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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 the inclusion of 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 represents a diverse array of topics relevant to addiction treatment, from seeking to understand the experiences and attitudes of women drinking in New Zealand, to specific treatment interventions and related technologies, to training evaluation.

In 2010 the ATRIG prize for best presentation by someone under the age of 35 years was awarded to Karen Faisandier, a PhD student with Massey University, for her presentation "From Insecure To Out-of-Control: What Does Attachment Have To Do With Problem Sex?", which is summarised in this Monograph.

When each of the papers included in this Monograph was presented at the Cutting Edge conference they would have attracted audiences of anywhere from 20 to 200 delegates (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 CANNABIS USE PROBLEMS IDENTIFICATION TEST (CUPIT): A MEASURE OF CURRENT AND DEVELOPING CANNABIS USE DISORDER AMONG ADOLESCENTS AND ADULTS

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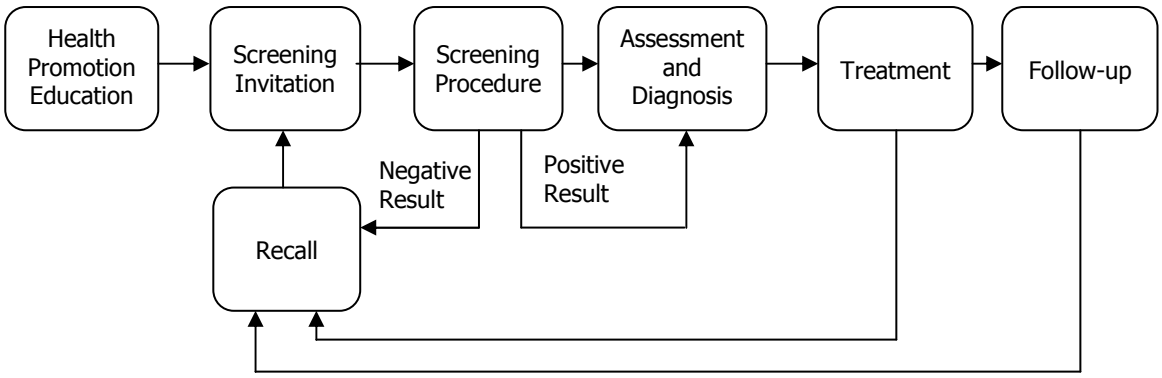
Introduction

Cannabis use and misuse are serious public health concerns worldwide[1]. Almost half of New Zealanders (46.4%) report lifetime use and one in seven past year use[2]. Significantly higher use (one in four) is reported among Māori[3]. Several concurrent developments signal an upsurge in cannabis use disorder (CUD); e.g. declining initiation age (<10 years) and prolonged initiation period beyond adolescence; increased potency; and dramatic growth in treatment-seeking for cannabis-related health, psychological, and social problems and harms[1,4,5]. Commonly reported are loss of memory, motivation, energy and well-being, psychological distress (anxiety and depression), physical health problems (respiratory, nausea, headaches, sleeping disturbances), strange thoughts, paranoia, lowered self-perception (self-esteem and confidence), and multiple social (relationship, familial, school, employment, financial, criminal/legal) problems[4]. Adolescents are significantly more likely than adults to develop dependence at a given dose[5,6]. Further, while early initiators and long-term, regular users are at greatest risk of dependent cannabis (and other drug) use, impaired mental health, delinquency, lower educational achievement, risky sexual and criminal behaviour, even *occasional* (weekly) adolescent use continued into young adulthood predicts later drug use and other problems[5]. The magnitude and potential societal ramifications of cannabis-related harms provide a mandate for opportunistic screening and early intervention (SEI) to avert or arrest progression of an incubating CUD by intervening *as early as possible* in its trajectory[6].

In the public health SEI model screening is a preliminary filtering process for identification of those with a possible problem and those at risk of developing a problem, not for diagnosis or assessment (see Fig. 1)[6]. Screening is especially relevant for generalist settings where detection of risky use is important, interventions typically brief, and referral likely[4]. SEI aims at reducing the number of future cannabis-dependent individuals by intervening as *early as possible* in the trajectory to dependence[10].

Figure 1: Public Health Model For Cannabis Use Problems: The Screening Pathway



Despite the ubiquity of cannabis use and harms, detection remains low. Most users with cannabis-related problems neither access/seek specialist treatment nor mention their cannabis use when presenting to their healthcare provider for other concerns[4]. With their high contact rates and other favourable characteristics, community-based primary health and social services are ideal sites for routine cannabis SEI among their clientele[4-6]. Fleming (2002) estimates busy practitioners will detect more than 80% of drug users if they limit their questions to cannabis[7].

Community-based cannabis screening opportunities abound. They include GPs, nurses, hospital wards, outpatients, accident and emergency centres (intoxicated, trauma, injury), psychiatrists, psychologists, youth counsellors, social workers, juvenile and adult justice, workplace, school and university counsellors[6]. The wide range of workers' roles, education, training, skills and experiences, demands an acceptable, reliable, efficient, rapid and easily-administered screening tool. Given the inefficiency of generic drug screens, and the various limitations of existing cannabis-specific screening tools[6,8], the CUPIT was developed to meet the need for a simple, brief cannabis screener suitable for use across diverse community settings to detect both currently problematic (case-finding) and *potentially* problematic (risky) use among typically heterogeneous users of all ages[9].

Method

The methodology for the development and validation of the CUPIT has been described in detail elsewhere (see Bashford et al. 2010)[9]. For the purposes of this paper a brief overview follows.

The CUPIT was systematically developed in a three-phase prospective design over five years. First, an item pool of 39 candidate questions was generated from a comprehensive literature review and international Expert Panel/s (N=20) survey consultation. The CUPIT internal structure and cross-sectional psychometric properties were then systematically tested among 212 adolescent (n=138) and adult (n=74) past-year users. Twelve months later, respondents' baseline CUPIT scores were evaluated for their longitudinal ability to predict respondents' diagnostic group membership.

Measurements

Participants first completed the CUPIT item pool alone. Clinical participants (n=40) provided urine samples. Shortly thereafter, individual in-person assessment interviews were conducted. The comprehensive assessment battery included several well-established measures of cannabis-related pathology for CUPIT validation, with DSM-IV/ICD-10 diagnoses of CUD as criterion standard. Twelve months later, participants were re-assessed on all baseline measures except the CUPIT.

Sample Characteristics

Participants aged 13-61 years were recruited from multiple community settings: specialist AOD treatment clinics, adult justice, juvenile justice, and alternative education programmes for at-risk youth, Māori health and social services, secondary school students, tertiary students and job-seekers, and the general population. Two-thirds (*n*=138) were ≤18 years, the median age was 16 years, 56% were male, and 30% reported Māori ancestry.

Respondents' baseline 12-month DSM-IV/ICD-10 diagnoses were 72% dependence, 19% abuse, and 68% both diagnoses. Twelve months later, larger sample (*n*=194) proportions qualified for a diagnosis (76% dependence, 17% abuse, 74% both diagnoses). At both assessment points, however, 86% did not believe they had a cannabis use problem[9].

Results

From 39 original candidate items, statistical analysis yielded a 16-item CUPIT with two dimensions representing dependence (impaired control) with 10 items, and abuse (problems) with six items. Comprehensive statistical analyses of the 16-item CUPIT revealed its excellent test-retest and internal consistency reliability, concurrent, criterion and discriminative validity. At follow-up the CUPIT's receiver operating characteristic (ROC) diagnostic performance demonstrated significant 12-month predictive capability. That is, baseline CUPIT scores performed well in distinguishing those who would qualify for a CUD diagnosis of cannabis dependence or abuse 12 months later from those who would not[9].

Discussion

The CUPIT is a highly acceptable, reliable and valid brief screener for use across community settings and consumers of all ages. Its novel capability is to reliably classify both currently diagnosable and potentially problematic cannabis use among users. These properties derive from the CUPIT's systematic development and longitudinal validation among typically diverse cannabis-using adolescents and adults in the community.

Requiring very little effort, the CUPIT offers busy practitioners a useful cannabis screener that is:

- tailored to cannabis (c/f. prototypical, or generic tools);
- empirically-constructed and longitudinally tested;
- local: specifically developed primarily for New Zealanders among typically diverse at-risk cannabis-using adolescents and adults;
- simple, brief, self or other-administered, universally and culturally-appropriate, adaptable;

- highly-acceptable across all ages, particularly to younger users;
- reliable (consistent) and valid (accurate) for identifying (current) and predicting (future) CUD;
- discriminates diagnostic groups (non-problematic, potentially and currently problematic);
- clinically relevant: the mixed adolescent/adult sample was drawn from both clinical and general populations for maximum generalisabilty[9];
- readily-accessible online to download for no cost at: http://ncpic.org.au/static/pdfs/updated-cupit-tool-may-2010.pdf

(For the interested reader, in-depth discussion of the CUPIT's psychometric properties and operational characteristics is found in Bashford et al. 2010[9], Bashford 2009[6].)

From the public health SEI perspective, individuals identified with diagnosable disorder, as well as those with early-stage (*pre*-clinical) problems or risky cannabis use, are primary target groups for an early/brief intervention[10]. While routine opportunistic screening among *all* adolescent, adult and preadolescent attendees in primary health care is recommended, special screening efforts should target several high-risk groups particularly vulnerable to the adverse effects of cannabis, including adolescents (<=12 years); persons presenting with respiratory, sleep, anger, relationship, cardiovascular issues; anxiety, depression, or psychiatric symptoms (psychosis, bipolar, suicidal behaviour); children with antisocial, behavioural, or learning problems; Māori; pregnant women; various disenfranchised groups such as juvenile and adult offenders, unemployed, homeless persons; diverse ethnic, and other culturally-diverse persons, e.g. gay/lesbian[6].

Users commonly do not recognise they have a problem with cannabis, have little interest in quitting, and are reluctant to discuss[4]. To help overcome denial, resistance, and ambivalence, and to engage younger users and generate motivation to change, cannabis use is best introduced and discussed in the context of a general health or 'lifestyle risks' interview and screening/assessment as a 'cannabis check-up' (*not* 'disorder detection')[4]. Alternatively, integration of assessment techniques into standard clinical practice can be implemented by computerised reminder systems for conducting cannabis screening and self-administered questionnaires completed in reception or triage[6]. The CUPIT should be scored immediately, and results fed back to the respondent to facilitate discussion about what their score suggests as a meaningful point on a cannabis problems scale. Appropriate procedures should then be promptly followed (e.g. initiate referral, brief intervention, further assessment) according to the practitioner's role, context, and scope of practice[4]. Recently developed comprehensive guidelines, resources, and training designed to assist community-based practitioners in detection and management of cannabis-related problems among their clientele are accessible online at http://ncpic.org.au[4].

Conclusion

Cannabis use is adversely impacting the health and social functioning of a large and rapidly expanding cohort of New Zealand's adults, adolescents and, alarmingly, children. As the CUPIT development sample exemplified, most are either unaware or feel that they do not need assistance. At first point of contact for health and other care, medical and social services consultations present a unique opportunity to

reduce the burden of harm associated with cannabis use. Routine opportunistic and targeted cannabis screening and early intervention may prevent transition to dependent use and more severe problems. Towards this desirable goal, with its rapid, reliable, efficient classification of a broad spectrum of cannabis-related problems, the CUPIT offers busy community-based practitioners an easily-administered tool to help them in their SEI efforts to reduce cannabis-related harms in the community.

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BRIEF INTERVENTIONS IN YOUNG PEOPLE – WHAT'S THE POINT?

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Introduction

In the 1960s Chafetz designed an effective alcohol and other drug (AOD) brief intervention (BI) for use in emergency Departments[1]. Since then, hundreds of BI studies have been conducted evaluating addiction treatment that seldom lasts more than 40 minutes. Meta-analysis of these studies has show that BIs not only lead to more people attending AOD treatment but can also decrease substance use and substance related harm[2]. The World Health Organisation's Alcohol Use Disorders Identification Test, or AUDIT, is a familiar starting point for conducting a brief intervention[3].

Brief interventions have been shown to be effective in adolescent populations[4], which is encouraging as teenagers, despite having high rates of substance use disorder, seldom seek help for their substance use. Young people do present, by their own choice or otherwise, at numerous other agencies such as Child Youth and Family (CYF), Child and Adolescent Mental Health Services (CAMHS) and school health services. Conducting BIs in these settings can help to identify those at risk and can increase the chance that they will attend treatment.

The Substances and Choices Scale (SACS) is a screening instrument that has been designed and tested in New Zealand and has good reliability and validity[5]. When researching the acceptability of the SACS, many of the participants reported liking it because it made them *"think a bit more about their substance use*". This feedback led to the development of the SACS brief intervention (SACSBI), a BI based on the SACS screening instrument. More information about the SACS and the SACSBI is available on the internet - see www.sacsinfo.com.

Brief Interventions In CAMHS

The Werry Centre has recently funded an evaluation (conducted by the Waitemata DHB Clinical Research and Resource Centre) of the utility and acceptability of the SACSBI for general and Hauora Māori CAMHS workers. Questionnaires, which included components of the Short Alcohol and Alcohol Problems Perception Questionnaire (SAAPPQ), were used to measure CAMHS workers' attitudes to AOD

work pre and post training. In general, CAMHS workers' attitudes towards providing AOD screening and brief interventions were largely positive and the training led to most participants feeling more able to provide AOD screening and brief interventions. In addition, focus groups were conducted, which affirmed that the skills CAMHS clinicians already had could be adapted to provide effective AOD interventions. More specifically, participants reported that they felt they could adapt the SACSBI to their own specific work situations and this flexibility of approach could comfortably accommodate the cultural needs of Māori youth. A six month follow up is planned with the original CAMHS cohort to establish whether attending the SACSBI workshop has had any longer term impact. This will look at attitudes to AOD work, actual screening and brief interventions in CAMHS, and referrals to appropriate services. In addition, the Werry Centre Workforce Development Team has embarked on 'Training of Trainers' in brief interventions with the aim to roll out further training in CAMHS across New Zealand.

Brief Interventions In CYF

'Fresh Start' is the name that the government has given to recent changes to the CYP&F Act. As a part of 'Fresh Start' CYF Justice agencies want to better identify levels of substance abuse amongst child and young offenders. They have decided to adopt the Substances and Choices Scale (SACS) as their primary AOD screening tool from 1 October 2010. Furthermore, they plan to train staff in the SACSBI to further support children and young people in their care. Matua Raki is piloting SACSBI training with CYF Justice workers and an evaluation of this training is currently underway.

Conclusions

Brief Interventions are an evidence based and effective way to minimise AOD related harm in at risk young people. The SACS is a screening instrument that is valid and acceptable to NZ young people. It is a useful starting point from which to conduct a BI. The SACS and SACSBI are both accessible on the internet. The Werry Centre and Matua Raki have trained 'trainers' to deliver a workshop teaching youth workers in CAMHS and CYF to deliver the SACSBI. CRRC is evaluating this training in CAMHS and has found that CAMHS workers are generally positive about it and feel that it is relevant to their practice. Furthermore, the SACSBI is acceptable within Hauora Māori setting. A follow up evaluation is planned. Matua Raki plans to roll out SACS training across CYF Justice workers nationally and there will be changes to policy and pathways in CYF to accompany this as part of 'Fresh Start'.

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CURRENT BENZODIAZEPINE USE IN PSYCHIATRY

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Various guidelines both in New Zealand and internationally from governments, medical colleges and research groups have been developed to support benzodiazepine prescribers[1-18.] Clinical experience with patients on benzodiazepines has led us to question whether they may be over-prescribed, prescribed inappropriately or not discontinued in concordance with guidelines.

A review of the literature revealed a paucity of New Zealand data regarding benzodiazepine use in psychiatry. International data on expert opinion and benzodiazepine prescribing patterns showed varying patterns of use. In some there was a tendency toward long-term low-dose benzodiazepine therapy[19,20,21], but another showed a small number of long-term users[22]. An international study of expert opinion found a perception that the risks associated with benzodiazepines are over stated[23]. Most benzodiazepine treatment was in concordance with evidence-based clinical guidelines; however these studies also indicate some practice contrary to guidelines.

Psychological complications associated with benzodiazepine use, including dependence, sedation, and rebound anxiety, are well recognised and repeatedly acknowledged in the literature[18,24,25]. The aim of the current investigation was to gauge clinical opinion about benzodiazepine prescribing by New Zealand psychiatrists and discover reasons for prescribing outside of guideline recommendations.

Method

A review of literature was conducted to understand the current clinical context for this research.

An online survey was designed to obtain a national perspective of prescribing and was emailed to all consultant psychiatrists in New Zealand through the Royal Australia and New Zealand College of Psychiatrists (RANZCP). One hundred and eleven responses were received from 440 recipients of the survey - a response rate of 25.2%.

Guided by the survey responses, benzodiazepine guidelines from eight authorities were chosen and reviewed for indications, dose and duration, suggested concomitant therapies and precautions mentioned.

In-depth interviews were conducted to gauge clinical opinion about benzodiazepine use and to compare the views of addiction psychiatrists with those in general psychiatry. In the region we knew of five psychiatric addiction specialists. All five were interviewed for this study. Local health board generalist consultants were chosen using random numbers and five of a total of 31 were interviewed.

Questions for the survey and the in-depth interviews were based on several research sub-topics outlined in Table 1.

Table 1: Sub-topics Forming The Basis Of Questions

1.	Which benzodiazepines within the class are used (and rationale for specific drug selection)?
2.	For what purpose/s are benzodiazepines used?
3.	Usual dose/durations of treatment with benzodiazepines.
4.	Nature of information given before Rx, at regular review and upon cessation of treatment with benzodiazepines.
5.	Clinical problems encountered with benzodiazepines: side effects, adverse reactions, dependency/addiction, tolerance.
6.	Alternatives to benzodiazepines.
7.	Perceptions of patients' experience with benzodiazepine therapy.

Results

Important findings from both the surveys and in-depth interviews were:

1. Ninety-one per cent of surveyed psychiatrists saw three or more indications for benzodiazepines most commonly for generalised anxiety disorder, acute manic/hypomanic episode of bi-polar disorder, acute psychoses and alcohol withdrawal. Six of the ten interviewees believed them to be prescribed too frequently in psychiatry. Sixty-four per cent of survey respondents thought benefits of benzodiazepines outweighed risks, and 24% thought risks outweighed benefits.

2. Lorazepam or Clonazepam were chosen as preferred benzodiazepine, with 61% and 60% of survey respondents choosing these respectively. Interviewees also expressed concern about whether the use of these was evidence based, or 'trendy.' "I think Clonazepam's taken over in the minds of most people that practise psychiatry in Wellington, for some reason…I don't necessarily think it's particularly better than any other long-acting alternative." – Interviewee 5.

3. Fifty-one per cent of survey respondents thought that limited availability of psychological treatments resulted in higher benzodiazepine prescribing rates than

are ideal. This was statistically significant (51.4% [CI = 41.68% - 60.95%] $p<0.001$).

4. Interview analysis showed a theme that treatment with benzodiazepines interfered with the efficacy of psychological treatments. Reasons given were because of the side-effects of sedation, decreased cognitive capacity and decreased ability to learn new skills. However, interviewees also recognised that overwhelming anxiety can be just as detrimental to one's capacity to learn. This belief was mirrored in the survey results with 56% believing benzodiazepines interfered with cognitive behaviour therapy.

5. Interviewees expressed concern that benzodiazepines were being initiated appropriately but not reviewed, resulting in long-term courses which are not indicated, especially during acute hospital admissions and possibly not weaned or reviewed before discharge. "I think it's a problem which often starts in acute psychiatric units, when the benzodiazepines are instigated for management of acute behavioural disturbance, and maintained thereafter without being weaned off once the acute behavioural disturbance has finished." – Interviewee 2.

6. Interviewees mostly agreed that short-term benzodiazepine use (not exceeding six weeks, with the upper limit varying from one week to six weeks) was acceptable. However, they also acknowledged that in some cases of severe mental illness, and after other treatments had failed, that there may be a role for long-term benzodiazepine treatment. The efficacy of this was debated however, with only one of the addiction specialists mentioning the long-term role of benzodiazepines, compared with four of the psychiatrists in other fields.

Discussion

Review of the guidelines listed in Table 2 showed variations in the indications for benzodiazepine use. Some recommended for short-term treatment, not longer than 2-4 weeks for GAD and insomnia[1,7,10,11]. Others state that they are not recommended in GAD[6] and are associated with less-favourable outcomes in panic disorder[10,11]. They are thought to have a place as an augmentative treatment while commencing antipsychotics, mood stabilisers or antidepressants in GAD, bipolar disorder, panic disorder, depression, and schizophrenia[1,3,8,9,11-13]. Some guidelines suggest there is a place for long-term treatment in severe, refractory GAD and panic disorder[11,18].

Table 2: Reviewed Guidelines For Benzodiazepine Prescribing

Best Practice [1,2]
RANZCP[3,4,5]
Guidelines for Assessing and Treating Anxiety Disorders [6]
Benzodiazepines – Use & Abuse: A Guide for Prescribers [7]
National Institute for Health and Clinical Excellence (NICE) [8,9,10]
Maudsley Prescribing Guidelines [11]
American Psychiatric Associated Practice Guidelines [12-17]
APA Task Force Report [18]

In several instances, the use of benzodiazepines described in our survey and interview analysis deviate from these guidelines. This could indicate that benzodiazepine prescribing practice in New Zealand is not sufficiently evidence-based, or it could show a perceived lack of relevance of the guidelines.

Some guidelines indicate that benzodiazepines can be used in the long-term in cases of severe disorders when other treatments have failed. Psychiatrists agree, with five of the interviewees believing there was a place for long-term benzodiazepines as a treatment for severe illness as a last resort. This finding is similar to that of international studies which have shown that off-label or long-term benzodiazepine use is common in psychiatry[20,26].

In both the comment boxes available in the survey and the interviewees' responses, there was evidence that psychiatrists feel long-term benzodiazepine treatment is not always a decision that is made clinically. Rather, it is a failing of prescribers to review medications adequately, or an over-generosity with them. Of particular concern to the interviewees was the initiation of benzodiazepines during acute psychiatric admissions which are not followed up and often continued unnecessarily after discharge.

Cognitive Behaviour Therapy (CBT) is a recommended first line treatment for anxiety disorders in New Zealand [1,6]. Fifty-six per cent of clinicians surveyed believe that benzodiazepine treatment can interfere with CBT, and all of the psychiatrists interviewed agreed that the effects benzodiazepines have on cognition and learning will make CBT less effective. There is evidence of this in the literature, with a review of comparison studies showing that CBT with a placebo results in greater efficacy after discontinuation of the drug than CBT with a benzodiazepine, and that PRN benzodiazepines may inhibit CBT[25].

It is pertinent to note that 51% (CI = 41.68% - 60.95%) of survey respondents believe that a limited availability of psychological treatments leads to higher rates of benzodiazepine prescribing than are ideal. CBT has been shown to have the same or higher treatment retention rates[25], and thought to have lower rates of relapse[1] than pharmacological treatments. This finding is of concern, as it implies a less-favourable outcome for patients. A North American study showed a similar finding, that access to psychological treatments was much lower than the observed requirement[27]. This is a difficult issue to address in the context of resource allocation.

Conclusion

Psychiatrists in New Zealand believe there is a role for benzodiazepines in psychiatry, with 64% of survey respondents believing the benefits of benzodiazepines outweighed risks. However, there are different opinions about what this role might be, with disagreement between different guidelines, and clinical practice deviating from these.

Areas of particular concern that we have identified are with unintended long-term benzodiazepine treatment and the low availability of CBT potentially resulting in higher benzodiazepine prescribing rates than are ideal.

This is an area which needs further study. It will always be difficult to manage the use of benzodiazepines in psychiatry, as evidence from studies and trials are not always representative of outcomes for individual patients, yet it is evident from these findings that concerns surrounding prescribing do exist.

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FROM INSECURE TO OUT-OF-CONTROL: WHAT DOES ATTACHMENT HAVE TO DO WITH PROBLEM SEX?

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'Problematic' sexual behaviour is frequently described using controversial terms and, while there is currently no united clinical conceptualisation, the term 'out-of-control sexual behaviour' (OOCSB) encompasses a range of possible presentations[1]. OOCSB involves sexual behaviour that causes functional impairment and/or distress, and includes behaviours such as compulsive partner or anonymous sex, compulsive masturbation or compulsive use of pornography; multiple ongoing relationships or affairs; exhibitionism, voyeurism, or other fetishes[*]; dangerous or illegal sexual practices; and anonymous, online or telephone sex[2]; and its prevalence has been estimated to be 3-6%[3].

Although the etiology of OOCSB is unknown, one increasingly proposed factor involves Bowlby's attachment theory[4]. Bowlby posited that personality formation, psychological well-being, and interpersonal capacity are each crucially impacted on by early care-giving experiences. Recent advances by both attachment researchers and neuroscientists have provided evidence for Bowlby's theory[5-7]. Research linking romantic attachment and OOCSB has increased internationally, and those with OOCSB have been found to have more insecure attachment than those without[8]. However, there is no New Zealand research in this area.

Therefore, the primary aim of the present study was to investigate romantic attachment and OOCSB in a New Zealand sample, and hypothesise that those with OOCSB would have higher insecure attachment than those without OOCSB. The present paper presents preliminary results from the study as data analysis was incomplete at the time of the conference poster presentation.

Methods

Participants were 889 New Zealand, English-speaking residents over the age of 18 who had computer and internet access and ability in order to complete the study's online survey. Of these, 268 were excluded because of missing data. This left a sample of 621 (386 men, 233 women, and 2 transgendered people) who were

* For the purposes of this research, paedophilia is not included as it is associated with unique etiological, assessment, and treatment considerations.[9-10]

mostly European (n = 521), heterosexual (n = 477), in a relationship ranging in duration from 1-10 years (n = 563) that included being married (n = 196), living with a partner (n = 170), and dating (n = 116), with a mean age of 35.68 years (SD = 12.68, range = 18-77).

The online survey included 136 questions comprising demographic information (gender, age, ethnicity, New Zealand residency, intimate relationship history, current relationship status, duration of longest relationship, sexual orientation, and substance use), a measure of OOCSB (Sexual Addiction Screening Test-Revised, SAST-R[11]), and two measures of romantic attachment (Relationship Scale Questionnaire, RSQ[12]; and the Experiences in Close Relationships-Revised, ECR-R[13]). Participants were grouped into those with and without OOCSB on the basis of a SAST-R core item score over 6[13], and the two attachment measures provided six attachment scores.

The study was granted Massey University Human Ethics approval (HEC Southern A, Application 10/09), and a national press release invited participants to visit the Sex Therapy New Zealand Ltd (STNZ) website which linked them to the study's information sheet on a Massey University webpage. Following this, volunteers could be directed to the questionnaire, and informed consent was implied if they chose to submit their responses. The data was analysed using the Statistical Package for the Social Sciences[14].

Preliminary Findings

A 2 x 2 between-groups multivariate analysis of variance was performed to investigate differences in the six attachment scores between men and women in the OOCSB and non-OOCSB groups. Results of evaluation of assumptions of normality, homogeneity of variance-covariance matrices, linearity, and multicollinearity were satisfactory. Table 1 shows the mean scores on the attachment measures for men and women between the OOCSB and non-OOCSB groups. There was a statistically significant difference between the OOCSB groups on the combined dependent variables, F (6, 610) = 18.48, p < .001, partial η^2= .154. There was also a statistically significant difference between men and women on the combined dependent variables, F(6, 610) = 6.05, p < .001, partial η^2= .056. While these main effects were significant, there was also a statistically significant interaction between the OOCSB groups and gender on the combined dependent variables, F (6, 610) = 5.27, p < .001, partial η^2= .049. The OOCSB group had lower secure attachment and higher insecure attachment scores, but this difference was greater for women than for men. These differences were significant despite the small effect sizes, indicating sufficient power to detect small effects. Further analyses are planned to examine group differences for the various attachment scores.

Conclusions

These preliminary findings support the study's hypothesis, in that those in the OOCSB group had higher mean insecure and lower secure adult attachment scores than those without OOCSB, although this effect was stronger for women than for men. These findings suggest that there are differences in adult attachment for those with OOCSB, but that these differences vary for men and women. Although the study is limited by the use of a non-representative sample and self-report bias, the results

suggest attachment as a promising area of research into OOCSB, and further research is planned to develop and evaluate an attachment-based treatment approach for OOCSB. Full data analysis is underway as part of the first author's Honour's research and it is hoped the full results will be published in due course.

Table 1: Mean Adult Attachment Scores According To OOCSB Group And Gender

Subscale	Gender	OOCSB Group		Non-OOCSB Group	
		M	SD	M	SD
RSQ					
Secure	Men	3.28	0.74	3.58	0.65
	Women	2.90	0.76	3.65	0.73
Fearful	Men	2.36	0.89	2.09	0.79
	Women	3.01	0.98	2.15	0.88
Preoccupied	Men	3.05	0.91	2.84	0.79
	Women	3.30	0.91	2.97	0.70
Dismissing	Men	3.10	0.84	3.02	0.89
	Women	3.37	0.89	2.99	0.75
ECR-R					
Avoidance	Men	3.42	1.23	2.80	1.16
	Women	3.66	1.30	2.66	1.26
Anxiety	Men	3.59	1.32	3.02	1.27
	Women	4.42	1.33	2.83	1.31

Note. ECR-R score range: 1-7. RSQ score range: 1-5.

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OUTCOME EVALUATION OF A COMMUNITY ALCOHOL AND OTHER DRUG INTERVENTION PROGRAMME FOR OFFENDERS SERVING COMMUNITY SENTENCES IN AUCKLAND, NEW ZEALAND

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Background And Introduction

The occurrence, nature and degree of offending behaviour are often linked with the use of alcohol and drugs by individuals, with considerable impact on psychosocial and physical harm to the individual, their families and the wider community. In 2006 the New Zealand Government drove an initiative, the *Effective Intervention Programme,* to address the links between alcohol and drug use and offending behaviour and to reduce substance related harm to the individual and to society. The initiative was later (2009) integrated as part of a wider government priority, the *Drivers of Crime* initiative, to address the underlying drivers of crime in order to divert individuals away from long-term patterns of offending[1].

As part of the initiative, the Community Alcohol & Drug Services in Auckland set up the Specialist AOD Offender Programme for alcohol and drug assessment and treatment. Clients were referred from the Northern Region Corrections and Northern Region Community Probation and Psychological Services (CPPS). Following assessment clients continued on to treatment by attending four motivational enhancement sessions within a group setting. At the end of the four week programme clients were given the option to remain engaged in treatment as either group or one-to-one, or to discharge from treatment.

The aim of this study was to follow up the cohort of clients directed to the Specialist AOD Offender Programme via CPPS and to assess whether self-reported substance use, impact of use and recidivism changed over six months.

Methods

All referrals by CPPS to the Specialist Offender Treatment Programme, between May and December 2009, who were considered by the CADS alcohol and drug clinicians as being suitable for the programme were invited to participate in a self-reported outcome evaluation. The cohort completed the Alcohol and Drug Outcome Measure (ADOM)[2,3] at treatment entry and three and six months post-programme. The 3 and 6 monthly follow up contacts were conducted by phone. Clients answered questions about treatment and its impact on criminal behaviour and their health at follow-up. Clinicians and researchers were asked about their views on using the ADOM to evaluate client outcomes in practice.

Findings/Discussion

Between May and December 2009, 1715 referrals were made by CPPS to the Specialist AOD Offender Programme. Data for 278 clients consenting to follow-up were available at entry; 96 completed three month and 53 six month follow-up. Post-programme three month analysis (n=96) showed a significant reduction in alcohol and cannabis use. Physical health interference on daily functioning improved at three months and psychological health improved at six months. At both assessments most clients reported the programme had helped them reduce offending and were motivated to continue addressing their substance use. Enabling clients to address their AOD problems empowered them to address other health and psychosocial issues.

Clinicians reported on the clinical utility of the ADOM in day-to-day practice. They reported that it was straightforward and brief to administer and an effective therapeutic tool facilitating clinical practice through recording change in client substance use and impact of use over time. The ADOM served as a template to focus clinical discussion on behaviour change and recovery.

The primary aim of this study was to evaluate the effectiveness of the Specialist AOD Offender Programme through assessing whether self-reported substance use, impact of use and recidivism changed over six months. The findings suggest that the Specialist Offender Treatment Programme enabled clients to make changes in their use of substances as well as in their physical and psychosocial well-being. The study also suggested that the ADOM can be used successfully within usual day-to-day clinical practise. This pilot furthered the validation of the ADOM within a cohort of clients referred to treatment by CPPS. Further field testing of the ADOM within different AOD treatment settings and treatment modalities is recommended.

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AN EVALUATION OF KINA TRUST LIVING WELL WORKSHOPS

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The Kina Trust views addictions as family and community issues and promotes Family Inclusive Practice (FIP) through advocacy, service development, developing and distributing resources and providing training and supervision to the workforce. *Living Well* is a resource developed by Kina Trust to promote the health and well-being of families and friends affected by a loved one's alcohol and other drug use. This work is based on the 'Stress Coping Model', a primary health model developed in the United Kingdom. The approach has been demonstrated to mitigate the effects of stress and the increased rates of psychological and physical symptoms experienced by people with family alcohol and drug issues (1). This paper addresses *Living Well,* FIP training for people working in primary care, developed and run by Kina Trust.

Aim

To evaluate the *Living Well* workshops to inform the Kina training strategy in utilising this resource.

The overall aims of the evaluation were to determine:

- Participants' reactions to the training.
- How the training workshops increased training participants' capacity to work with family members.
- Issues experienced by workshop participants using the *Living Well* approach in working with families in primary care settings.

Methods

During October and November 2009, Kina Trust delivered seven *Living Well* training workshops. The training was attended by a range of professionals predominantly from non-alcohol and other drug specialist settings and working in a range of primary care settings.

The objectives of the training were to provide workshop participants with an understanding of:

1. Family addiction issues.
2. The continuum of alcohol and other drug use.
3. The Stages of Change model.
4. How to apply the *Living Well* model in their service.
5. Family risk and resilience.
6. Accessing other services.

Evaluation activities included an immediate post training survey, focus groups and an online three-month follow-up survey. The evaluation was undertaken by Kina Trust staff and reported by Martin Dawe, Health & Safety Developments. The evaluation methodology was relatively cost-effective and provides a sound basis for any further development and evaluation.

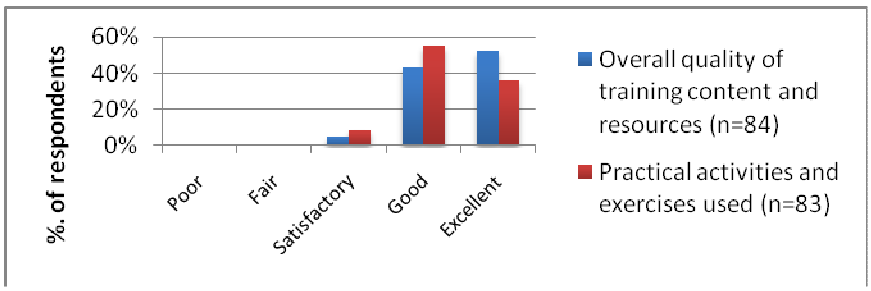
Immediate Post Training Survey Results

Data from 84 workshop participants were gathered at the completion of the seven sessions. Of the 84 participants completing the feedback form, 75 (89%) stated a professional role. Most stated the 'other' category (30, 36%) followed by social worker (15, 18%), nurse (12, 14%) and general counsellor (7, 8%). An additional three (4%) were AOD counsellors, a small number, which is to be expected as the workshops were not targeted at this particular group.

Quality Of The Training

All respondents rated the quality of the training content and resources as satisfactory or better, with 95% rating the quality as good or excellent. Similarly, all respondents rated the learning activities used in the training as satisfactory or better, with 92% rating the learning activities as good or excellent. These results are shown in Chart 1 below.

Chart 1: Perceived Quality Of Training (2 items)



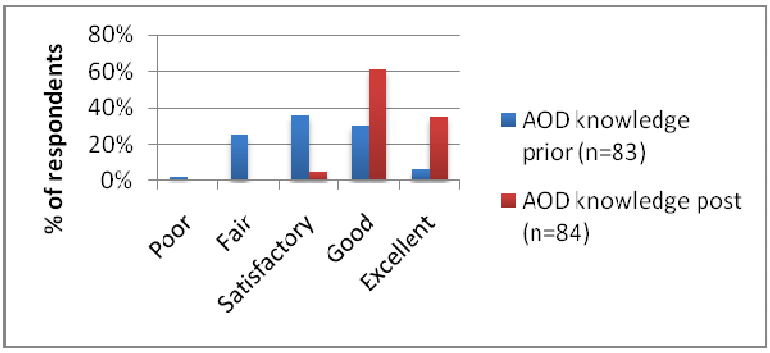
Perceived Knowledge And Skills Prior To And Post Training

Respondents were asked to rate their knowledge and ability on key items relevant to the training objectives immediately post training, with some items asking for perceptions comparing knowledge and abilities prior to training and post training. Results are outlined below.

Knowledge About Alcohol And Other Drug Concerns And Families

Prior to the training 30% of respondents rated their knowledge as poor or fair, with a further 36% rating their knowledge as satisfactory, 30% as good and 6% as excellent. After the training all participants rated their knowledge as satisfactory or better with 95% rating their knowledge as good or excellent. This represents a substantial gain in perceived knowledge. These results are shown in Chart 2 below.

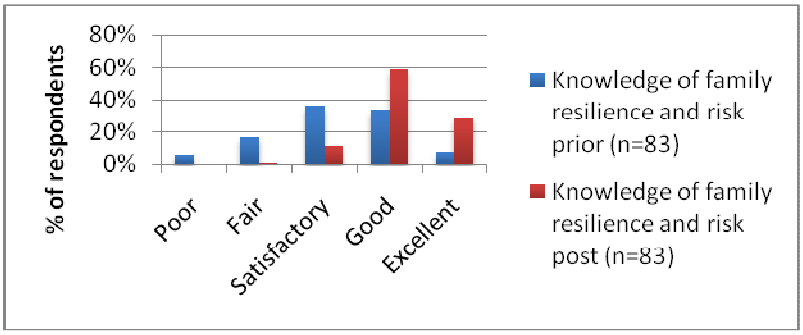
Chart 2: Change In Perceived Knowledge About Alcohol and Other Drug (AOD) Concerns And Families Pre And Post Training



Knowledge Of Family Resilience And Risk

Results indicate that respondent self-ratings of knowledge of family resilience and risk increased substantially after the training. For example, 23% of respondents rated their knowledge as fair or poor prior to the training and only 1% rated their knowledge as fair or poor after the training. Those rating their knowledge as good or better increased from 41% prior to the training to 89% after the training. These results are outlined in Chart 3 below.

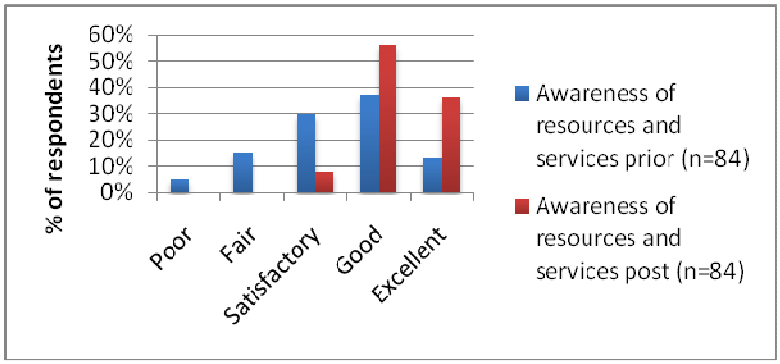
Chart 3: Change In Perceived Knowledge Of Family Resilience And Risk Pre And Post Training



Awareness Of Resources And Services To Support Families

Results indicate that respondent self-ratings of awareness of resources and services increased substantially as a result of participating in the training. After the training all respondents rated their awareness as satisfactory or better, with 92% (compared with 50% before the training) rating their awareness as good or excellent. Results are shown in Chart 4 below.

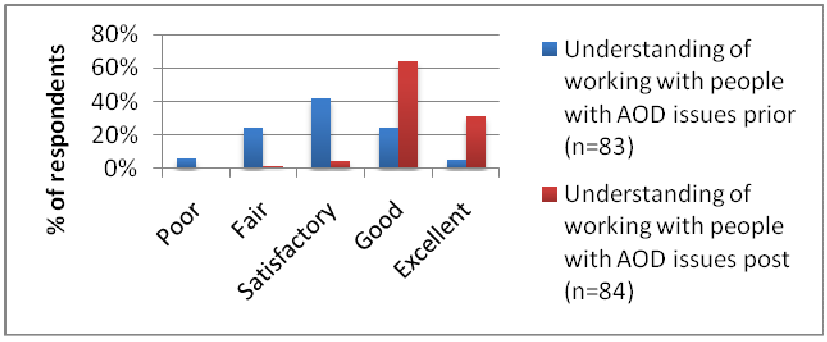
Chart 4: Change In Awareness Of Resources And Services To Support Families Concerned About Alcohol And Other Drug Issues Pre And Post Training



Understanding Of Ways To Work With People Experiencing Alcohol And Drug Issues In Their Families

Prior to the training 30% of respondents rated their knowledge as poor or fair, with a further 42% rating their knowledge as satisfactory, 24% as good and 5% as excellent. After the training 99% of respondents rated their knowledge as satisfactory or better, with 95% rating their knowledge as good or excellent. This represents a substantial gain in understanding of ways to work with people experiencing alcohol and drug issues in their families. These results are shown in Chart 5 below.

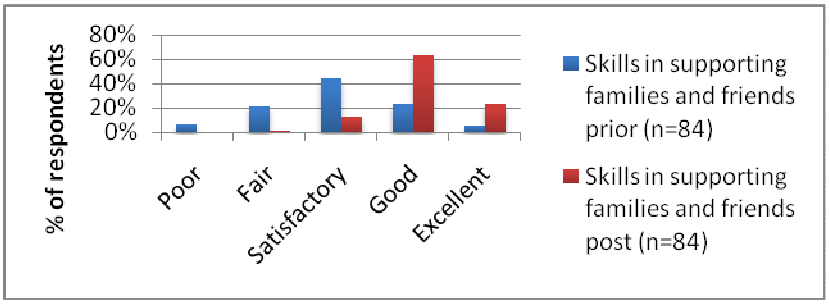
Chart 5: Change In Perceived Understanding Of Ways To Work With People Experiencing Alcohol And Drug Issues In Their Families Pre And Post Training



Skills In Supporting The Families And Friends Of People With Alcohol And Drug Issues

Results indicate that respondent self-ratings of their skills in supporting families improved as a result of participating in the training. After the training 99% rated their skills as satisfactory or better, with 86% (compared with 28% before the training) rating their skills as good or excellent. Results are shown in Chart 6 below.

Chart 6: Change In Perceived Skills In Supporting The Families And Friends Of People Experiencing Alcohol And Drug Issues Pre And Post Training



The respondent self-ratings indicate substantial gains in all key learning areas. Training improvement suggestions provided by participants were relatively minor and include developing a training DVD and/or a train the trainer approach. Participants noted that they planned a range of ways of applying the training and using the resources in their practice settings.

Focus Group Results

Focus groups were carried out with selected participants of the workshops in four locations in February 2010. The focus group results indicate that the training was useful in equipping participants to intervene in alcohol and other drug related family issues and that the resource is applied in a range of contexts.

Participants noted that key barriers or challenges to using the training and resources include the cost of the *Living Well* booklet, organisational issues (e.g. lack of support) and lack of local services to support families.

A number of suggestions for improving the training, resources, and provision of on-going support were made for further consideration by Kina Trust, including provision of refresher courses, access to advice, further resources and more training. Some of these barriers and challenges could be relatively easily addressed by Kina Trust, while others would require a more intensive approach of combining the training with active organisational support.

3-Month Post Training Follow-up On-line Survey Results

All workshop participants were invited to complete an on-line follow-up survey approximately four months after completing the training. Twenty one participants responded by the survey cut-off date of 21 April 2010 (i.e. approximately a 25% response rate). The small number of respondents is a limitation to drawing more definitive conclusions from these data. However, if further workshops are evaluated in a similar manner, then firmer results could be obtained as overall respondent numbers are increased.

Responses show that participants perceived that they have gained substantially in terms of knowledge, skill and confidence in working with families with alcohol and other drug issues. Results were consistent with the immediate post training survey and the focus groups.

Approximately half of the respondents had been able to integrate the workshop learning into their practice and a further 25% had integrated the learning in a limited way. This provides a benchmark for any future training expectations with this type of workforce.

Key barriers to integrating the learning were identified as time pressures and cost of the *Living Well* resource, while just over 40% indicated that there were no barriers.

Results also highlight that almost all workshop participants who responded to the on-line survey had experienced benefits of the *Living Well* approach; in particular, the ability to provide information to families and general improvement in their practice with families.

Considerations For The Future

The results suggest that the *Living Well* training and resources warrant further implementation. To achieve this, it is suggested that further investment is required including:

- Funding of further *Living Well* training with the provision of *Living Well* booklets.
- Funding to support the reduction or elimination of the cost of the booklets to facilitate distribution and implementation of the approach.

Participants suggested that the provision of a refresher course and access to advice/support when issues arise were two key ways for Kina Trust to further support participants' integration of the *Living Well* approach. Prioritisation and funding for these and other suggestions could be explored by Kina Trust as a means of building on the positive results achieved thus far.

The piloting of training combined with structured organisational support of participants to integrate the *Living Well* model is warranted to determine if contextual and organisational barriers or challenges could be more effectively overcome.

Continued evaluation of the training and use of the *Living Well* model is recommended to further determine the effectiveness of the approach. At a minimum, the evaluation developed should be continued, but consideration could be given to additional methods such as interviews with families and whānau, managers and supervisors and direct observation of practice. This would better measure changes in actual practice and the benefits of such changes.

<u>Conclusions</u>

Participants were overwhelmingly positive towards the training and indicated substantive gains in all key learning areas, including participants' perceived capacity to work with family members regarding alcohol and other drug issues. Overall, the evaluation indicates that people working in a range of non-alcohol and other drug specialist services/settings found that the *Living Well* approach is an accessible model and is generally able to be integrated into practice. The results suggest that the *Living Well* training and resources warrant further implementation.

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TEXT REMINDERS IN AN OUTPATIENT AOD SERVICE: ONE WAY TO REDUCE NON-ATTENDANCE

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The 'did not attend' (DNA) rate across the Taranaki AOD service varies from 30-50% and accounts for a significant amount of down time. During the last year there has been increasing demand for appointments and this has resulted in increased waiting times for appointments. Reasons for non-attendance to outpatient appointments which have been identified include forgetfulness, mix up over dates and times, and practice errors[1-4].

Sexual health[5], primary care[2], genitourinary[6], ophthalmology[3], ENT[4] and health promotion[1] outpatient clinics previously have trialled text messaging to remind clients of their appointments. This has, in general, resulted in improved attendance rates and thus reduced DNA rates.

Other benefits of reducing DNA rates have been reduced waiting times, improved continuity of care, and improved cost effectiveness of service delivery[1-4,7].

In order to address the high DNA rate at the Taranaki AOD service a trial of sending text messages to remind clients of their appointment that day was introduced.

Method

The Taranaki AOD service provides outpatient clinics run from the hospital as well as outreach clinics across the province. The service is staffed by case managers, counsellors, doctors and nurses, all of whom run clinics. Eighty-seven percent of all clients enrolled in the Taranaki AOD service have a cell phone number registered with the service.

From October 2009, the receptionist of the doctor's clinic sent text message appointment reminders to all clients booked on that day who had current cellphone numbers recorded in either the patient file or electronic file. The text message reminded the client that they had an appointment that day. Similarly, from November 2009 text messages were sent to one of the counsellor's clients reminding them of their appointment. Clients from these two clinicians comprised 39% of the total number of clients of the Taranaki AOD service. Both clinicians were selected to participate in the trial as their clinics were up to date and booked on the Taranaki electronic booking system.

Both counsellor and doctor data were pooled together. The total DNA rate for these two clinicians for the period from October 2009 to July 2010 was compared with the

DNA rate for the same doctor and counsellor for the 12 month period prior to the commencement of the trial. Chi-square was used to test for significance.

Results

Table 1: Appointments Attended And Not Attended Before And After Introduction Of Text Reminders

	Attenders	Non-Attenders
Before text reminder	866	585
After text reminders	778	320

Before the introduction of text reminders 40.3% of clients did not attend their appointment (585/1451), whereas after the introduction of text reminders 29.1% of clients did not attend their appointment (320/1098). A chi-square analysis of the difference between before-text reminders and after-text reminders was significant, $\chi 2(1, N=2549)=34.1$, $p<0.001$.

Discussion

During the time when text reminders were sent out to 87% of the Taranaki AOD service clients the DNA rate was reduced significantly compared to the previous year when such reminders were not sent. This is consistent with the findings of previous studies which used text reminders. Also consistent with previous findings is the waiting time for appointments. The waiting time for the medical officer, for example, has halved from four weeks to two weeks. As highlighted by previous authors[1-4,7], for the Taranaki AOD service, this also resulted in more effective and efficient use of clinical services and was cost effective.

During the pilot, feedback from patients who received reminders was positive and those who were not sure of their appointment time would ring to confirm their time. Another unforeseen positive consequence of the trial was that patients would update their details so that they would also receive a text reminder when their appointment was due.

This study has a number of limitations. Firstly, at the outset of the study not all clients had a cellphone number recorded (87% had a valid cellphone number recorded), so not all clients were able to receive a text reminder. In addition, some clients did not receive their text message until later in the day either because there was a delay in the text getting through or their phones were switched off. This reduced exposure rate may have negatively impacted the findings of the study. However, given the significant association found in this study, it is predicted that a greater exposure rate to text reminders would have resulted in an even greater association between these and appointment attendance.

Overall it is recommended that all clients within the Taranaki AOD service be sent text reminders of their appointments for that day. This would result in less clinician down time and help contribute to reducing waiting times for clients to be seen.

Future possibilities are to link the use of client appointment reminders to the electronic file so that they are sent automatically on the day of the appointment and to also send a reminder the day before the appointment.

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YOUNG WOMEN: SOCIALISING AND ALCOHOL

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The Alcohol Advisory Council of New Zealand (ALAC) wanted to better understand the places where young women drink alcohol and any associations that they have with those places. In mid-2009, ALAC commissioned Empathy to undertake qualitative work to explore:

- Where young women drink, particularly when they drink with friends, and the reasons they drink at different locations.
- Who young women choose to drink with, and why they drink with those people.
- What associations young women have with different socialisation points, or locations, and why they have those associations.

Methods

A suite of innovative qualitative research activities, summarised in Table 1, were undertaken. Nine women between the ages of 18 to 30 were recruited as the core participants for the project. Other participants were involved at various stages through the different research activities, recruited through the core participants. The overall group involved more than 30 participants covering a range of age, locations, relationship status, income levels and ethnicities.

Table 1: Summary Of Research Activities And Participants

Research activity	*Participants and description*
Two discussion panels	Core participants
Nine participatory research workshops	Each core participant with three to five of their friends
Txt or pxt your whereabouts initiative	Each core participant with three to five of their friends
Seven rapid ethnography: Behavioural observations	Each core participant with three to ten of their friends
15 rapid ethnography: 'Fly on the wall' observations	Public observations
7 short impromptu video interviews	Additional participants with no known connection to the core participants
4 'fly on the wall' Facebook observations	Four core participants and their 'friends'

Findings

The research revealed information on why young women socialise with alcohol, where they socialise with alcohol, emotional connections to those places and the role that alcohol plays.

Why Young Women Socialise With Alcohol

The young women expressed a range of motivations to socialise and drink alcohol. We propose that this range of motivations is captured by seven key 'social motivations' (see Table 2).

Table 2: Alcohol-related Social Motivations

Social motivation	*Description*
Let loose	Let go and have some fun. Be uninhibited. Dance, sing, go wild
Catch-up	Chat about life, love and the latest or next events
Network	Connect with a wider circle or make new contacts
Celebrate	Mark a special occasion or milestone. Birthdays, engagements, successes
Do something nice	Step above the usual. Do something special
Clock-off	Signify the end of the working week. Transition
Hang-out	Chill-out, relax, unwind

Where Young Women Socialise With Alcohol

The young women are socialising in many different places. In some of those places, alcohol is usually consumed, in some it is often consumed, and in others it is rarely consumed. Each of the locations where participants were likely to drink alcohol while socialising were investigated.

Empathy worked with the panel and focus group participants to identify the various places and situations in which young women drink, to understand why they drink there and the emotional connections that were at play. The characteristics of each were analysed in order to draw out themes and create groupings. By examining the similarities and differences in how our participants felt about the various places, 10 key 'socialisation points' are proposed (see Table 3). In addition, it appears that the different locations are associated with different social motivations or reasons for socialising.

Emotional Connections And The Role Of Alcohol

The reasons why the young women chose the locations that they did were also examined. Empathy worked with the participants to understand their feelings associated with each place.

It appears that 'emotional connections' exist in the minds of the young women between the different social motivations and various locations. That is, the young

women associate each place in which they socialise and drink alcohol with particular reasons that they have for socialising.

Table 3: Where Young Women Socialise With Alcohol

Location	*Description*
Cafes	A relaxing place where you catch up with one or two friends over a food or coffee.
Restaurants	A more formal place for birthday dinners and sets of couples.
Pubs	Rowdy places with pokies, pool tables, and the smell of beer and men.
Bars	A more sophisticated place, where you go to have a nice drink and some nibbles.
Clubs	Somewhere with great music, where you can let loose and get your groove on with friends.
Someone's house	Good company in a relaxed, unpretentious environment.
Someone's garage	A low-effort, chilled-out place with old couches.
Someone's car	An easy, intimate place to hang out with your inner circle.
Public outdoor spaces	Where everyone is allowed and welcome for free fun in the fresh air.
Work	You don't want to seem stiff, but you don't want to get out of control.

We propose alcohol plays one of three roles in those emotional connections:
1. Initiation
2. Maintenance
3. Enhancement

For some locations, alcohol *initiates* the emotional connection. That means that alcohol is the key factor in making the emotional connection possible between the social motivation and the socialisation point.

For some locations, alcohol *enhances* the emotional connection with the social motivation. This means that while drinking alcohol is not crucial for making the emotional connection possible between the social motivation and the socialisation point, it enhances it. Because of this the emotional connection is also enhanced.

For some locations, alcohol *maintains* the emotional connection with the social motivation. Like the last role, drinking alcohol is not crucial to making the emotional connection possible between the social motivation and the socialisation point. However, unlike the previous role, it is just one of many factors at play and does not increase the level to which the emotional connection is satisfied.
The role of the emotional connection varied according to location and social motivation. The young women were usually not actively aware of the emotional connections that drove their choices.

Other Insights

The range of research techniques allowed for other insights to be uncovered. These include:

When a drink is not a drink

We found that when the young women talked about 'drinking', they meant a session of heavy drinking. A glass of wine with food did not count as 'drinking' in the minds of the young women.

The drivers of front-loading

For the young women front loading, or drinking at home before going out, was not just about cheap drinks. It was about having control over the environment, and getting into the right head-space before going out.

Alcohol and face-to-face networking

Social networking websites are hugely popular, but face-to-face interactions were highly valued by the young women. We found that the convention for the young women was one drink per person, per conversation.

Behaviour and venue are connected

The young women choose a place to go based on the way they wanted to feel. The venue then dictates behaviour.

<u>Conclusions</u>

The research suggests that the young women have established strong emotional connections between each social motivation and the various satisfying locations. These emotional connections help them to decide where they feel like going, or whether they feel like accepting an invitation to a particular place. They are usually not actively aware of the emotional connections that are associated with their choices.

These emotional connections appear to be associated with the many varied locations that are chosen for satisfying each social motivation. So, for example, the same things that enable women to let loose and go crazy in a dance club are the things that enable women to let loose and go crazy at home.

Alcohol, however, plays an important role in satisfying each of the social motivations and in the role of the emotional connections. Depending on the location, alcohol might initiate, maintain or enhance the emotional connections.

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