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ADDICTION TREATMENT RESEARCH MONOGRAPH

2009

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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.

The research contained in this monograph was undertaken and written up by clinicians, consumers, and academics, and by Māori, Pacific Peoples and Pakeha. It covers issues from the very specific, such as Horne and colleagues' examination of bone density in methadone maintenance clients, to the very broad, such as Paul Burns' examination of the relationship between addiction and mental health services.

When each of these papers were presented at the Cutting Edge conference, they will have attracted audiences of anywhere from 20 to 200 (given the multiple streams during which many were presented). While the more diligent conference attendee may have taken extensive notes, for many others the recollection of what was presented will have faded. The Addiction Treatment Research Monograph provides a permanent and widely available record of research of great relevance to those with an interest in addiction treatment in New Zealand.

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THE NATURALISTIC TREATMENT OUTCOME PROJECT (NTOP): FIVE YEAR OUTCOMES

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The Naturalistic Treatment Outcome Project (NTOP) sought to describe the type and range of clients presenting at outpatient services in NZ and to measure a multi-dimensional outcome for a representative outpatient sample. The baseline profile of clients in this sample was described in greater detail in the 2001 Treatment Research Monograph[1]. Particularly of note was the high rate of psychiatric comorbidity, with 77.1% of the sample diagnosed with an Axis I anxiety or mood disorder.

Methods

One hundred and five randomly selected clients were recruited from CADS Christchurch and CADS Hamilton and were interviewed within the first two months following initiation of the index treatment episode. All participants consented to be recontacted for follow-up nine months after the date of their initial CADS assessment, and 102 were successfully recontacted, a follow-up rate of 95%. A further follow-up interview was conducted five years later, completed by 70 participants, with a further five initial participants deceased, so that the follow-up rate was 70% of the non-deceased sample.

Outcome measures adopted were:

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

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

Participants were also asked at both follow-ups to identify factors contributing to improvement, and at five year follow-up only barriers to improvement.

Results

Table 1 shows changes across time for all substance use related variables. These were mostly changes made in the first nine months and sustained at five years, but it is notable that drinking frequency increased between nine months and five years while the number of substance use diagnoses and diagnostic category continued to improve between nine months and five years, with abstinence/no diagnosis increasing from 34% to 57% and dependence decreasing from 65% to 41%.

Table 1: Substance Use

Variable	Baseline	9-months	5 years
Percent days abstinent (SD)	35% (34)	60% (38)***	60% (39)***
Percent drinking days (SD)	32% (30)	19% (25)***	27% (35)+
Drinks per drinking day[a] (SD)	16.3 (14.3)	12.8 (14.5)	9.9 (7.3)**
Percent cannabis days (SD)	32% (42)	17% (32)***	13% (26)***
Joints per smoking day[b] (SD)	3.3 (3.3)	1.5 (1.3)***	1.1 (1.0)***
Number of substance diagnoses (SD)	2.6 (2.2)	1.8 (1.9)***	1.2 (1.8)*** +++
Abstinent	2%	13%***	16%*** +++
No diagnosis	13%	21%	41%
Abuse	7%	2%	1%
Dependence	78%	65%	41%
Problem gambling	17%	7%**	6%

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

Table 2 shows changes in health and social functioning scores. There was a significant reduction in rate of mood and anxiety disorders, with comorbidity in general reducing from three-quarters to half of the sample. This finding was mirrored by an improvement in SF-12 mental component scores, while physical component scores did not change. Employment rates did not improve in the first nine months but then exhibited a substantial increase by five years, so that the majority of the sample was employed. Improvements in arrest rate, relationship status and child custody were not significant, but scores for overall rates of social problems, as measured by the Social Problems Questionnaire, did reduce significantly by nine months and were maintained at five years.

Participants were also asked "Compared with when you came to CADS nine months/five years ago, how would you currently rate your drinking or drug use overall?" The majority responded that things were a little better (nine months 14%, five years 19%) or much better (nine months 69%, five years 70%).

Table 2: Health and Social Functioning

Variable	Baseline	9-months	5 years
Any mood disorder	52%		33%*
Any anxiety disorder	61%		40%**
Any co-existing disorder	72%		53%**
SF-12 mental component (SD)	39.4 (7.2)	42.2 (7.4)***	43.6 (6.0)***
SF-12 physical component (SD)	45.3 (6.5)	46.1 (6.0)	45.4 (7.1)
Currently employed	25%	20%	69%*** +++
Arrested, past six months	21%	14%	11%
Married/cohabiting	27%	24%	36%
Custody of children	29%	33%	38%
Social problems (SPQ)	12.7 (7.9)	9.7 (7.0)***	8.4 (7.3)**

*p<.05, **p<.01, ***p<.001 compared to baseline, +p<.05, ++p<.01, +++p<.001 compared to nine months

When asked to identify promoters of change, the three key areas at nine months and five years follow-up were relationships/support, treatment, and self (readiness to change and personal factors). The two key barriers to change reported at five years were relationships supports and health, which was most commonly mentioned in relation to mental health specifically.

Conclusions

Significant improvements in functioning were observed across a range of measures. For the most part these were changes that occurred in the initial phase before the nine month follow-up interview and were maintained at five years. The two exceptions to this were substance use disorders which improved at nine months and improved further at five years, and employment which showed no improvement initially but then improved substantially, so that it was perhaps the area exhibiting the greatest change.

Taken in isolation, many gains are modest, but cumulatively they represent a substantial improvement for the individuals followed up in this cohort, as is captured by the fact that almost three-quarters rated themselves as much better.

When promoters of change were examined, a wide range of factors were identified but most of these could be summarised by a "change triad": social network, treatment and self. Factors identified were relatively stable over time (i.e. present at both follow-up interviews at similar rates). Perhaps the greatest surprise for the promoters of change was the absence of employment, identified by only 7% of the sample at five year follow-up, despite the rate of employment having increased three-fold.

Factors that acted as barriers to making positive change were identified at the five year follow-up. This revealed that the most common barrier was the same category

as was found to be the most common promoter of positive change: social networks. Thus social networks need to be thought of as a double-edged sword, the presence of a social network may be less important than the quality of that social network.

Overall the client group who participated in this study could be characterised as presenting to treatment with multiple problems: multiple substance use disorders, high comorbidity rates, and a range of social issues. Improvements were observed across almost all areas, and treatment was identified as a significant factor in this improvement. Identifying the other key factors that clients felt were important to making change highlights specific areas to focus on as part of treatment. Treatment should aim to maximise other change promoters, such as good quality social supports, motivation, insight and development of coping skills.

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"THE ADDICTIONS SECTOR AND MENTAL HEALTH SECTOR SHOULD NE'ER THE TWAIN MEET"

This submission is an abridged version by Paul Burns of the original report written by Hayley Theyers, Paul Burns, Kelly Ware, Mary Campbell and Tara Trounson and submitted to Blueprint in May 2009 as part of the Consumer Advisor Training.

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Background

In August 2008 various course participants from the mental health and addiction sectors met at the *Blueprint Consumer Advisor* training. Nineteen people with lived experience of either addiction and/or mental health sectors were split into four learning sets and each learning set was given a topic. Five participants made up Learning Set Four and were given the topic:

"The addictions sector and mental health sector should ne'er the twain meet"

The members of Learning Set Four included two consumer advisors (including one for youth), a manager of a needle exchange, a consumer consultant and a consumer liaison.

Method

Learning Set Four completed a group brainstorm as to the process they wished to adopt to explore this issue. This topic is often debated (normally by clinicians and those funding services rather than consumers) and is a highly contentious topic. It was decided that as members of the learning set were only representatives of Mental Health (MH) and Alcohol and Other Drug (AOD) consumers, it was necessary to seek the opinion of a wider group of consumers to ensure adherence to the "nothing about us without us!" philosophy.

To this end, a confidential questionnaire was developed. In addition to sociodemographic details, participants were also asked their opinions on different aspects of mental health and addiction treatment services.

Questionnaires were distributed in a range of forums. Some of the learning set held consumer forums, some asked consumers directly if they would participate, and questionnaires were emailed out to members of the "Aotearoa Alcohol and other Drug Network". All participants of the Consumer Advisor Training Programme and the Association of Mental Health Senior Consumer Advisors were also given an opportunity to partake.

Results

Sixty-eight questionnaires were completed. Participants were aged between 20-70 years. Thirty-seven respondents were female, 36 male and five did not disclose their

gender. Forty-seven percent described themselves as European New Zealanders and 16% as Māori.

Forty-five percent identified as having an addiction only diagnosis, 31% as a mental health only diagnosis and 21% identified as having been diagnosed with a co-existing mental health and addiction disorder. Fifty-one percent of respondents reported having accessed a Crisis Assessment Team (CAT).

When asked to comment on whether mental health and addiction services should be combined, 54% responded yes, 35% no and 11% were unsure. When asked to choose the type of model they would like to see used if services were to combine, a parallel model (AOD and MH services would be in close proximity but in different buildings) was rated as the most preferred model (47%). This was followed by the integration model (one key worker looks after both addiction and mental health needs) (35%) and the sequential model (two key workers, one for primary diagnosis and one for secondary diagnosis) (8%). Ten percent of respondents were unsure as to what model would be the best.

The majority of participants agreed with the suggestion that 84% of clients have a co-existing mental health disorder, although a number also indicated that they were surprised at how high this percentage was.

Thirty-nine respondents (57%) considered that addiction was a mental health issue, 16 (24%) thought that it was not, three (4%) thought that it was partly and 10 (15%) were unsure.

In terms of including a cultural component into AOD and mental health services, the majority of respondents were in favour of this but stipulated that they must be used at the individual's choice and discretion. For instance, some Māori clients had at times been directed towards cultural services despite the fact they wanted mainstream services. Others at times had wanted cultural input into their care but it was not available at that service or at that time. This highlights the need for Māori/Pacifica/Asian staff in mainstream services as well as stand alone cultural services.

Conclusions

Overall the findings of this survey supported the idea of combining mental health and addiction services. These ideas were also supported by the five members of the learning set who, in addition, felt it was important that more discussion on the planning of this was needed. Unfortunately, the historical combining of services has been done in an uninformed way. Services have recognised the importance of combining, but there has been a lack of guidelines, cohesion and/or clear direction on how this could or should be done. This survey highlighted the hugely important premise that all service planning and, indeed, amalgamation of services planning has to have consumer input, whilst also taking into account input from clinicians who truly have consumer interests at heart.

Services in different regions also have to plan in a way that is going to incorporate and meet the needs of their consumers as one size does not fit all. Services will need to communicate effectively with one another, so that a holistic approach for all can

be administered. This will ensure that the respective services effectively communicate, resulting in treatment plans that have a co-coordinated approach. It will also give consumers the voice and respect necessary to achieve the best possible outcomes. This is in part similar to holistic models such as "Te Whare Tapa Wha" whereby everything in our body/mind is connected and holistic service delivery should underpin all service delivery!

Whether or not addiction can be seen as a mental health issue was a very important question to ask in this survey given it can be a contentious issue amongst tanagata whaiora and clinicians from both sectors. Our results gave a definitive yes from over 50% of our survey participants. Sadly, service provision in general is not currently in line with this premise. There is still a belief, even amongst clinicians who should not discriminate by default given their positions, that addiction is a choice and AOD consumers should be punished. Better outcomes will only be achieved when this aversive and punitive practice is stamped out.

Culture was identified as a necessary component for well-being amongst Māori and Polynesian people interviewed, and some Europeans, and should be extrapolated out to encompass subcultures within our society rather than just ethnicity.

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DEVELOPMENT AND TESTING OF THE ALCOHOL AND DRUG OUTCOME MEASURE (ADOM)

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In order to inform clinical decision making, promote active involvement of clients in their treatment and continually strive to improve the quality of care in everyday clinical settings, there is an increasing call for the implementation of routine outcome monitoring during alcohol and other drug (AOD) treatment provision using brief outcome measures that reflect the outcome domains of treatment[1-5].

The Ministry of Health in New Zealand has invested substantial resources in outcome monitoring through initiatives such as the Mental Health Research and Development Strategy (MHRDS). Through this strategy a team of researchers were commissioned to define a routine outcome monitoring system of potential benefit to AOD clinicians and clients within the context of day-to-day treatment[6]. A key recommendation arising from this initial work was the need to develop a brief generic AOD outcome monitoring instrument suited to the New Zealand clinical and cultural context and client population. It was emphasised that such an instrument should comprise a brief structured interview for collaborative use in everyday clinical practice between a client and their clinician as a means of reviewing treatment progress. As part of this recommendation a draft prototype was proposed.

The aims of the second phase of the commissioned New Zealand Alcohol and Drug Outcome Project (ADOPT) research project were:

1. To refine the draft prototype titled the Alcohol and Drug Outcome Measure (ADOM); a brief, two-part alcohol and other drug (AOD) outcome measure designed for use with clients in everyday clinical settings.
2. To test the psychometric properties of the ADOM with a range of clients across a number of treatment settings.

Ethical approval for the project was granted by the New Zealand Health and Disability Ethics Committee. The client participants in the psychometric testing phase were provided with a $20 petrol voucher at the end of data collection to assist with travel costs.

Methods

Development and Design

As the draft ADOM prototype had not been subject to critical review or presented for feedback to the sector, the initial step was to refine the original version. This involved a series of consultations and review processes. Firstly, consultation was undertaken with an expert interdisciplinary panel of six senior AOD clinicians who were recognised as clinical leaders in the sector and were familiar with the principles of in-treatment outcomes monitoring and key implementation issues[6]. Secondly, consultation was undertaken with 14 key informants representing treatment service managers, clinicians, consumers and Māori and Pacific representatives from a range of services across New Zealand. Thirdly, input was sought from 25 clients and their respective clinicians. Participants at each stage were provided with questions to respond to related to feasibility (acceptability, relevance, practicality and perceived utility) within a clinical context and/or to suggest alternative potential questions, keeping in mind that the purpose of the ADOM was to inform clinical decision making at the level of the client/clinician.

Amendments were made following each round of consultation and were determined in consultation with a project advisory board comprising clinicians, Māori, Pacific, consumer and Ministry of Health representatives, as well as a consultant researcher highly experienced in the development and implementation of mental health and AOD sector outcomes monitoring and information technology systems. The outcome of this process was an 18-item questionnaire divided into Part A, covering type and frequency of substance use and injecting risk (11 items), and Part B, covering mental health, physical health and social issues.

Psychometric Testing

The psychometric testing aspect of the study was conducted in seven general outpatient addiction treatment units and two opioid substitution treatment services in two urban centres (Christchurch and Auckland). Clients included Māori and Pacific clients and clinical staff members were from a range of professional backgrounds.

Instruments

In addition to the ADOM, the measures listed below were administered to participating clients at the first (treatment admission) and third (four to six weeks post admission) assessment points:

- Degree of Drug Use Index (DDI): a self report method of collecting substance use data from New Zealand Māori and non- Māori participants with demonstrated reliability, validity and sensitivity to change in a New Zealand setting[1].
- Timeline Follow Back (TLFB): an internationally valid and reliable calendar self-report method for collecting substance use data[7].
- Treatment Outcome Profile (TOP): TOP questions pertaining to injecting risk behaviour, criminal activity, health and social functioning over a four week period[3].

- SF-36 Health Survey (SF-36): the two multiple response questions pertaining to problems with work or other regular daily activities as a result of physical health or emotional problems[8].

The DDI and TLFB were employed as comparative measures for Part A of the ADOM, whilst the TOP and SF-36 questions were employed as comparative measures for Part B.

Procedure

The AOD clinicians involved in the research were provided with training and ongoing supervision. Clients were informed about the project during the intake process of their respective service and informed consent was obtained from those who volunteered to participate. The clinicians administered the ADOM at treatment admission, one-to-seven days post-admission and four-to-six weeks post-admission.

Findings

A total of 63 AOD treatment clients successfully completed the baseline interview, 61 of whom completed the test-retest interview and 56 of whom completed the sensitivity to change interview. Analyses of the test-retest reliability, concurrent validity and sensitivity to change of Part A of the ADOM, covering type and frequency of substance use, consistently produced excellent results. Comparable results for Part B of the instrument, covering associated health and social issues, were generally satisfactory. The low correlations between Part B of the ADOM and some of the comparative items, e.g. pertaining to attending college or school, risk of eviction from housing and illegal activity, were most likely due to their low rate of endorsement. In addition, there was an imperfect match between a number of the Part B ADOM items and comparative measure items which impacted on the results.

Conclusions

In conclusion, this commissioned research resulted in the development of a brief outcome monitoring instrument with two parts: Part A covering substance use and related risk and Part B covering physical and mental health and social issues. Part A of the ADOM has excellent potential as a generic measure of type and frequency of AOD use. The potential utility of Part B of the ADOM as a generic measure of AOD-related health and social issues requires further consideration. In addition to the aforementioned issues of low endorsement for some Part B items on comparative measures and imperfect matching, the poorer (but still acceptable) performance of Part B in general also, in part, reflects the universal tension for such instruments between brevity and scope. To promote use in busy clinical settings, feasibility characteristics are key[9], requiring lowering of psychometric property expectations to meeting minimal requirements. The recommendation of the research team was that field testing of the ADOM be undertaken in a small number of clinical services with particular attention paid to staff uptake and perceived clinical utility and with a view to potential further refinements to Part B. The Ministry of Health is currently considering Part A for inclusion in the national suite of outcome measures for the mental health and addiction treatment sector.

Acknowledgements

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"KI TE MĀRAMA I TE TANGATA ME MĀRAMA HOKI I TŌNA AO"
(IF YOU WISH TO UNDERSTAND A MAN, KNOW THE WORLD IN WHICH HE LIVES)

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Introduction

"Ki te mārama i te tangata me mārama hoki i tōna ao" (if you wish to understand a man, know the world in which he lives) is a contribution to the field of cultural and clinical practice. It offers insight into the connections between cultural and clinical modes of delivery and the inevitable interface between the two. In a broader sense, it also speaks to the application of traditional concepts within contemporary realms – synergies and parallels, but also conflicts and contradictions.

This is a summary of findings of a Masters thesis and is a demonstration of how it might be possible to walk in two worlds, and how this might be achieved. The methodology uses literature and formal interviews to formulate the research findings and to support the development of a Mātauranga Māori model of practice and service management – The Raukura Framework.

A single hypothesis is central to this work: "Are cultural competencies critical for Māori mental health practitioners?

Method

Firstly, the approach required was an examination of key reports and statements, and the formulation of a questionnaire for the structured interviews with respondents from within the alcohol and drug sector. I also attended national and international hui that contributed to the information-gathering process.

The methods used to inform this thesis have been developed on conventional lines and have incorporated methods and approaches that are not unfamiliar to most qualitative researchers. However, where appropriate, the research has also embraced cultural approaches and practices that are designed to ensure the overall integrity of the study has been maintained.

While this approach has largely been intuitive, readings on kaupapa Māori theory and discourse have inevitably informed my ideas and the manner in which the research has developed.

This investigation analyses the results and offers a theoretical framework based on the Raukura (the three feathers). The Raukura was a legacy left for the people by

the prophets Te Whiti Rongomai and Tohu Kakahi of Parihaka in Taranaki. It conveys the following message:

"He Kororia ki te Atua I runga rawa (Glory to God on high)
He Maungarongo ki runga I te whenua (Peace on earth)
Whākaaro pai ki nga tangata katoa (Goodwill to all mankind)."[1]

The Raukura framework has emerged from the research and as a consequence of the various interviews, discussions, hui, meetings and reviews of literature. However, it has also been informed by more philosophical ideas and perspectives; the teachings of my ancestors and the timeless insights they have offered. To this end, three high level principles have also informed the development of the framework. And, while these are not immediately visible within the design of the framework, they have, nevertheless, shaped its function and purpose, philosophical intent and overall focus. These principles are:

- an acknowledgement of spirituality and spiritual forces
- the importance of making peace within yourself and with others
- the necessity of maintaining goodwill despite conflict.

Results and Findings

The following preliminary framework (Table 1) was developed as a result of the literature review and interview process.

Model description and use in modern practice

Rangimārie: translates simply as peace and is a theme that has clearly emerged as part of this thesis. It is in fact the cornerstone of this investigation and provides the fundamental basis on which the thesis sits. Within this concept of research, rangimārie is demonstrated in a number of ways. For example, in a service operating under this principle within this framework it means the development of a supportive attitude that includes working with others. Today many Māori may not see or access a kaupapa Māori service, so this reflects working with others despite the fact they may be based in a Western practice setting. This is the 'any door is the right door' approach. It is about sharing knowledge and understanding that will contribute to the well-being of all people.

Another view is that to reach a place of peace one must clear away obstacles that prevent peace from being an achievable outcome within the framework. This can be seen as walking from the dark to light, or in a Māori world view Te Po (night) to Te Ra (Day); the real goal is Te Marama (the world of light).

Table 1: The Raukura Framework for Māori Mental Health Practitioners

	Focus	***Issue***	***Opportunity***	***Threats***
R	**Rangimārie** The elements of a supportive attitude	Peace to all men and values based approach	Everyone has the same opportunity to contribute to all men	Doubts are cast by those who don't understand
A	**Ake ake te tangata** Credibility and role modelling	Mentoring	Māori autonomy in health offers much potential, and the use of whanaungatanga in practice	• Shortage of mentors • Resources to support mentoring
U	**Ūkāipō** Nurturing	Connection to the land and birth a place to nurture	Māori health gains must be seen within the overall context of Māori development	Environment and political impacts on practice
K	**Ko Wai Au** Empathy	Identity, a place to stand	Māori have the capacity to contribute to innovations in health – nationally and internationally	• Balancing between two worlds • Limited understanding in the non-Māori world
U	**Uenuku** (the rainbow)	Allowing for potential	Māori custom and protocol can be used as a base for positive health gains	Challenges to systems in place
R	**Rangahau** Direction	Research	Best practice needs to be evidence-based	• Not seen as a part of practice • No funding to allow this practice in its true place.
A	**Aki Aki** Active leadership	Leadership	Māori leaders in health are required and may emerge from a variety of settings	• Workforce is getting older • Stretched resources is currently the status

Ake Ake Te Tangata: this concept has been a central component of the findings of the research: role modelling and mentoring are practices Māori have used on the marae for centuries, and to bring this concept into a modern day time frame is of major importance. Role-modelling wellness and well-being is a critical part of this framework, which is at the foundation for any service and person working within it. This means the service must employ people who are willing to carry this kaupapa forward to the community.

Ūkaipō: to be nurtured is an essential part of life. When a baby is born and is fed from the breast of its mother the bond is forever. However, within this framework the concept is about nurturing no matter what the situation may be or who the person may be. A person without nurturing is cut off from one of the natural principles in life. Today we see our men in jail and wonder why gangs are popular with our whānau. It is the nurturing factor of this lifestyle that attracts our men and

women, given that many have been cut off from their mothers. This type of life can be seen as a culture that affects the next three supports: whānau (close family), hapū (extended family) and iwi (tribal).

Ko wai au: knowing who you are has been reflected very strongly in this investigation and has had to be included in this paradigm of understanding. The knowledge of *who I am* links not only to a person knowing themselves but also to hapū (family) knowing who they are. This knowledge can further include a community knowing who they are and how they relate to each other; that is providing empathy. To have empathy is something for which you cannot train – it is natural. Māori call it manaakitanga, taking care of others before ourselves. Before undertaking this journey I had no idea of this concept as I did not know who I was or where to stand as a male in a modern world.

Uenuku: within the context of this thesis Uenuku is used as a metaphor for human potential. Its colours and nebulous design have often inspired human thought and as such it serves as a reminder of our collective capacity to grow and evolve – a desire to move forward and reach our potential. An awareness of the unique individuality of each person raises their potential ability to feel they are contributing to our world. Providing an environment for this process should be at the forefront of every health plan. I have had experience of many whānau who, having achieved their own wellness, have asked how they can give back to and support others in appreciation for what they had achieved.

Rangahau (research): this is an area that can be used to measure and ensure good outcomes for Māori through the use of the Whānau Ora Health Assessment Tool. The aim of the tool is to guide and develop health programmes where whānau, hapū, iwi and Māori communities play leading roles in achieving whānau ora. It also places Māori at the centre of programme planning, implementation and evaluation. It is the belief that through the four pathways we can ensure the best practice and outcomes for all. Research must focus on trends and measurements that support development[2]. To repeat the central belief of this thesis – to move forward we must understand our past. However, as our people have a traditional oral history, in a modern world we need to balance this with the evidence base to gain access to and be on the same playing field as many mainstream services. This is something we have not done well in the past. Our own practice research which reveals that we have not done well also allows us to challenge our practice – rather than being told how to do something we can use development services and tipuna rights, rather than customary rights, to support the changes needed in health and welfare.

The research framework is about finding quality of service, both from a practitioner and service level, which brings both a qualitative and quantitative focus to the service. Because in the past research was not understood it was seen as having no value[3].

Initially I thought like this. Today, however, when we look for best practice models and outcomes, we need evidence that supports the service. When aligning the service with a strategic plan, thorough research is needed to back up arguments. Knowledge is power and alongside a mātauranga world view is the Māori practitioner's best attainable standard.

Aki aki Leadership: leaders are not born they are created through development. This research has found that leadership is a key component in the development of the future. When taken into practice, establishing leadership has to be maintained and evidenced to support the work we are trying to do. To support this within this framework, I have looked at New Zealand and found a model for addiction services and practices from Kina Trust that supports good development of Family Inclusive Practice (FIP).

A successful outcome for counselling, achievable over time, will be when the tangata whaiora addresses his or her misuse of drugs, alcohol and other addictions, acknowledges cultural identity, and reunites with his or her whakapapa.

Conclusions

We have trod a path that has shown the use of cultural and practical skills in a framework that was really designed in the mid-1800s. The first section explained the foundation of the philosophy behind the framework, based on the teachings of my own tipuna. The values in these principles offer a key to the leadership for our country as they did for our people so many years ago. The next section of the framework describes the way forward for services and practitioners in Aotearoa.

Today, while we consider the effects of a recession, money is seen as the major problem. For Māori, however, this concept is not new – we have endured a 'recession' for years. Leadership is our answer to this.

Services today are the same; they focus on the financial side of service delivery and forget the other fundamentals that should be balanced when working with whānau. This new framework supports a much more focused approach that is interwoven to support each part, to balance the service, the worker and the whānau who are accessing it.

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BRIEF INTERVENTIONS IN EMERGENCY DEPARTMENTS

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Alcohol dependence is a serious problem in both the United States of America and New Zealand. It is estimated that for every one individual diagnosed as dependent on alcohol, at least six more individuals are at risk or have previously experienced negative consequences as a result of alcohol use[1]. Thus, perhaps as much as 35% of the population are using alcohol at levels which substantially increase health risks and disease acquisition rates for more than 60 conditions. In addition, approximately 40% of patients admitted to trauma centres have a positive BAC[2]. A RAND study found that only 15.5% of traumatically injured inpatients had any indication in the medical record that substance abuse had been assessed[3]. Seven percent of those patients were legally intoxicated.

In New Zealand alcohol-related accidents cause at least 1000 deaths annually and 30% in ACC payouts[4]. New Zealand leads the OECD in alcohol related accidents for under age 19 and consumption rates in the world for persons under age 17. These data provide a persuasive argument for some form of early intervention. Due to the role of alcohol in illness, injury and even death, and the burden placed on emergency departments for medical intervention, it seems prudent to establish protocols to screen for alcohol use and to intervene. Alcohol intervention in an Emergency Department needs to be brief for apparent reasons.

The questions of effectiveness and cost efficiency are crucial to the implementation of a Brief Intervention programme. Numerous studies have demonstrated both cost savings and efficacy[5-7].

Methods

The study reported herein was designed as a pilot project to demonstrate Brief Intervention (BI) effectiveness. It was initially thought that a BI would be provided only for university students presenting at a community hospital Emergency Department (ED) with agreements to provide service to a proximate university. The design ultimately included university enrolled students and members of the local community.

BI were designed and implemented at two hospital EDs; a small community hospital and a large regional medical centre. Patients presenting at the EDs were screened during the triage procedure and randomly assigned to either the Control or Experimental Treatment group. The AUDIT was used and placed in the medical record of those patients assigned to treatment. Physicians were to provide a 5-7 minute BI, as appropriate, based upon the AUDIT score. Severe trauma cases were not screened upon admission.

Physicians providing BIs were provided two two-hour training sessions in the purpose and conduct of a BI. Triage staff was instructed in the proper use and scoring of the AUDIT in addition to the random study procedures.

Initial intake data for inclusion in the study were collected over a four week period and tracked for twelve months.

Results

A total of 774 patients were included in this study. The treatment group consisted of 385 patients and 389 were in the control group.

Table 1: Initial Screening Sample

	Treatment				Control				
	Non-University		University			Non-University		University	
Age	Male	Female	Male	Female	Age	Male	Female	Male	Female
≤ 17	2	1		1	≤ 17	2			
18-25	75	35	80	60	18-25	79	32	79	63
26-35	64	22	1		26-35	67	19	1	1
36-55	28	6			36-55	26	6		
>55	9	1			>55	13	1		
Subtotals	178	65	81	61	Subtotals	187	58	80	64
			Total =	385				Total =	389

After a period of twelve months 573 patients could be tracked as a retained sample (Table 2).

Table 2: 12 Month Follow-up: Retained Sample

	Treatment				Control				
	Non-University		University			Non-University		University	
Age	Male	Female	Male	Female	Age	Male	Female	Male	Female
≤ 17					≤ 17				
18-25	51	20	64	45	18-25	62	23	60	48
26-35	55	14			26-35	56	13		
36-55	19	4			36-55	21	4		
>55	4	1			>55	9			
Subtotals	129	39	64	45	Subtotals	148	40	60	48
			Total	277				Total =	296

The 573 patients retained represents 74% of the original sample. The treatment group (n=277) achieved 72% retention and the control group (n=296) 76%. These patients were reviewed at the twelve month period following the four week sampling time.

Table 3 and 4 report initial and post BI rates of drinks per week as self-reported.

Table 3: Alcohol Consumption Rates at Initial Screening (Drinks per Week)

	Treatment				Control				
	Non-University		University			Non-University		University	
Age	Male	Female	Male	Female	Age	Male	Female	Male	Female
≤ 17	18		6	18	≤ 17	5			
18-25	21.08	12.32	31.16	19.2	18-25	20.10	15.80	30.72	18.84
26-35	16.08	8.16	54		26-35	15.80	7.35		5
36-55	9.03	3.00			36-55	9.66	3.20		
>55	12	4.00			>55	11.50	6		

Table 4: Alcohol Consumption Rates at 12 Months (Drinks per Week)

	Treatment				Control				
	Non-University		University			Non-University		University	
Age	Male	Female	Male	Female	Age	Male	Female	Male	Female
≤ 17					≤ 17				
18-25	16.21	9.36	12.93	9.80	18-25	24.34	17.85	31.50	19.97
26-35	12.74	4.01			26-35	15.97	7.89		
36-55	8.50	2.50			36-55	9.51	3.57		
>55	9.24	3.15			>55	11.25			

The Experimental Treatment Group saw 21.6% decrease in alcoholic beverage consumption at the conclusion of the 12 months following initial intake. During this same period the Control Group experienced an increase of 2.3% in alcoholic beverages consumed. In addition, the Experimental Treatment Group had 47% fewer return visits to the ED in comparison to the visit rates evidenced by the Control Group (Table 5).

Table 5: Number ED Visits at 12 Months: Retained Sample

	Treatment Group	Control Group
No. of patients	277	296
No of ED visits	543	1095
Average No. Visits/pts	1.96*	3.70

* 47% fewer visits than Control Group

Discussion and Conclusions

Some confounding issues exist with this study. The university student admission rates at the community hospital ED were relatively high in comparison to the total sample at that facility. This is due to the proximity of the hospital to the university and treatment agreements between the hospital and university. Students who heavily abuse alcohol typically are, for various reasons, more likely to withdraw from the university, leave the community and thus not be retained in the study. Furthermore, some of the students may have had additional treatment in interventions related to legal violations or university policy violations as a condition of continued university enrolment. These factors were anticipated but could not be controlled for in the study. As such, the findings may be skewed.

Despite shortcomings in controlling the confounding variable of university withdrawal, it does seem warranted to make several conclusions. Screening is not necessarily difficult or burdensome, it is not costly and in approximately seven minutes of BI, at-risk drinking patients can be identified and treated sufficiently to reduce alcohol consumption levels significantly. BIs also reduced repeat visits to the EDs, thus lowering the overall cost of treating alcohol-related injuries and illnesses over a 12 month period. The provision of a BI by a physician at a "teachable moment" improves the chances of patient harm reduction.

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DECISION GROUP: INITIAL OUTCOMES, LESSONS LEARNED

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In late 2008, CADS Dunedin had a very large number of clients for its size (around 1150 clients for a staff of approximately 16 clinician FTEs). Several revisions of admission criteria and prioritisation processes were undertaken to reduce the long waiting times. This was combined with a plan to trial the appointment of a clinician specifically to screen new clients and refer on as appropriate.

Individual treatment was the norm at that time. As part of the solution to the backlog of referrals and a slow-moving caseload, a group treatment was offered for those who were beginning treatment and were unsure of what they required. This was named the "Decision Group". At the conclusion of the group, either a plan for further treatment or a decision to not enter treatment would be the outcome. No firm hypotheses were made but it was anticipated that the rate of "no-shows" would be high, many clients would not continue with treatment following attendance at the group, that substance use would continue (because it was not addressed directly), some symptoms may change (mood) over the course of the group, and an increased willingness to face the personal issues may occur.

Method

A semi-structured series of 5 x 2 hour, weekly sessions were offered to people on the existing waiting list. The content of the session included the opportunity to self-assess the severity of AOD problems, to explore personal values and to gain insight into the impact of substance use on life ("Step 1" of the 12-Step Facilitation approach). In addition, the opportunity to receive feedback from "significant others", challenges from other group members, encouragement and support were provided. The group was conducted by two staff (an AOD clinician and an occupational therapist) off-site from the CAD Service between April and September 2009. Each client completed and reported on their "Change Plan" at their last session of the group. Clients also completed the Depression, Anxiety and Stress Scale (DASS)[1], the Acceptance and Action Questionnaire (AAQ-II)[2], and a brief measure of Valued Action derived from the Chronic Pain Values Inventory (CPVI)[3] at both the first and last session they attended.

Of the people on the waiting list, 112 people were offered an appointment. Eighty of these were screened and referred to other services and five did not attend the screening. Twenty-seven people were screened and commenced the group. A total of sixteen people had completed the group by the time a poster presentation was due to be completed.

Results

Subsequent Use of the Service

No clients contacted by CADS in connection with the group had been re-referred to CADS or remained on the CADS waiting list at the time of completion of the study.

Substance Use

60% of clients reported a decrease in substance use. No clients reported an increase in use over the course of their attendance at the group.

Change Plans

Six of the sixteen clients sought one-on-one treatment following completion of the group. There were a number of alternative treatments chosen which impacted minimally on the resources of Dunedin CADS. These included Detoxification Service (1), Community Support (3), Medical intervention (3), Psychologist (2), Community Day Program (2), Residential Programme (2), and Self-management (1). Four individuals chose more than one option.

Symptom Changes

The DASS provided scores for three sets of symptoms loosely referred to as "Depression, Anxiety and Stress". This was not a diagnostic indicator but simply provided a measure of perceived change for an individual of their own experience. Pre-post data were available on 14 of the 16 people who completed the 5-session group. Although a comparison of the group mean ratings indicated that all three showed an average decrease of symptoms in the desired direction (less "anxiety, depression and stress") at least three people in each group reported an increase in scores.

The AAQII is a 10-item measure on which higher scores are purported to reflect a tendency to accept rather than avoid one's emotional experiences. Only one of the 14 clients showed a decrease in scores on this measure, with the mean score improving significantly from pre- (mean = 40, sd = 9.8) to post-treatment (mean = 47, sd = 11.1, p = 0.042).

The Valued Action measure asked clients to score the same six valued domains (on a scale of 0-5); firstly, for importance and, secondly, for success in taking action about them. This yielded a score out of 30 for each scale on each occasion (see Table 1). There was a clear discrepancy between ratings of importance and action (importance vs success p=0.001 pre-test and p=0.002 post-test) (ie despite considering a domain important, people reported they did not take action as if it was). However, the overlap between the distributions of scores for the pre and post-treatment comparisons were considerable (pre-post importance p=0.58, pre-post success, p=0.47) and indicated no change.

Table 1: "Valued Action" – Mean Ratings

	Importance at pre-test	Success at pre-test	Importance at post-test	Success at post-test
Mean	24.1	16.1	24.7	17.7
SD	4.6	6.2	5.1	7.7

Discussion

A group format for initial treatment in the Dunedin CADS service (coupled with a brief screening process) was an efficient and effective way to manage a backlog of referrals. Despite the short duration of the group and no significant changes in symptoms, there was a clear increase in willingness of clients to accept their own emotional experience. It was interesting to note that average scores on the measure of acceptance used here were below the preliminary cut-off associated with psychological distress[2] before the formation of the group and were just above this cut-off figure after the group.

Several other observations of practical utility were also made by the group facilitators:

- "Participant mix" of the group is important (gender, age, referral type, substance use, background, etc.).
- The value of peer supported problem solving and non-judgemental group facilitation were noted strongly by both staff and clients.
- Group boundaries around attendance and behaviour required clarity and repetition.

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DRUG AND ALCOHOL TALK: UNDERSTANDING HOW OPPORTUNITIES ARE USED

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Introduction

In this presentation we reported back on a project first introduced at Cutting Edge in 2008. Health consequences of alcohol and other drug (AOD) abuse are a major cause of preventable death and morbidity both internationally and in New Zealand. GPs are, in theory, well placed to deal with issues of AOD because they are community-based, easily accessible to the population and often the first point of contact into the health system. Government policy expectations[1-4] are that GPs will detect AOD risk behaviours and provide appropriate advice. Screening for AOD risk is particularly important as there is evidence that early detection and intervention is beneficial. However, barriers exist, such as the often cited GP time pressures and the sensitivity of the topic[5]. Fear of harming the doctor-patient relationship means, despite expectations, opportunities that present for AOD screening and intervention in primary care might not always be taken up by the doctors. Earlier studies reveal that despite policy expectations, AOD issues are not necessarily handled well in primary care[6-10].

The aim of this project was to investigate opportunities that arise for AOD discussion in NZ primary care consultations and how these opportunities are used.

Methods

A set of naturally occurring GP-patient consultations were made available for this study by the ARCH (full name now present in the header) corpus data management. The ARCH research group manages a digitally searchable research dataset consisting of doctor-patient consultation recordings, content logs, transcripts, accompanying medical notes and interpretive interviews with some participating patients and GPs. These were collected during two prior studies of clinical interactions and stored for future communication research with consent of both the doctor and patient. From 171 naturally occurring GP-patient consultations, a subset (56) was identified for analysis of AOD talk, by search of the content logs. Logs were searched for named substances of abuse: alcohol, tobacco, cannabis, and for topics where some AOD-related discussion is expected: liver, heart, injury, depression, stress, lifestyle etc. In-

depth interactions analysis was done on the selected subset of digital videos and transcripts. Interactions analysis is a form of Conversation Analysis where the researchers use sociolinguistic techniques to identify not only what was said but how it was expressed. Two medical practitioners experienced in AOD clinical practice, a sociolinguist experienced in health-related conversation analysis, and a clinical medical student with special interest in addiction did the interactions analysis and cross-checked findings. Consultations were also analysed for patient/GP factors such as whether the person was known to the GP, doctor and patient ages and gender and patient education level (this information was collected at the time of recording the consultations). This analysis was conducted as it was possible that a GP who knows a patient well may already know about AOD usage and not enquire, and extremes of age plus gender differences could influence ease of sensitive conversations.

Findings

Fifty-six GP consultations met these criteria (32.7%). Some mention of AOD (a word or more) was found in 85% (48/56) of these consultations and any discussion (more than a mention) in 75% (42/56). The AOD topics raised included alcohol, cigarettes, caffeine, sedatives (anxiolytics) and analgesics. There was no mention of cannabis smoking or use of other illicit substances in any consultations in this sample, despite expectations based on population substance usage. Of the 48 cases where there was actual mention of an AOD topic, 87.5% (42/48) went beyond a single brief question/comment and response to some further exchange, ranging from quite full discussion or advice giving, to briefer exchanges of varying length where few or no details were discussed. Of the instances where there was some further exchange, discussion or advice, smoking was discussed in 57% (24/42) of cases, alcohol in 40% (17/42) and other (prescription) drugs in 17% (7/42). Patient/GP demographics collected at the time of the consultations were analysed for any apparent patterns of doctor or patient age/gender mix, doctor years of experience or patients' education status that might impact on the nature of such interactions. None were found, although the study was not specifically powered for this.

Discussion/Conclusions

AOD talk in primary care arises less often than expected and talking that does occur is mostly smoking and alcohol use. Previous research (unpublished) by this group has identified that health practitioners avoid asking about, and are reticent to document, illicit drug use. The findings from this current study with regard to the lack of discussion of cannabis and other illicit drug use are consistent. The video observations made in this project also indicated that verbal and body language discomfort is common during AOD discussions and GPs and patients reflect the discomfort of each other, even though the substances being discussed in these consultations were not illicit drugs. This interesting observation deserves further investigation, especially in regard to the apparent avoidance of illicit drug enquiry. Findings from the current study support previous research that suggests that New Zealand GPs often raise AOD in a manner that gives and maintains face[11], at the expense of missing an opportunity for enquiry or brief intervention[12-13]. GPs make assumptions and put AOD questions in statement format "you are not a drinker or anything?" Smoking discussion causes less discomfort than alcohol[14], but smokers see questions coming, become defensive or rapidly change the topic. GPs facilitate

abrupt topic changes and do so themselves. Naturally occurring AOD discussions do not follow recommended GP screening tools[15]. More detail of this particular finding, including verbatim examples, is available in the full report which is available on the MOH website[16]. This has raised additional questions to our earlier ones[5] deserving further research.

Mutual face work, previously described in health care settings[11], was very apparent in this study. This occurs when GPs give and accept understatements to help the patient save face and avoid discussing a potentially threatening topic with the patient. The patient keeps face by giving socially acceptable answers and providing the GP with reason to end the AOD discussion. Hence, both the GP and patient actively work to avoid opportunities to discuss AOD in the consultation.

The full report and recommendations arising from this study are now available on the MOH website[16].

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BONE DENSITY AND BONE METABOLISM IN PEOPLE ON METHADONE MAINTENANCE TREATMENT

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Background

Following the appearance of the human immunodeficiency virus (HIV) in the early 1990s and the shift to the harm minimisation model in methadone maintenance treatment (MMT), concerns about the potential adverse effects related to long-term treatment have arisen. One such concern is the potential risk of osteoporosis (significantly lowered bone mineral density) secondary to opioid induced effects on the cells that regulate bone calcium levels[1] and/or opioid induced hypogonadism[2] (lowered sexual function)[3]. In addition to opioid-related effects, patients on MMT often have co-morbid conditions associated with osteoporosis including tobacco dependence, alcohol use disorders and poor nutritional status.

Kim et al.[4] studied bone density in 92 MMT patients in Boston in the United States of America and found that 44 (48%) were osteopenic (had mildly lowered bone mineral density) and 32 (35%) were osteoporotic (had significantly lowered bone mineral density). Significant predictors of lowered bone mineral density (BMD) were male gender, lower weight and heavy alcohol use.

This study aimed to explore this issue in MMT patients in Auckland.

Method

All clients of the Auckland Methadone Service over the age of 30 years (approximately 960 clients) were invited to participate. Eighty-three attended for the interview and scans. At the interviews, conducted by Dr Horne, a standardised questionnaire developed by the Osteoporosis Research Group at the University of Auckland Medical School was administered. This provided information on: history of fractures, family history of fractures/osteoporosis; HIV, Hepatitis B and C status, chronicity and treatment; past medical problems, all current medications, past and current calcium intake, past and current steroid use, any use of medication to treat osteoporosis, smoking history and exercise level. In addition, they were asked for details of current methadone dose and length of treatment and current and past

drug and alcohol use. Women were also asked questions covering reproductive health, contraceptive medication use and hormone replacement therapy. Height and weight were measured.

Bone mineral density scans of the lumbar spine (L1-L4), proximal femurs, total body and non-dominant proximal forearm were performed using dual-energy x-ray absorptiometry (DXA). The total body scan provided measurements of total body fat mass and lean mass as well as bone density data. Vertebral morphometry was also assessed.

Full blood count (FBC), liver function test (LFT), albumin, glucose, potassium, sodium, calcium, phosphate, urea and creatinine were measured and blood stored for vitamin D levels and for markers of bone turnover. The second void of urine in the morning was tested for calcium, phosphate and creatinine and part of the sample stored for later measurement of markers of bone turnover. Forty participants completed the blood and urine testing.

Bone density in the participants was compared to normative data from the DXA manufacturer's database (USA). In addition, data from the women in the study were compared to the Australian Geelong database.

Results

Demographic data are outlined in Table 1 below.

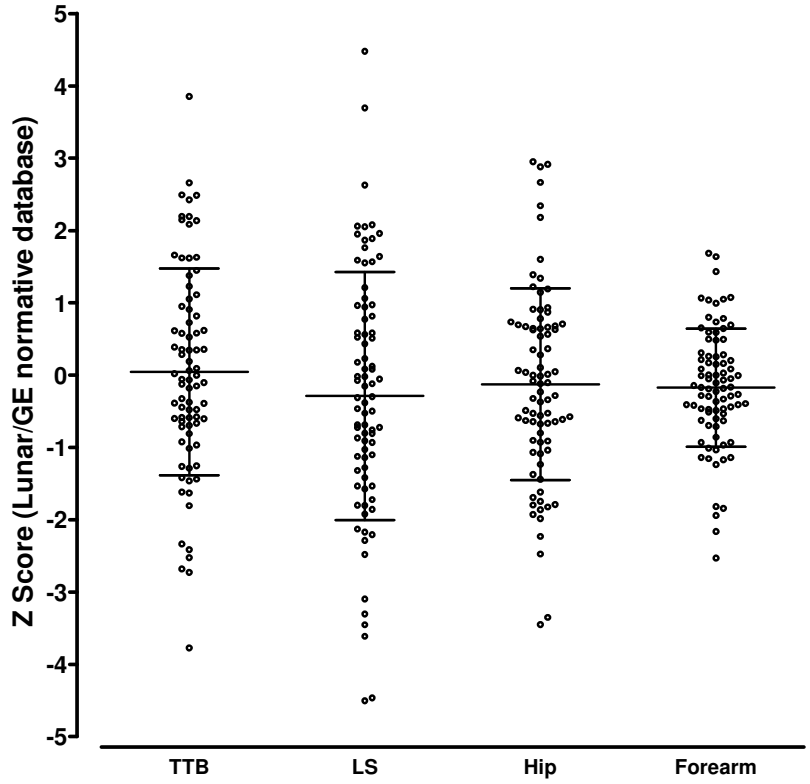
Table 1: Demographic Data in Study Subjects, n=83

Variable	N	%	Mean	SD
Age (years)			46	7
Gender				
Male	48	58		
Female, premenopausal	21	25		
Female, postmenopausal	14	17		
Weight (kg)			76	18
Calcium intake (mg/day)			984	586
Exercise (METS/day)			31	8
Current smoking	70	84		
Prevalent fractures	61	73		
Methadone dose (mg/day)			90	(60-120)*
Duration of methadone therapy (years)			12	8
Co-morbidities:				
Hepatitis B	10	13		
Hepatitis C	50	60		
HIV	0	0		

* median (inter-quartile range)

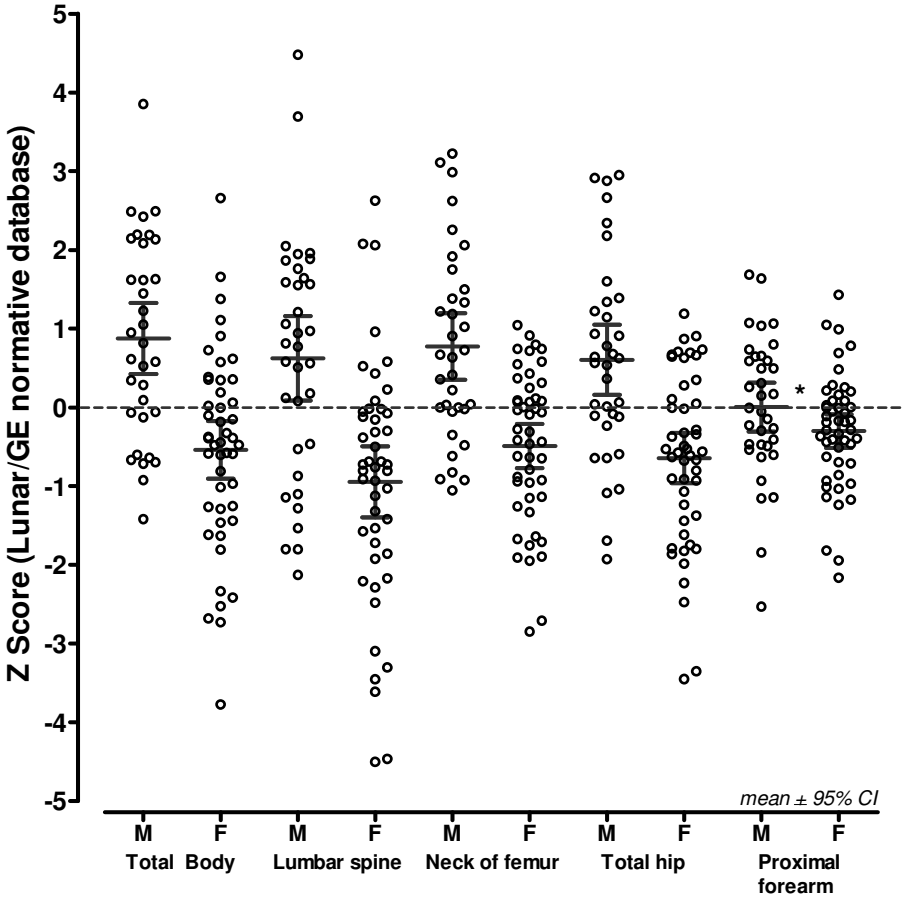
The mean BMD values at each site for the whole group were similar to those in the USA normative database (Figure 1).

Figure 1: BMD is normal throughout the skeleton in methadone users



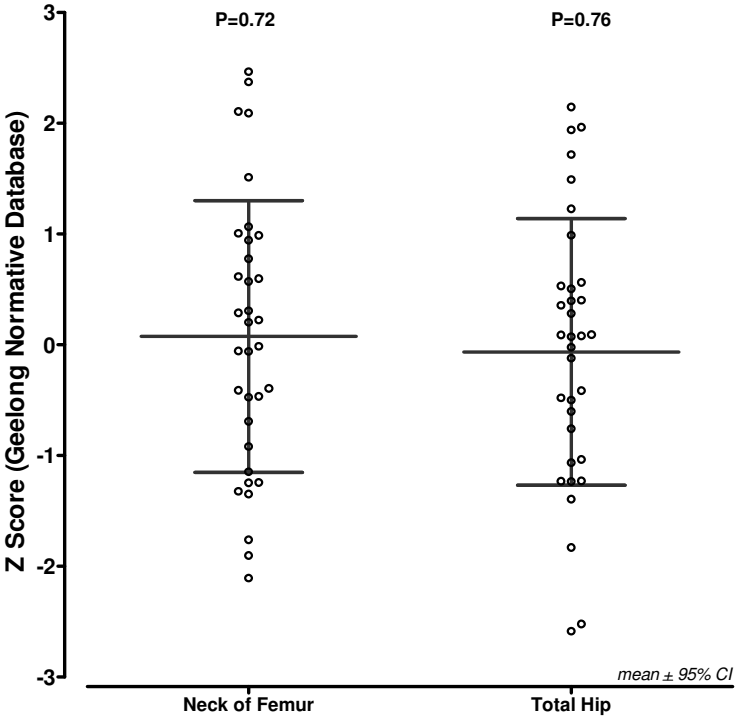
Analyses by gender suggested slightly higher BMD in the male MMT patients and slightly lower BMD in the female MMT patients (Figure 2).

Figure 2: BMD in methadone users by gender



Comparison of the data for women methadone users to the Geelong normative data, however, demonstrated no difference (Figure 3).

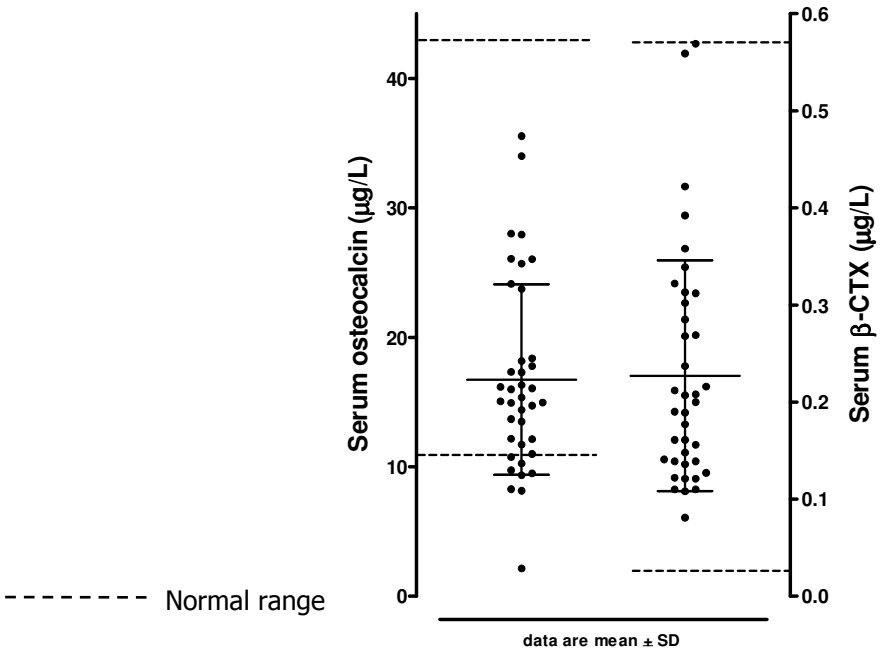
Figure 3: A comparison between female methadone clients and Geelong normative BMD data



Normative data from the Geelong study for men are not available.

Markers for bone turnover were normal (Figure 4).

Figure 4: Markers of bone turnover are normal in methadone users



From the 83 (36 female and 47 male) bone scans, 48 (57.8%) were in the normal range (75% of females and 46% of males), while 26.5% exhibited osteopenia (22.2% of females and 29.8% of males) and 15.7% exhibited osteoporosis (2.8% of female and 23.4% of males). Eight of the males had a testosterone level below the normal range; five had a normal bone density, one was osteopenic and two were osteoporotic. One female was found to have hyperprolactinaemia.

Discussion

These data suggest that people on methadone maintenance treatment are not at increased risk of osteoporosis and that routine measurement of bone density in this population is not required.

This is in contrast to the results of the Boston study by Kim et al. In that study 97% of men and 75% of women had low *T*-scores, whereas in our study only 53.2% of men and 25% of women (40% of whom were post-menopausal) had low *T*-scores. In our study median age was similar (46 vs 42 years), median methadone dose was higher (90mg vs 77mg), and median length of methadone treatment was longer (12 vs 3 years). This suggests that factors other than methadone dose and length of treatment could account for the higher incidence of low *T*-scores in the Kim et al. sample. It is also possible that the longer time in treatment recorded in our clients was a protective factor contributing to improved health care and nutritional status and minimising any potential reduction in bone mineral density.

Those working in MMT services should, however, be alert to the known factors that increase the risk of osteoporosis and fragility fracture, i.e. low body weight, previous low-trauma fracture, family history of fracture, smoking, high alcohol intake and hypogonadism. MMT clients considered to be at risk should be referred for BMD measurement.

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DEVELOPMENT OF A SERVICE EVALUATION TOOL (NAMED *POTALANOA*) FOR PACIFIC ADDICTION SERVICES

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This study involved the development of a service evaluation tool for Pacific addiction services across New Zealand. A specific tool for Pacific services capable of evaluating both clinical and cultural practices was identified as important.

This study builds on previous work carried out with Pacific providers within the Alcohol and Other Drugs (AOD) sector. It is part of a three-phased project. The first phase involved looking at the key aspects of service delivery within Pacific AOD services from clinicians' perspectives. This extended into Phase II which sought to explore the assessment of Pacific AOD practices of service delivery. This current study addresses one of the recommendations from Phase II which identified the need for an organisational evaluation tool specifically for Pacific AOD service providers.

The main aim of the current paper is to briefly describe the development of this tool and to examine user acceptability of the developed tool, *Potalanoa*, and adaptability of the tool to specific service settings.

Methods

The development of *Potalanoa* comprised two phases:

1) the development of a preliminary tool and pilot;
2) testing to explore the acceptability and feasibility of using the tool with four Pacific AOD services across New Zealand.

The preliminary tool was piloted with two Pacific community alcohol and drug counselling services in Auckland and the testing of the tool proper (*Potalanoa*) was

conducted with four services spread across New Zealand (Auckland, Hamilton, Porirua and Christchurch. The testing of *Potalanoa* involved two components: a first visit by the researchers which involved observing each service use *Potalanoa,* and a second visit (six months later) which examined the outcome of having used the tool. At both visits the research team collected the responses of each service provider through focus group interviews.

Findings

1) Phase I: Development and Design

The development of the preliminary tool involved seven areas that had 37 focus points. The areas were identified from literature and through extensive consultation with advisory board members and other key stakeholders.

Feedback from the pilot found the tool lengthy and repetitive. Therefore the tool was modified to 12 broad statements representing 12 areas. It was also aligned with the National Sector Standards. The 12 statements covered the following areas: client and family rights; organisational governance, policies and procedures supporting best practice; quality systems; staff support; client pre-entry and entry to treatment service; client assessment; treatment for client; exit, discharge or transfer; community participation; collaboration and liaison with other services and agencies; clients records; safe and appropriate physical environment.

2) Phase II: Testing of Potalanoa

In this phase of the study the tool's name, *Potalanoa,* had arisen and considered appropriate because it captured the idea of discussing issues with the intention of "coming up with solutions". The term is a Tongan term that means "a talk/conversation/dialogue/discussion/ sharing".

The services all generally found the evaluation to be understandable and acceptable. There was also general consensus that the incorporation of the evaluation process within existing team meetings was ideal. The involvement of all staff within a group setting was believed to be an essential aspect of the evaluation process. One site reported that the evaluation process helped them to identify "where there was a breakdown in the service and to look for ways of getting back on track through the action points".

Discussion/Conclusions

In this study the service providers reported that a tool that was simple, brief and easily recognisable as Pacific was the ideal self-evaluation tool. There also has to be buy-in by everyone in the organisation, not just management, as part of the process is acceptance that *quality* is the responsibility of everyone in the organisation. In this study it was found that the successful implementation and action of the self-evaluation tool involved the participation of every staff member. The role of a facilitator is important because the facilitator draws people into the discussion and sets the tone of the session.

For Pacific services, the interplay of cultural and clinical issues is complex. The idea of recognising Pacific-specific processes which are integrated with their clinical practices and capturing those nuances throughout the tool was an important issue

for Pacific services. The attractiveness of *Potalanoa* is that it gives the team members, as a collective, the space and opportunity to address these complexities without the pressure of external scrutiny.

The research team recognises that there were limitations in this study; for example, small sample size. However, notwithstanding these, the study has produced the first Pacific-specific service evaluation tool that has feasibility, acceptability and adaptability to settings delivering AOD services in New Zealand. The benefit of *Potalanoa* is that it provides Pacific AOD treatment services a framework for recognising the strength of their services and areas where improvement is required, with the opportunity to make changes where necessary.

The *Potalanoa* tool and manual can be accessed from the following website: http://www.crrc.co.nz/completed.php#padopt.

PRISMS OF ADDICTION - REFLECTIVE PRACTICE AMONGST UNDERGRADUATE STUDENTS STUDYING ADDICTIONS

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Reflective practice is a combination of cognitive and emotional experiences occurring in or outside the classroom while assimilating one's past knowledge and experiences[1]. This assimilation process is heavily influenced from the learner's personality, culture, political views, and social background[2]. Within the field of addiction studies, this process is pertinent for the ongoing pursuit of professional development. Lay and McGuire[3] (2008 p. 146) posited that exploring the stigma that is attached to addictive behaviour was key to "increase awareness of how personal experiences become storied in the context of broader cultural discourses". Therefore, this exploratory study is an attempt to explore the mentioned suppositions by asking students to engage in reflective practice.

Aim

- To explore reflective practice of undergraduate students who are studying a 'communities and addictions' paper as part of the health science degree.
- To explore the stigma of addictive behaviour within the students' discourse.
- To identify any evidence of emerging empathy.

Methods

There were 14 participants who volunteered to take part in the study out of a total 27 students. The sample comprised 12 women and two men between 20-46 years with a modal age of 21 years. The participants were from diverse ethnic backgrounds including European, Māori, Pacific Peoples and Asian. The students were instructed to write a 500 word reflective piece after they critically evaluated the disease model in a 2000 word essay.

Results

Five main themes emerged from the qualitative data and these themes are briefly described below:

Personal Theme

This theme described the integration of both classroom and personal experience to illustrate an empathic stance to suffering from an addiction.

> Having struggled for many years with binge eating and smoking two packets of cigarettes per day, I have some understanding of what it feels like to not be able to control one's behaviour. I can easily relate to the female AA speaker who said that she didn't 'get life or herself'

> and that addiction is a mental illness because I have felt like that for a large part of my life (female, 46 years old).

Cultural Theme

This theme described how one's cultural background influenced the assimilation of academic knowledge[2]. The quote below presents one student's view of the stigma of asking for help within a given culture.

> Within my own culture (Niuean), on the other hand, it does take some convincing and explaining to realise that AA is an option. It can be seen as shaming in some sense to have to go to these types of meetings and that it shows that one cannot handle things on their own and within their own family (female, 24 years old).

Moral Theme

This theme described how students can hold personal judgments about addictive behaviour. This statement suggests that this student was developing empathy as she challenged her old beliefs.

> Therefore, as my research for the essay went underway I began to see the limitations of the disease model. This in turn confronted my previous belief, and made me realise how quick I was to adopt a perspective that presented a quick ease to my mind. Thus, this assignment has given me a better understanding of alcoholism while also changing the approach to my dad's excessive drinking behaviour (female, 21 years old).

Spiritual Theme

This theme described how spiritual or religious beliefs can influence the reflective process, particularly when responding to the 12 steps approach to the disease model. Spirituality was often incorporated within a given culture.

> From a personal point of view, the 12 steps with emphasis on a greater power are easy for me to relate to as they are seen as a form of confession and prayer for forgiveness and strength. However, from such vague terms in the steps might create confusion among other believers or ethnic groups with different ways of making sense of a higher power and prayer' (female, 21 years old).

Academic Theme

This theme described how the students' reflective practice was an incentive to deeper learning.

> Not one model or treatment program that can be applied to every single addict (female, 21 years old).

<u>Discussion</u>

The findings in the study brought to light important points regarding reflective practice among undergraduate students studying addictions. The students'

commentaries supported Boud and colleagues' (1996)[1] model that reflective practice was the assimilation of affective and cognitive components. This assimilation illustrated revisiting of old information to formulate insight into a particular experience[2]. By doing so, the learning challenged the students' stigmatisation about addiction which also laid the foundation for developing empathy. Empathy has been known to be important for future professionals in the helping professions, especially addictions[3].

The themes that emerged as a pattern of the students' commentaries addressed important elements for a possible framework when teaching undergraduate students in the health sciences about addictive behaviour.

Conclusions and Future Directions

Overall, reflective practice has allowed the students to learn on a deeper level processing both academic and personal information. The themes provided a focus for future research in reflective practice within addiction studies. The findings also illuminated the way for the lecturer to reflect upon future lectures in addiction studies (e.g. empathic development, cultural issues in mainstream models, stigmatisation towards those suffering from an addiction).

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