



# **National Addiction Centre**

**(Aotearoa New Zealand)**

# **ORIENTATION TO THE ADDICTION TREATMENT FIELD AOTEAROA NEW ZEALAND**

**Matua Raki**

National Addiction Treatment Workforce Development

This manual is a collaboration between the National Addiction Centre, University of Otago, Christchurch, and Matua Raki National Addiction Treatment Workforce Development Programme



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# 1.0 INTRODUCTION

This orientation document aims to provide an overview of key information for the national addiction treatment sector of Aotearoa New Zealand and briefly covers a wide range of relevant topics and issues. It does not aim to be comprehensive and should be viewed as being complementary to local initiatives in orientating new staff to the sector both at an individual service level but also at a national level.

It has been written primarily for people who have fairly recently joined the sector (ie within the last six months), but is also highly relevant for those who are on the brink of joining the sector. Thirdly it provides a range of practical information for colleagues working in mental health services, who want more information about the addiction sector.

## *1.1 Acknowledgment*

The material below has been assembled by staff of the National Addiction Centre (NAC) – Doug Sellman, Fraser Todd, Daryle Deering, Simon Adamson - with input from Ian MacEwan (DAPAANZ) and Terry Huriwai (Matua Raki) as well as Pacific consultation with Phil Siataga, (Waipuna Trust). This material represents an orientation to the national addiction treatment sector as basically seen through the eyes of the National Addiction Centre and therefore is likely to have certain biases to it. The key values of the National Addiction Centre will feature in this bias. There are three key values as follows: a focus on people rather than ideas; to be guided by the best scientific information available; and to be proactive about social and historical justice by acknowledging the Treaty of Waitangi as the founding document of Aotearoa New Zealand. While much of the information below is common addiction related knowledge, there is a considerable amount of content in this orientation package that draws heavily on the teaching materials of the NAC which include workshops, undergraduate and postgraduate courses. The NAC is making this information freely available to the national field in order to support practitioners in their quest to more effectively assist tangata whaiora.

## *1.2 Why is national orientation material needed?*

The addiction treatment sector has grown considerably over the past thirty years. In the 1970s the sector was largely an alcohol-only one with focus on residential treatment based on a 12 Step model and little consideration given to culture. Since that time, there has been a broadening out in terms of the drugs being considered, especially cannabis, opioids, benzodiazepines and, more recently, stimulants. Opioid substitution treatment began in New Zealand in the late 1970s through the pioneering work of Drs Fraser MacDonald and John Dobson. In to the 1980s there was an increasing focus on additional psychiatric and medical problems that people with addictions presented with, which continues to be a challenge to the sector to this day. The increasing breadth of problems that people present with has been further broadened in recent years by the identification of behavioural addictions, beginning with pathological gambling and including compulsive overeating, as well as the beginning of serious consideration of nicotine dependence as a legitimate area for the addiction treatment sector to be concerned with. Added to this breadth of presenting problems presenting have been the continuing development of treatment and services over the past 30 years or so, with a shift from residential to outpatient

treatment along with daypatient options. The Māori renaissance began a little earlier in addiction treatment than in other health sectors, but continues to be a challenge for many workers in the field. Further, the dominance of a strictly abstinence-based approach based on the 12 Step model has been added to by a more flexible and pragmatic harm reduction (harm minimisation) approach and the development of other psychological modes of intervention, notably cognitive behavioural therapy and motivational interviewing. Most recently, there has been a significant development in pharmacotherapy with the appearance of new anticraving agents, beginning with naltrexone. Finally there have been significant organisational developments that have occurred in more recent years in terms of key services, policy/funding organisations, academic units, as well as various regional and national meetings and conferences as will be detailed below.

A major problem that arises with this plethora of developments is a wide variety of treatment philosophy and approaches within the field and patchy uptake of new knowledge about addiction, as well as knowledge about developments in the sector. The average treatment worker may find it hard to keep up to date with developments and thus can miss out on feeling a sense of consistency and collegiality with national colleagues, which impacts on new workers joining the field. Joining the addiction treatment sector is at present a somewhat random process and it can take many years for new workers to get to know and understand key concepts and basic organisational structures of the field. Hopefully this orientation material will help speed that process up.

# 2.0 ADDICTION

The NAC in conjunction with the National Committee for Addiction Treatment (NCAT), the voice of the addiction treatment sector, has previously worked on a definition of addiction in terms of services, which takes into account the increasing breadth of the sector. Here it is:

*"Addiction treatment services are those that assist people and their families affected by a range of disorders, described in the DSM-IV, including the substance use disorders, pathological gambling as well as other impulse control disorders increasingly being referred to as "behavioural addictions". The term "addiction treatment" is used to include a broad range of interventions for the presence of established disorders, as well as the presence of problematic substance use or problematic engagement in the relevant behaviours, which may precede the development of the specific disorders."*

From this definition it can be seen that addiction treatment services are not only aiming to provide assistance for people with established addiction but also for people who are in the early stages of developing an addiction.

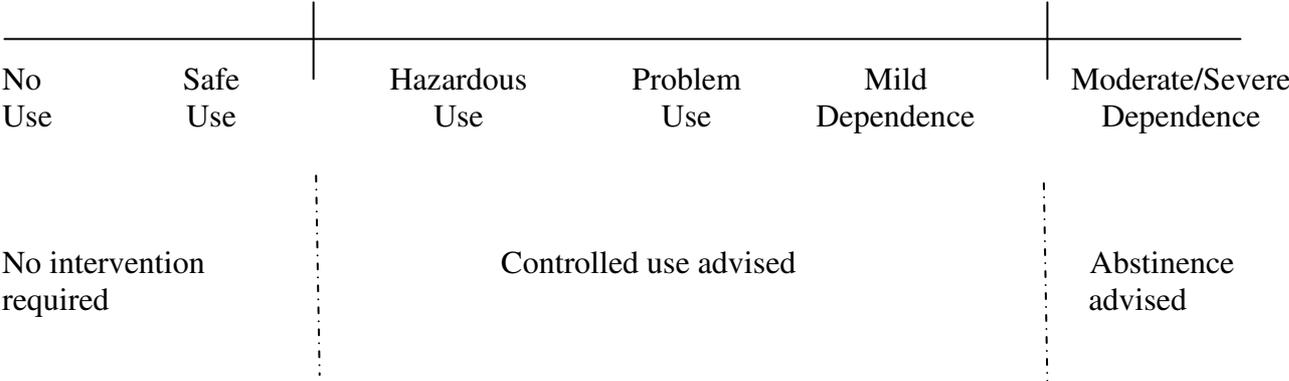
But what is addiction? Read on.

## 2.1 Drug use continuum

Alcohol use is traditionally conceptualised as occurring on a continuum of use from no use through to severe dependence. A similar approach is also useful for other substances of misuse as well as adapted for compulsive behavioural disorders such as problem gambling and compulsive overeating.

Such a continuum is useful in that different levels of intervention can be broadly applied to the degree of use problems and assessment strategies have been developed to identify the level of intervention needed, at least for alcohol use.

The diagram below outlines this continuum and the treatment advice that is appropriate at the various points along the continuum.



## 2.2 *Hazardous use*

Use which, while not causing current problems, is at a level of use that is likely to cause problems in the future. For alcohol, safe levels of alcohol consumption above which harm is likely to occur have been defined by the Alcohol Advisory Council of New Zealand (ALAC):

- Males – 21 standard drinks per week, no more than six standard drinks on any one occasion, at least two alcohol free day per week.
- Females – 14 standard drinks per week, no more than four standard drinks on any one occasion, at least two alcohol free day per week

A number of “exceptions to the rule” of standard drinks per week/occasion (men 21/6, women 14/4) are as follows: being pregnant, thin, young or old; having a positive family history of alcohol problems or other drug history; driving, operating other heavy machinery or swimming; and having significant medical problems or psychiatric problems.

NB: A recent Australian government discussion document based on a comprehensive review of the scientific literature has recently identified “low-risk” drinking as no more than two standard drinks on any given day for both men and women. These figures are likely to influence a review of the ALAC drinking guidelines.

In New Zealand a “standard drink” is defined as 10 grams of pure alcohol (12.7mls by volume), while in other countries a standard drink varies from 8 to 20 grams. Unlike Australia, New Zealand law does not require that alcoholic beverages state the number of standard drinks per bottle/can on the label. The alcoholic strength of a beverage is given by volume, not weight, so that it is the figure of 12.7mls per standard drink that must be used to calculate the number of standard drinks consumed. Given the range in size and strength of alcoholic beverages on sale it can be difficult to accurately estimate the amount consumed in standard drinks. As a guide however:

*Beer:* a 335ml can of 4% beer contains 13.4mls of alcohol and is usually counted as one standard drink (or three standard drinks to a jug).

*Wine:* a pub measure of wine is typically 100mls, so that wine of 12.7% alcohol by volume will equate to exactly one standard drink, with a bottle of the same wine containing 7.5 standard drinks.

*Spirits:* a nip of spirits sold in a New Zealand bar is 18ml, so a typical 37% strength spirit would represent slightly over one standard drink (13.3ml) for a double nip. A 750ml bottle of 37% strength spirits contains 22 standard drinks and an 1125ml bottle contains 33 standard drinks.

Some time after adopting the drinking guidelines described above ALAC changed terminology from “safe drinking” to “responsible drinking” in recognition of the fact that drinking problems can still occur in those who drink within the ALAC drinking guidelines, albeit much less commonly than in those who drink above the guidelines. We prefer the concept of “low-risk” drinking.

## 2.3 *Problem use*

Use which is currently causing problems, but does not meet DSM-IV criteria for a diagnosis of dependence (see below). This category would include substance abuse as defined by DSM-IV. Please note that the term “abuse” is not infrequently used in a pejorative way to indicate any use of an illicit substance. For precision, we advise that the term should be used only when referring to the DSM-IV definition.

## 2.4 *Diagnosis of addiction*

Over the past twenty years diagnostic systems have been dominated by the American Psychiatric Association's "Diagnostic and Statistical Manual" (DSM). The DSM has undergone three revisions during this time: DSM-III (1980) to DSM-III-R (1987) to DSM-IV (1994) to DSM-IV-TR (2000). The most important shift for addiction was from the DSM-III to the DSM-III-R. The diagnostic criteria for substance dependence in DSM-III-R (1987) represented an international consensus on the concept, based on a landmark paper ten years earlier [Edwards & Gross 1976] and has continued to this day. Dependence is a syndrome that involves dyscontrol, salience and compulsion to use drugs, just as much as it involves tolerance and withdrawal.

The term "addiction" has not been used as a diagnostic term in the past 20 years, being replaced in the major diagnostic systems (ICD9 (1977) and DSM-III (1980) by "dependence". Adopting the term dependence collapsed the false dichotomy between physical and psychological addiction that had previously prevailed, but the term addiction never really went away. In fact, over the past ten years or so the term has undergone a revival. This has been in significant part due to the neurobiological revolution that has brought us to the point of now being able to glimpse the brain pathology associated with addiction. Addiction has fitted the emerging understanding of brain pathology better than the term "dependence", which has continued to be associated with the physiological features of tolerance and withdrawal; but, moreover, patients have generally preferred the term "addiction" over the rather limp sounding "dependence". The sound of the word "addiction" (like "cancer") alludes to something one should take immediate note of, something one should fear getting.

The term "dependence" continues to be the formal diagnostic term rather than addiction. Substance dependence is the generic term but specified as alcohol dependence, cannabis dependence etc, depending on the specific substance under consideration. Dependence is the primary diagnosis in the addiction treatment sector and all clinicians should be not only familiar but have in memory the seven diagnostic criteria for dependence, as outlined below. A diagnosis of substance dependence is made when use of the particular substance has brought about at least three of the seven criteria in a 12 month period.

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Table 1: Diagnostic criteria for substance dependence (based on DSM-IV-TR) mapped on to four key elements of addiction – dyscontrol, salience, compulsion to use, physiological features

### Dyscontrol

1. Substance is often use more than intended
2. Unsuccessful attempts to cut down or control use

### Salience

3. Much time is spent in substance use
4. Important activities are given up or reduced

### Compulsion to use

5. Continued substance use despite knowledge of associated medical or psychological problems

### Physiological Features

6. Acquired tolerance
  7. Withdrawal symptoms and/or relief use
-

While DSM-IV does not provide specific criteria for defining whether dependence is mild, moderate or severe, many clinicians find such a sub-classification useful despite the fact that the cut off point between mild and moderate-severe can be somewhat arbitrary.

- a. Mild Dependence  
3-4 criteria met and only mild negative impact on the person's life,
- b. Moderate/Severe Dependence  
5-7 criteria met and significant negative impact on the person's life.

The importance of using mild or moderate-severe sub-classification highlights one of the weaknesses of the DSM-IV construct. Just using dependence as a diagnosis does not relate to outcome and treatment approaches particularly well. People who meet criteria for mild dependence can learn to control their drinking or substance use again without further problems, while people with severe dependence seldom can. The concept of moderate-severe dependence is therefore widely used and is akin to the term addiction.

Substance abuse is a residual diagnosis. Before it can be made, dependence on the particular substance being considered must first be excluded. If this can be done then a diagnosis of substance abuse can be made if the person is experiencing at least one of the following problems as part of a maladaptive pattern of use: failure to fulfil major role obligations; hazardous use; legal problems; or social/interpersonal problems.

## **2.5        *Addiction as an erosion of free will***

The term addiction is derived from the Latin *addictus* referring to the relationship a slave had with his/her master - an enslavement. The question, "How much 'free will' does a person with addiction have?" invites discussion about the degree of enslavement associated with compulsive behaviour that patients with the disorder suffer from. This is important information that will break down the long-held, erroneous view that addiction is simply a self-inflicted disorder of weak-willed people and therefore any suffering on their part can be discounted and conveniently ignored. As information accumulates, it is becoming clearer that addiction is more like other serious psychiatric conditions, such as schizophrenia, than we ever previously thought, in which a person's behaviour has become driven by disordered brain processes diminishing their normal ability to consciously plan and guide rational, adaptive behaviour.

Using the standard continuum of drug use, from "no use" through "safe use", "hazardous use", "problem use" and "dependence", it is clear that dependence in itself might include mild degrees of enslavement in which a person's 'free will' is still largely intact. Measurement of the intactness of executive functions of the brain is still in its infancy and certainly not available for clinical use at the present time. However, a person may meet the necessary three of the seven criteria of dependence (DSM-IV-TR 2000) (as above in Table 1), be therefore diagnosed with dependence but not have "addiction" in terms of serious erosion of 'free will' that is becoming central to the new conceptualisation of addiction. We would argue that addiction can be equated with "moderate-severe dependence" to indicate a disorder in which a person's 'free will' has been eroded to the extent that a threshold has been reached beyond which the likelihood of a person responding with compulsive drug seeking behaviour to associated cues is high.

## **2.6      *The psychology of addiction***

Twenty years ago addiction was conceptualised to be the result of two fundamental psychological processes. The brain was largely uncharted territory in the minds of addiction clinicians. The first process was positive reinforcement in which a person is likely to repeat a behaviour that is rewarding, in this case drug use. A person repeatedly uses drugs because of an anticipated enjoyable 'high'. However, once the person continues to regularly engage in drug use, adaptation occurs and then sooner or later, in the absence of the drug, they begin experiencing withdrawal symptoms. Subsequent drug use relieves the discomfort of withdrawal symptoms. This is negative reinforcement; using the drug to avoid the negative consequences of abstinence and to feel normal. The primacy of withdrawal symptomatology in the concept of dependence 20 years ago was a reflection of this psychological process being viewed as the central feature of addiction. Interestingly, this concept of addiction still has wide currency in wider health and, indeed, educated public circles, which is that people with addiction continue to use drugs primarily to avoid withdrawal symptoms. However, if this was actually true then the treatment of addiction would be relatively easy; it would simply consist of a managed withdrawal programme, detoxification. However, the rate of relapse following withdrawal in people with moderate-severe dependence is high, about 95% within two years of detoxification (alcohol and opioid dependence) [Vaillant 1988]. The theory does not accord with reality.

Although positive and negative reinforcement remain as key elements in the progression of voluntary drug taking to a state of addiction, they are limited in themselves in explaining the increasing autonomous nature of drug seeking behaviour by people with addiction. About ten years ago, appearing through the academic mist, was increasing reference to changes in the brain consolidating cue-based associated learning and this has been the key to understanding what addiction is from a psychological perspective and, most importantly, what has helped explain why addiction is, relatively, so hard to treat.

There is still a significant gap between knowledge of addiction from a psychological perspective and what is known from a neurobiological perspective. However, in terms of the latter, there have been major strides made over the past 20 years coming out of basic neuroscience. Three main strands that together begin to form a coherent picture are: the evolution of the human brain; neural pathways focused around the reward pathways; and the nature of consciousness. These topics go beyond that of an orientation workbook but are highly recommended areas for further reading and study.

## **2.7      *What causes addiction?***

Addiction is a complex disorder, as we all know, however the term "complex disorder" has a specific technical meaning. A "complex disorder" is one that is caused by multiple interacting factors and these factors are divided into two main types: genetic and environmental. Addiction then as a "complex disorder" is one that is caused by multiple genetic factors interacting with multiple environmental factors.

What is the evidence that addiction is influenced by genes?

The best evidence for a genetic influence in causing addiction is found in a range of studies on alcohol dependence: family, twin, adoption, animal models and molecular genetics. In 1979 a researcher by the name of Cotton, collected together all the family studies available at the time, there were 39, and found that in all of them, the relatives of alcoholics were more likely to have alcoholism compared with relatives of the (various) control groups. He also found that on

average 30% of the alcoholics had at least one parent who was alcoholic. Thus alcoholism has been known for a long time to be a strongly familial disorder, ie that it runs in families. However, this does not necessarily mean that it is genetically influenced. The familial nature of the disorder could theoretically be mediated by environmental factors, such as children observing drunk parents and taking on the behaviour for themselves through modelling.

One of the most powerful ways of disentangling environmental from genetic influences is twin studies. These studies exploit a quirk of nature that exists - there are two sorts of twins - identical twins (monozygotic – from one egg, identical genetically at conception) and non-identical twins (dizygotic – from two eggs, as similar genetically as siblings, because they are siblings!).

If one twin has got alcoholism, how likely is the other twin to also have alcoholism? This is called the concordance rate, ie the rate at which both twins have the disorder in question, which in our case here is alcoholism. If there were no genetic influences in the aetiology (causation) of alcoholism, then the concordance rate for monozygotic twins would be exactly the same as for dizygotic twins, assuming that their environmental influences are close to identical. However, what is found is that the concordance rate is quite different between the different types of twins. In dizygotic twins the concordance rate is about 10-15% ie if one twin has got alcoholism about 10-15% of the time the other twin will also have alcoholism. This is in contrast to monozygotic twins where the concordance rate is about 30-40%. Mathematical modeling of these concordance rates gives heritability estimates, ie how much of the causation of the disorder is thought to be genetic. It turns out that the heritability of alcohol and drug disorders is about 40-60%. That sounds close to 50%! It turns out that this degree of genetic influence is very similar to how much genes determine IQ, ie about half of IQ is caused by genes and the other half caused by environmental factors.

Adoption studies have provided further supporting evidence for a genetic influence in alcoholism. Adoptees brought up in an alcoholic family, ie one in which at least one of the parents had alcoholism, were no more likely to develop alcoholism as those not brought up in these circumstances. However, those who had at least one biological parent who was alcoholic were 3-4 times more likely to develop alcoholism over those without such a genetic heritage, irrespective of whether they were brought up in an alcoholic family or not.

Animal models have been fascinating. In-breeding experiments with rats have produced a strain that prefer to drink an alcohol solution compared with drinking water. Further, this alcohol-preference trait has been combined with high versus low volume drinking to produce a “high volume, alcohol preferring rat”; an alcoholic rat. These animals appear to enjoy drinking alcohol and will drink themselves to cirrhosis if given free access to alcohol. Once neuroadapted, they will go into alcohol withdrawal if the alcohol supply is stopped and then are observed to “relief use” when alcohol is reintroduced. Their alcoholism is the outcome of genetic inbreeding, not a poor or dysfunctional family upbringing!

As the quest for finding the “alcoholic” or “addictive” genes has quickened, the realisation that there may be many genes involved has become clearer. Whereas twenty years ago it was seriously thought there could be three or four primary genes influencing the aetiology of alcoholism, it is now generally conceded that there are many more, perhaps even three or four hundred.

## **2.8**      *Why use the term “addiction”?*

Firstly it is a favoured term by people with the disorder because it sounds more like what they are suffering from rather than the rather limp term “dependence”. Secondly, it is the favoured word by those working in neurobiology to denote there is more to this disorder than tolerance and withdrawal, the traditional features of dependence. The third reason is more pragmatic. It is a simple word that can be used service-wise to denote a wide range of disorders and therefore be inclusive, not only of the various substance use disorders, which include nicotine dependence, but can also be used to include the range of compulsive consumptive behavioural disorders that are increasingly referred to as behavioural addictions. Pathological gambling is the most scientifically validated of these to date but also under active investigation are compulsive buying, compulsive overeating, sexual addiction and others. If, in time, phenomenology, neurobiology, aetiology, clinical course and treatment are demonstrated to be similar then it is possible that the diagnostic systems will substitute addiction for dependence and incorporate both compulsive substance use and compulsive consumptive behaviours under an addiction diagnostic umbrella.

## **2.9**      *A concluding comment*

Addiction is unique to the human species and results from ancient genes interacting with modern human environments. These ancient genes originate from at least the time of the Ordovician Period (~500 million years ago) when fish evolved with the capacity of habit formation. Modern human environments feature technological advances such as the distillation of alcohol, tailor made cigarettes, hypodermic needles, electronic gambling machines and intensely hedonic food. These can each provide a compelling stimulus to an integrating structure in the “reptilian” part of the human brain, called the nucleus accumbens, which initiates automatic responses to seek and consume. If continued regularly, these compelling stimuli spark the development of compulsive behaviour in the individual, initiated outside of consciousness. Addiction runs a chronic relapsing course in the majority of sufferers. Commercialisation of addictive products in consumption based economies fuels the problem of addiction in modern societies, our contemporary human environment.

A deeper understanding of what addiction is will hopefully facilitate greater empathy for people affected by it. It also provides a solid starting point for appreciating that addiction generally presents as a chronic relapsing disease and why it is difficult to cure.

Before we move on to outlining some treatment issues, we will consider some of the main drugs that are encountered in addiction treatment services in Aotearoa New Zealand.

## 3.0 DRUGS

### 3.1 *What is a drug?*

The term "drug" (like the term "abuse") has a pejorative sound to it. Many people when hearing the word "drug" think of intravenous drug users ("junkies") or unmotivated cannabis users ("dopeheads"). They do not tend to immediately think of nicotine smokers or social drinkers of alcohol.

But what is a "drug" in this context? The term does not normally include chemicals, which are necessary for the maintenance of normal bodily functions. An extreme example of this would be oxygen. Medications prescribed for the treatment or alleviation of disease are not generally appropriate for inclusion here either. However, there is immediately a complication because there are some medications that have a psychoactive effect and at times are used recreationally as "drugs", such as morphine or diazepam.

The term "drug" in this context can be defined as any chemical entity that is used non-medically and is (generally) self-administered, through any route of administration, for its positive psychoactive effect. The psychoactive effect sought by drug users varies considerably for the different classes of drugs, but usually includes a change in mood and/or perception often referred to as a "high". The route of administration varies but the end goal is to deliver the drug into the blood stream from where it travels to the brain for its psychoactive effect. The mouth, stomach, nose and lungs are the commonest portals of entry into the blood stream of drugs; intravenous drug use obviously by-passes the gastrointestinal and respiratory systems and results in a rapid psychoactive effect, on par with smoked drugs.

### 3.2 *Classification of drugs*

Everyone has their own pet classification system. Here is ours:

1. Depressants
2. Stimulants
3. Cannabis
4. Opioids
5. Hallucinogens and Phencyclidines
6. Other

The effects of drugs are quite variable and many factors are involved in determining the experience a user has at any time. These include the expectations of the user, the underlying emotional state, the setting in which the drug is used and pharmacological factors, including dose, rate of absorption and blood levels achieved. Previous drug experience and conditioning are also important in determining the final response experienced by the user.

In any event, the primary reason people use drugs is simple; the effect of the drug improves the person's subjective sense of well-being. However, the intoxication effect or "high" associated with each of these classes of drugs differs a lot and is mirrored by an opposite post-intoxication effect experienced by the user following their drug experience. The quality of this post-intoxication effect is the same as that in withdrawal states associated with each drug.

Table 2: Intoxication and post-intoxication/withdrawal effects from drugs

	<i>Intoxication</i>	<i>Post-intoxication/Withdrawal</i>
<i>Depressants</i>	relaxed euphoria	agitated dysphoria
<i>Stimulants</i>	energized euphoria	retarded dysphoria
<i>Cannabis</i>	meaningful bliss	boring irritability
<i>Opioids</i>	warm "heaven"	cold "hell"
<i>Hallucinogens</i>	vivid high	drab low

### 3.3 *Depressants*

The four most important groups of drugs in this class are alcohols, benzodiazepines (BZs), barbiturates and various inhalants, although alcohols (ethanol and methanol) and BZs are by far the most common. Below are a list of the common BZ's and their mg equivalents based on Diazepam 5mg.

		(mg)
Short acting	triazolam (Halcion)	0.125
	temazepam (Euhypnos)	10
Medium acting	oxazepam (Serepax)	15
	lormetazepam (Noctamid)	0.5
Long acting	diazepam (Valium)	5
	chlordiazepoxide (Librium)	10
	flunitrazepam (Rohypnol)	0.333
	nitrazepam (Mogadon)	2.5
	flurazepam (Dalmane)	15
	clonazepam (Rivotril)	0.5

Common BZ street names include "blues" (Valium 10mg), "yellows" (Valium 5mg), "rollies" (Rohypnol 2mg), "rivies" (Rivotril 2mg), "moggies" (Mogadon 5mg).

In general, acute administration of depressants in low to moderate doses is accompanied by signs of central nervous system arousal and a disinhibition euphoria. At higher doses, however, they cause central nervous system depression with accompanying dysphoria and psychomotor retardation. They may also increase tension and, through disinhibition, facilitate the expression of aggressive behaviour.

Benzodiazepine misuse occurs in a variety of quite different populations, from adolescents through to the elderly. By far the most problematic use is found in younger people, in the context of multiple substance use, when it may be very difficult to assess the contribution being made by benzodiazepines to the overall picture. It is important to distinguish this group of benzodiazepine users from those who are dependent on a relatively stable therapeutic dose of benzodiazepines and who do not misuse alcohol or other drugs.

Inhalants are commonly the preferred drugs of child and early adolescent drug users because of their wide spread availability and low cost. The common solvents, associated with chemicals, and common examples of each are listed below.

Aerosol sprays	alcohols (isopropanol)
Petrol	aliphatic hydrocarbons (n-hexane)
Air freshener	aliphatic nitrites (butyl nitrite)
Degreasers	anaesthetics (methylene chloride)
Adhesives	aromatic hydrocarbons (toluene)
Paint thinner	esters (ethyl acetate)
Model cement	ketones (acetone)

### 3.4 *Stimulants*

The main drugs here (apart from nicotine) are the amphetamines and cocaine, which are structurally dissimilar but, nevertheless, have very similar neurochemical and clinical effects. One main difference, however, is the shorter "half life" and duration of action of cocaine compared with amphetamines.

Stimulants can be divided into five main groups as follows:

Amphetamine	amphetamine sulphate (Benzedrine) dextroamphetamine (Dexedrine) methamphetamine (Methedrine, Pure, P)
Amphetamine-like	methylphenidate (Ritalin)
Cocaine	
Nicotine	
Anorexiant	fenfluramine (Ponderax) phentermine (Duramine) diethylpropion (Tenuate dospan)

Low dose use of stimulants results in a magnification of the pleasure experienced from most activities. The user experiences a sense of euphoria, well-being and alertness; anxiety levels are generally reduced; energy, sexuality and self-esteem all increase; and the individual feels more sociable, enthusiastic and productive. The user often feels encouraged to repeat this pleasant and rewarding experience. Higher doses of the drug enhance the feeling of euphoria and as the user becomes increasingly preoccupied with this, withdrawal from other social activities may occur. Controlled use often shifts to compulsive use when the supply increases, when increasingly higher doses are used and when the user switches to a more rapid route of administration, such as smoking or injecting the drug. With increased use of high dose amphetamine or cocaine, the user experiences symptoms including euphoria, increased energy levels, disinhibition, grandiosity, impulsiveness, decreased need for sleep, increased feelings of sexuality, decreased appetite, impaired judgement, hypervigilance, compulsively repeated actions and marked psychomotor agitation. With chronic use of high doses of amphetamine or cocaine, the euphoria is replaced by dysphoric reactions. Agitation, anxiety, irritability, hyperactivity and paranoia develop. Most of

those individuals who increase their use of high dose amphetamines and cocaine will develop anxiety and paranoia and some will become frankly psychotic.

### **3.5 Cannabis**

The primary active ingredient of cannabis has been known for some time to be delta-9-tetrahydrocannabinol. It is relatively recently, however, that a specific cannabinoid receptor and an endogenous cannabinoid ligand (anandamide) have been discovered.

When cannabis is smoked, peak plasma levels are reached in about 10 minutes, although the most prominent physiological and subjective effects may not develop for 20-30 minutes. Intoxication usually lasts between two and three hours depending on the dose. In comparison, when ingested, a greater proportion of the drug is absorbed, resulting in a longer but less predictable "high". The onset of intoxication is usually seen in 30-60 minutes, peak blood levels reached within two to three hours and acute effects lasting up to eight hours. Cannabis intoxication includes a number of emotional changes characterised by a feeling of euphoria associated with a sense of self-confidence, well-being, relaxation, heightened sexual arousal, a sense of grandiosity and general increased meaningfulness. When used in a social setting, the euphoria is often accompanied by infectious laughter, talkativeness and increased sociability.

Adverse emotional reactions can occur with acute intoxication. They are most often reported in naïve users who are unfamiliar with the use of cannabis and by some patients given cannabis for therapeutic purposes. One of the most common adverse reactions is anxiety and panic symptoms. Intoxication may also be associated with mild levels of suspiciousness and paranoid ideation.

Anecdotal reports have indicated the possible development of a range of symptoms in chronic cannabis users which can look like depression or the negative symptoms of schizophrenia. This so-called "amotivational syndrome" consists of apathy, reduced self-awareness, impaired social adjustment, impaired memory and concentration, lack of motivation with reduction in goal directed drive, social withdrawal and lethargy. Such a syndrome appears to be uncommon and is difficult to distinguish from the effects of chronic intoxication with cannabis. Confounding effects include the presence of pre-existing disorder (affective and schizophrenia), malnutrition, personality dysfunction, lifestyle and concomitant drug use.

### **3.6 Opioids**

This group of drugs are usually divided in three subgroups as follows:

Naturally occurring	opium, morphine, codeine
Semisynthetic	diacetylmorphine (Heroin)
Synthetic	pethidine, methadone, buprenorphine, dextropropoxyphene

The euphoric effects of these central nervous system depressant drugs are well publicised, although despite what is popularly thought opioid intoxication is quite different from that seen with stimulants. In the first one or two minutes after injecting an opioid drug such as morphine, the user experiences a "rush" of feelings in the lower abdomen (said to resemble an orgasm) accompanied by a warm flushing of the skin. This is followed by a floating, intoxicated feeling

accompanied by euphoria. The usual opioid withdrawal syndrome of a “street user” is a relatively benign mixture of emotional, behavioural and physical symptoms beginning within 12 hours of the last dose. Irritability is the main emotional reaction early on, coupled with a strong craving for opioid drugs. A subsequent post-withdrawal syndrome can last up to six months and longer, particularly with longer half-life opioids such as methadone. Symptoms include low level lethargy, irritability and depression, leaving the ex-user vulnerable to relapse.

### 3.7 *Hallucinogens and phencyclidines*

The common hallucinogens are:

LSD (d-lysergic acid diethylamide)	“acid”
Psilocybin	“magic mushrooms”
Mescaline	“cactus”
MDMA (3,4-methylene dioxymethamphetamine)	“love drug” “ecstasy”
Anticholinergics	
Benzhexol (Pipanol)	“pinkies”
Benztropine (Cogentin)	
Procyclidine (Kemadrin)	
Datura	

The common phencyclidines are:

Phencyclidine	“PCP” “angel dust”
Ketamine	

Acute intoxication with LSD (and the group of related hallucinogenic drugs) typically includes alterations in mood and changes in perception. The mood changes are generally euphoric but can also involve feelings of dysphoria, anxiety and panic. The duration of these symptoms depends on the properties of the drug; with LSD the effects last from four to 12 hours.

MDMA (3,4-methylene dioxymethamphetamine) or “ecstasy” produces a mixture of central stimulant and psychedelic effects; its psychoactive properties are described as being distinct from both stimulants and hallucinogens. Acute effects include euphoria, feelings of well-being and increased self esteem, inner contentment, increased physical and emotional energy, enhanced mental and emotional clarity and insight, heightened sensual awareness, feelings of enhanced communication and emotional intimacy between partners.

## 4.0 CO-EXISTING DISORDERS

Co-existing psychiatric disorders are the rule and not the exception in addiction treatment populations. Patients with addiction are clearly part of the larger population of mental health patients and addiction services need to be capable of comprehensive assessment and treatment planning, which includes co-existing psychiatric disorders, and should work towards better integration with other mental health services.

Data from various research studies, such as the Australian National Survey of Mental Health and Well-Being, show that having a current substance use disorder significantly increases the probability of having a co-existing mood or anxiety disorder, with such combinations associated with greater disability than any one diagnostic category alone. Close to half of women and a quarter of men with a current substance use disorder will also meet criteria for an anxiety or mood disorder, with approximately one in seven of those with a substance use disorder seeking professional assistance for that problem during the survey year.

National Addiction Centre research [Adamson et al 2006] has shown that the rate of co-existing psychiatric disorders in a representative sample from Community Alcohol and Drug Services was 74% for a current diagnosis and 90% for a lifetime diagnosis. Current diagnoses were primarily anxiety disorders (65%) and mood disorders (53%). The most common single diagnoses were major depressive disorder (34%), social phobia (31%) and post-traumatic stress disorder (PTSD, 31%) and the Axis II diagnosis of antisocial personality disorder (ASPD, 27%). Rates of ASPD are likely to be substantially higher in services with a criminal justice focus. Also of note in this study was the high rate both of bipolar I disorder (11%) and pathological gambling (11%).

Of the co-existing psychiatric disorders identified in the above study, particular attention should be given to the rates of social phobia, PTSD and bipolar I disorder. Social phobia and PTSD, when presenting concurrently with a substance use disorder, are likely to be significantly entwined with the substance misuse, as there is evidence that substances may be used to manage symptoms for both social phobia and PTSD, and that either diagnosis is associated with a more severe substance-related presentation. As a consequence, it has been suggested that disorder-specific interventions could very well be an important element of successful treatment for these patient groups. Furthermore, these disorders may present significant difficulties in the delivery of treatment for substance misuse, with group-based treatment programmes and self-help groups unacceptable to many socially phobic patients, and to some patients with PTSD, while patients with PTSD may additionally have significant interpersonal issues which, for example, may preclude working with male clinical staff in the case of patients with a history of sexual or physical abuse by male perpetrators.

Bipolar I disorder is often difficult to accurately identify in the absence of a careful history by a qualified and experienced clinician. Bipolar I disorder and substance use disorders may interact powerfully to worsen the course of each and the recognition of bipolar disorder is important to allow appropriate medication treatment, such as mood stabilisers.

We strongly recommend to all new workers to the addiction treatment field that you become familiar with these common co-existing disorders: major depression, mania, social phobia, post-traumatic stress disorder and antisocial personality disorder. Remember “common things occur commonly”.

In addition to a familiarisation with the diagnostic criteria for major mental disorders, clinicians would do well to consider the ways in which service delivery may act as barriers to optimal treatment for patients with co-existing disorders. See Todd et al (2002) for a discussion of these issues within the New Zealand context.

A comprehensive guide to working with patients with co-existing conditions can be downloaded free from: <http://www.chmeds.ac.nz/departments/psychmed/treatment/coexisting.pdf>. Addiction treatment clinicians are also strongly encouraged to undertake formal qualification-based education in this area.

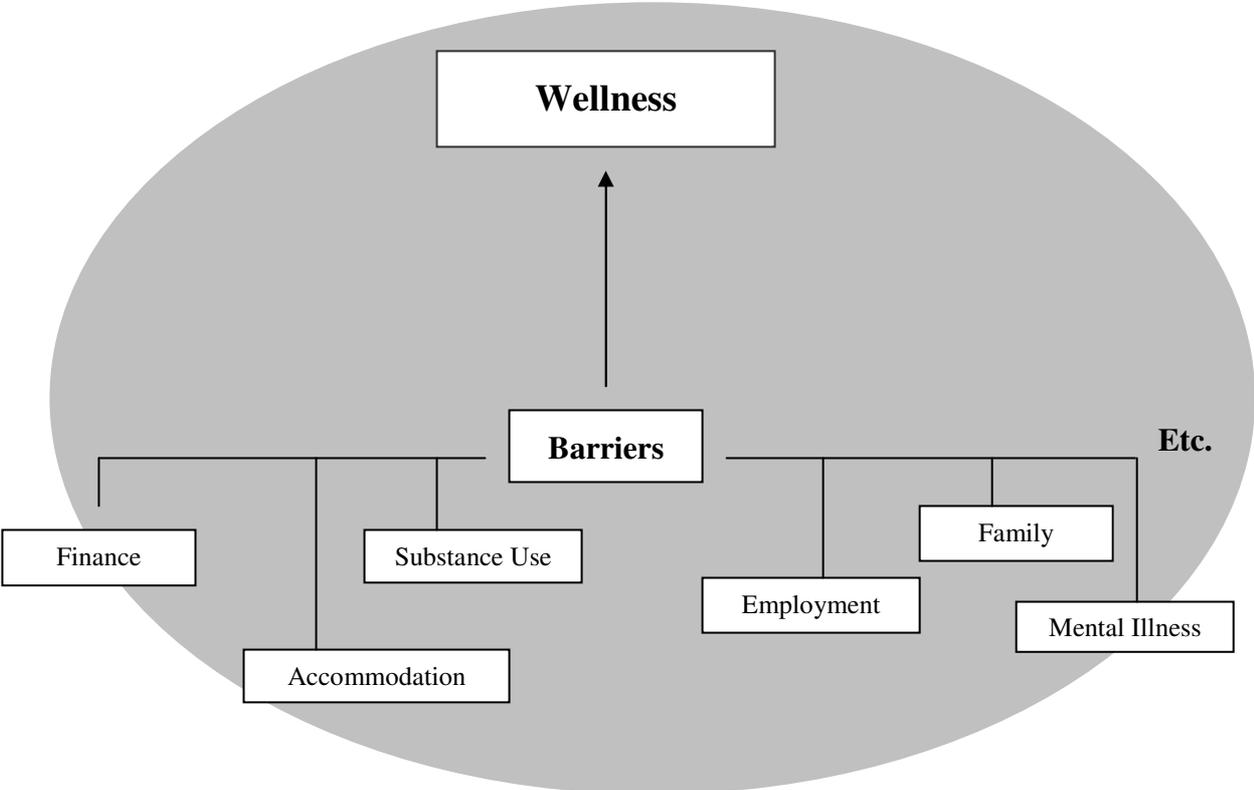
# 5.0 ASSESSMENT

An assessment is an essential part of the clinical process and significantly influences the quality of overall treatment and has a number of purposes. It is an important initial step in engaging the person in ongoing treatment, it helps identify the key problems the person is experiencing, it facilitates management planning and it can be an intervention in its own right by educating the person about their problems and helping motivate them to change.

When problems are straightforward and limited to a few areas of the person’s life, focusing purely on the person’s problems is all that is needed. However, when more severe levels of dysfunction occur, as in moderate to severe dependence, multiple areas of the person’s life are likely to be affected. In such circumstances, comprehensive assessments and management plans are indicated, but it is important that these do not simply become a list of dysfunctions. A wellness or strengths model approach is the way to go.

## 5.1 Wellness approach

What this means is that the patient and their whānau are seen and understood as a whole from the perspective of what it means for them to be well and problem areas are seen as barriers to wellness. While treatment is often limited by resource constraints to a few tasks aimed at removing certain barriers, it is important that the overall perspective of wellness is maintained.



## **5.2 *Levels of assessment and intervention***

The continuum of alcohol problems previously outlined (see 2.1) leads naturally to different levels of assessment.

### **1. Screening**

Screening involves simple, brief tests applied to a whole population to determine whether a person has some kind of alcohol problem or not. The Alcohol Use Disorders Identification Test (AUDIT) is the preferred tool for this (see Appendix 4), although the ALAC responsible drinking guidelines in terms of standard drinks per week/occasion (men 21/6, women 14/4) are also useful in screening. Remember the six standard drinks for men and four standard drinks for women per drinking occasion may be under review.

### **2. Brief Assessment and Intervention**

If a person is identified by screening as having a possible alcohol problem, they need to be briefly assessed to determine the extent of that problem. If it amounts to mild dependence or less, then controlled use is the preferred outcome and a brief intervention can be effectively undertaken focusing on social or safe drinking. Again, the ALAC drinking guidelines are useful in establishing a goal for this intervention.

### **3. Comprehensive Assessment and Management Planning**

If a person is found on brief assessment to suffer moderate-severe dependence, or if their problems are complicated by significant mental health or physical illness, a comprehensive assessment and management plan is indicated.

For many drugs other than alcohol and the increasing variety of identified compulsive addictive behaviours, there is less evidence to support the concept of harmless social use and it is unclear when hazardous use begins. However, the concept of problem use, dependence and the differentiation between mild and moderate/severe dependence remains very useful. Similarly, there are few screening instruments for drugs such as cannabis or morphine, although there are excellent instruments for identifying problem gambling. Overall, compared with alcohol, brief interventions have less evidence to support their effectiveness with other drugs. There is some evidence emerging to support structured brief interventions for cannabis misuse, although these “brief” interventions are quite different from those used for alcohol, especially in terms of their brevity - most involve 4-6 one hour sessions.

## **5.3 *Brief assessment and intervention***

Undertaking brief clinical assessment and intervention for people with mild alcohol problems are key skills for all health professionals, given the high prevalence of alcohol problems as well as the relative ease by which brief assessment and intervention can be undertaken across the full range of health care settings. Addiction treatment clinicians should be expert at this.

A brief clinical assessment is indicated for anyone presenting to a health setting who has been screened as misusing alcohol and if shown to be beyond safe/social/responsible drinking through screening methods the next step is a brief clinical assessment.

There is no broad consensus on what constitutes a brief clinical assessment, except that it is completed in a relatively short period of time and covers enough alcohol history to enable the clinician to take an appropriate next step in intervention and management.

A central feature of a brief clinical assessment is determining whether or not the patient has ever had more severe alcohol problems in the form of moderate-severe dependence. This is because the next step in management for someone who has previously suffered moderate-severe dependence is likely to be different to those who have never had such severity of alcohol problems. If a patient has been “screened in” and then found not to have moderate-severe dependence in a brief clinical assessment then a brief clinical intervention is indicated.

The brief assessment schema outlined in Appendix 6 has been designed to take about 10 minutes to complete in typical situations of people with mild alcohol problems. If the assessment takes longer, and the patient begins to reveal information indicating they have more than mild alcohol problems, a more extensive intervention should be considered.

A critical component of conducting any assessment, including a brief clinical assessment for alcohol problems, is formulating a summary of the key positive findings and checking these out with the patient. This provides an excellent bridge between the assessment and the next step, a brief intervention.

There is no universally agreed format required for an effective brief intervention. A meta-analysis of brief intervention trials, however, was able to identify the following six common elements of successful brief interventions, summarised as the acronym FRAMES:

	<b>F</b> eedback of personal risk of impairment
Emphasis on personal	<b>R</b> esponsibility for change
Clear	<b>A</b> dvice to change
A	<b>M</b> enu of alternative change options
Therapeutic	<b>E</b> mpathy as a counselling style
Enhancement of client	<b>S</b> elf-efficacy or optimism

The brief intervention schema outlined in Appendix 6 has been designed to take about five minutes, so that accompanying a brief assessment the whole procedure can be typically completed in about 15 minutes. It is divided into four steps – Summarise, Brief Tutorial, Giving Advice and Negotiating a Review.

#### **5.4 *Comprehensive assessment and management planning***

A comprehensive assessment is indicated when a person has been identified as probably having moderate-severe dependence or has obvious co-existing psychiatric disorder(s) in addition to their addiction problems. The outline provided in Appendix 5 is one way of structuring a comprehensive assessment. It represents a standard approach which has an emphasis on identifying and determining the extent of presenting pathology. In real life clinical practice there is a wider well-being context in which this standard comprehensive assessment and management planning needs to be actioned within.

Experienced clinicians will arrange their interview to suit their own style of working and while the assessment may differ in sequence of information presented, the content is usually similar. We recommend that if you are relatively new to this that you attempt to master the model outlined before incorporating too many personal idiosyncrasies.

There are two key elements of a comprehensive assessment without which the assessment is not comprehensive. The first is additional information gained from interviewing a “significant other” of the patient in order to broaden the scope of data collected as well as confirm details offered by the patient. The second is completion of a report. A comprehensive assessment is incomplete until an appropriate report has been completed that details the key aspects of history and examination but, moreover, details the clinician’s ideas about what is going on for the patient, what can be done about it and what the likely outcome is going to be.

Comprehensive assessment and management planning is a fundamental skill for the dedicated/specialist addiction treatment sector. A new National Postgraduate Certificate has been suggested that would focus on confirming that clinicians have attained a high standard of comprehensive assessment and management planning in real life clinical work.

## 6.0 TREATMENT

### 6.1 *Treatment of whom?*

Who are the people the addiction treatment sector are being called upon to treat? This was the fundamental question driving the development of the Matua Raki (National Addiction Treatment Workforce Development Programme) strategic plan at the outset. Using data from a variety of sources, eight representative cases were formulated to describe the tangata whaiora of New Zealand addiction treatment services. Here they are:

1. Tama is a 17-year-old Māori young man who was brought up by a whānau Aunty in a small town when his teenage mother gave him up for adoption. He was referred to the addiction treatment service by the Youth Drug Court where he was screened to have probable alcohol and cannabis dependence. His charges were assault (while intoxicated) and burglary (money for alcohol, cannabis and gambling). He has a background history of stealing, truanting and fighting dating from primary school years, early in which he also had great problems concentrating in class and had specific difficulties with reading. Tama subsequently had multiple suspensions from several schools and was finally expelled at age 15. He is now smoking 15 cigarettes per day and over the past year has lost about \$4000 on pokie machines at pubs (attended underage).
2. Sina is a 21-year-old Samoan woman estranged from her traditional family, which emigrated to New Zealand in the early 1970s. She is the youngest of 10 children, was born and educated in New Zealand, although left school with no formal qualifications. Sina has been in a relationship with a man, eight years her senior, for the last three years and through him began to use cannabis regularly. Her parents have never felt he was right for their daughter and strongly urged her to finish the relationship a year ago, whereupon she left home abruptly to live in her boyfriend's flat. She subsequently found out about her boyfriend's criminal past and his infidelity. On confronting him she was kicked out of the flat and, feeling too ashamed to approach her parents, she has moved in with an Aunty. Without a steady supply of cannabis she is feeling "stressed out" and irritable, is not sleeping normally in addition to feeling distressed and embarrassed about her situation. Through the local minister a referral has been made to the local addiction treatment centre.
3. Denise is a 27-year-old Pakeha woman, who reluctantly works as a prostitute in a massage parlour. She self-refers to the addiction treatment service, desperate to be prescribed methadone following a "bad experience at the parlour", saying she is "sick of the junkie life-style". She is also estranged from her two children. She has been injecting opioids for the past seven years and currently uses 120mg Morphine Sulphate each day. Over this time period she has been a daily user of cannabis and regular user of benzodiazepines and alcohol. Over the past 12 months she has also been using "P" once or twice a week. She has been smoking 25 cigarettes per day for nearly 10 years. Denise is found to be gaunt and sick looking, despite trendy clothing and heavy application of makeup. She is also significantly depressed on a background of longstanding fears and anxieties related to experiences of being raped by her stepfather from age 9-13 years. Finally, she is also hepatitis C positive.
4. Matthew is a gay, professional 32-year-old Pakeha man, who is in a committed relationship. He works as a computer programmer in a large multinational company. He was recently caught defrauding the company of \$20,000+ and has been advised by his lawyer to have an assessment at the addiction treatment service which he attends with his partner. He has been

using escalating amounts of methamphetamine in a three day on and four day off pattern for the past six months; he looks depressed. Matthew has been a recreational user of a variety of drugs (ecstasy, LSD, cannabis, alcohol) since his teens, but never “lost control” as he has with methamphetamine. Since being caught he has been feeling that “everything is lost” and if it was not for the support of his partner says he would have killed himself.

5. Petra is a 35-year-old senior bank teller of mixed European and Asian descent who a year ago remarried on the rebound but soon found out her new husband enjoyed rugby and drinking alcohol with “the boys” more than he enjoyed spending time with her. She became increasingly lonely and began going down to the local pub where she found enjoyment in playing on the pokie machines, particularly after a \$500 win early on. She also enjoyed the camaraderie of other punters and progressed to betting larger amounts. Further, normally a less than 10 cigarettes per day smoker, on the nights of playing the machines she began smoking 20-30 cigarettes and then drinking half a bottle of wine to deal with stress on arriving home. She soon began withdrawing from old friends as she started losing significant amounts of money, initially hundreds of dollars and then up to \$500 at a time. Petra worked out a scheme of writing fraudulent cheques from “quiet accounts” at the bank where she worked, considering it a form of “borrowing”, intending to pay the money back once she won the money back. She “borrowed” about \$40,000 in this way, before being caught drawing on three further \$10,000 cheques in the same way. Her new husband is now extremely angry and she is agitated, depressed and feeling very shamed. She presents at her addiction treatment service for help in the company of a GA member who befriended her at a meeting she attended.
6. Ron is a 40-year-old overweight truck driver of Māori descent who announces he is “not interested in all that new-age Māori stuff” when asked about his ethnicity. He lives with his longstanding partner following marital separation six years ago. He has a 15-year-old son whom he has not seen for five years. Ron is referred to the addiction treatment service by his probation officer following a second DIC. He had an alcohol assessment following his first DIC five years ago but declined further treatment at the time, once he regained his driving licence. He has continued to drink two jugs of beer at the end of each working day and “some top shelf” in the weekends. He has also been smoking 20 cigarettes a day for the past 17 years.
7. Heather is a 53-year-old Pakeha woman who has been very shy all her life. She lives alone and has become increasingly anxious and housebound over the past ten years since her husband left to live with his secretary. She is referred to the addiction treatment service by her GP because of her benzodiazepine misuse. She has been increasingly completing a monthly benzodiazepine prescription early and seeking new supplies. On assessment Heather is additionally found to have been drinking increasing quantities of wine delivered to the door through internet shopping for the past ten years, as well as an escalating engagement in international electronic gambling via the internet. She has now spent her entire inheritance of \$70,000 received three years ago from the estate of her deceased mother. She has been a 25 cigarette per day smoker for 35 years and is increasingly breathless on any exertion.
8. Jack is a 70-year-old married Pakeha man, who worked as a farmer until five years ago when he suffered a back injury. He and his wife sold the farm and moved into town where he has been increasingly house-bound with pain and lack of interests. He used to go to the local pub on Friday nights and have a few beers with friends but with his change in life-style, his alcohol consumption has now escalated to daily drinking which includes whisky, which he feels helps the pain and his sleep. Jack's wife went to the GP as she has found him

to be increasingly irritable and at times verbally abusive in contrast to his previous placid personality. Further, one evening recently, whilst very intoxicated, he spoke of getting out the gun and "topping" himself. The GP referred Jack to the addiction service for urgent assistance.

As can be seen, alcohol use is involved in seven of the eight cases. Alcohol dependence is the prototypical addiction in the addiction treatment sector and has attracted more research on its treatment than other addictions. Alcohol dependence is therefore a good place to start when considering treatment of addiction and a lot of the issues described below (Section 6.4) for the treatment of alcohol dependence are applicable to the treatment of other addictions. Remember also that multiple substance use is the rule not the exception. Before more specific discussion of the treatment of alcohol dependence, however, the next two sections will address the term "harm reduction" in the context of treatment philosophy, comprehensive management and clinical case management.

## **6.2 *Harm reduction and treatment philosophy***

The treatment of addiction is different from most other health endeavours because of traditional moralistic attitudes towards drug use. These moralistic attitudes drive unrealistic treatment expectations, to the extent that sometimes it has seemed that the only worthwhile treatment outcome from addiction treatment has been complete abstinence from all drugs.

The addiction treatment sector has perhaps "shot itself in the foot" at times in the past by taking on this impossible challenge and expecting an ideal outcome for every person accessing treatment services. Harm reduction has been a more recent approach that has, in some ways, brought the addiction treatment sector back to reality.

Harm reduction is a term that has somewhat different meanings to different people. In terms of drug policy it is often used to describe measures that specifically relate to decreasing harm from using drugs separate from reducing use of drugs. In terms of addiction treatment, it is generally used to emphasise interventions which are specifically aimed at reducing harm from drug use with no specific aim at reducing use of the drug.

We like to use the term "harm reduction" to refer to a pragmatic approach towards treatment outcome expectations; the type of approach that, in fact, is brought to bear on most other disorders by other health professionals. For instance, consider two other common health problems; major depression and Type 2 diabetes. Clinicians working with people suffering these two disorders do not back themselves into a corner with an expectation that the only worthwhile treatment outcome is total euthymia or a completely normal blood glucose all of the time. Continuing mood symptoms and intermittently abnormal glucose readings are tolerated as part of the overall care and pragmatism that is part and parcel of normal clinical practice. However, every step that people take towards better mood or greater stability of normal blood glucose readings is viewed by the clinicians involved as a plus and seen as a positive move in the right direction of reducing the overall harm associated with their disorder. Any intervention that assists the person achieve reduction of harm from their drug use, whether or not they are progressing towards abstinence from drugs, should be viewed as good. This is the attitude that is likely to bring about the best results overall for the people seeking addiction treatment.

However, one risk of being too pragmatic is losing therapeutic vision for the ideal. Given current treatment methods available for addiction, the optimal treatment result that can be achieved will almost always be associated with abstinence from the problem drug or compulsive activity that

has ensnared the person. Practicing “harm reduction” should never be an excuse for not being optimistic and proactive towards every person we encounter that they might achieve an optimum outcome from treatment. But in the end, the old adage, most often associated with Edward Trudeau (1848 – 1915), a physician who spent his life caring for people affected with tuberculosis before the advent of anti-tuberculous medications:

To cure sometimes;  
To relieve often;  
To comfort always;

remains one of the best ways of describing an appropriate treatment philosophy for guiding addiction treatment.

### **6.3 *Comprehensive management plan***

An excellent structure for thinking about a comprehensive management plan for any person presenting to an addiction treatment service is as follows.

1. More information required
2. Setting
3. Treatment of medical conditions
4. Psychopharmacology
5. Psychological intervention
6. Family and social interventions
7. Education/work/occupation
8. Education of patient and significant others
9. Self-help groups

1. Following assessment, even highly comprehensive assessment, there will always be more information to gather that will assist in overall treatment. This is of two sorts: firstly is the past information not gathered at assessment; and, secondly, is all the ongoing new information that develops as the case progresses. The common question asked at the beginning of follow-up interviews “How have things been since we last met” is not just a pleasantry.

2. The setting in which management progresses needs to be kept constantly in mind. Would this person benefit from some day care or day treatment? When will it be appropriate to discharge this person from inpatient/residential treatment? Do they need to complete the full programme? The setting in addiction treatment also has a major bearing on the goals of treatment. Most daypatient and inpatient settings require people to be abstinent from all non-prescribed medications, whereas outpatient services are able to be more flexible in meeting the person where they are at along the continuum of being abstinent from using all drugs through to continuing to use drugs regularly.

3. Attention to the person’s overall physical health can at times be crucial in assisting them with recovery. Remember there is a body below the eyebrows.

4. 5. and 6.

These are the central elements of most management plans – medications, psychological therapy and family work. See below for more details on each.

7. One of the key aspects of addiction is salience as shown by the amount of time taken up by the person in their pursuit of thinking about and getting drugs, taking drugs and then recovering from the effects of getting and taking drugs. Once the decision to cut down or stop using has been made, there is inevitably a lot more time on the person's hands. Unless filled up with something compelling, this time can act like a vacuum, sucking the person back into their previous addictive behaviours. Thinking, discussing and initiating education for youth, work for adults and useful productive occupational activities for seniors is critical to include in a comprehensive management plan and for many people will end up being the most important element that brings about and sustains recovery.
8. How much do you want to learn about your health problems when you go and see your doctor or other health professionals about them? That's right! We want to know just about everything; the same with our patients. However, we should not be simply bombarding our patients with absolutely everything we know about the treatment of opioid dependence or what causes social phobia or how to access the invalid's benefit, or all three. The art here is to tune in to what the priorities for new knowledge for the person are through allowing time for discussion with them and to be prepared to go looking for information if you do not specifically know it yourself.
9. Involvement in a self-help group can infrequently be the number one thing that initiates and maintains a person's recovery. Having a number of personal contacts with Alcoholics Anonymous, Narcotics Anonymous, Gamblers Anonymous, Rational Recovery etc will be a great resource for you in becoming a really effective addiction treatment worker.

## **6.4 Clinical case management**

Clinical case management (CCM) is an approach for working with people who have moderate-severe substance use or behavioural addiction disorders who also have co-existing mental health disorders. For such clients a continuing care approach, punctuated with times of more intensive treatment, is frequently required. As with other chronic health conditions this approach involves cross service boundaries and input over time from a network of primary care, specialist and self-help/mutual help services.

Because of the heterogeneity of clients who experience co-existing disorders and the diversity and complexity of clients' treatment needs there is no *one size fits all* approach. CCM must be *individualised* and provided in *flexible* and *creative* ways in order to meet the health related treatment needs of both youth and adult clients and their significant others and whānau. Correspondingly, treatment workers who provide CCM require a number of key attributes and therapeutic skills. These include having a strong interest and commitment to working with individuals with a range of substance use disorders and addictive behaviours and their significant others and whānau, a community as well as a broad health perspective, the ability to work systemically and the ability to engage and retain clients within a therapeutic relationship. In addition, mental health expertise is required as well as skills in psychological therapies, particularly motivational interviewing and cognitive behavioural strategies, and skills in working with families and whānau.

It is important to emphasise that individuals with co-existing mental health and substance use disorders will seek and receive assistance from a variety of sources within and external to mental health and addiction treatment services. However, it is equally important to emphasise that effective CCM does not equate to brokerage, whereby clients are passively referred to a range of

external agencies with little active involvement of the clinical case manager or key worker. In addition, it is important to acknowledge that clinical case managers/key workers will bring varying knowledge and skills to working with clients, depending on their educational preparation and experience as well as their cultural perspective.

A mix of client and service related factors will determine the intensity and scope of CCM. These include characteristics of the client group and level of severity and complexity of clients' treatment needs, what a service is funded to provide, its capability (including staff mix and competencies) as well as availability of other community resources. How CCM is delivered will also vary according to the service setting, eg rural, urban, NGO, primary care or specialist service. For example, CCM will be delivered differently by one mobile staff member working in a rural setting compared with CCM delivered by an urban multi-disciplinary team within a highly structured service setting.

The overall goals of CCM are:

- To engage and retain clients in treatment
- To promote clients' active participation in their treatment, incorporating significant others and whānau wherever possible
- To promote behaviour change, increase health and well-being (wellness) and participation in community life (role and social functioning)

Ten key general strategies of CCM are:

1. Enhancing clients' motivation and commitment to change
2. Supporting and enhancing clients' self-directed strategies
3. Providing cognitive behavioural and other specific individual, family and whānau and group interventions as required
4. Providing information about self-help/mutual help groups and recovery whānau
5. Working with significant others and whānau
6. Providing information about medications and promoting medication adherence
7. Providing information about mental health disorders and monitoring symptoms
8. Providing information about addiction and monitoring substance use/addictive behaviours
9. Linking (brokerage) and co-ordinating care
10. Evaluating progress and adjusting treatment goals

## **6.5 Treatment of alcohol dependence**

People who suffer from moderate-severe alcohol dependence are unlikely (probably less than 5%) to be able to drink normally again and are the group of alcohol misusers who are most likely to develop physical complications such as cirrhosis of the liver. Therefore, treatment for these people must be directed towards assisting them to achieve long-term abstinence from alcohol as an optimal goal and reducing their alcohol use as much as possible in any event.

Patients with alcohol dependence generally do not present themselves for addiction treatment. They more commonly present to a non-addiction setting with complications due to their addiction.

Medical complications are myriad; common examples include hypertension, cardiac arrhythmias, reflux oesophagitis, gastritis, abnormal liver function tests, pancreatitis, macrocytosis, subdural haematoma, polyneuropathy, hypertriglyceridemia, elevated HDL-C, hyperuricaemia, trauma and accidents (about 50% of fatal traffic accidents involve alcohol). Alcoholism has been referred to as the contemporary syphilis because of its ability to mimic

almost any medical condition. Common psychiatric symptoms secondary to alcoholism include severe depression, acute anxiety, paranoid reactions and memory loss.

The second major way alcohol dependence presents is via family members either under “stress” themselves or directly complaining about their family member’s drinking and associated behaviour. Thirdly, many patients come to attention via the courts for alcohol-related crime.

### **6.5.1      *Alcohol detoxification***

Uncomplicated alcohol withdrawal begins shortly after cessation of or reduction in drinking and almost always resolves within 5-7 days. The two classic complications are withdrawal seizures and alcohol withdrawal delirium (“DTs”). The normal clinical course of alcohol dependence is that patients begin drinking abnormally in their teens and develop their first withdrawal symptoms in their twenties.

There is good evidence that the majority of alcohol dependent patients can undergo detoxification without the specialised knowledge and skills of trained health professionals. However, where there is a lack of adequate social supports (not uncommon for people with significant alcohol problems), some form of organised care is required. This role can usually be fulfilled by a social detox unit which is located in the community to achieve maximum accessibility to its target group, works to create a supportive home-like atmosphere and has ready access to specialised medical and psychiatric backup.

Specialised medical detoxification is required for a relatively small number of people who experience complications during the withdrawal period, due to very severe withdrawal symptoms and/or the existence of concomitant medical or psychiatric disorders which require hospitalisation.

The approximate percentages of people requiring detoxification catered for in the various settings has been estimated to be: home “detox” ~60%; social “detox” ~30%; specialist medical “detox” <10%.

The majority of patients withdrawing from alcohol will require no more than attention to adequate hydration, lots of “TLC” and the administration of prophylactic thiamine (Vitamin B1) for prevention of Wernicke’s encephalopathy. This should be the standard home or social detox regime, while normally continuing current prescribed medications for any other medical conditions.

### **6.5.2      *Post-detoxification treatment***

Traditionally, “alcoholism treatment” has referred to participation in a post-detoxification residential programme. These programmes generally consist of a multi-modal mix of education, counselling, group therapy, family work and introduction to the self-help groups, particularly Alcoholics Anonymous.

There is a significant literature indicating doubt about the cost-effectiveness of long residential programmes in altering the natural history of the chronic-relapsing nature of severe alcohol dependence and it is this literature which has partly led to the closing of residential programmes as well as shortening of surviving programmes.

The natural history of alcoholism appears to be that 20-30% of patients will become abstinent following treatment in the short to medium term, despite the length, type or setting of the

treatment. Programmes that offer longer, more intensive, more psychotherapeutic, residential treatment of less than three months in duration, have not been shown to achieve longer periods of abstinence for the average patient with alcohol dependence compared with shorter, less intensive, less psychotherapeutic, outpatient treatment. All professionally delivered treatment, does however, appear to bring about a significant reduction in patients' overall alcohol intake and improvement in their overall health status.

Patients who should be referred to a residential programme are those who have severe dependence problems with severely disrupted social systems and who have failed a sustained period of outpatient treatment. Although this treatment has variable impact on preventing the next relapse, it does provide care to suffering patients and their families and allows a period of recovery from the current relapse. It is a form of *short-term asylum* (using "asylum" in the most positive way to refer to a resting place or haven) for suffering patients and their families. The value of and the need for this kind of time-out for convalescence and establishment of new hope should never be underestimated.

Therapeutic communities are a special form of residential treatment that are longer in length and focus on personality change. If patients remain in treatment for about four months at a minimum, enduring change will occur as they establish and consolidate a new way of being themselves without using drugs.

The provision of services which are easily accessible and user-friendly is likely to reduce the total amount of alcohol consumed by a person in a relapse (and therefore reduce the total life-time body dose and associated medical complications which are dose related), as well as reduce psychosocial/legal complications.

Treatment of alcohol dependence, and all other addictions, therefore, is more usefully aimed at harm reduction rather than effecting a cure, because long-term recovery does not appear to be directly and predictably related to "treatment". However, this somewhat awkward truth should not undermine therapeutic efforts to assist patients to achieve the best outcome for themselves, which at this stage of knowledge in terms of addiction recovery, usually involves a long period of abstinence, if not life-long abstinence, from the particular substance or addictive behaviour.

### **6.5.3 Relapse prevention**

The achievement of long-term sustained, stable, satisfying abstinence from alcohol (recovery) is the optimal therapeutic goal for alcoholic patients. However, until the recent advent of new medications, there has been no specific treatment which has been shown to be predictably effective in helping alcohol dependent patients achieve this goal.

There are a number of psychological interventions currently being utilised for people with alcohol and drug problems. The three most frequently used are Cognitive Behavioural Therapy (CBT), Twelve Step Facilitation Therapy (TSF) and motivational approaches under the general rubric of Motivational Interviewing (see Section 6.5 for further details).

A large, multisite American study, known as Project MATCH, was a randomised controlled trial of CBT, TSF and Motivational Enhancement Therapy (MET) based on Motivational Interviewing. No differences were found between these three different modalities in the study, although major reductions in drinking were obtained across all three groups, which were sustained in large part at three year follow-up. These findings suggest that it is not the specific content of therapy that matters but that the process of an organised treatment is effective in

reducing problematic drinking. MET was found to be particularly useful for angry or ambivalent patients.

Recovery often appears to be more related to the influence of natural healing processes rather than targeted medical interventions. The power of AA appears to be in harnessing natural healing processes.

George Valliant is a major contemporary researcher and writer in the field. One of his major contributions has been the book, *The Natural History of Alcoholism* which concluded that the crucial factors important to a person achieving recovery, apart from social stability, are:

- i. A substitute dependency;
- ii. External reminders that drinking is aversive;
- iii. Increased sources of unambivalently offered social support (new relationships); and
- iv. A source of inspiration, hope and enhanced self-esteem.

He argues that Alcoholics Anonymous appears to be an effective means of bringing all four factors to bear. He advises all alcoholic patients seeking a new beginning to their recovery, of the importance of their first 100 AA meetings.

Systematic research on AA is difficult because of the organisation's tradition of anonymity. However, it is clear that a good number of patients who do recover, attribute their success to the 12 Step Programme of Alcoholics Anonymous. Systematic studies in the USA have suggested that about 30% of patients who do well, have been regular attenders of AA.

The famous twelve steps of AA are as follows:

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defeats of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take a personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

The equally famous, but not so well known, twelve traditions of AA help explain why this organisation has lasted the test of time.

#### **6.5.4 Medications**

Two medications used traditionally in the treatment of alcohol dependence are disulfiram (Antabuse) and calcium carbimide (Dipsan). Both inhibit hepatic aldehyde dehydrogenase and thus act by interfering in the hepatic breakdown of alcohol to acetate via acetaldehyde, which

accumulates and produces the “antabuse reaction” consisting of flushing, tachycardia and nausea if the patient drinks alcohol. These medications may help reduce the amount of drinking after a relapse but have not been found to enhance counselling in maintaining remission.

In 1992, a new era in the treatment of alcohol dependence was ushered in with the publication of the first randomised controlled trial of naltrexone (an opioid antagonist) versus placebo. In this study naltrexone halved the relapse rate in men with alcohol dependence. A replication which involved men and women soon followed and further confirmations have occurred. Naltrexone became a subsidised medication in New Zealand in 2004 but only available to patients being treated in accredited drug treatment units with the result that it is currently under-utilised in New Zealand.

Another anti-craving agent, acamprosate (a GABA analogue), has been shown to also be effective in the treatment of alcohol dependence, especially in Europe, in those who have recently become abstinent from alcohol but its efficacy was not shown in a more recent US trial, The Combine Study, when both compared with naltrexone and added to naltrexone.

It is expected that further new anticraving and novel antiaddiction agents will be developed over the next few decades and become common practice in addiction treatment. This new era in treatment is very similar to the change in the treatment of tuberculosis (Tb) once antituberculous medication was discovered. Tb used to be treated with programmes out in the country combining fresh air, good food, group therapy and intermittent contact with family – ring a bell?

In addition to new medications being developed, the addiction treatment field in New Zealand has become increasingly sophisticated around the use of medications for a variety of co-existing psychiatric and medical conditions. A list of 30 key medications forms the basis for one of the NAC postgraduate papers “PSMX:424 Pharmacotherapy of Addiction and Co-existing Disorders” as follows:

Buprenorphine, Bupropion, Carbamazepine, Chlorpromazine, Citalopram, Clonazepam, Clonidine, Diazepam, Dihydrocodeine, Disulfiram, Flucloxacillin, Interferon/Ribavirin, Lithium, Metoclopramide, Methadone, Methylphenidate, Morphine, Naloxone, Naltrexone, Nicotine, Nortriptyline, Oxycodone, Paracetamol, Promethazine, Propranolol, Quetiapine, Sodium Valproate, Thiamine, Varenicline, Zopiclone.

## **6.6**        *Common psychosocial interventions*

Community-based treatment is now widely available in New Zealand and serves the greatest number of clients. The psychosocial interventions used by workers in these treatment settings need to follow the best available treatment models. Those with a substantial evidence base for treatment effectiveness are noted as follows:

### **6.6.1**        *Family Inclusive Practice*

Family inclusive practice, by taking a contextual view of addiction, ensures therapy includes significant members of the social environment in which the individual is located. This approach assumes that interventions are more effective when they include family members. It supports the view that individuals influence other members of their environment, especially family, and that family members, in turn, have an impact on others. Family inclusive practice is linked to

ecological models, resilience models, systems theory, multicultural and bicultural models of practice.

Most treatment practitioners are well aware of the pain and disruption that is caused when a family/whānau struggles with addiction. Sometimes it is referred to as a family disease because the serious consequences of alcohol and drug use have a ripple effect on those living and surrounding the user. Relationships with family/whānau and other intimate relationships are often troubled because the relationship with alcohol and/or drugs grows more and more intimate and becomes more important than intimate relationships. Over time family patterns may unknowingly enable the user. Interactions amongst family members may become habitual and repetitive. Family/whānau members are interdependent and one member's behaviour affects others.

Historically alcohol and drug problems were viewed as individual problems and often treated on an individual basis. In the last three decades the role of family members in the start and maintenance of alcohol and drug behaviours has gained recognition. Research has shown that alcohol and drug treatment that involves family have resulted in higher levels of abstinence.

The Ministry of Health has published a resource on how families can be involved in the delivery of mental health services. (MOH 2000) and other Ministry of Health documents (eg National Mental Health Standards, Standard 10), require providers to work effectively with family members and significant others in their services. However, despite these recommendations, family inclusive practice is still not routinely delivered.

Benefits for Family inclusive practice are various:

- Support systems are in place beyond the sessions
- Families/whānau and significant others can provide comprehensive information and insight in problematic situations and patterns
- Families may start addressing their issues or problems around dependent behaviours
- Everyone involved gains insight and learning, receives support and opportunities to make changes
- Children can be referred to programmes available or receive input from specialist services.

Using family inclusive practice acknowledges that alcohol and drug use is indicative of what else is going on in the family and allows for everyone to receive the support they need. Identifying the stresses and problem behaviours, support systems, coping strategies and increasing open communication are a key in changing and helping a family affected by alcohol and drugs. When working with a client individually, discussion may take place about others; family/whānau and significant others that play an important role in the client's life.

In kaupapa Māori services, inclusion of whānau is considered to be standard practice. Practising the principle of whānaungatanga means embracing whānau and incorporating them in treatment. It is about acknowledging the inter-connectedness and inter-dependence of an individual and all members of the whānau, immediate and extended family, community and wider society. Pacific Island cultures also see the person as an integral part of a bigger picture and family and culture play an essential role in the health and well-being of a person. Working towards good health means that everybody is included and affected by interventions and outcomes of the treatment.

### **6.6.2 Motivational Enhancement Therapy (MET)**

Motivational interviewing (MI) is a client-centred, directive method for enhancing intrinsic motivation to change (by exploring and resolving ambivalence) that has proven effective in helping clients clarify goals and commit to change. Motivational enhancement therapy was developed for the purposes of Project MATCH (see earlier 6.2.3) and essentially is MI packaged into four sessions. The aim is to increase client change talk and diminish client resistance. The extent to which clients verbally defend the *status quo* (resistance) will be inversely related to behaviour change. The extent to which clients verbally argue for change (change talk) will be directly related to behaviour change.

The practitioner works to elicit from the client the desire, ability, reasons and need for change to build a commitment to do so. The importance for there to be changes, confidence to undertake them and a readiness to do so are measured and used to strengthen the commitment.

Using open-ended questions, affirmation, reflective listening and summarizing as ways to avoid resistance and develop a discrepancy between values and behaviour, the practitioner builds self-efficacy, the belief in the real possibility of initiating and maintaining change.

### **6.6.3 Cognitive-Behavioural Therapy (CBT)**

CBT is a broadly applicable therapeutic approach that assists patients to become more aware of the connections between their thoughts and their behaviour. It seeks to modify negative or self-defeating thoughts and behaviours. CBT uses the client's cognitive distortions as the basis for prescribing activities to promote change. Practicing new behaviours is a key to the success of CBT.

CBT works on helping the person recognise relapse cues and to intervene so lapses occur less frequently and with less severity and is therefore highly focused on relapse prevention. Likely problems are anticipated and clients are assisted to apply various tactics for avoiding lapses including social skills training to teach drug refusal skills. Commonly encountered problems are lack of support from others for the treatment goal, negative mood or depression, strong or prolonged withdrawal symptoms, boredom and not taking up alternative activities, flagging motivation and feeling deprived.

CBT in the context of relapse prevention distinguishes between a lapse and a relapse as a matter of degree and severity. The latter tends to signify a giving up of the treatment goal, while the former may happen when tempted but the goal is still desired. There is a focus on trying to avoid a lapse become a relapse by quickly managing the situation and framing it as a learning opportunity in an effort to return to the treatment goal. It allows for lapses as part of the journey of recovery.

### **6.6.4 Social Behaviour and Network Therapy (SBNT)**

To give the best chance of a good outcome, people with addiction problems need to develop positive social network support for change. This therapy mobilises or develops positive social network support for change in drinking or drug using behaviour. Through identifying and contacting network members and supporting the client to engage their support, work is done with the network to:

- reach and maintain agreement about drinking/drug use goal
- improve coping and communication
- increase pleasant social activities alternative to drinking/drug use

- maintain the cohesion of the network
- make relapse prevention plans and
- identify further sources of social support.

Social network support for change is relevant to everyone presenting for treatment:

- It is adaptable to different cultures and social contexts because it is based on the social context of the individual
- It is applicable with isolated individuals and with people estranged from their networks.

# 7.0 THE ADDICTION TREATMENT FIELD IN NEW ZEALAND

## 7.1 *Clinical practice*

Over the past decade or so, there has been increasing professionalisation of the addiction treatment field in New Zealand. Important developments during this time have included the establishment of the Addiction Chapter of Addiction Medicine (AChAM) within the Royal Australasian College of Physicians in 2002 and the growth of Drug and Alcohol Nurses Australasia (DANA). However, the majority of workers in the addiction treatment sector do not come from a professional base such as medicine or nursing. Therefore, arguably the most important development in New Zealand has been the emergence of the Drug and Alcohol Practitioners' Association of Aotearoa-New Zealand (DAPAANZ) and the defining of what a registered AOD practitioner is, particularly for those without a health professional base.

Registered AOD practitioners are described as those workers who utilise AOD knowledge and specialised clinical judgement to assess AOD and co-existing needs and who plan and implement relevant evidenced-based interventions to support people to address identified issues.

Unique features of addiction treatment practice include:

- Knowledge about drugs, drug use and other hedonic activities
- Understanding compulsive use of substances and other hedonic activities
- Ability to carry out addiction-specific assessment and interventions
- Knowledge relevant to co-existing disorders
- Knowledge and skills related to drug withdrawal
- Relapse prevention skills and behaviour replacement strategies.

Registered AOD practitioners practice independently and in collaboration with other stakeholders to perform their professional functions and/or to refer appropriately to ensure comprehensive care is provided to the best levels and standards available.

Practice undertaken by registered AOD practitioners occurs in a range of settings and in a variety of clinical and cultural contexts in collaboration with individuals, families, whānau, groups and communities. Practice is undertaken within the area(s) and at the level of the practitioner's expertise, with due regard to ethical, legal and other relevant standards. Registered AOD practitioners may also manage, teach, evaluate and research AOD practice.

The beliefs, knowledge, skills and activities of registered AOD practitioners are outlined in *Practitioner Competencies for Alcohol and Drug Workers in Aotearoa-New Zealand, 2001*.

## 7.2 *Educational pathways*

Currently there are a number of educational pathways, undergraduate and postgraduate, for people who wish to work in the addiction treatment field in New Zealand. This is positive given the national addiction workforce development plan's key aim of increasing the percentage of workers with qualifications so that by 2015 one third of the workforce will have postgraduate qualifications and one third will have graduate qualifications.

There are three main Universities offering postgraduate papers in the addiction area: University of Otago, University of Auckland and Massey University.

### **7.3**      *Cultural perspectives*

The addiction treatment field has had an awareness of a range of ‘cultural’ perspectives since any of us can remember and in many ways has been in the vanguard of the development of appropriate responses to these in the health sector overall. Twenty years ago the terminology was “special needs groups” but this somewhat paternalistic way of describing cultural perspectives has not been the main way of referring to this area for many years. Some of the old “special needs groups”, such as patients with co-existing disorders and youth, with their own cultural issues and challenges for addiction treatment workers, have now become so mainstream and central to the addiction treatment field that they probably no longer need to be given a special status in order for them to be included in routine discussions about the sector. However, there is always a risk of marginalisation of sub-groups in the overall sector, particularly when clinicians do not feel confident about working with certain groups, so continuing consideration of the wide variety of potential groups is necessary.

We comment below about three key cultural groups: Māori, Pacific and Gay/Lesbian but, first, some data on the risk of developing substance use disorders in relation to ethnicity here in New Zealand, specifically Māori and Pacific.

Te Rau Hinengaro is the Māori title to a recently reported New Zealand Mental Health Survey. In this major national household study of nearly 13,000 New Zealanders 16 years and over, the lifetime risk of developing a substance use disorder was 3.1 times higher for Māori and 2.6 times higher for Pacific compared with Other (read Pakeha). When these data were adjusted statistically to take into account age, gender, education and household income, the level of risk of developing a substance use disorder drops for both Māori and Pacific. For Pacific it drops to 1.2, which is still somewhat above Other. However, for Māori the risk remains double that of Other (2.0). These data support the service development strategy that has been adopted over the past two decades of establishing dedicated Māori and dedicated Pacific treatment services.

#### **7.3.1**      *Māori*

Those working in the addiction treatment sector need to practice cultural safety and cultural competence. To start with, this means being aware of what the client and themselves bring to the therapeutic relationship across a range of ethnocultural presentations. However, this is not enough. Increasing access, retention and outcomes for Māori behoves practitioners, Māori and non-Māori, to also consider how they can incorporate in their practice relevant values, beliefs and practices that are culturally congruent for Māori, taking into account that Māori are not a homogenous group. Some Māori may choose, or require, a more intensive Māori cultural milieu and there are dedicated Māori services that offer this choice.

Over the past ten years there has been a growing literature documenting the development of appropriate Māori responsive treatment and the next section lists one of these papers from the stable of Huriwai and Robertson.

### **7.3.2 Pacific**

It is also a mistake to consider Pacific people as a homogenous grouping. The seven largest Pacific populations in Aotearoa New Zealand are Samoan, Tongan, Cook Islands Māori, Tokelauan, Niuean and Fijian and there are important differences in the consumption of various substances and other addictive products across these populations. The Pacific Drugs and Alcohol Consumption Survey 2003 is the best data available on the use of alcohol, tobacco, kava, marijuana, other recreational drugs and gambling for Pacific People in New Zealand.

In recent years a dialogue on ‘Pacific Cultural Competency’ has emerged in the Mental Health and Addictions sector. Pacific models of care have been emerging underpinned by a conviction in the value of holistic interventions which integrate clinical and cultural competencies.

### **7.3.3 Gay and lesbian clients**

It is important to acknowledge sexual orientation when considering problematic alcohol and drug using behaviours. It is also important to keep in mind the continuing prejudice that exists toward gay and lesbian citizens. Some disturbing statistics include: 80% of our gay and lesbian clients report severe social isolation; they typically hear anti-gay slurs 12 times a day; one in five will attempt suicide; 70% will withhold information about their orientation until satisfied they won’t meet homophobic or uninformed attitudes; and 42% of homeless youth identify as lesbian/gay. Treatment needs to recognise and utilise different support structures with many gay and lesbian people identifying close friends as family (MacEwan, 2005).

## **7.4 National organisation**

The addiction treatment sector is based in 150 dedicated addiction/AOD teams set in one of the 21 DHBs or in one of 16 larger NGOs or Iwi. Other AOD specialists work in general mental health, Māori health or services for young people. DHB addiction services have not always been part of the mental health service structure but virtually all are now.

There are about 800 full-time alcohol and drug and gambling treatment practitioners at the current time.

The overall direction of treatment is led by the Population Health Directorate within the Ministry of Health. It sets the national policy and contracts with DHBs the provision of services. NGOs are contracted in turn by DHBs to provide their services.

The sector leadership is provided through the National Committee for Addiction Treatment (NCAT), “the voice of the addiction treatment sector”, which has up to 20 members, most of whom represent key treatment services and other national organisations related to the field, and there is a smaller number of elected and ex-officio members.

The membership of NCAT (as at May 2008) is as below. This group represents many of the leaders of addiction treatment sector at the current time.

Andrew Raven – Hawkes Bay DHB (elected member)  
Annemarie Wille – Matua Raki  
Bruce Levi – Tupu/Waitemate DHB (Pacific representative)  
Cate Kearney – Alcohol Drug Association (Co-chair)  
Cheryl Duffy – Canterbury DHB

Chris Kalin – Odyssey Auckland (Co-chair)  
Daryle Deering – National Addiction Centre  
Eileen Varley – National Association of Opioid Treatment Providers  
Hone Makatea – Māori Treatment Providers Representative  
Lynette Hutson – Salvation Army  
Phil Townshend – Gambling Sector Representative  
Rhonda Robertson – Matua Raki (consumer representative)  
Robert Steenhuisen – Waitemata DHB  
Ross Bell – New Zealand Drug Foundation  
Sheridan Pooley – Waitemata DHB (consumer representative)  
Takurua Tawera – Māori Treatment Providers Representative  
Terry Huriwai – Matua Raki (elected member)  
Tim Harding – DAPAANZ  
Wolfgang Theuerkauf – National Addiction Training Providers Network

NCAT communicates with the sector through tri-annual Leadership days held in Auckland, Wellington and Christchurch in a rotating pattern. The Committee meets after each of those days.

The workforce development leadership is provided through Matua Raki, funded by the Ministry of Health. For the first three years Matua Raki was an integral part of the NAC, hosted by the University of Otago. DAPAANZ was also very closely associated with the Matua Raki/NAC entity. This arrangement has recently undergone several reviews.

The NAC is the leading academic centre for the addiction treatment field in New Zealand. Other important academic centres are at the Auckland, Massey and Auckland Technology Universities, the Wellington Institute of Technology and Te Wananga O Raukawa.

DAPAANZ is the professional organisation with 600 of the workforce in membership. It encourages the alcohol and drug treatment workforce to work with safety and accountability, consistency in quality of care and improved treatment outcomes for clients. It seeks to ensure that the workforce is recognised as competent and equal to other health professionals under the HPCA Act.

## 8.0 TOP JOURNAL ARTICLES

We wanted to assemble a list of key papers – peer-reviewed journal articles – that had in some way been inspirational to us at the NAC in terms of addiction and which we therefore consider highly beneficial for a dedicated new addiction treatment worker to read as they begin their work in the field. Initially we thought about assembling the top 10 articles but in the end this grew to 20 and included seven of our own.

### 8.1 *Top 13 international journal articles*

Out of the hundreds of thousands of articles on offer in the literature, below is a list of 13. We present them in the order of when they were published, from 36 years ago to the present, to give a sense of the history in the development of ideas and knowledge in our field as it has unfolded over this time.

We do not pretend that these are *the* top 13 articles, but rather *a* list of key articles that we at the NAC have found particularly illuminating in terms of helping us in growing understanding about addiction and how best to help people in the recovery process. We consider that these articles should be read as a matter of priority and we hope you enjoy them as much as we have. They are listed in order of year of publication as follows:

Frank JD. Common features of psychotherapy. *Australian and New Zealand Journal of Psychiatry* 1972; 6: 34-40.

Dole VP, Nyswander ME. Methadone maintenance treatment: A ten-year perspective. *Journal of the American Medical Association* 1976; 235 :2117-2119.

Edwards G, Gross MM. Alcohol dependence: Provisional description of a clinical syndrome. *British Medical Journal* 1976; 1: 1058-1061.

Vaillant GE. What can long-term follow-up teach us about relapse and prevention of relapse in addiction? *British Journal of Addiction* 1988; 83: 1147-1157.

Chapman P, Huygens I. An evaluation of three treatment programmes for alcoholism: An experimental study with 6- and 18-month follow-ups. *British Journal of Addiction* 1988; 83: 67-81.

Gold MS, Miller NS. Seeking drugs/alcohol and avoiding withdrawal: The neuroanatomy of drive states and withdrawal. *Psychiatric Annals* 1992; 22: 430-435.

Volpicelli JR, Alterman AI, Hayashida M, O'Brien CP. Naltrexone in the treatment of alcohol dependence. *Archives of General Psychiatry* 1992; 49: 876-880.

Fergusson DM, Horwood J, Lynskey MT. The comorbidities of adolescent problem behaviours: A latent class model. *Journal of Abnormal Child Psychology* 1994; 22: 339-354.

Sobell MB, Sobell LC. Controlled drinking after 25 years: How important was the great debate? *Addiction* 1995; 90: 1149-1153.

Bierut LJ, Dinwiddie SH, Begleiter H, Crowe RR, Hesselbrock V, Nurnberger JI, Porjesz B, Schuckit MA, Reich T. Familial transmission of substance dependence: Alcohol, marijuana, cocaine and habitual smoking. *Archives of General Psychiatry* 1998; 55: 982-988.

Project MATCH Group. Matching alcoholism treatments to client heterogeneity: Treatment main effects and matching effects on drinking during treatment. *Journal of Studies on Alcohol* 1998; 59: 631-639.

Miller WR. Rediscovering fire: Small interventions, large effects. *Psychology of Addictive Behaviors*, 2000; 14: 6-18.

McLellan AT, Lewis DC, O'Brien CP, Kleber HD. Drug dependence: A chronic medical illness. *Journal of the American Medical Association* 2000; 284 :1689-1695.

## **8.2 Top seven NAC journal articles**

We also thought you might be interested in what we consider to be the top seven journal articles from the NAC that involve each of us as primary author at least once, which we think make the most important contribution to the field. Here they are, again in order of publication year:

Sellman JD, Sullivan P, Dore GM, Adamson SJ, MacEwan I. A randomised controlled trial of motivational enhancement therapy (MET) for alcohol dependence. *Journal of Studies on Alcohol* 2001; 62: 389-396.

Huriwai T, Robertson PJ, Armstrong D, Kingi TP, Huata P. Whānaungatanga - a process in the treatment of Māori with alcohol- and drug-use related problems. *Substance Use & Misuse* 2001; 36: 1033-1051.

Todd FC, Sellman JD, Robertson PJ. Barriers to optimal care for patients with co-existing substance use and mental health disorders. *Australian and New Zealand Journal of Psychiatry* 2002; 36: 792-799.

Deering DE, Frampton CMA, Horn J, Sellman JD, Adamson SJ, Potiki TL. Health status of clients receiving methadone maintenance treatment using the SF-36 health survey questionnaire. *Drug and Alcohol Review* 2004; 23: 273-280.

Adamson SJ, Todd FC, Sellman JD, Huriwai T, Porter J. Co-existing psychiatric disorders in a New Zealand outpatient alcohol and other drug clinical population. *Australian and New Zealand Journal of Psychiatry* 2006; 40: 164-170.

Adamson S, Sellman D, Deering D, Robertson P, de Zwart K. A profile of the alcohol and drug treatment population in New Zealand: A comparison of 1998 and 2004 data. *New Zealand Medical Journal* 2006; 119(1244). <http://www.nzma.org.nz/journal/119-1244/>.

Sellman JD, Baker MP, Adamson SJ, Geering LG. The future of God in recovery from drug addiction. *Australian and New Zealand Journal of Psychiatry* 2007; 41: 800-808.

# APPENDIX 1: DSM-IV CRITERIA FOR ALCOHOL DEPENDENCE

## DSM-IV SUBSTANCE DEPENDENCE

Maladaptive pattern of use with at least three of the following occurring within a 12 month period:

1. Use is often more than intended (quantity or time)
2. Unsuccessful attempts to cut down or control use
3. Much time is spent in use (time +++)
4. Important activities given up or reduced
5. Continued use despite knowledge of associated medical or psychological problems
6. Tolerance (acquired)
7. Withdrawal

## DSM-IV SUBSTANCE ABUSE

\* Never had dependence on this substance

\* Maladaptive pattern of use with at least one of the following recurrent associated problems over a 12 month period

1. Failure to fulfill major role obligations
2. Hazardous use
3. Legal problems
4. Social or interpersonal problems

# **APPENDIX 2: DSM-IV ALCOHOL DEPENDENCE CRITERIA (HEAVIEST 6 MONTHS) AND SUGGESTED QUESTIONS (ADAPTED FROM ZIMMERMAN 1994)**

- 1. Alcohol taken in larger amounts or for longer periods of time than intended**  
When you drank, did you often drink more than you had planned?  
Did you often drink for more time than you had planned?
- 2. Persistent desire or unsuccessful attempts to cut down or control alcohol use**  
Did you frequently think about cutting down or stopping drinking?  
At times did you try to cut down or stop but couldn't?
- 3. A great deal of time spent in activities necessary to get alcohol, drink alcohol or recover from its effects**  
Did you spend a lot of time doing things or planning ways to get alcohol?  
How much time did you spend drinking?  
Did you spend a lot of time recovering from drinking, for example with hangovers?
- 4. Important social, occupational or recreational activities given up or reduced because of alcohol use**  
Did you spend so much of your time drinking so that you missed work a lot, or spent less time with family or friends, or gave up hobbies or interests?
- 5. Continued use despite knowledge of having a persistent or recurrent medical or psychological problem likely to have been caused or exacerbated by alcohol**  
Did drinking cause physical or psychological problems?  
IF YES: Like what? Did you keep drinking despite this?
- 6. Tolerance**
  - a. Over time, did you drink a lot more to get high or get the same effect as before? IF YES how much more?
  - b. Did you develop a tolerance to alcohol so that the same amount as before did not have the same effect?
- 7. Withdrawal symptoms or relief use**
  - a. Did you experience any of the symptoms of withdrawal when you tried to stop alcohol or cut down your use?
  - b. Did you often drink or take anything else to stop withdrawal symptoms or prevent them coming?

# APPENDIX 3: TIPS FOR CUTTING DOWN ALCOHOL USE

## *Take smaller sips*

- Sip less often and take small sips. Count the number of sips it takes to finish a glass and then try increasing the number for the next glass and so on.

## *Occupy oneself*

- Do something else enjoyable while drinking that will help distract attention from the glass and drink more slowly: for example, eating, listening to music, playing darts, talking and so on.

## *Change the drink*

- Changing the type of drink can help break old habits and reduce the amount drunk.

## *Drink for taste*

- Drink more slowly and enjoy the flavour.

## *Imitate the slow drinker*

- Identify someone who drinks slowly and become a shadow, not picking up the glass until he does.

## *Put the glass down between sips*

- If the glass is held it will be drunk more often. Do something else with your hands instead of lifting the glass to the lips.

## *Dilute spirits*

- Top up spirits with non-alcoholic mixers.

## *Reduce amounts in rounds*

- Buy your own drinks, or one round, and then go solo; do not buy yourself a drink when it is your round; order non-alcoholic drinks every so often.

## *Drink and eat*

- Eat before drinking or whilst drinking; this slows down the absorption of alcohol and doing something else may also reduce the amount drunk.

## *Take days of rest*

- Abstain from alcohol at least one day per week, or preferably two, three or even four days per week. Take up other forms of entertainment or relaxation.

## *Start later*

- Start drinking later than usual: for example, go to the pub later.

## *Learn to refuse drinks*

- Rehearse ways of refusing drinks. For example, “No thanks, I’m cutting down” or “Not tonight, I’ve got a bad stomach”.

[Adapted from O’Hagan, Robinson and Whiteside 1993]



## **Scoring the AUDIT**

Score 0-4 for the five options for questions one to eight

Score 0,2,4 for questions nine and ten.

The maximum total is 40.

A score of 8+ has been shown to be indicative of at least hazardous use of alcohol.

# APPENDIX 5: STRUCTURE TO A COMPREHENSIVE ASSESSMENT

## *HISTORY*

### 1. Introduction:

*(name, age, occupation, marital status, children, current social circumstances)*

### 2. Presentation:

*(nature of referral, including client/patient's definition of presenting problem[s] and expectations of help).*

### 3. Alcohol and Drug/Addiction History:

#### A) Alcohol and Other Drugs

- a. Pattern of substance use *(current or most recent use, first use, first regular heavy use, first withdrawal symptoms, heaviest periods of use, longest periods of abstinence)*
- b. Substances used in life, including nicotine *(regular, ever - frequencies)*
- c. Person's stated or implied reasons for using.
- d. Complications of alcohol and drug use
- e. Dependence/abuse status *(using standardised questions for alcohol, cannabis and then for other drugs)*

DSM-IV	Alcohol	Cannabis	Opioids	Sedatives	Stim.	Halluc.	Inhal.	Poly
1								
2								
3								
4								
5								
6								
7								

- f. Treatment history *(including use of self-help groups)*

#### B) Behavioural Addictions

Pathological Gambling:

Have you ever gambled or bet too much?

### 4. Other Psychiatric History

- a. Past diagnoses/treatment
- b. Screening of current and lifetime diagnosis of the following:
  - i. Generalised anxiety disorder: Have you ever worried a lot about terrible things that might happen, even when it was unrealistic to worry as much as you did?

- ii. Social phobia: Is there anything that you were ever afraid to do or felt uncomfortable doing in front of other people, like speaking, eating or writing? What were you afraid could happen when ...?
  - iii. Agoraphobia: Were you ever afraid of going out of the house alone, being in crowds, standing in a line, or travelling on buses or trains? What were you afraid could happen?
  - iv. Panic Disorder: Have you ever had a panic attack, when you suddenly felt frightened, anxious or extremely uncomfortable? Have you ever had one when you didn't expect to at all?
  - v. Post-traumatic stress disorder: Have you ever experienced a very traumatic event which was extremely distressing?
  - vi. Anorexia nervosa: Have you ever had a time when you weighed much less than other people thought you ought to weigh and when you continued to feel overweight?
  - vii. Bulimia nervosa: Have you ever had eating binges during which you ate a considerable amount of food in a short period of time and during which your eating was out of control?
  - viii. Obsessive compulsive disorder: Have you ever been bothered by thoughts that didn't make any sense and kept coming back to you even when you tried not to have them? Was there ever anything that you had to do over and over again and couldn't resist doing, like washing your hands again and again or checking something several times to make sure you had done it right?
  - ix. Dysthymic disorder: Have you ever been bothered, or experienced depressed mood most of the day, more days than not, for a period of several years?
  - x. Major depressive syndrome: Has there ever been a period of time when you were feeling depressed or down most of the day nearly every day? (*As long as two weeks?*)
  - xi. Manic syndrome: What about ever having the opposite of depression when you were feeling so good or high that other people thought you were not your normal self or you were so high that you got in trouble?
  - xii. Delusions (reference and persecutory): Did it ever seem that people were talking about you or taking special notice of you? What about receiving special messages from the TV, radio or newspaper or from the way things were arranged around you? What about anyone going out of their way to give you a hard time or trying to hurt you?
  - xiii. Hallucinations (auditory and visual): Did you ever hear things that other people couldn't hear, such as noises or the voices of people whispering or talking? Did you ever have visions or see things that other people couldn't see?
- c. Exploration of self-harm, suicidality, homicidality and other areas of risk (past/current)

## 5. Current Prescribed Medications

(*psychiatric and medical, including dose*)

**6. Medical History:**

- a. Past diagnoses/treatment
- b. Current symptoms/problems in systematic review (*nervous, endocrine, CV, respiratory, GI, GU, skeletal*)
- c. Estimated risk of infection (*especially Hep B, Hep C, HIV*)

**7. Legal/Forensic History**

*(convictions, jail terms, charges pending, current legal status)*

**8. Family History**

- a. Structure of family of origin
- b. Family disorders (*alcohol and drug, psychiatric, medical and legal in first and second degree relatives*)
- c. Living in the family while growing up (*including general family functioning, adequacy of specific relationships within family and occurrence of physical/sexual abuse*)
- d. Current relationships (*with members of family of origin*)

**9. Personal/Developmental History**

- a. Significant life events in infancy
- b. Relationships outside family of origin (*from childhood through to the present, including psychosexual development and marriage, key enduring friendships, sexual orientation, cultural identity*)
- c. Education and work (*from school through to the present*)
- d. Personality (*including description by client/patient and the presence of conduct disorder, attention-deficit-hyperactivity disorder, antisocial personality disorder [using standardised questions] and any other personality disorders*)

**10. Current Psychosocial Functioning**

*(work, relationships, accommodation, finances, social networks, ongoing stresses, coping skills, problem solving skills)*

# ***MENTAL STATE EXAMINATION***

- 1. Appearance and Behaviour**  
*(physical appearance, clothing, movements, state of intoxication, state of consciousness)*
- 2. Speech**  
*(speed, articulation, volume, relevance)*
- 3. Affect and Mood**  
*(signs of depression, elation, anxiety)*
- 4. Thought Process**  
*(specific thought disorder)*
- 5. Thought Content**  
*(preoccupations, overvalued ideas, delusions)*
- 6. Perception**  
*(illusions, hallucinations)*
- 7. Insight/Motivation and Readiness to Change**  
*(degree of awareness/acceptance and ability to co-operate with treatment, stage of readiness to change)*
- 8. Cognitive Screening**  
*(“I’m now going to ask you a routine set of questions related to memory and concentration.”)*
  - a. Orientation (Time/Place/Person)**                      year, season, month, day, date, time
  - b. Registration**    four unrelated objects
  - c. Attention and Concentration**                      “100-7 test”; spell world backwards
  - d. Naming of Objects**                                      name watch strap, clasp and tell time
  - e. General Knowledge**                                      Prime Minister of New Zealand  
Capital City of Australia  
Closest planet to the sun
  - f. Interpretation of a Proverb**                              concrete/abstract
  - g. Constructional Ability**                                      draw a clock face
  - h. Short-term Recall**    of the four unrelated objects

# ***SUMMARY OPINION***

## **1. Diagnosis (using first three Axes of DSM-IV multiaxial system)**

- Axis 1**      Substance use disorders, behavioural addictions and other psychiatric disorders  
(including conduct disorder)
- Axis 2**      Personality  
Mental Handicap
- Axis 3**      Physical conditions

## **2. Problem List**

Current issues  
(physical health, mental health, work, family, relationship,  
accommodation, financial, legal, any other)

## **3. Formulation**

The formulation is an explanatory statement. It attempts to answer a key clinical question; “why is this person presenting in this way at this time?”. It is a statement that links individual characteristics and issues (past and present) to diagnoses in a way that generates treatment goals and management plans.

*(2x4 grid may help in organising ideas: Bio-psycho/socio-environmental x predisposing/precipitating/perpetuating/protecting factors)*

# ***MANAGEMENT***

## **1. Management Goals**

## **2. Management Plan**

Nine key areas to address:

1. More information required
2. Setting
3. Treatment of medical conditions
4. Psychopharmacology
5. Psychological intervention
6. Family and social interventions
7. Education/work/occupation
8. Education of patient and significant others
9. Self-help groups

All of the above considered over the short term as well as the long-term.

### **3. Prognosis**

- a. Natural course of the illness
- b. +ve factors that modify the course in this client/patient
- c. -ve factors that modify the course in this client/patient
- d. Synthesis and prediction (symptoms and general functioning)

# APPENDIX 6: BRIEF ASSESSMENT AND INTERVENTION

## *ASSESSMENT*

### *History*

1. **Demographics**
2. **Beginnings** (age at first intoxication, regular use, first alcohol-related problem)
3. **Pattern** (overview of pattern including the main problems and the six month period of heaviest use of alcohol)
4. **Dependence** (applying the DSM-IV criteria to the heaviest six month period of heaviest use to establish a lifetime diagnosis or not)
5. **Current use** (quantity/frequency in the past six months)
6. **Other drug use** (brief history of other drug use)
7. **Treatment** (brief A&D treatment history)
8. **Psychiatric** (brief psychiatric history)
9. **Medical** (current significant medical conditions)
10. **Family** (family history of A&D)
11. **Miscellaneous** (is there anything else you would like to tell me at this stage, not necessarily related to your drinking?)

### *Examination*

1. **General Appearance** (checking obvious mental and physical disorder)
2. **Readiness to Change** (establishing stage of change – precontemplation, contemplation, determination, action)

# ***INTERVENTION***

## **Step 1: Summarise assessment findings**

- drinking pattern (quantity and frequency)
- drinking-related problems
- symptoms of dependence
- presence of contra-indications
- positive family history

## **Step 2: Brief tutorial**

- outline ALAC drinking guidelines
- educate about what is a standard drink
- relate these guidelines to their own drinking, by calculating number of standard drinks consumed per session/week, and presence of contra-indications (driving, liver damage etc)
- give the information that about 20-30% of New Zealanders misuse alcohol
- invite their comment

## **Step 3: Giving advice**

- advise of risk of continued heavy drinking (individualise)
- advise drinking within the ALAC drinking guidelines which may include abstinence
- in an engaging interactive way, suggest several drinking behaviour changes – if patient wishes to change

## **Step 4: Negotiating change**

- negotiate a new drinking goal and/or change in drinking behaviour
- negotiate a review of this goal (normally less than three months)