements in the amount of injecting equipment other than needles and syringes. The rate of 40% sharing any other equipment is very encouraging, considering that previous studies have found that up to 100% of people were sharing other equipment.

Table 3: Summary of Associated Risk Factors across all 3 serosurveys

| | 1997 | 1998 | 2004 |
|------------------------------|-------------|-------------|-------------|
| Prison in last year | 10% | 9% | 9% |
| Re-using someone else's N/S | 19% | 21% | 15% |
| Using new N/S every time | 40% | 48% | 50% |
| Sharing spoon | | 50% | 25% |
| Sharing tourniquet | | 31% | 21% |
| Sharing water | | 22% | 11% |
| Sharing filters | | 23% | 6% |
| Condom use last time had sex | | 35% | 26% |

The main conclusions of this survey are that:

- There is no evidence of any real change in the seroprevalence of HCV since 1998. The higher prevalence of HCV in this survey is explained by respondent sample characteristics.
- The prevalence of HIV among IDU using needle exchanges remains low.
- Most IDU using needle exchanges had been tested for HCV and HIV, although many were unaware of, or did not understand, their results.

- A high proportion of IDU were not immune to HBV and are at risk of infection.
- There is evidence of a significant decrease in sharing of injecting equipment other than needles and syringes.
- Risky sexual behaviour is still highly prevalent amongst IDU and there is possible evidence of a decline in condom use.

It is recommended that:

- Serosurveys of needle exchange clients be conducted regularly every two to three years.
- HBV vaccination should be targeted to IDU and the provision of free vaccination considered.
- The study's findings provide only limited support for the introduction of targeted screening for HIV, HBV and HCV among IDU.
- The Needle Exchange Programme should encourage IDU to collect their test results and provide education about testing and explanation of test results.

Although hepatitis C treatment with antiviral therapy can prevent progression to chronic liver disease, this therapy is limited by poor tolerability and poor efficacy. Other treatments are still in the early stages of development. Unlike hepatitis B, there is currently no hepatitis C vaccine available and the development of an effective vaccine is not imminent. The key to control of hepatitis C, therefore, lies in prevention programmes focusing on those at risk of infection, and those who are already infected, to avoid further disease transmission.

In addition, in order to reduce the transmission of hepatitis C, IDUs must always use sterile injecting equipment. Reasons for unsafe injecting behaviour may include lack of knowledge, opportunistic use of drugs, fear of buying equipment, peer pressure not to adopt safer practices, lack of accessibility of equipment, cost and limited appropriate settings for safer using (e.g. custodial settings).

The provision of injecting equipment is only a part of the most effective approach to reducing harm caused by injecting drug use. Education, advocacy and empowerment for IDU are the other requirements and these things require resources.

WHOLE TEAM TRAINING - BUILDING DUAL DIAGNOSIS CAPACITY IN MENTAL HEALTH TEAMS

**Megan Jones
District Mental Health Service
Waitemata District Health Board**

**Funding: Dual Diagnosis Team, Community Alcohol and Drug Services,
WDHB**

Contact: *Megan.jones@waitematadhb.govt.nz*

Background

There is a significant amount of literature outlining the noteworthy relationship between psychosis and substance misuse. Furthermore, there is evidence suggesting that the use of substances such as cannabis and methamphetamine may impact on developing psychotic disorders. The literature purports that people who experience a psychotic episode and continue to misuse substances are likely to assume a poorer prognosis¹.

Despite increasing awareness of the difficulties of dual disorders, substance misuse continues to go unrecognised by mental health clinicians. Furthermore, when substance misuse is correctly identified, the treatment response may be inappropriate or ineffective. Hence both inadequate assessment and ineffective treatment often leads to a poor prognosis for service users, which may include more frequent relapses, hospitalizations and an increased cost of care².

The Dual Diagnosis (DD) Team is a multidisciplinary team of clinicians. They provide both clinical care for service users and training for mental health clinicians around the assessment and management of dual diagnosis of mental health and alcohol plus other drug issues. The DD team has provided training in the form of workshops across mental health services in the Auckland district since its inception in 1995.

This research project piloted an innovative way of training mental health clinicians using a model of Whole Team Training (WTT). WTT has been offered in Birmingham (England) since early 2003 through the Compass Programme. The aims of whole team training are to provide:

- A specialised training package in substance misuse disorders that meets the needs of the mental health team being trained.
- The theoretical underpinnings of working with service users who have a dual diagnosis of mental health and substance misuse disorders.
- Training on how to screen and assess for co-existing disorders and provide interventions such as motivational interviewing, relapse prevention and working with families.
- An understanding of harm reduction principles and strategies.
- Ongoing supervision and coaching for mental health staff within their own clinical environment.

Method

The project was delivered in full collaboration with the Early Psychosis Intervention (EPI) Centre who agreed to be recipients of WTT. A qualitative design, based on action research, was applied to evaluate the effectiveness of WTT. Evaluation consisted of file audit, staff survey and selected interviews at baseline and three and six month follow up to determine the effectiveness of WTT.

Findings

At the six month evaluation point there were noticeable differences in the clinical practices of EPI Centre clinicians. These differences related to an improvement in how clinicians assessed, planned and implemented interventions for substance use. One of the strongest influences and predictors of clinicians increasing their skills and knowledge in working with alcohol and other drug (AOD) issues was directly correlated to the amount of time they had spent in ongoing supervision and coaching from a skills coach/trainer.

EPI Centre staff reported experiencing a demystification of AOD counselling. With the interventions being made explicit, EPI Centre staff also felt that they were better able to work with AOD issues. This resulted in no referrals being sent from the EPI Centre to other AOD services.

Links between the two services were strengthened with the EPI Centre and DD staff commenting on the enjoyment of working with each other. DD staff reported that the ongoing enthusiasm from the EPI staff was inspiring, whilst the EPI Centre staff reported that contact with the DD staff gave them an increased awareness of AOD issues.

Limitations of the Study

One of the limitations was the availability of the project coordinator, who was employed on a 0.2FTE. One day per week did not allow for much time to fully develop relationships within the DD team. Therefore, consultation meetings held with the team were rather formal and may not have allowed all clinicians and trainers the opportunity to collaborate about the specifics of the WTT project.

The issue of service users participating in the research arose when the skills coaches were placed within the EPI Centre. Skills coaches were able to provide 'live supervision' and attend clinical visits with EPI Centre clinicians. However, there still needed to be a consent process for service users around agreeing to have the skills coaches attend visits. Verbal consent was gained from clients by EPI centre clinicians. If clients did not agree, then the visit did not proceed. However, it is difficult to know how much detail was offered to each client and how clear the process of consent was. This is an issue for future WTT that employs the use of skills coaches.

This project draws on the hypothesis that service users within the EPI Centre will benefit from the staff receiving more training and developing skills in the area of addressing substance misuse. However, there is no empirical evidence that this occurred. There is however, clear evidence that staff values and practices around

the significance of AOD misuse were altered throughout the implementation of the WTT project and it is anticipated that these changes have resulted in some benefits for service users.

One of the biggest challenges faced by the project group was the staff changes within both the DD team and the EPI Centre. These had a flow on effect for the project group. From the beginning of the project one of the concerns has been how to maintain a change in culture and practice when employees resign from a service and normal attrition occurs. Although we expected this would be an ongoing issue, we did not expect that it would need to be addressed so frequently within the context of the six month project.

A further complicating factor for those involved in the project group was that the idea of WTT was largely a conceptual one with minimal framework documentation³ on which to base the project. Although ideas were discussed and postulated, a lack of more formal structure was difficult for members of the project group, especially those who started some months after the commencement of the project.

Strengths of the Study

The WTT approach was able to identify the gaps and respond to the needs of the specialist team and their consumer population. It was identified that WTT was a way of bringing the trainees and trainers together to really identify where the areas of knowledge deficit were. It enabled a more individualistic and user-friendly model of training that produced tangible results and captured the "critical components".

This project is easily transferable to other clinical settings. A number of people involved in the project identified its transferability to other settings, both within AOD and Mental Health. The WTT project principles could, in fact, be applied to a number of training topics within a variety of settings.

Conclusions

The WTT project has revealed a need to review existing AOD training and its delivery to Mental Health clinicians. Furthermore, there is scope to examine how the principles of WTT might be applied in order to achieve better outcomes for clinicians and service users in both AOD services and Mental Health services.

Whilst WTT is initially a more resource intensive model, longer term, by enhancing AOD skills in mental health teams, we can anticipate improved outcomes for service users through providing a more integrated service.

References

1. Drake R, Mueser K. Psychosocial approaches to dual diagnosis. *Schizophrenia Bulletin* 2000;26 (1):105-118.
2. Graham HL. Implementing integrated treatment for co-existing substance use and severe mental health problems in assertive outreach teams: training issues. *Drug and Alcohol Review* 2004;23(4):463-70.

3. Graham HL. Cognitive-behavioural integrated treatment (C-BIT): A treatment manual for substance misuse in people with severe mental health problems. Chichester, West Sussex, England: John Wiley & Sons Ltd, 2004.

AN INVESTIGATION INTO THE HEALTH NEEDS OF PACIFIC YOUTH LIVING WITHIN THE WAITEMATA DISTRICT HEALTH BOARD DISTRICT

**Natalie Leger
Tupu Services
Auckland**

**Funding: Pacific Programme Manager/Waitemata District Health Board
(WDHB)**

Contact: *Natalie.Leger@waitematadhb.govt.nz*

The purpose of this project was to capture the Pacific youth voice about concepts of health and wellbeing and how health and other services across the sectors can support and assist Pacific youth in meeting their health needs.

The Pacific population within the WDHB district, contrary to general population trends, indicates that the Pacific population is younger and growing at a faster rate (1). Presently, Pacific youth comprise over 17.3% of the total Pacific population in the WDHB district. As such, in keeping with population based health service provision, the Pacific youth population living within the WDHB district reflects the need for their inclusion in the planning and provision of youth health services.

Method

Focus groups were conducted within the WDHB district.

The focus groups were gender specific and a specific cross-section of age groups was chosen for each setting:

- Secondary school setting: 15 year olds
- Church setting: 17-24 year olds
- Alternative educational settings: 17-24 year olds

In total 49 Pacific youth participated in the focus groups with the majority being New Zealand raised.

Findings

Analysis of the focus groups in relation to service provision identified three main themes: confidentiality, culture and connection.

Confidentiality

Confidentiality presented as the main key factor that participants required in relation to health services. Silence and isolation was identified as a common experience that participants faced due to a belief that confidentiality would not be maintained. Location and environment of services was very important, primarily in relation to a fear of being seen by someone who may then break confidentiality. Responses also

indicated who Pacific youth would feel comfortable talking to and who they would not. This was often dependant upon the presenting issue.

"Confidentiality is really important; I will lie if I have to."

"For some things I would not want my parents to find out, like relationships with boys or smoking, so you could go to your doctor as they keep things confidential.....maybe it's not OK cause someone might see you and then they find out.....maybe go to someone in the community who knows what to do but is not connected to your family."

Culture

Parental/family involvement

This is dependant upon the presenting issue. In the areas of sexual health or risky behaviours that Pacific youth may engage in, the majority stated that they would not involve their parents for the following reasons:

- fear of physical punishment
- not wanting to bring shame upon their family.

Physical punishment was presented by participants as a cultural norm and the main solution used by Pacific parents in dealing with any problems. Many reflected that this is done as a way of teaching and out of love but that it did not 'fit' with the New Zealand way of life and that the negative effects of this type of punishment outweighed any positives.

"You need to speak to our elders; they need to know how we feel about what they do, just because they had it done to them doesn't mean they need to carry it on, it affected me getting the bash all the time, just for doing little things, it made me feel like they didn't want me, I am a no body, it affects you as you grow up and then you do bad things and then they blame you – you need to talk to them cause we can't tell them."

The concept of "I is We" is very strong within Pacific cultures meaning that any actions taken directly impacts upon the family and that knowledge of engagement in risky behaviours would bring great shame.

"If you do something wrong it will bring shame to your whole family, everyone will find out."

The 'ideal' would be to involve parents/family. However, most participants felt this was not something that they could achieve on their own and that the main consideration in family involvement being safe and effective is that this must be done by a Pacific health worker due to cultural understanding, knowledge and the use of ethnic specific languages. *"A Pacific person would be best to speak to parents, position matters and my parents would feel better speaking to a PI person, some parents' English is not good or they don't speak English at all, process is important for parents so they can listen and understand, they may say Yes when the Palangi person is there but once they leave it's different, Palangi won't understand PI parents reactions."*

Ethnicity of health workers

Key factors relating to the ethnicity of health workers were: presenting health issue, family involvement and understanding both cultures, with the majority of participants stating that they would like to be given the choice of seeing either a Pacific or European health worker.

For matters relating to sexual health, Pacific youth would prefer to see a European worker as the belief is that a European worker would understand, accept and not pass judgement upon them and that no shame would be brought to their family.

"I would want to see a Palangi about sexual health, cause they won't judge you and you can talk about these things with them."

For a matter relating to receiving physical punishment they would prefer to speak with a Pacific person in the belief that they would understand and not get their parents into trouble.

"A Pacific person would understand if you got a 'hiding', so I would feel better talking to a Pacific person."

The ideal would be a worker who would understand their perspectives as young Pacific people raised in New Zealand with parents who are predominantly island born and raised.

"Culture is all around us at home, we come to school and its different, you look around and think why am I not like the rest of them?"

Youth culture

Participants often made reference to being teenagers and experiencing all that comes with this stage of growth and development and stated that they wanted to be treated separate but equal, acknowledging that commonalities do exist for all youth irrespective of ethnicity. Further exploration meant that in terms of health services they would want to be under the same structure and systems as Palangi but with cultural considerations being applied through having access to both Pacific and European health workers.

"Don't want to be treated differently, treat us equal as Palangi but with understanding of our ways too."

Connection

This theme includes areas that participant's identified as being important to the design and delivery of health services.

Qualities of youth health workers

Many participants reflected the view that other than the presenting issue, it did not matter what colour skin the person had but how they acted and their professional skills did matter. Understanding their needs and behaviours as young people, being genuine, honest and talking at their level were necessary requirements. Age was mentioned by a small number of participants as relevant and only female participants stated that gender matching was important.

"It doesn't matter if they are white or black the main thing is to tell someone so that things don't get worse, as long as the person is honest and genuine and its confidential."

Environment

The location of youth health services was explored through two possible options:

- School based health services or
- Community based health services.

Participants identified positives and negatives for both options with a final overall outcome presenting school based health as the best option. However, the points raised in favour of community based health are valid and many participants identified the ideal as having both types of services available to support Pacific youth who are both in school and out of school.

A presenting concern about school based health was that there is no where to go on the weekends and holidays, a time stated when young people are most likely to engage in risky behaviours and need support. A youth health centre based in the community was identified as being accessible at these times.

"If it's just at school then what happens on the weekends and holidays, this is when we may need help."

Community based health was viewed by participants as being best set up not just as a health centre but as a place that youth from all cultures could go to, hang out, play some sport or games and access youth health workers at the same time.

"Need a youth hang out place that has activities, programmes, food, competitions, a place that is enjoyable to us and you can get health people to be there also that you can see someone if you need to and people don't know why you are there."

Participants who were no longer in school, collectively stated that school based health would not be the best option, as their own experiences indicated that the system had failed them in that limited support was offered to assist them with addressing the problems that they faced.

"They need to help people like us, my school had nothing and look where I ended up, so I think the community would be better."

Based on the information given, it appears that school based health services vary greatly with some schools having limited services available and other schools providing very comprehensive services.

"Different schools have different things." – "We had lots." – "We had nothing."

Presentation

Participants did not want a youth health service that would be exclusively for Pacific youth but one that would be for youth of all cultures; youth friendly, with young people having an input into how the place looked.

"It needs to be different for young people than for our elders, the young generation are different, so physical environment is important, have some PI art and posters that are cool so you can feel comfortable."

Participation

For many participants, involvement in this study was due to wanting to make a difference and to contribute towards improving the health and well-being of Pacific people. Participants all agreed that it would be a good idea for the WDHB to continue to include Pacific youth in the development of youth health services through ongoing consultation and evaluation of services that they provide.

"I came today to help and to make a difference, our health is important, I would like to be part of a group that can talk to the health board."

Conclusion

The following recommendations relating to service provision and a suggested Pacific youth health action plan has been presented to the WDHB:

- All secondary schools within the WDHB provide school based health services that are consistent and equal across all school settings.
- Pacific youth not in school have access to youth specific primary health services.
- Priority be given to addressing the areas of sexual health, mental and emotional health, diet and nutrition for Pacific youth.
- Consideration be given to planning for community based youth specific primary health service under the "One Stop Shop" model within the WDHB.
- A Pacific youth health advisory group to the WDHB is established.
- Resources and funding is made available to develop and implement youth specific primary health services within the WDHB.

References

1. Walker RA. Demographic profile for Waitemata District Health Board: Analysis of 2001 census. Statistics New Zealand, 2002.

To all the Pacific youth who participated in this study, thank you for sharing your experiences, thoughts and ideas.

Malo 'aupito, Fa'afetai lava, Fakaue lahi, Meilaki Ma'ata, Vinaka

Thank you

LONG TERM TREATMENT ATTENDANCE: CLINICAL AND MANAGERIAL ISSUES

Justin Pulford
Wolfgang Theuerkauf
Community Alcohol and Drug Services (CADS)
Auckland

Contact: *Justin.pulford@waitematadhb.govt.nz*

The Auckland Community Alcohol and Drug Services (CADS) provide a wide range of treatment options. Outpatient psychosocial counselling is the largest and most frequently utilised of these. Client attendance at this counselling service is typically brief: 50% of new admissions attend three or fewer appointments. However, a number of clients do remain in treatment for a considerably longer duration. This study sought to broaden our understanding of this longer-term population (defined as clients who attend more than 20 appointments during a single treatment episode) and to identify any clinical or managerial issues that they present. Areas of research interest included: the amount of treatment resource consumed by this population, their demographic and clinical profile, and their perceived treatment needs.

Methods

Data were collected via a retrospective file review and by interviews with CADS staff. File data were sought from all clients discharged from the CADS counselling service between 1 July 2004 and 30 June 2005 who had attended 21+ treatment appointments. The data collected pertained to service use, client demographics, alcohol and drug use, use of mental health medications and self harm/suicide risk. Interviews were conducted with five CADS clinicians. The focus of each interview was on the characteristics and needs of the 21+ client population (as perceived by the clinician) and the experience of providing a service to this population in the current service structure (factors that facilitate/impede effective service provision).

Findings

Resource Consumption

There were approximately 2500 client discharges from the CADS counselling services between the period 1 July 2004 to 30 June 2005. Only 34 of these discharged clients attended 21 or more one-on-one appointments during their treatment episode. This represents less than 2% of the total discharge population. Collectively, these 34 clients attended 990 one-on-one appointments, 208 group appointments and were the subject or recipient of 750 telephone calls. Their respective clinicians also attended a further 52 care co-ordination/case support appointments. These 34 clients also accounted for 226 cancelled appointments and 74 missed appointments. The mean treatment duration was 443 days (SD: 226; median 444; range: 177-1302).

Demographic, AOD & Mental Health Profile

Eighty-eight percent of these 21+ appointment clients were New Zealand European (30/34), 3% (1/34) Māori and 9% (3/34) 'other'. Sixty-eight percent (23/34) were female and the mean age was 46.1 years (SD 12.5; range: 21–70). Information pertaining to AOD use was only available for 32% (11/34) of the sample¹. Alcohol misuse was the most commonly identified issue (10/11 cases). Information from standardised mental health and risk alert screens were also available for 65% (22/34) of the sample. These screens were completed at the time of treatment admission. Use of a mental health medication was reported by 15 of these clients, 6 were considered a 'medium' or 'high' risk for self-harm and 3 a 'medium' or 'high' risk for suicide ideation.

Perceived Treatment Needs

The five clinician interviewees identified three 'types' of longer-term client: a crisis group, a practical support group and an intensive counselling group. The treatment needs of the longer-term client were considered to vary according to each grouping. The 'crisis' group consists of chronic relapsing clients with a long history of CADS contact (i.e. multiple treatment episodes over several years). These clients are characterised by their instability and significant trauma history. They are a group that require extensive support in a range of areas (AOD, mental health, trauma, head injury), yet are unlikely to be receiving such support. Most have a well established relationship with the CADS service and present in times of severe crisis. Treatment typically centres on the immediate crisis and reducing the potential for harm insofar as possible. Opportunities to effect lasting changes in AOD consumption or resolve underlying problems rarely present due to recurring instability. Of all client groups, it is this population that requires the greatest clinical effort. This effort often occurs outside of scheduled appointment times in the form of crisis management, service liaison and follow-up.

The 'practical support' group is a relatively stable population in need of ongoing support as they establish routine life patterns. They may also be characterised by the presence of a significant mental illness (e.g. personality disorders, schizophrenia or paranoia) for which they are most likely to be receiving specialist mental health treatment (although their stability in this respect differentiates them from the dual diagnosis population described above). Treatment is practical in focus with this population, is primarily centred on areas external to the person and encompasses many life areas (e.g. social support, leisure activities or employment). One interviewee described employing a 'social-work' type approach with this client population (i.e. supporting them with day-to-day activities and connecting them to appropriate support services). Treatment outcomes are often positive, although progress may be slow.

The 'intensive counselling' group is characterised by the presence of deep rooted personal trauma (e.g. sexual, physical, emotional abuse) which they are actively seeking to resolve. They are a group who have made a commitment to treatment and, unlike the chronic relapsing population who may have similar abuse histories, are in a position to realise lasting positive change. The importance of addressing the

¹ Information was only sought from database records. Client AOD use would have been documented in the hard copy of the client file.

wider non-AOD specific issues (e.g. sexual abuse history) in order that lasting change may be achieved was stressed by interviewees, as was the need to develop a trusting therapeutic relationship. Many examples of positive treatment outcome were reported as a result of meeting these conditions. The treatment focus with this population is introspective, primarily centring on the individual's internal state. Treatment provision was described as a very ordered process with this client group; clinical effort concentrated in scheduled appointment times, minimal between session work and regular client attendance.

Discussion

The data confirmed that the overall number of long term clients is low (< 2%). The perception held by clinicians about the size of this population, however, varied from small to sizeable. Both of these views are correct when the low number of clients is held against the sizeable number of appointments used by these clients when compared to the shorter term clients or in relation to the total number of appointments available in the treatment agency for all clients. From a management perspective, this inevitably raises the question of the efficiency of the use of a limited resource. This is the case, in particular, when the agency is faced with a waitlist. To meaningfully answer this question will require more specific and detailed information about the cost and benefit. Such analysis can only be based on the measurement of clearly defined treatment outcomes, information which is not available at present.

There are some distinct features of the long term client (i.e. the 'three types'). However, the ability to predict the longer term attendance at the point of treatment entry based on these features is very limited, since many clients with the same or similar features can be found in the short term attendants. The first author's PhD research would suggest reliable predictors of longer-term treatment retention, whether based on client-, clinician- or service-variables, have not been identified in the published research literature either. It remains quite possible, therefore, that the only truly distinctive feature of the 21+ client is the fact that they remain in treatment for 21+ appointments. Accordingly, there is no identifiable basis for the creation of a specific clinical pathway for these clients at this point in time.

THE GOOD, THE BAD AND THE UGLY: AGENCY PERSPECTIVES ON STUDENT PLACEMENTS

**Deirdre Richardson
Wellington Institute of Technology**

Contact: deirdre.richardson@weltec.ac.nz

Introduction

Clinical placements enable students to integrate knowledge and skills that they have gained throughout their training within a practising environment (Rosie & Murray, 1998). Alcohol and drug studies students have extremely varied experience of the clinical environment. Some have paid work experience, some have experience of being a client, whilst for others it may be their first experience in any capacity in the clinical environment.

In addition, the nature of the clinical placement can differ tremendously; ranging from a residential setting based on 12-step philosophy and strong Christian values; a NGO that offers a menu of services such as community support, home detoxification, counselling, drop in, group work and family/whanau work; a NGO that sees clients for face to face counselling sessions only; to a kaupapa Māori service or a statutory service operating within a district health board – its focus often dependent on dominant regional beliefs.

A Clinical Practice and Professional Development course must be completed at each of the three stages of WelTec's Bachelor of Alcohol and Drug Studies Degree. These courses all have clinical placement requirements, with clinical hours, tasks and responsibilities increasing as the student progresses through the degree. In 2006 there were 119 students completing these courses throughout the country, 72 at stage one, 29 at stage 2 and 18 at stage 3.

In 2005, WelTec alcohol and drug students were surveyed on their views of student placements. The key findings included the benefits of being able to put theory into practice, the team experience and learning gained from staff, particularly 1-1 observations and supervision. Challenges identified included practical issues such as time, money, travel and office space. Other challenges were lack of staff support and negative staff attitudes, personal issues (especially developing confidence) and client issues such as non-attendance, drop-outs and their suitability for the student course requirements.

The aim of this study was to build upon the 2005 findings through gaining the placement agencies perspective of student placements. This information would further assist in the design of the clinical placement teaching programme so that it can work optimally for the student and placement agency and thus be of greatest benefit to the client.

Method

A qualitative approach was taken because the paucity of research in this area made it more appropriate to search for theory rather than test it (Bryman, 2001). Data were collected using a structured questionnaire with both open and closed questions. The content of the questionnaire was based on areas highlighted by previous research and in consultation with colleagues.

Survey details

- 32 questionnaires were sent to agencies across New Zealand who have WelTec students on placement. There were 20 returned, giving a return rate of 62.5%
- 24 questions were included with a range of open ended and likert rating scales. Questions included views on:
 - benefits and challenges of student placements
 - what staff associated with successful and not so successful placements, and
 - what could be changed to improve placements.

Qualitative data analysis techniques were applied with responses coded to identify common themes.

Results and Discussion

Benefits of student placements

There were four key themes identified regarding the benefits of student placements. The first theme was the opportunity for agencies to learn from the students as they brought up-to-date knowledge and often an untainted perspective with which to question the status quo. This theme is highlighted by the following comments, *"help us clinicians stay abreast of our own work and clinical knowledge" ... "bring information, fresh knowledge, stimulate discussion" ... "bring awareness of changes that need to be implemented that we may not see"*.

The second theme that emerged was the importance of students with regard to the agencies workforce development and recruitment, offering agencies the opportunity to identify and recruit future employees. For example, *"Increases the A & D workforce as there is a continual shortage when recruiting... those not employed by us we often employ" ... "Advantageous for our agency to have access to new prospective counsellors" ... "Opportunity to make contact with prospective staff"*.

Consistent with the aims of clinical placements, agency staff recognised placements as an opportunity for students to gain experience. As such, *"Provides experience of intensive residential, day client, part time day client and outpatient, ... experience of evidence based treatment... of team approach" ... "Integration of theory and practice happens" ... "students are able to practice theory"*.

Finally, in conjunction with workforce development issues, students on placement provided an extra resource. Agency staff stated that *"We gain a pair of hands to help with various roles, especially facilitation of some groups, and once trained in a specific role to help fill in if needed" ... "they help with caseloads" ... "extra hands on deck"*.

Challenges of student placements

Two clear themes were identified regarding the challenges of student placements, these being time and supervision. Respondents commented on the challenges of finding time when they have competing demands and a busy workload. For example, *"Students can take time away from our own work"...*

"Time orienting them" ... "Staff time explaining and teaching."

Linked with the difficulty in finding time was the ability to appropriately supervise students. For example, *"Time to supervise" ... "the lack of staff to supervise"...*

"monitoring their safety and how they interact with clients".

Successful placements

Agency staff was asked to identify factors they associated with successful placements. Four key themes emerged. Firstly, staff named the importance of the student being open to learning and working with the agency. For example,

"Having a helpful and open attitude with staff or agency" ... "Openness to constructive criticism" ... "Insight / self awareness" ... "open to information" ...

"Willingness to learn".

Secondly, key student attributes that are likely to apply to many work situations were identified, these being students having a high level of motivation and showing initiative rather than waiting to be shown what to do. As such,

"students who are proactive in their learning" ... "more experienced students can take more initiative in seeking their own learning experiences" ... "self motivated". This theme may also be linked with the demands on time and resources that many agencies face as students with these qualities take less time to manage and are a resource to the agency in terms of their clinical work.

Consistent with the benefits students bring in terms of up-to date knowledge and providing an extra pair of hands, experience and knowledge has a strong role in successful student placements. Agency staff commented that *"more experienced students can be given more responsibility ..can take more initiative in seeking their own learning experiences".*

The fourth theme was one that is likely to apply across many vocational situations this being personal qualities especially as they relate to work attitude and behaviour. For example, ... *"reliability ...commitment" ... "willing to ask questions" ... "strong team players" ... "well organised" ... "emotional maturity" ... "intelligent well committed students".*

Less successful student placements

Conversely, agency staff was asked to identify factors associated with less successful placements. Three themes emerged, firstly and perhaps logically lack of knowledge and/or experience, as exemplified by the following statements, *"lack of alcohol and drug knowledge" .. "inexperience leading to fallout for client and team" .. "less experienced students - 1st year students have less of an integrated understanding of addiction and clinical issues."*

The second theme to emerge, recovery issues, was not anticipated but adds to the debate regarding the role of recovery status when working in this field. There were

specific ways in which recovery impacted as demonstrated by the following comments, *"older students in recovery (but not all students)" .. "recent abstinence for addiction (linked to) ... belief they are already experts and lack of professionalism" ... "if the only point of reference is personal experience of addiction and/or recovery"*.

Consistent with factors associated with successful placements interpersonal qualities were identified as being important for less successful placements. Comments suggest how students respond to feedback and the demands of a professional environment are most pertinent. For example, *"when stressful situations become over-dramatic" ... "over personalises with constructive criticism" ... "emotional immaturity" ... "little empathy and unwilling to ask questions" ... "lack of identity" ...*

Organisational skills was the fourth theme that was identified as important and again is something that is likely to be relevant to many workplace situations. Comments included, *"lack of punctuality, lack of safety" ... "coming and going" ... "they do not make contact with organisation or return calls" ... "student is unreliable"*. The way in which these issues would impact on the success of a student placement and the added stress they may cause agency staff and clients is obvious.

Things can only get better ...

One of the aims of the study was to assist the design of the clinical placement part of the teaching programme. As such, agency staff was asked what the three parties involved, i.e. the student, teaching programme and agency, could do to improve the student's time in placement.

With regard to the student they stated students could improve their planning regarding the goals they hoped to achieve from the placement. Secondly, students could show initiative by being proactive and questioning rather than passively waiting for instructions. This fits closely with positive comments regarding students who display initiative and who are highly motivated. Lastly, linked with the importance of time for agencies and students, was the view that students could manage their time better. This related to attendance and course work.

Feedback regarding what the teaching programme could improve included comments regarding scheduling of the courses with more counselling practice prior to placement and cognitive behavioural approaches taught earlier. Secondly, agency staff stated that communication and liaison could be improved with better pre-placement planning, for example screening of students and matching students with agencies. Finally, linked with the interpersonal qualities that both helped and hindered placements and also with issues regarding students being in recovery was the suggestion that students be required to undertake their own counselling.

Finally, agency staff provided suggestions on what they could improve upon. Unsurprisingly, the issue of time was identified, such as *"more time given to help students" ... "put time aside for observation of clients" ... "by having more one to one time available"*. In addition, several agencies mentioned money, *"being able to make some financial contribution to student's time"* as something they thought needed to be considered.

Conclusions

Undoubtedly students' clinical placements are valuable experiences for both agencies and students but it seems for different reasons. There are greater similarities with regard to the key challenges for both agency staff and students, these being time and money. Whilst there is a body of research regarding student placement with regard to other clinical fields, most notably, nursing, the lack of research specific to the alcohol and drug sector make these findings extremely important for the future development of undergraduate study in this area. The ability to identify personal and professional development factors that are linked to successful student placements will be of great benefit. Student's cognizance of the importance of showing initiative, confidence, positive and open work attitude, good time management and awareness of one's recovery when in a professional role will undoubtedly assist them to make their placement a more profitable experience for all.

References

1. Bryman, A (2004) *Social Research Methods*. Oxford: Oxford University Press.
2. Rosie, J & Murray, R (1998) An evaluation of learning on clinical placements in radiography. *Medical Teacher*, 20(3), p 227-236.

FETAL ALCOHOL SYNDROME: NEW ZEALAND BIRTH MOTHERS' EXPERIENCES

Jenny Salmon
Department of Psychological Medicine
University of Otago
Dunedin

Funding: Small grant from The James Hulme Bequest Trust, Department of Psychological Medicine, University of Otago, Dunedin

Contact: *jvsalmon@ihug.co.nz*

The aim of this study was to describe the 'lived' experiences of New Zealand birth mothers, from pregnancy onwards, of offspring diagnosed with Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effects (FAE).

Methods

A qualitative paradigm was used. A feminist standpoint theory and a phenomenological perspective were adopted to explore the retrospective experiences of the mothers. Eight New Zealand resident multipara biological mothers aged 18 and over, who had nurtured or were still living with an affected offspring were studied. Their ages ranged from 29 to 64 years. They had nine affected children among them, whose ages ranged between eight and 30 years. Purposive sampling was used. The mothers were interviewed in depth using broad, unstructured, open-ended questions. Data were analysed using grounded theory.

Findings

The mothers described many issues of concern for their FAS/FAE offspring, but for the purposes of this paper only the core themes will be discussed. These related to health, social, educational, the judicial system, lack of knowledge by the professionals and problems in diagnosis, to being oppressed and stigmatized. Offsprings' cognitive issues included attention-deficit, absence of fear, diminished memory/comprehension and inability to acknowledge and understand consequences. Behavioural issues included excessive crying, or no crying, as a baby, lying, stealing, hyper-activity, aggressiveness, destructiveness, promiscuity, few friends and a high pain threshold. Other issues were delayed milestones and numerous health problems.

All mothers stated that the pregnancy/labour/delivery of the FAS/FAE child was different from their other non-compromised pregnancies/labour/delivery. Mothers said that the doctors used medical language which they did not understand. Seven mothers were either married to or partners of alcoholic males when they conceived their FAS/FAE child. All mothers had been drinking alcohol prior to conception. Some of the mothers continued to consume alcohol because they did not know that they had conceived. All mothers were unaware of FAS and its effects on the unborn child.

Two males were diagnosed with FAS, three males with FAE, two females with FAS, one female with FAE and one female with possible fetal alcohol effects (PFAE) plus attention-deficit hyper-activity disorder (ADHD). Eight babies had low Apgar scores (average 6, out of 10) and low birth weight (average 6lb 2oz). The women were of middle to high socio-economic status.

Discussion

The women found themselves nurturing their disabled children in a society that largely devalued and medicalised the lives of individuals with disabilities as well as stigmatizing them. It is society itself which creates the disability because of held attitudes, beliefs, values, discrimination and oppression.¹ Therefore, disability for these mothers, was viewed as a 'personal tragedy' and a social problem or 'burden' for the rest of society,² which kept the affected individual out of the schools, out of the workforce and out of the mainstream of community life.³

Issues raised related to the incorrect behavioural conception of the cognitively-disabled individual by the policing and judicial systems, violation of mothers' and children's rights and the importance of appropriate and adequate support networks for the family. Other issues concerned labelling, child abuse, promiscuity, stealing, lying, risk-taking, daily structuring, unpredictability, lapses in memory, adoption and fostering together with lack of information on the disorder.

A most disturbing issue to emerge was that seven women had never heard of and knew nothing about FAS prior to or during their pregnancies. All women said that their child was 'different' and viewed as 'different' by other people. Society blamed the mother for the child's difference. Parent-blaming is a common approach to disability, driven by moralism rather than scientific understanding.^{4,5} An important finding was that all women were either partners of, or married to, heavy drinkers/alcoholics, with six of the women coming from drinking families. The findings of the project concluded that whatever programmes were used within New Zealand in the past to reduce alcohol consumption among pregnant women had failed.

The mothers felt that all women of child-bearing years should be banned by law from purchasing and consuming alcohol and that there should be greater public awareness of the disability. They also said that alcoholic beverages should carry a warning label. Only by total abstinence from drinking alcohol by all women worldwide will FAS be prevented.

The women viewed the medical and health support networks a failure, with many gaps being identified. The major one was a lack of diagnostic professionals and services and the consequences for the child of incorrectly identifying the disorder. They reported it was the experiences of other parents which represented almost the major source of help. For appropriate recognition and intervention strategies to occur, the FAS child requires to be diagnosed correctly, which also bodes well for the future.⁶ The mothers experienced great difficulty in obtaining a diagnosis for their child and were constantly fighting the system. Frequently, the doctor gave, according to most women, an incorrect diagnosis, usually attention-deficit hyper-activity disorder (ADHD), so as not to lay blame or guilt on them. FAS individuals are often

viewed as similar to ADHD children.⁷ One mother did not feel guilty about her child being diagnosed with FAS as she wanted the correct diagnosis. Even when children are suspected of being affected by FAS, getting a diagnosis is a major challenge.⁸ When the mothers did receive the proper diagnosis for the child, they expressed much relief because, as well as knowing what was actually wrong with the child, it also 'made sense of confusing behaviours they had observed and thought were the consequence of their own poor mothering skills'.⁹

While battling to obtain a correct diagnosis for their children, the women felt oppressed and belittled by the male doctors they encountered in the health systems (which remain male-dominated). This experience is in keeping with most mothers of disabled children, not just FAS individuals.¹⁰ For much of this century the lives of people with disabilities have been dominated by the medical profession with their identity being defined for them in terms of sickness, involving pathology or disorder.¹¹

Whatever the reality of the competence of staff, they were granted the mantle of the expert (as the birth mothers soon realized) and were the gatekeepers to the welfare, health and educational services that disabled individuals require.¹² Thus, the doctors, having the knowledge, retained the power¹³ rendering the mothers 'voiceless' in each patriarchal medical encounter. However, the use of feminism gave them a 'voice' and through their intimate relationship with their offspring, they realized that the child's behaviour was not of its own conscious making. By understanding and learning from their child, they became the experts. The mothers interceded in many ways between their offspring and people and circumstances that fostered misunderstanding of them and their needs. Caregivers need to have a clear understanding of FAS in order to reframe their perspective of their stubborn and uncooperative child to that of a child with a central nervous system impairment.

All women felt that the educational system had, overall, failed to meet the needs of their children, so that each individual, after entering mainstream schooling, experienced a disrupted education. Students with disrupted school experiences had twice as many learning and behaviour problems as those without disrupted school experiences.¹⁴ Therefore, the women believed that FAS children should be taught according to their educational needs and not chronological age. The needs of children who have a disability (including intellectually) often are not met, or at least, not met without there having to be seemingly endless advocacy by the parents, disability groups and other professionals."¹⁵ Therefore, instead of appropriate teaching strategies being compiled for slow-learning offspring, the individual is ridiculed by some of their contemporaries and teachers as well as being viewed as troublemakers. The teachers see the syndrome as a 'hidden' disability, because only with FAS are there observable anomalies. The mothers said that more classroom help and resources were required so that FAS children can receive one-to-one support and attention in mainstream schooling rather than 'special education' (segregated systems which arose out of the response to the 'special needs' of those unable to cope in the mainstream sector).² Since educational programmes in the past had generally failed, the mothers (the experts) called for appropriate individual intervention programmes to be drawn up for each FAS child.

Another issue of concern was that the structure put in place within the household was not counter-balanced by that in the classroom. A structured environment is vital to a FAS child. Unless the offspring is totally structured in the classroom and receives the attention and help that is required with school work, the individual becomes frustrated, culminating in classroom disruption, which later leads to trouble with the law.¹⁴

Some women felt that because their child had been involved in the police or legal systems, they were unjustifiably viewed as 'bad mothers'. Because these systems are unfamiliar with FAS, the courts are unlikely to recognise the person's cognitive disability and behavioural problems. The mothers believed that the unpredictable memory lapses and gains of their offspring happened just often enough to convince those who were unfamiliar with FAS that they were deliberate 'behaviours' made manifest under the control of the affected individual. The reality is very different, as no one is more frustrated by the situation than the disabled person. Finally, although FAS children know right from wrong, they cannot relate cause with effect and have no regard for the consequences of their actions.

These findings represent an important step in furthering the understanding of the lives of offspring with FAS in the midst of societal prejudice, oppression and discrimination. The women's personal experiences provided order and a measure of cohesion in terms of the experiences of birth mothers of FAS offspring. All medical and health professionals have a valuable role to play in the early detection of FAS and its prevention.

References

1. Oliver M. The politics of disablement. Basingstoke, UK: MacMillan, 1990.
2. Barnes C & Mercer G. Disability. Cambridge, UK: Polity Press, 2003.
3. Ballard K.(Ed). Disability, family, whanau and society. Palmerston North, NZ: Dunmore Press Ltd., 1994.
4. Ong-Dean C. Reconsidering the social location of the medical model: An examination of disability in parenting literature. *Journal of Medical Humanities* 2005; 26(2/3) 141-158.
5. Jackson RJ. The challenge of fetal alcohol syndrome: Overcoming secondary disabilities. Eds Streissguth A & Kanter J. Seattle: University of Washington Press, 2002.
6. Wekselman K, Spiering K, Hetteberg C, Kenner C & Flandermeyer A. Fetal Alcohol Syndrome from infancy through childhood: A review of the literature. *Journal of Pediatric Nursing* 1995; 10(5), 296-303.
7. Short RH & Hess GC. Fetal Alcohol Syndrome: Characteristics and remedial implications. *Developmental Disabilities Bulletin* 1995; 23(1), 12-29.
8. Leslie M & Roberts G. Enhancing Fetal Alcohol Syndrome (FAS)-related intervention at the prenatal and early childhood stages in Canada. Canadian Centre on Substance Abuse. Ottawa, 2001.
9. Landsman G. Mothers and models of disability. *Journal of Medical Humanities* 2005; 26(2/3), 121-139.
10. Read J. Disability. The family and society: Listening to mothers. Berkshire, UK: Open University Press, 2003.

11. Christensen C. Disabled, handicapped or disordered: What's in a name? In Christensen C. & Rizvi F. (Eds). *Disability and the Dilemmas of Education and Justice*. Buckingham, UK: Open University Press, 1996.
12. Moore M, Beazley S & Maelzer J. *Researching disability issues*. Buckingham, UK: Open University Press, 1998.
13. Fawcett B. *Feminist perspectives on disability*. Essex, UK: Prentice Hall, 2000.
14. Streissguth AP. *Fetal Alcohol Syndrome: A guide for families and communities*. Baltimore: Paul H Brookes Pub. Co.,1997.
15. Ballard K. Concluding thoughts. In Ballard K. (Ed) *Inclusive education: International voices on disability and justice (167-180)*. London: Falmer Press, 1999.

**WHAT MAKES THEM STAY, WHAT MAKES THEM GO? FACTORS
ASSOCIATED WITH THE RETENTION OF YOUTH IN AOD TREATMENT
PROGRAMMES IN AOTEAROA, NEW ZEALAND**

**Ria Schroder
J. Douglas Sellman
National Addiction Centre (NAC)
Department of Psychological Medicine
Christchurch School of Medicine and Health Sciences
University of Otago**

Funding: The Alcohol Advisory Council of New Zealand (ALAC)

Contact: *ria.schroder@otago.ac.nz*

Background

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. A number of studies have reported links between length of time in treatment and a range of treatment outcomes, including reductions in substance use and criminal activity and improvements in educational achievement, employment status and psychological well-being (1-4). Although retention in treatment has been identified as an important aspect of successful treatment outcome, very little is known about the factors that contribute to treatment retention or attrition. This is particularly true of treatment for adolescents with substance use problems.

The aim of this current study was to identify factors associated with treatment retention (measured as length of stay) among young people who had attended youth AOD treatment services during 2003/04 in Aotearoa New Zealand. The results of this study provide an overview of the profiles of young people who entered youth AOD treatment services in New Zealand in 2003/04 and address factors associated with treatment retention.

Method

This paper presents data from the first 52 participants interviewed in the Youth Treatment Retention Study (YTRS). This study aims to interview 80-90 young people who attended AOD treatment in Aotearoa New Zealand during 2003/04. Participants were recruited from seven youth AOD treatment services throughout New Zealand. These services represent a range of treatment modalities including day, residential and outpatient services using a variety of treatment approaches including mainstream, kaupapa Māori and Pasifika.

Participants completed a 90 minute structured interview whereby information was gathered on sociodemographics, substance use, mental health, general health, family/peer relationships, treatment experiences and reasons for staying in or leaving

treatment. Information about participants' treatment experiences and treatment retention was also gathered using clinical file searches and clinician questionnaires.

Results

Sample Description

Of the 52 participants interviewed 31 (60%) had attended a day/residential treatment service and 21 (40%) an outpatient service. The sample was similar across both treatment modalities in terms of age at interview (median age 17.9 years, range 15.4-22.6 years), the proportion who had spent time in CYFS care (61%) and level of secondary education (median=2.8 years).

Significant differences between participants were noted in gender, criminal convictions and ethnic identity. Those attending day/residential services were more likely to be male (71% vs. 38%) and to have had a criminal conviction at the time of interview (71% vs. 43%). Participants who attended outpatient services identified with a broad range of ethnicities: Pacific (29%), mixture of European/Māori/Pacific (24%), European/Pakeha (23%), European/ Māori (14 %) and Māori (10%). Conversely, participants who attended day/residential services only identified with three ethnic groupings, European/Pakeha (45.2%), European/ Māori (35.5%) and Māori (19.4%). The high number of Pacific people identified in the outpatient group is not surprising given that one of the outpatient services that referred to the study was a Pacific specific service.

High levels of substance use were noted across both treatment modalities, with 100% of participants having used alcohol and cannabis, 96% nicotine, 51% stimulants, 44% hallucinogens, 43% inhalants, 27% opioids and 19% other drugs more than 10 times in their lives. High levels of self-reported cannabis (90%) and alcohol (75%) dependence at the time of entering treatment also indicated significant rates of substance misuse among participants from both treatment modalities. High rates of psychopathology at the time of entering treatment were also noted: depression (46%), conduct disorder (51%), ADD/ADHD (30%) and PTSD (16%).

Follow up time (1.8 years), age at treatment entry (16 years) and source of referral (referred by family, school or health professional (58%), court mandated (29%) and self-referral (14%)) were also similar across treatment modalities.

Significant differences were noted between treatment modalities in the reasons that young people were discharged from treatment services. While 62% of participants discharged from outpatient services were discharged for reasons categorised as being conducive to treatment (completed treatment, job training, started another course, returned to school/work) only 29% of day/residential participants were discharged for this reason.

Treatment Retention

Length of stay (LOS) was measured separately for day/residential and outpatient services. LOS for participants attending day/residential treatment services was measured as number of months in treatment. For those in outpatient services LOS was measured as number of sessions attended. The median LOS for those attending

day/residential services was three months (range 0.13-13.02) and for those attending outpatient services 3.5 sessions (1-24).

A second measure of retention 'early engagement' was also calculated. This was used to examine differences between young people who showed initial tendencies to engage in treatment and those who failed to show initial engagement. Early engagement for those attending day/residential services was defined as attending treatment for longer than one month and for those attending outpatient services as attending treatment for more than two sessions.

Overall results indicated little association between client characteristics and treatment retention (LOS or early engagement). The two client variables that were significantly related to LOS were only applicable to youth attending day/residential services. These variables (diagnosis of conduct disorder and experiencing AOD cravings at treatment) were negatively correlated with LOS.

Programme characteristics such as source of referral, reason for discharge and relationships with staff were not found to be associated with LOS in any treatment modality. However, some programme variables were shown to be associated with early engagement. Positive relationships with staff, experiencing autonomy in the programme and perceiving that improvements had been made in relation to AOD use and other life areas were associated with early engagement in AOD treatment services.

Discussion

This study not only provides the first foray into factors associated with AOD treatment retention in Aotearoa New Zealand, it also provides an extensive overview of the types of young people who are attending AOD treatment services in this country.

This study illustrates that young people attending day, residential and outpatient services present to services with a complex number of issues not just limited to substance misuse. In addition, it indicates that who an individual is, where they come from and what their problems are does not determine why they stay in or leave AOD treatment. However, there are growing indications that how young people feel about treatment services, the way they connect to the service and their sense of belonging in the service are important factors in treatment retention. It is important to note that it is not just factors related to individual relationships with staff (e.g. therapeutic alliance) that have been identified but also general belonging within the treatment service as a whole. Such results reinforce the need to ensure that youth services are designed and run in a manner that facilitates 'youth real' approaches to treatment provision.

References

1. Friedman AS, Glickman NW, Morrissey MR. Prediction to successful treatment outcome by client characteristics and retention in treatment in adolescent drug treatment programs: A large-scale cross validation study. *Journal of Drug Education* 1986;16(2):149-165.

2. Melnick G, De Leon G, Hawke J, Jainchill N, Kressel D. Motivation and readiness for therapeutic community treatment among adolescents and adult substance abusers. *American Journal of Drug & Alcohol Abuse* 1997;23(4):485-506.
3. Spooner C, Mattick R. & Howard J. The nature and treatment of adolescent substance abuse: NDARC Monograph No. 26. New South Wales, Australia: National Drug and Alcohol Research; 1996.
4. Stark MJ. Dropping out of substance abuse treatment: A clinically orientated review. *Clinical Psychology Review* 1992;12:93-116.

A NEW ZEALAND ONE-STOP SHOP? DEVELOPMENT OF THE SPECIALIST PROBLEM GAMBLING TREATMENT WORKFORCE

Sean Sullivan

Abacus Counselling Training & Supervision Ltd

Funding: NZ Ministry of Health

Contact: *sean@acts.co.nz*

Problem gambling treatment practitioners comprise a small but core part of the problem gambling treatment workforce¹. The Ministry of Health (MoH) assumed responsibility for the minimisation of harm from gambling as a result of the Gambling Act 2003 and has initiated processes to develop and align the workforce with mental health and addiction workforce development and training initiatives¹. The National Mental Health and Addiction Workforce Plan 2006-2009² now incorporates the problem gambling treatment workforce and expands the focus outside of workforce supply against client demand to a whole system approach. This includes education, training, recruitment and retention, leadership and management as well as organisational culture.

Previous research^{3,4} with clients had identified a desire to receive support for negatively impacting issues in addition to therapy to minimise gambling harm. These included financial counselling, relationship counselling, medical support, referral to Gamblers Anonymous, accommodation and employment and others. For many of these issues, such expertise may be provided in-house, while other expertise would be recruited into the service as needed. This was posited as a 'wider model' of treatment and support for the delivery of this was sought from practitioners and organisations as well as ascertaining whether the earlier client support remained valid. Part of this ongoing project is to identify current workforce resources, treatment content, support for the wider model approach and ability to provide such treatment.

Methods

1. Feedback was sought in 2005 by interviewing all (then) 17 problem gambling treatment provider organisations as to support for the wider model.
2. Feedback was also sought (2005-2006) anonymously from all practitioners as to support for the wider model.
3. A sample of clients' responses was sought from treatment services as to the priority they placed upon a range of issues to be addressed during therapy.
4. Feedback and support was sought for a draft assessment process that addressed the impacts and needs of the wider model, a formal treatment plan and outcome measure.
5. A qualifications and experience survey of all practitioners is being conducted to ascertain the ability of practitioners to deliver the wider model and to identify gaps to be addressed through training.

At this time, methods one to three have been completed and four and five partially completed.

Findings

Organisation survey: Sixteen (94%) of the 17 problem gambling treatment providers then providing these services throughout New Zealand participated in the request to provide feedback on the wider model. All organisations supported the provision of the wider model of treatment. A typical response was:

“This approach is imperative as (problem) gambling impacts on every aspect of life and relationships”

All organisations, nine being Iwi-based providers, advised that the wider model suited all cultures. There was also 100% support for wider screening, providing feedback for formal treatment plans and for effective follow-up and outcome measures. Almost all (94%) supported ongoing training and up-skilling of their practitioners. Approximately half believed they could commence immediately to provide the wider model, however only a quarter believed they currently had sufficient staff to maintain it. All organisations intended to stay in the problem gambling treatment field.

Practitioner support: 67 of an estimated 100-110 practitioners responded to the anonymous survey. There was 100% support for the wider model, 73% supporting all support/therapy, including budgeting, being provided 'in house' by practitioners and 27% supporting referral out for non-gambling issues. The majority (81%) supported practitioners incorporating liaising with other organisations on issues such as housing, employment or legal, on behalf of their clients.

Clients' priorities (n=32): Issues prioritised by more than 50% of clients were addressing issues such as why gambling was addictive and why they were unable to control their gambling, their likely success in controlling their gambling, and how their health was currently affected (e.g. depression levels, use of alcohol and other drugs). Lower, but significant, priorities were budgeting (48%), confidentiality (42%), addressing relationships with family (35%) and others (28%), legal issues (40%), assisting with Work & Income (25%) and housing (18%).

Draft assessment feedback: 29 interviews of an estimated 110 practitioners have been completed to date with strong support for the draft documents. Suggestions for changes or modifications have been recorded for this Delphi process.

Practitioner qualification and experience survey: 72 of an estimated 110 have to date participated in this process. 64% currently are completing, or have completed, a bachelors or higher degree, with the majority being relevant to their practice. There is general confidence in their providing interventions in a range of non-gambling issues, and support for further training and for DAPAANZ (addiction focussed professional body) providing competency accreditation.

Conclusions

Problem gambling treatment organisations, their practitioners and their clients support the wider model treatment approach. There is optimism expressed by practitioners in participating in the process or up-skilling to do so. Although this core group comprise only a small proportion of the workforce, their buy-in is an important step. Following completion of the last two surveys/interviews, gaps will be identified in the ability to provide the wider model and tertiary institutions identified to provide appropriate skills transfer opportunities to address such gaps. Competency accreditation will be a further priority, especially as a result of the restricted activities imposed under the Health Practitioners Competence Assurance Act (providing a psychosocial intervention in the treatment of a serious mental illness requiring approval of a registered health practitioner)⁵.

References

1. Ministry of Health. Preventing and minimising harm 2007-2010: Consultation document. Three year service plan, problem gambling needs assessment, and problem gambling levy calculations. Wellington: Ministry of Health, 2006.
2. Ministry of Health. Tauawhitia te Wero – Embracing the challenge: National Mental Health and Addiction Workforce Plan 2006-2009. Wellington: Ministry of Health, 2005.
3. Sullivan S. Forms, forms & more forms: improving clients' progress. Paper presented at the PGC Problem Gambling Symposium. Auckland, July 2003.
4. Sullivan S. Housing, budgeting, exercises and depression therapy. Paper presented at AUT International Gambling Conference. Auckland, May 2005.
5. Health Practitioners Competency Assurance (Restricted Activities) Order 2005.

THE CADS/ABACUS PROBLEM GAMBLING SCREENING PROJECT: GAMBLING PROBLEMS COMMONLY CO-EXIST IN AOD CLIENTS

Sean Sullivan *
Robert Steenhuisen #

*** Abacus Counselling Training & Supervision Ltd**
Community Alcohol and Drug Services (CADS), Auckland

Contact: *sean@acts.co.nz*

The two aims of this study were:

1. To estimate the prevalence of co-existing problem gambling in an alcohol and other drug (AOD) setting.
2. To ascertain the acceptance by AOD practitioners of screening their clients for problem gambling issues.

The co-existence of alcohol and other drug problems with problem gambling has been identified in a number of overseas studies, ranging between 10% and 22% of clients attending community-based or residential treatment¹. In a New Zealand AOD study, 11% of clients were identified as probable pathological gamblers and another 7% problem (sub-clinical) problem gamblers². Increased suicide risk has also been identified for those affected by both alcohol and gambling problems³.

Methods

Four Auckland CADS settings together with six smaller AOD settings from other regions participated in the study by offering the EIGHT gambling screen⁴ to all clients attending for help with alcohol and/or other drug problems. A goal of 1,000 participants from AOD settings (in addition to participants from other settings) was set for the validation study.

Practitioners who participated in the project were offered the option of either receiving information about the process and resources, or brief training from specialist problem gambling treatment providers as to screening and other brief intervention strategies. Three of the four Auckland settings and two of the six other settings elected to receive the training. The trial ran for varied periods at each setting depending upon other demands on each service. The trial was terminated at the end of July 2006 to meet reporting requirements under the head validation project.

Results

669 participants were screened. Of these, 119 (17.8%) were positive on the EIGHT gambling screen and a further five (0.7%) were positive on another gambling screen (SOGS) but negative on the EIGHT Screen (18.5% positive for problem gambling in total). A further 2% were almost positives. Of these positives, 70% (n=87) scored

highly (>5) on either screen. A score of four or more on the EIGHT Screen identifies a gambling problem warranting intervention, while a score of six or more is highly correlated with Pathological Gambling Disorder.⁵ For the SOGS, a score of five or more identifies probable pathological gambling.⁶

Ages of problem gambling positives were similar to all participants (positives mean age 36 years SD 10.4; all 35 years SD 11.5). Similarly positives were just as likely to be either gender (19.7% of males and 19.5% of females were positives for problem gambling; 42 participants' gender missing). This remained similar for those that scored highly on either screen (70% male and 68% female).

Table 1: Ethnicity of problem gambling positives

| Ethnicity | Percentage of all participants of this ethnicity positive | | Percentage positive & high scorer | |
|-------------|---|----------|-----------------------------------|---------|
| Māori | 21.4% | (34/159) | 55.9% | (19/34) |
| Pacific | 17.2% | (11/64) | 72.7% | (8/11) |
| NZ European | 19.7% | (71/361) | 71.8% | (51/71) |
| Chinese | 11.1% | (1/9) | 100% | (1/1) |
| Indian | 9.1% | (1/11) | 0% | |
| Other | 30% | (6/20) | 83.3% | (5/6) |

Feedback from screening practitioners was that few clients declined to participate, although accurate records were not kept for those that declined. Practitioners in general reported positive feedback from clients when presented with the screen or with screen results.

Conclusions

These findings indicate that one in five clients presenting to AOD services may be experiencing gambling problems as well as alcohol or other drug issues. Perhaps more importantly, 70% of these may also meet criteria for Pathological Gambling Disorder, an Axis 1 mental health disorder. These high levels are found across Māori, Pacific and NZ European clients. Although clients were not screened for depression, the high levels of both gambling and alcohol affected people admitted to hospital following a suicide attempt in New Zealand,³ support screening for gambling problems in AOD services. Although enquiry could be made directly about suicidal ideation, the likely impact of continued problematic gambling upon treatment for alcohol or other drug abuse has been identified.

This study suggests that a substantial proportion of AOD clients may be experiencing gambling problems and are willing to disclose them through a brief screen provided at triage. This opportunistic screening would increase substantially the numbers of problem gamblers receiving help from AOD services alone. In 2005, 3,435 new problem gambling clients contacted the Gambling Helpline and 2,714 new clients attended face to face services, with some overlap probable.

There appear to be good reasons to screen for problem gambling in AOD services both from addressing issues relevant to treatment for alcohol and/or other drug abuse issues and to enable reduction of harm resulting from problem gambling.

References

1. Sullivan S & Penfold A. (2000) Coexisting problem gambling and alcohol misuse: the case for reciprocal screening. In Adams P (ed) Proceedings from the 'Problem Gambling and Mental Health Conference in NZ'. Compulsive Gambling Society of NZ Conference, Auckland, July 1999.
2. MacKinnon S. Pilot Project Report: estimates of the proportion of Auckland Regional Alcohol & Drug Services clients with co-existing gambling problems. Auckland: RADS, August 1996.
3. Penfold A, Hatcher S, Sullivan S & Collins N. (2006) Gambling problems and attempted suicide. Part I. High prevalence amongst hospital admissions. *Int J Ment Health Addiction* 4:265-272
4. Sullivan S. GPs take a punt with a brief gambling screen: development of the Early Intervention Gambling Health Test (EIGHT Screen). In A Blaszczyński et al (eds) *Culture and the Gambling Phenomenon*. Proceedings of the 12th Annual Conference of the National Association of Gambling Studies. Sydney, November 1999.
5. Sullivan S, Penfold A, Cooke M & Goulding M (2006) Eight Screen Validation: final report. Auckland: Abacus. www.acts.co.nz
6. Lesieur H & Blume S (1987) The South Oaks Gambling Screen (SOGS): a new instrument for the identification of pathological gamblers. *American Journal of Psychiatry*, 144:1184-88.

YOUNG VOICES - YOUNG PEOPLE SPEAK ABOUT THEIR SUBSTANCE USE

Mirjana Vilke
Wellington Institute of Technology

Contact: *Mirjana.vilke@weltec.ac.nz*

Adolescence is viewed as a formative period for health and well-being across the life span. Clinical experience and research have confirmed that motivational enhancement therapy (MET) and cognitive behaviour therapy (CBT) have been effective in reducing harmful behaviours such as drinking and driving, alcohol-related injuries, alcohol-related problems, traffic violations among older adolescents and drunkenness and driving after drinking among younger adolescents (1).

Te Taihere Hauora, Health Promoting Schools, is a worldwide movement developed by the World Health Organisation in the early 1990s to promote and support the health and well-being of children and young people (2). Since 1997, many schools in New Zealand have become part of this movement. Hauora/wellbeing refers to physical, mental, emotional, social and spiritual health and sees the school as a part of a wider community which reaches out and is supported by parents, local health services and other agencies. Research has established that substance misuse in adolescence negatively impact young people's wellbeing (3). As a number of young people still attend school when they start exhibiting problems related to alcohol and other drugs, (4) the author decided to provide an intervention for alcohol and drug use in a small number of colleges in the Wellington area.

Aims of the study

- a. To determine the effectiveness of motivational enhancement therapy and cognitive-behavioural therapy with adolescents who are abusing substances, when the method is used as early intervention and is offered in a non-clinical setting (school).
- b. To research adolescents' ideas regarding the initiation and maintenance of psychoactive substance use, the role of psychoactive substances in young people's lives and their ideas about containing the amount of use.

Method

A multiple-baseline design across subjects was used. Participants were referred to the program by teachers or school guidance counsellors in Wellington colleges because it was identified that substance use/abuse/dependence by the students was interfering with educational and behavioural goals. The ten participants who were involved in the study started the intervention after a three to eight week baseline period. They took part in a two hour initial and post assessment as well as ongoing session by session assessment. Follow-up data were collected 12 months after treatment completion. The assessment included a semi-structured clinical interview and a battery of self-report measures, the results of which will be reported

elsewhere. Treatment consisted of eight to ten sessions of manualised motivational enhancement and cognitive behaviour therapy and focused on enhancing participants' motivation through the use of motivational interviewing; coping with cravings through the use of cognitive therapy techniques; goal setting, assertiveness training and development of refusal skills through role plays; problem solving and decision making skills and the development of a long-term coping plan. The treatment was conducted in each participant's school, at their convenience, once a week.

By the completion of the study all sessions will be transcribed and data analysed qualitatively in relation to the following cognitive variables: reasons for drug use, expectancies, readiness for behaviour change and self-efficacy.

Preliminary Results

Findings presented in this study are drawn from preliminary analysis of the interviews with participants, audio-recordings of the sessions, self-report measures and author's diarised notes referring to treatment process.

Participant Involvement

Young people entered the programme for different reasons and at different levels of readiness to change their drug using habits e.g. pre-contemplation and contemplation versus determination and action stages. A few participants came to the programme because they had already decided to do something about their drug use, while others were referred by school counsellors or teachers because of behaviour problems related to their drug use e.g. truancy and lack of ability to concentrate.

Forty percent of participants completed the whole program and 20% completed three or four sessions. The programme was not equally suitable for all young people with our data showing that the programme was more suitable for older adolescents (15, 16 and 17 year olds). Some research requirements e.g. length of the baseline assessment may have had a negative impact on treatment retention. In the future a more immediate start would be beneficial.

Outcomes

At the end of the treatment, participants showed a 36% reduction in their alcohol and cannabis use both in terms of numbers of days and quantities used.

A three year follow-up is in progress. Data so far confirm that young people who have received the intervention show harm-reduction effects i.e. less or no problems with police, stable patterns of schooling/work, more stable relationships within the families of origin, more insight into their drug use and having plans for the future.

Adolescents' Perceptions

In addition to the treatment sessions, in-depth interview data were gathered both during the treatment and at the follow-up sessions to gain insight into the participants' perceptions of the intervention and of their substance use. While data are still being analysed, content analysis has revealed the following themes:

Potential benefits of offering alcohol and drug interventions through schools

The benefits of a school based alcohol and drug intervention included easy accessibility and availability of the programme as well as supportive and non-judgemental attitudes of the practitioner who was based in their environment.

Initiating and maintaining factors for psychoactive substance use

Participants quoted both positively and negatively reinforcing consequences of their substance use.

Positively reinforcing statements (i.e. adding a positive aspect to one's life) included:

"I like using because it is fun, because I like being drunk/stoned, it helps me relax. Some people think it is cool. I like the detached feeling; I like the rituals, it is interesting, I like the out of body experiences, it makes the world a better place, helps your creative side, goes into your fat cells and makes you slim. It's social, drug use makes you free."

The negatively reinforcing consequences (i.e. taking away a negative aspect from one's life) most often mentioned by participants were the ability to forget the problems and get away from life-troubles.

"Pot use calms me down, lets me get away from troubles in my life, helps me sleep, dulls the pain. People often use because they are depressed, they have weed around them and it is so easy to get; they want to try it."

Negative aspects of using drugs

Many participants were aware that things could escalate and get much worse if they were caught smoking/dealing. They also talked about the negative impact that their drug use has on their families and close friends as well as negative physical and mental health consequences.

"I could get worse, I could get caught smoking/dealing, I could go to jail. Chemists become suspicious; it can be awkward if you don't know what you are doing. I've been reminded of my brother. My mum/dad/best friend would not trust me. My memory is bad and I get low marks. It is expensive, does damage to your internal organs - lungs, heart, some people get paranoid; I don't like throwing up."

Support that would help young people to cut down or stop their use

Most participants agreed that non-judgmental practitioners who relate well to young people, programmes in communities, schools and churches as well as organisations like Welltrust are very important and instrumental in helping young people cut down or stop their use.

Conclusions

The initial quantitative and qualitative results suggest that the majority of participants who have fully or partially finished the program changed aspects of their lives in accordance with harm-reducing effects i.e. they have less or no problems with police, they engage in stable patterns of schooling/work, they enjoy more stable relationships within their families of origin, they have better insight into their drug

use and have plans for the future. Complex cause and effect relations are still to be analysed. A number of themes relating to various issues around participants' drug use are emerging. These will be analysed and developed further as the study progresses.

References

1. Monti PM, Colby SM, O'Leary T. eds. Adolescents, alcohol and substance abuse: Reaching teens through brief interventions. New York: The Guilford Press, 2001.
2. St Ledger L. Schools, health literacy and public health: Possibilities and challenges. *Health Promotion International* 2001;16(2):197-205.
3. Sivo-Cole P, Weissberg R. Substance use and abuse among urban adolescents. In Gullota TP, Adams GR, Montemayor R. eds. *Substance misuse in adolescence*. Thousand Oaks, California: SAGE Publications, 1995.
4. Johnston LD, O'Malley PM, Bachman JG. National survey results on drug use from the Monitoring the Future Study, 1975-97. Rockville, MD: National Institute on Drug Abuse, 1999.

AUTHORS INDEX

| Author..... | Page Numbers |
|--|---------------------|
| Adamson, Simon J. | 1, 4, 20 |
| Annandale, Magila | 7 |
| Aotearoa NZ Regional Service Committee / Narcotics Anonymous | 10 |
| Athanasos, Peter | 15 |
| de Crespigny, Charlotte | 15 |
| Deering, Daryle | 20 |
| Frampton, Chris | 20 |
| Henderson, Charles | 25 |
| Horn, Jaki | 20 |
| Jones, Megan | 31 |
| Leger, Natalie | 35 |
| Macpherson, Cluny | 7 |
| Potiki, Tuari | 20 |
| Pulford, Justin | 40 |
| Richard, Ta'i | 7 |
| Richardson, Deirdre | 43 |
| Robertson, Paul | 4 |
| Salmon, Jenny | 48 |
| Schroder, Ria | 53 |
| Sellman, J. Douglas | 1, 4, 20, 53 |
| Solomona, Moana | 7 |
| Steenhuisen, Robert | 60 |
| Sullivan, Sean | 57, 60 |
| Theuerkauf, Wolfgang | 40 |
| Vilke, Mirjana | 63 |