Cutting Edge 2003

CONFERENCE PROCEEDINGS

An annual treatment conference on alcohol, drug and addictive disorders,
Copthorne Hotel & Resort, Bay of Islands

28 - 30 August 2003

ALCOHOL ADVISORY COUNCIL OF NEW ZEALAND
Kaunihera Whakatupato Waipiro o Aotearoa

Hosted by the Alcohol Advisory Council of New Zealand (ALAC) (Principal Sponsor), and the National Addiction Centre, in conjunction with Nga Manga Puriri, the Treatment Research Interest Group (Alcohol, Drugs & Addiction) (TRIG), National Association of Opioid Treatment Providers (NAOTP), Auckland Regional Alcohol & Drug Services (RADS), Odyssey House - Christchurch, Nelson Alcohol & Drug Services.

CUTTING EDGE 2003 PROCEEDINGS

ACKNOWLEDGEMENTS

Thank you again to all those who helped me to gather, retain and share the large amount of information from the Cutting Edge conference.

Meg Harvey
Proceedings Writer

1. EXECUTIVE SUMMARY

Waiho i te toipoto, kaua i te toiroa.
(Let us keep close together, not wide apart)

- Cutting Edge 2003 was held in the Copthorne Hotel & Resort in Waitangi on August 28, 29 & 30

- Three hundred and three delegates attended the conference

- The theme of this year's conference was The Spirit of Partnership, in reflection of the local of the conference

- The Keynote speakers were Eric Broekaert from Belgium, Lloyd Geering from Christchurch, Tipene Filipo from Auckland and Keith Evans of Adelaide, Australia

2. BACKGROUND TO CONFERENCE

The inaugural Cutting Edge Conference was held in Auckland in 1995. The concept of a conference named Cutting Edge, hosted by the Alcohol Advisory Council of New Zealand (ALAC) originated with Ian MacEwan. Making Cutting Edge an annual treatment conference for alcohol and drug clinicians was further developed by Doug Sellman (NAC) and Ian MacEwan, with ALAC and the NCTD (now the NAC) as joint hosts in this venture.

With a view to the NCTD taking over the organisational role it was decided to invite Lisa Andrews from the NCTD to attend the Auckland 1997 conference as an observer. Lisa was subsequently appointed as Conference Secretariat and was later joined in this role by Mo Pettit.

The idea behind the Cutting Edge Conference was to get some momentum within the alcohol and drug treatment field in terms of better liaison and the sharing of ideas through the provision of a regular meeting point to share in the ongoing struggle of providing and improving alcohol and drug treatment in New Zealand.

Early in its development, Doug Sellman was also a keen advocate to incorporate into the conference the full range of problems that the field deals with, so in addition to alcohol problems (ALAC's primary focus), the 1999 Christchurch conference was for the first time held in conjunction with a then biannual Opioid Conference. Over the last two years there has been an increasing opioid presence at the conference as well as problem gambling, with the inclusion of psychiatric comorbidity as a theme since 1997.

Establishing the focus of the conference has lead to much vigorous debate over the years, between those leaning towards a predominantly research focus and those wanting a much more inclusive format. Conferences have therefore tended to be a potpourri of clinical research, service promotion, treatment innovation and workshops.

The success of Cutting Edge is evidenced both by the increasing number of delegates attending each year and noticeably in recent years a greater ethnic mix, moving away from delegates being predominantly Pakeha to many more Mäori and Pacific Nations Peoples attending.

Lisa and Mo continued in their secretariat role, successfully organising conferences in Wellington, Christchurch, Rotorua and Napier. At the start of 2002 Mo left the NCTD and Lindsay Stringer was only too happy to fill the gap that was created. This transition has gone extremely smoothly, with Lisa and Lindsay efficiently organising conferences in Nelson (2002) and Waitangi (2003).

3. SUMMARY OF THEMES

The theme of Cutting Edge 2003 was The Spirit of Partnership. This arose from discussions the Organising Committee had around the location of this year's conference – Waitangi. As in past years the topics covered within the days of the conference were assorted and looked at every corner of the varied and diverse field we work in.

It was encouraging to see the number of presenters who paid close attention to the theme and incorporated it into their presentations. The theme of culture has been increasing over the years at Cutting Edge conferences, with more and more presentations from Mäori and Pacific Nations workers/consumers. This year's theme provided a formal recognition of this. It was gratifying to see so many non-Mäori or Pacific speakers who brought the partnership issues and ideas in this country into their papers, as well as even greater numbers of presentations from different cultures.

Once more a great range of substances of abuse were covered throughout the conference. There were a number of papers centred around methadone and a lot of coverage of alcohol as well as consideration of benzodiazepines, methamphetamine, tobacco and cannabis. Again problem gambling also gained prominence with a number of papers. This year the sorts of treatment discussed over the three days were not so much programmes themselves as much as facets that contribute to treatment such as integration of dual diagnosis, consumer expectations, gay friendly services, bi-cultural partnership and the involvement of youth in their own treatment.

4. KEYNOTE ADDRESSES & PLENARY SESSIONS

KEYNOTE ADDRESS #1: Research-practice encounters in therapeutic communities (Eric Broekaert)

Eric Broekaert was from Belgium and is a Professor in Orthopedagogics (Special Education). He has been working with European therapeutic communities for twenty years and is honorary Vice-President of the European Federation of Therapeutic Communities. He pointed out that science meets practice in therapeutic community treatment. His speech centred around this integration.

When therapeutic communities started out in Europe they were not so keen on science, but researchers were amongst the first to set up these communities. In 1981 the European Federation of Therapeutic Communities was founded. They thought what was needed was the meeting of practitioners and scientists. Then in 1983 they held a European Workshop on Drug policy Oriented Research. The results of this workshop were presented at meetings to be sure there was agreement from the therapeutic communities with their conclusions. They learnt a lot about diagnosis and client characteristics.

The late 1980s saw the development of dual diagnosis in Therapeutic Communities. A lot of changes occurred in the 1980s because of European versions of American systems, e.g. no more humiliating learning (was too like concentration camps was the complaint). They also wanted to be less confrontational. Eric made the observation that American females "like" to live under male domination whereas French women do not at all.

In terms of the implementation of research, in the 1980s they thought they had it ideologically set, but then services told them not to be too ideological. At this point

therapeutic communities became a bit insular. From 1990 they were pushed to show results so they brought in experts from the outside. It then became a balance. In the 1990s they got funding for a large European project. Thus from 2000 they started to develop their own instruments. One thing they did look more closely at was gender differences. They discovered through all this that the development of scientific networks is very important.

From their evaluation of treatment systems they found that the time spent in programmes is the most important factor to measure success. In terms of the development of their scientific methodology the 1980s did not have enough evidence-based research, while the 1990s had more qualitative research. From 2000 the priority of research has been evidence plus the challenges of post modernism and subjectivism.

Eric's conclusion was that research has never been a first interest, but has now changed from a bastard child to a partner. He ended with a note of, "HAPPY PRESENTATION END."

KEYNOTE ADDRESS #2: The new open society and its dangers (Lloyd Geering)

Lloyd Geering was this year's speaker from outside the A&D field and he certainly gave us a lot to think about in terms of the society we live in. Lloyd is an ordained Presbyterian minister and holds degrees in Mathematics and Old Testament Studies. He was awarded an Honorary DD by the University of Otago in 1976, a CBE in the New Year Honours in 1988, and made a PCNZM in 2001. He has published a number of books in the area of contemporary religion and spirituality.

He started by noting that we look at society from a close up perspective, but he wanted us to look at it from a long distance to see long term trends. Lloyd saw many of the reasons for drug addiction arising from the new, open society we are living in. The talk began by looking at society. Society is more than a group of people. Lloyd asserts there

is no such thing as an individual person – individuals are the result of a social process. Society's existence is as long as humanity's. The process has occurred over aeons of time and involved the evolution of language and culture. Human society is a community held together by real, but invisible bonds. Human society a social organism – a unity. We are held together by culture and culture provides identity.

Lloyd stated that today rampant individualism is blinding us to the benefits of society. When society disintegrates it loses its creative power. The oldest society is the extended family. The next type of society to evolve was the tribe. For a time the extended family and tribe were indistinguishable. Tribalism was superseded (with the development of agriculture and settling) by city, state, nation and empire. Today's type of society is global. The blending of family and tribe started genetically with blood ties. Now genetics is increasingly supplemented by the evolution of a bonding culture (shared views and culture).

Lloyd then moved on to discussing religion. Religion means many things to different people. The essence of Latin religion refers to the experience of being bound together, a conscious concern for what really matters in life. Late 19th century scholars concluded religion is social acts or beliefs that bind individuals to his/her community for the preservation of society.

It is only 2000 years ago that we were even aware we had religion. During the Mythological age culture and religion were one and the same and all society was tribal. Then there was a cultural change in 500BC with the first axial period producing prophets, philosophers, and seers. In this period more universal cultures emerged (known today as the world's religions). The big three to emerge were Christianity, Buddhism and Islam. At their best they grew to be impressive and inclusive societies. These were all closed societies (i.e. the family, tribe, religion).

The characteristics of a closed society include a clear and absolute boundary, which provides and preserves social identity for itself and for the personal identity of its

members. It also preserves fixed patterns of behaviour, exerts strong social pressure to conform, and expels those who transgress. It commends uniformity of life style.

In the last 200-300 years, in the west it has started to change to an open society. This second axial period has emerged only in the western world in the form of Renaissance humanists, Protestant reformers, enlightenment free-thinkers, and empirical scientists.

The thrust is personal freedom, a global human family, and equal opportunity. The types of closed society (family, tribe, religion) have been eroding. With the characteristics of an open society boundaries of traditional societies became vague and lack clear and definable identity. Members are responsible for establishing their own personal identity and have to be responsible for a whole lot of choices. Personal identity and destiny take precedence over those of the society. Open society exerts little social pressure to conform, only extreme anti-social behaviour is punished, members are free to develop their own lifestyles, and diversity is valued while conformity devalued.

Closed societies kept people in a child like dependence, which is why hierarchies developed. Now people are freer to make their own decisions. Lloyd feels there is a lot to be said for open society, but they are also more vulnerable (from outside and in). It produces an uncertain future and there is not certainty of purpose. Open societies can easily disintegrate because of the lack of a strong unifying culture. It was the late twentieth century when open societies vividly developed – the same time as drug addiction was growing.

Einstein said that to be religious is to have found an answer to the question of the meaning of life. Lloyd proposed that young people are now left disadvantaged and vulnerable without closed society. The personal freedom they have come to value is a serious threat to society. Open society is a breeding place for anti-social behaviour. There have been attempts to revive closed societies (e.g. Nazism substituting religion). Lloyd sees the growth of the open society as related to the rise of new age religions, the rise of fundamentalism (diverse and exclusive), and the trafficking in drugs offering instant happiness and /or enlightenment.

Closed societies are often intolerant of drug use - Buddhism and Islam have an absolute ban on alcohol. That said, even religious people who don't use drugs fall prey to excessive ways of reaching ecstasy, for example speaking in tongues. As we have seen the decline of more sober types of religion there has been an outburst of Pentecostal religion (the religious equivalent of drugs according to Lloyd).

The dangers of the open society include making us freer (and at an even earlier age) and turning life into a mega-supermarket with many choices inviting us to shop around and find what suits us. It pressures us with competition, glittering advertising, offers consistent answers, instant cures and instant ecstasy, discourages the striving for long-term achievement, prompts us to live for the present, opens the way for illegal drug traffic, encourages the gambling spirit, and increasingly provides throwaway goals.

Lloyd concluded that in attempting to understand why society is as it is, the solution is to not look for quick fixes. This, however, shouldn't prevent us from giving our best efforts. He summarised that we are all responsible for one another whether we are in a closed or open society.

KEYNOTE ADDRESS #3: Tuakana and Teina: The Treaty and Pasifika relations (Tipene Filipo)

Brother Filipo currently teaches at Hato Petera College and the University of Auckland in the School of Education. He is currently studying towards a Doctorate of Education. Brother Filipo talked about a Pacific view of the Treaty and its implications with Pasifika/Maori partnership. He started by giving some background to the Marists arriving in New Zealand and the significance that holds for him, as well as the significance of his family history in Samoa and Niue.

He then discussed how his personal history relates to the Treaty through Whanaungatanga. This is achieved by the cultural practices of fa'a Samoa of Fa'a'aloalo (to respect - like mana in Mäori), Tautau (to serve) and Momali (to witness or walk with).

At the moment Pacific Islanders are the Teing (younger in respect of support) to the Tuakana (elder) of the Mäori people. Brother Filipo noted that what is useful to the tuakana is inevitably useful to the teina. In the health sector and from the indigenous perspective, where teina or tuakana is harmed or violated the consequences of that relationship and your own well-being is affected.

In terms of the significance of the Treaty for Pacific Islanders, it was noted that the Treaty allows Pacific Islanders by invitation to settle in New Zealand. The other link is New Zealand's influence in the Pacific as a protectorate or former colonising power, e.g. Niue and Rarotonga.

Brother Filipo feels he is part of a system that fails his own people (as well as Mäori). We need to make sure we don't become agents of racism that kills. In any right indigenous mind it is not possible for people to sign away their mana (as in article one of Treaty). Brother Filipo further talked about how it takes an indigenous to know an indigenous and that Mäori spirituality had a place in the Treaty. Pacific people too have a relationship with the Crown and Mäori.

He concluded that we are journeying backwards towards the future. We need to give mana to the Treaty.

KEYNOTE ADDRESS #4: Policy and prevention: Spirit of partnership (Keith Evans)

Keith is originally from Wales, resided in New Zealand for many years (when he headed up ALAC), but is now living in Australia. He has qualifications in nursing, psychology, and management. Keith is currently Director of Drug Programs and Population Strategies and Primary Health Care with the Department of Human Services in South Australia. He started by talking about the scarring of the indigenous people in Australia. Uluru (Ayres Rock) reflects the position of indigenous people in Australia with all the white people climbing the rock and the aboriginal people below. Policy needs to have meaning for the

dispossessed and down trodden to have any meaning at all. We spend a lot of our time focusing on problems, but ignoring the reality around us. In Australia they are just starting to help with the most affected people.

Keith feels we have not solved the 'drug problem' - people believe the problem is worse than ever. We have hui, meetings, conferences, Cutting Edge, but he worries that we aren't getting it right yet and we should be. We know what causes the problems and how to solve them – we just don't do it. Drug policies should be: companionable, inclusive, flexible, hopeful and successful. A National policy has to come from the country more fully and engage the community. If pictured as a pyramid the client should be at the top with community below and policy underneath that. Policy should be at the bottom, not the top. If you consider it from a gap analysis perspective policy ought not to have a whole range of gaps in it. Unfortunately we generally see sins of omission rather than commission.

Keith went on to discuss lessons learnt from cardiovascular disease and the difficulty in getting people to change. He feels we need to address spirit, mind and body. Over time it has become more uncomfortable discussing the spirit. He pointed out that unless you can provide for those most at risk you are not providing. A strong treatment service is required before we can move to issues of why we have problems. As governments become more worried about expenditure they go for cheaper options and while more can be done is it as effective?

We need to help young people make healthy choices, protect the community, strengthen support, intervene at the earliest possible time, and provide timely and effective treatment programmes. Keith noted that it is time for a new beginning – the thing that will drive change is the desire of enough people who are dealing with the issues to do so. Keith concluded that we need to end faction fighting, end conflict between treatment and prevention, end "my evidence is better than yours" (where is the place for experience?), and end blaming others. We need to own the resolution of the problem. It is time to share the path forward.

Keith's final note was to beware those who say I HAVE THE ANSWER and avoid those who say THERE IS NO ANSWER.

KEYNOTE ADDRESS #5: Cutting edge of workforce development (Terry Huriwai)

Terry Huriwai is a former probation officer, who now works for the Mental Health Directorate in the Ministry of Health. Terry very graciously and bravely stood in for Anne Roche and did an admirable job conveying someone's else's ideas while inserting a good number of his own at the same time! He started by noting it is about time to build up capacity in a number of domains for workforce development. Workforce development is a broad term that pulls together individual organisations and systems. It is aimed at facilitating and sustaining the workforce, and is multi-faceted, systems focused, broad and comprehensive. It incorporates everything and contains multiple disciplines and various levels of involvement. While workforce development is often tied up with education and training that is not sufficient. It has a large target audience.

The workforce is comprised of specialist services, primary care, wider health and allied health, education system, criminal justice system, licensed trade and regulatory bodies. Its various levels include systems, current workers, and the future workforce. We need more focus from individual learners to effect system change. We require system enhancement, not just addressing skills deficit.

Terry then talked about the New Zealand situation, the development of strategy and an evaluation of where we are. He noted that the leaders and potential leaders need to be involved in the process and we need to get out of our comfort zones. There are different ways of acknowledging knowledge. We need to think of different ways of learning and where people sit on the continuum of education.

Terry concluded that workforce development is not just training, but also the development of strategy in New Zealand (Mental Health has a workforce strategy, but

we need a specifically A&D one). We will need leadership in development and implementation. We need to remember that it is about addictive behaviour not just A&D and that there are different learning styles and contexts.

PLENARY SESSION #1: Ministerial presentation (Damien O'Connor)

Damien O'Connor was the representative for the Ministry of Health at the Powhiri. While the marae was a grand setting for Damien's talk, it unfortunately meant it was a little difficult to hear him. He noted it was very important to be at a place so significant to Mäori and indeed all New Zealand. He talked about how drug addiction is devastating and destructive. Drug abuse can have effects before it becomes addiction. He has watched drugs ravage a friend of his. Users need the help of family and friends. Damien mentioned the National Drug Policy and its aim to minimise harm. Consequently, the goal should be to stop abuse as quickly as we can. He noted there is scope for both abstinence and prohibition. He feels there is no safe level of use for an alcoholic or drug addict and we must aim for abstinence for all addicts.

As the Minister was discussing the National Drug Policy's multi-facilitated approach he received some questions from the audience regarding the closure of Taha Mäori at Hanmer. He continued to talk about the relevance of drug use to crime. He realises one size does not fit all, which is why we need various treatment types. A further interjection to the Minister regarding the knowledge of Mäori on how to heal themselves prompted him to note that we need to use data in New Zealand to improve our own performance. He then discussed some of the treatments available in New Zealand, what has priority and what is being done currently. He finished by noting that until the blueprint targets are met the Ministry is continuing with present policy. There will continue to be much debate as to best way to approach problems.

PLENARY SESSION #2: Cutting edge of change: Ministry perspectives (David Chaplow)

David Chaplow, the Director of Mental Health, is a psychiatrist who has had clinical as well as teaching experience. He is also fluent in Te Reo. He noted that the Ministry has not been obvious or enthusiastic in support of our sector until now. He also admitted that knowledge of the A&D sector is in its infancy. Using the example of a friend's son he helped with problem drinking he pointed out that the Misuse of Drugs Act doesn't seem to work when you need it and is clumsy.

There are also disreputable providers and exploiters, and an important issue is credentialing. He asked the question where does Ministry of Health fit into picture? There is much interdirectorate co-operation with Medsafe in terms of methadone. He talked a lot about investigations into methadone and the beginnings of mapping out A&D services. He also asked what are the outcomes across services that matter? This question requires clarity and the necessity of common principles that underline services.

These principles need to cover – team support, accountability, clear clinical pathways, training commensurate with responsibility, and alignment of providers within district and regions. Stand alone treaters are a concern and they need support and guidelines. He is interested in best practice, what are we doing, and how do we measure the success? There was some query as to which courses are best for qualifying to provide methadone treatment.

David also discussed the inability of the Alcoholism and Drug Addiction Act to match treatment type to client need and the inconsistency of the Act with the NZ Bill of Rights. He also mentioned the lack of certified institutions and institutions being unable or unwilling to accept some clients. He queried whether we need to maybe just tweak the Mental Health Act (he thought no) or leave it as it is? Changing the Act may mean more services are required and there will be a need to be able to take acute admissions.

David discussed the National Treatment Forum (currently funded by ALAC) and how the Ministry and the NTF are beginning to develop regular sector meetings. He also mentioned that DAPAANZ is well on the way to developing credentialing and on way to developing a code of ethics. Finally David touched on utilising Hua Oranga & HoNOS. He ended with a plea to join together and be seen to be a oneness to further the aims and development of services.

PLENARY SESSION #3: Are you heading in the right direction? (Te Whanau Manaaki o Manawatu)

Te Whanau Manaaki o Manawatu is a consumer support network from Palmerston North. They beautifully greeted us all in a multitude of languages and acknowledged the history this special place (Waitangi) brought. Everyone had to turn to person next to them and if they were a provider say how they have consumer input in their service and consumers had to say how they have input (and anyone else had to say what they were doing there!!).

The presentation started with four people stand up in a circle and talking about the issues for consumers (AA meeting, who will I get to baby-sit, friends still abusing, needing a safe place to live). There was some singing before acknowledging the journey takes many turns with many barriers and that it is hard to survive in mental health system.

In being on this journey they realised the importance of having an active whanau – it is the foundation. Looking at the community they saw no ongoing support for people in recovery and their families. They turned their observation into a needs analysis. Consumers wanted more meetings, contact with people in recovery, safe accommodation, access to alternative healing options, and life skills training. There was an obvious lack of services including whanau (a lot individual focus instead) and no funding for family to attend family week at residential services. All this provided the rationale for Te Whanau Manaaki o Manawatu to exist.

What do Te Whanau Manaaki o Manawatu do? Their vision is to search for and seek wellness for the whole whanau/family and their mission is to safely reintegrate people affected from alcohol and drug addiction back into whanau, hapu, community and life, while being drug and alcohol free. They see themselves as qualified by experience and complementing, not competing with, other self-supporting groups in recovery.

They organise Whanau fun day activities, peer support, advocacy, noho marae (learning to be Mäori), provide a safe whare/house, activity based education programmes, Te Punawai Whanuitanga network (tuakana-teina), miri-miri (taking care of ourselves), life skills, and learning to have fun.

PLENARY SESSION #4: Treatment for opioid dependence in a "Spirit of Partnership" (David Benton)

David is the co-ordinator of the Lakes Methadone Service, the clinical director of the Hanmer Clinic Tauranga and the chairperson of the National Association of Opioid Treatment Providers (NAOTP). He talked about treatment for opioid dependence and made the point that it is not recovery from, but recovery of. David noted that it is about respecting one's self and others. Recovery from drug addiction has in common the foundations that are central to the Treaty relationship – mutual respect, co-operation and trust. It also shares the principles of Treaty – partnership, participation and protection. These principles should also be in play in the delivery of methadone maintenance. David had the beautiful phrase - I am a child of the universe and of the stars and have no less right to be here.

GP care of opioid cases is meant to be at 50%, but is only at 30%. The system wants them to take the more difficult clients, but have not trained them to do so yet. At the moment as far as opioid treatment goes only outpatient pharmacotherapy is subject to restrictions. David observed that deep down as a society we still see addiction as a moral failure. The concerns we currently have about methadone include giving drugs to addicts, the fear of addiction, the idea that they don't get better, poorly controlled

methadone treatment, increases in 'illegal' or 'diverted' methadone, and methadone patients 'running amok'.

David also spoke about policies and regulation and the fact that they are in place for quality and safety. He discussed that methadone is a medication, not a religion. Dispensing of methadone should be based on knowledgeable assessment by a trained clinician. He spoke about the unfortunate need to learn the current "dogma" of methadone. He reminded us of the components of effective treatment: to be flexible and adequate, the goal of maintenance, rapid induction, trained staff with positive attitudes, be affordable, and have treatment practices in line with research.

Research shows a relapse rate of 80% or more. Relapse can often be fatal. David discussed how flexible treatment processes are really important. He noted that in programmes if telling the truth leads to punishment then clients will lie. Under certain circumstances the majority of methadone clients will tell the truth.

David sees medicine as often ineffective in treating chronic illness. Opioid dependence is a chronic, relapsing condition. Methadone's role is to reduce withdrawal and craving, prevent relapsing and restore normal physiological functioning.

There is a passage from active addiction to abstinence with methadone and recovery in the journey in the middle. The main difficulty with bringing about change is maintaining the change. Continuing care takes time and support. David pointed out that we need to remember that one person is powerless to control another's drug use. How do we get people to trust us? By being trustworthy and respecting the person.

PLENARY SESSION #5: Methadone: One drug, many problems (Geoffrey Robinson)

Geoff Robinson is a doctor in the Wellington area and arguably New Zealand's top alcohol and drug clinician. He spoke about methadone specifically, which

complimented David Benton's talk very well. The drug methadone is a synthetic opioid, unlike morphine in structure, acidic, highly addictive, an analgesic, cough suppressant, prevents withdrawal, reduces opiate craving, and provides blockade to other opioids. Geoff noted it is a very safe drug to prescribe both short and long term. The original methadone programmes had no protocol, but lots of rules. No mental health services were involved and there was seven day dispensing. There was also a lot of conflict with abstinence models of addiction.

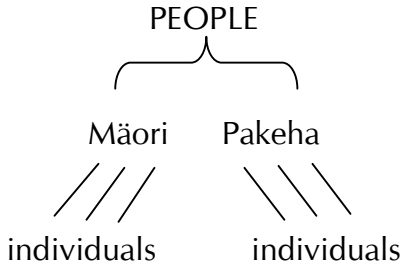
After the heroin era New Zealand saw a rise in homebake, buprenorphine and morphine misuse. It was then that we became more aware of side effects and blood concentration assays and awareness of variation in clearance of methadone. There was also the 'Great thickening debate' regarding taken out thickeners from methadone syrup so that it would be safe if people tried to inject their methadone (following the harm reduction model). Soon after this takeaways developed and the HIV (injecting) threat arose. Next services were told they had to maintain their most high risk/difficult clients and demands started to outstrip resources. Then, as the history of methadone goes, we saw the Hepatitis C epidemic start, the waiting lists develop, the polydrug use policy, the 1992-96 national protocols, and the inter-clinic transfer debate.

Now the issues we are facing/learning about relate to two different forms of methadone, its interactions with other medications, street methadone, the NMDA receptor (related to tolerance and pain), serotonin uptake inhibitors and metabolism variance. In some people only 36% of methadone is biologically available. The half life of methadone is between 5 and 130 hours with an average of 22. Recent research has shown that SSRIs increase methadone levels. Geoff looked at present programmes (HDC and CODE) that have a lot of natural training, co-existing disorders, and the need for interim clinics.

Finally Geoff discussed the recent recognition of the medical condition of prolonged QT interval (also known as Torsades Syndrome) where abnormalities in the electrical activity of the heart place it at risk for a life threatening rhythm problem. Methadone may effect this, which raises questions about sudden death and methadone. Does methadone prolong the QT interval? Are ECGs needed for clients on methadone?

PLENARY SESSION #6: Hakari: Beyond biculturalsim (Fraser Todd/Takarangi Metekingi/Claire Aitken)

Fraser Todd is a psychiatrist from Christchurch and lecturer at the National Addiction Centre, while Takarangi Metekingi and Claire Aitken are from Moana House in Dunedin. They finished the conference with their interesting and thought provoking presentation on culture. They expressed a vision of New Zealand as a coherent fellowship of people in which diversity could be acknowledged and celebrated and pointed out that we have a deep tendency to divide it into dualities to make its complexities easier to understand. For example, we tend to create arbitrary divisions between brain and mind, good and evil, Mäori and Pakeha. On one level, we are all people, on another we are Mäori and Pakeha, and on yet another we are all individuals depending on the perspective we chose to work from.



Biculturalism is therefore based on an arbitrary division between people, a division that exists from one perspective but may not from others. And as with other dualities, it can be a very useful way of helping use organise a complex world, but can also create problems.

The history of the bicultural partnership in New Zealand has been fraught with protest, dissatisfaction and a discrimination. The principles of The Treaty of Waitangi – partnership, participation and protection - are not the same as The Treaty itself. They do, however, recognise the need to establish Mäori as equal partners with Pakeha. This has only recently begun.

There are a number of ways different cultures can come together, and two bodies of theory in particular are useful for understanding these processes. The first is

acculturation. Berry's model of acculturation describes four main processes; integration, assimilation, separation, and marginalisation. Acculturative stress occurs to different degrees depending on the type of relationship formed and is related to a range of adaptations, which compromise the health of individuals and the culture itself. Integration is associated with the lowest levels of stress, the best health outcomes, is clearly the desired type of relationship in most situations and is much more likely to develop in societies that see themselves as multicultural rather than mono- or bi-cultural. The second body of theory is Post-colonialism, which deals with the influence of imperial colonising powers on a society and the ways in which that society develops and emerges from the colonising influence. Concepts such as otherness, hybridity, struggle and resistance, and "no going back" are useful in this context.

Post-colonialism in New Zealand is heavily influenced by the myth of Britishness. Britain has never been a monoculture even though most people think of it as such. Fifty percent of present day British are of Celtic descent. Rather than referring to ethnicity or cultural identity of a population, therefore, Britishness refers to the centralised power structures that maintain power – law, education, finance, literature and arts. Many people of British descent are as disconnected from those power structures as are people of other ethnicities.

Characteristics of an effective partnership are understanding of self and other, respect, and empathy. Takarangi discussed Hakari – a feast or celebration of diversity within a single whole, where you embrace everyone and their differences. For Takarangi Hakari is about completing something started and about people and about giving him the right to stand in front of the conference and talk.

Hakari in its principles links to the 5 key principles for assessment and management of people and co-existing disorders:

- Safety
- Stabilisation
- Comprehensive assessment and management plan
- Clinical case management
- Treatment integration

Hakari in a cultural sense was taken to mean a society in which individual cultures could freely express themselves without discrimination or disempowerment from a dominant culture, where relationships between cultures could be forged and form the basis of a society that could celebrate the expression of this diversity. The key to achieving this was the nature of the partnerships formed in which meaningful dialogue was possible and from which mutual understanding could then emerge.

Finally, the clinical implications of this were discussed. Clinicians knew how to create these partnerships and how to establish meaningful dialogue about clinical issues with individual clients. The challenge is to re-create such partnerships between cultures, and both within and outside clinical practice. A key to this dialogue is an awareness of the things we share, while still appreciating our differences; recognition of the shared, appreciation of the unique.

5. DAY ONE OF THE CONFERENCE

CONFERENCE OPENING:

A very special and serene location was provided for this year's Cutting Edge in Waitangi in the Bay of Islands. The significance of the place and the connection to this year's theme of The Spirit of Partnership was not lost on anyone. The surrounding areas in Paihia and Kerikeri provided ample opportunity for sampling the local delicacies and crafts. The Copthorne Waitangi must be the most spectacular location for Cutting Edge so far. It was amazing to be able to step out of the conference rooms and onto beautiful beaches and gardens. Nga Manga Puriri proved to be very gracious hosts.

This year's powhiri was particularly special. Members of Nga Manga Puriri guided conference delegates from the hotel up to the marae on the Treaty grounds in Waitangi. After a small delay, due to a mix up in the Associate Ministers travel plans, delegates were called onto the marae with the call of conch shells. We were then challenged by some of the local iwi's youth who performed excellent haka. After the third wero (challenge) was accepted we took our seats by the meeting house. Speeches and waiata (provided by children from the local kohanga and kura and iwi youth) followed, with much mention of the foreshore issues, being hotly debated at the time. After the official welcome delegates were guided around the grounds with a number of points of interested being noted.

The Ministry of Health representative, Damien O'Connor, then gave his speech to the crowd, which received a mixed reaction and prompted a number of questions. This was followed by a wonderful Waiata from the youth of the marae called Auahi kore – Smokefree, that's me!

SUMMATION OF DAY ONE:

Time flies when you're having fun – it only seemed a few months between saying goodbye in Nelson and then greeting each other again in Waitangi. With so many changes occurring in the A&D field, in terms of staffing and drug use, it is great to be able to all gather together and touch base with so many different people.

Once again this year day one was largely taken up with keynote or plenary addresses. Damien O'Connor represented the Ministry of Health at the powhiri and spoke about where addiction treatment is in New Zealand. Following this, at the lunch break several meetings were held including the Psychologists Addition Network, the Doctors, the Drug and Alcohol Nurses of Australasia (DANA), and the Alcohol and Drug Consumer Meetings.

After the lunch break David Chaplow spoke about the Ministry perspective on the cutting edge of change in the A&D field. It was appreciated by many when he acknowledged the backseat A&D treatment had taken for many years. Following David was the first keynote of the conference with Eric Broekaert from Belgium. He proved to be an entertaining speaker.

The afternoon continued after a brief break with the first streamed session. The choices for the afternoon were representative of this year's theme. Stream options included Kahui o – Healing through Tikanaga, Te Reinga ki te Waharoa, weaving bi-cultural partnerships, Nine-month follow-up data from the Naturalistic Treatment Outcome Project and The methamphetamine roller coaster- the family ride.

The first day of the conference concluded with a keynote address from Lloyd Geering who spoke about The new open society and its dangers. Such a different perspective on the field was a welcome and refreshing change at the end of the day. After light refreshments DAPAANZ (Drug and Alcohol Practitioners Association of Aotearoa New Zealand) held its second meeting at a Cutting Edge conference.

Neither the poster session nor the research stream ran at this year's conference, which left a strange gap at times, but was also appreciated by others. Again it was clearly evident from the smooth running of the day the amount of work Lisa and Lindsay (the conference secretariat) and the organising committee had put into setting up the conference. The assistance from the local iwi was also visible and much appreciated. The Copthorne provided an adequate venue with plenty of delicious food to satisfy the delegates.

SELECTED PRESENTATIONS FROM SESSION:

- **A double-blind randomised controlled trial of electronic Screening & Brief Intervention (eSBI) for university student hazardous drinking (Kyp Kypri)**

The stream Kyp presented in included three of the more knowledgeable members of the field – Kyp, Simon Adamson and Justin Pulford and all three presentations were well attended and well received. Currently Kyp is with the Injury Prevention Research Unit at the University of Otago. Sadly the field is losing Kyp to the University of Newcastle, Australia in 2004.

Kyp's talk was on the very pertinent subject of student drinking and brief intervention treatment of this. Kyp noted that in their sample students at the University of Otago used a lot more alcohol than their peers. Ethnically, Mäori had higher AUDIT scores though this was not significant. The difference between Mäori women and European women was very large. Students had low readiness to change scores and over estimated drinking norms. The majority had not thought about reducing how much they drank. The key public health problem in this population was drinking to intoxication.

Kyp and his colleagues tested an electronic Screening and Brief Intervention (eSBI) tool through the University of Otago student health centre. The centre sees around 9000 individuals a year and the research team invited a random sample (aged between 17 and 26) to participate in the study. They ended up with a sample of 178. Using the AUDIT (on the largest amount consumed in a single episode in the last 4 weeks) 112 students

screened positive for problem drinking. In this group 8 refused to give follow-up consent, which meant the eSBI n = 104.

The students were divided into a control group and intervention group. The control group received an ALAC leaflet about drinking, which in retrospect Kyp thinks may have been too informative for a neutral condition. The intervention, all done on individual computers at the health centre, consisted of an assessment with personalised feedback about their drinking. The intervention group also had assessments at six weeks and six months.

Kyp found that at the 6 week follow-up the brief intervention group was drinking 20% less and at the 6 month follow-up they were drinking 16% less than at baseline.

- **A therapeutic community project (Sandy McLean, Hatarei Peka & Tau Marsters)**

Sandy, Hatarei and Tau were all from Odyssey House in Christchurch. Sandy is the Director of Odyssey, Hatarei is Manager and Tau Assistant Manager. They spoke about the results from 2 years of research they have been conducting at Odyssey House in Christchurch. The project began in April 2001 with the aim to improve the clinical process via improved assessment and to then provide better targeted intervention based on the assessment outcomes. The result has been clinical issues being identified earlier and individual's risk being identified on admission.

The presenters asked two questions – how real is the improvement we have seen and how real is the identity change? The team presented a wide range of statistics regarding drug use, psychiatric functioning, health and personality. Changes were found in clients: being more co-operative; having more value in their life; improving problem solving skills, health statistics and mental health states; and having greater feelings of well-being both personally and in their lives in general.

After six months the clients were reasonably highly functioning. Their self-transcendence scores on the TCI had dropped – the presenters wondered if this was because reality had become much more of their focus rather than the fantasy world they had been living in

with drugs. According to the Hopkins Symptom Checklist there were marked improvements at 3 and 6 month follow-ups. In conclusion they felt that their data provide evidence that people get well. The numbers are small, but they feel they are heading in the right direction.

- **The methamphetamine roller coaster - The family ride (Stuart Anderson & Linda Poyton)**

Stuart Anderson is the Programme Director at Higher Ground in Auckland and Linda Poyton is a Senior Counsellor. This presentation described data from 120 clients from June 2002 to June 2003. They started by describing their "Restoration of Hope" that has the 12 steps as a vital ingredient. It was established in 1984 for up to 25 clients and is half and half men and women. It is an 18 week residential programme for people 20 years and older. Their talk was a preliminary look at the data.

The presenters discussed a number of other observations from the programme. The first point of contact is usually with family and not the client. They have found that Court pressure can be a positive motivating factor. There is often a breakdown on social functioning and responsibility. Health is not a high priority. Clients are often employed or studying. A high proportion are involved in crime often dealing in their drug of choice or gambling. In women clients there can be eating disorders. The highest proportion of clients are in their early to mid 20s.

In the programme 18% were Caucasian, 17% were Mäori and 2% Pacific Islanders. This may be more reflective of the Auckland population than the rest of the country. Over half the clients had an education beyond 6th form. The first drug of choice was P, followed by cannabis and alcohol. In terms of personality 45% were Narcissistic. There are three phases in treatment – 42 days, 90 days and 126 days. Many leave in the first 42 days.

Stuart and Linda then presented a case study of a 26 year old woman. The case illustrated that family must be involved early on – if the client's family is not involved they are more likely to leave. Pacific Island issues of identity emerged and were significant.

The presenters finished by making some recommendations. These included introducing a gambling screen with other assessment tools, ongoing psycho-education for families/whanau and ongoing aftercare in multiple family groups. They also pointed out that therapeutic interventions need to be in the context of age related issues, such as relationships, social experiences and vocation.

6. DAY TWO OF THE CONFERENCE

SUMMATION OF DAY TWO:

The second day of Cutting Edge started with a spectacular sunrise over the Bay of Islands. First up, bright and early was the Te Whanau Manaaki o Manawatu consumer group talking about their work and organisation. The rest of Friday was quite a mixture of keynote speakers and streamed sessions. After lunch Tipene Filipo talked about the Treaty in relation to Pacific Island relations. The middle of the afternoon saw the other two keynotes of the day. Keith Evans from Australia spoke about policy and prevention and was a highly entertaining and informative speaker. He was followed by Terry Huriwai filling in for Anne Roche to talk about the cutting edge of workforce development.

There were two streamed sessions in the morning. The theme of The Spirit of Partnership continued with talks on Te Aka Roa O Te Oranga, Kanohi Ki te Kanohi and implementing the Treaty of Waitangi. Also on offer were a number of presentations on adolescents – on adolescent cannabis use and cognition, adolescent outpatients in substance use services and on Altered High, the RADS youth initiative. The second streamed session of the morning had two excellent presentations on Pacific Island issues – Pacific conversations with codes and categories and Pacific Nations clients at RADS. This session also contained talks on facilitating cohesion of training, community pharmacists, the Alcohol and Drug Outcomes Project and minimal methadone treatment.

Lunchtime was taken up with the Treatment Research Interest Group's AGM for some. Other lunchtime meetings on Friday lunchtime were for the Pacific People's, the detox workers and the Mäori Kai Mahi. Additionally the ADOPT team held a focus group about outcome measurement in the A&D field.

The third streamed session of the day finished off day two of Cutting Edge 2003. Topics covered included the search for personal spiritual fulfilment, tobacco smoking in an adolescent psychiatric population, the dual diagnosis service delivery model, integrated treatment systems for substance abusers, the place of spirituality in treatment and the revision of assessments under section 65 of the Transport Act.

SELECTED PRESENTATIONS FROM SESSION ONE:

- **Altered High – RADS youth service (strengths, specialisations, focus areas, challenges) (Christel Le Brun)**

This presentation had quite a journey getting to the conference and changed presenters a number of times along the way! In the end Christel (a Counsellor with Altered High) did an excellent and passionate job of conveying the work that is being done by RADS in Auckland to help youth with alcohol and drug issues.

The Auckland specialist youth service was launched in February 2000. Today RADS has Altered High (the mainstream youth service), Te Atea Marino (a Kaupapa Mäori specialist service incorporating Rangatahi Kaimanaaki) and Tupu (the Pacific Nations specialist service incorporating youth clinicians).

Altered High is an alcohol and drug service for young people aged between 13 and 20 and their families. It has a harm minimisation philosophy utilising a bio-psycho-social model with a developmental perspective. Their client group includes youth with mental health concerns, same sex attraction and issues around someone close to them using drugs. Altered High is keen on youth appropriate resources including newsletters, individualised care plans, laminated pocket cards, drug information cards and visual rating scales.

Christel also considered approaches for engagement with young people. These included having a developmental focus, remembering that young people can spot a fraud a mile away, making sure to discuss confidentiality, using youth appropriate language and

working with how the young person presents. Other ideas were checking out a young person's agenda and motivation, answering questions simply and honestly, asking their permission for sensitive questions, encouraging family involvement and taking into account cultural aspects and the young person's world.

The presentation concluded that working with young people is exciting, fun, demanding, challenging, and worthwhile. It has been rewarding for the staff, inspired them and enhanced their respect for young people's resilience. She has enjoyed working with such a passionate and committed team of clinicians

- **What's up Doc? A project to help GP patients affected by problem gambling (Sean Sullivan)**

Sean is a Director at Abacus Counselling and Training Services in Auckland. He has been working in the area of gambling in the A&D field for many years. His presentation was about research he has done with GPs around clients and their families effected by problem gambling.

They decided to look at problem gamblers presenting to GPs because only a small proportion of problem gamblers seek help (perhaps less than 10%) and this is usually in the late stage of their problem. GPs may have the opportunity to identify those unaware of health problems due to gambling and also make this identification earlier. The project, which was run with the Goodfellow Unit (General Practice and Primary Health Care at the University of Auckland), Mangere Health Resources Trust, Abacus and was funded by the Problem Gambling Committee, screened 3000 patients for personal and family gambling problems and depression.

GPs were paid an incentive for each patient screened and for each brief intervention they carried out. Researchers provided training, focus group facilitation, data analysis, information resource and reporting. This included regular feedback to participating GPs.

An initial pilot study found 17% of patients were affected by another's gambling. High levels of depression were also found and a lot of uncertainty was felt about a GP treating

problem gambling. Consequently, to date the main study has screened 649 patients at practices throughout Auckland. Again there have been high level of depression and two thirds of the problem gamblers have been female. Family members affected by gambling are also affected by depression and are often problem gamblers themselves. There continues to be uncertainty about GPs being able to deal with problem gambling.

Sean concluded the patients may need encouragement from their GPs to disclose gambling problems. There was no trend from patients or their families presenting with gambling problems to suggest what a GP needs to ask. There was a high degree of depression in both problem gamblers and their families. GPs seemed receptive to the intervention, though the project is still in its early days.

- **AOD services: The largest provider of problem gambling services??? (Alison Penfold)**

Alison works with Sean (from the previous presentation) at Abacus Counselling and Training Services in Auckland, also as a Director. Her presentation looked at the treatment of problem gamblers within A&D services. She started by pointing out that there are over 700 A&D treatment workers in New Zealand and only 40 problem gambler counsellors, even though problem gambling is estimated to be about one third the size of A&D problems.

The presentation covered the comorbidity levels among problem gamblers and A&D clients. Alcohol misuse amongst problem gamblers seeking help is between 21-55%. Problem gambling amongst alcohol misusers seeking help ranges from 10-22%. Overseas there have been some obstacles to A&D services screening for problem gambling including: a lack of awareness of the prevalence of problem gambling; the view that gambling treatment is inconsequential to substance abuse treatment; a lack of confidence due to knowledge deficits around problem gambling and its interventions; screening for gambling being seen as an intrusion on the therapeutic relationship; and problem gambling being seen as less life-threatening than substance abuse. Alison questioned the relevance of these to the New Zealand setting.

Some of the advantages Alison sees to screening for problem gambling in A&D services are a reduction in relapsing alcohol use, identifying relevant issues to optimise counselling resources, best practice from a client centred, life-enhancement approach, and many skills used in alcohol misuse interventions being transferred to gambling. She made particular note of the increased risk of suicide with comorbid disorders. When a gambling problem is identified as well as an alcohol problem attempted suicides rose from 8% of the population to 43%.

Alison did not think it was for her to say whether A&D services will be the largest providers of problem gambling services in the future, but she did offer up many reasons why there is good potential for this. These included the high incidence of gambling problems in A&D, the good skill match of A&D counsellors, the potential of over 700 skilled counsellors being available nationally and the same models of the "continuum" and harm reduction being used commonly in both areas. Additionally clients with alcohol and gambling problems are particularly "at risk" and it is considered to be "best practice" to deal with problems concurrently instead of separating them out.

SELECTED PRESENTATIONS FROM SESSION TWO:

- **Pacific conversations with codes and categories (Fuimaono Karl Pulotu-Endemann & Helen Warren)**

Helen is a Registered Nurse and Lecturer at the University of Auckland who has worked in A&D field for many years. Karl also has a background in nursing and currently a member of the ALAC board. Both wear many hats for their various jobs. We were greeted in every Pacific Island language. The presentation borrowed from the principles of the Treaty – partnership, participation and protection. There is partnership with many different services. Pacific peoples have a cultural focus and this presentation was about scientific versus cultural partnership. They wanted Helen's work to stand up scientifically, so that it was not rubbished as "just" Pacific Island work. Karl feels this has been achieved.

Helen had been nervous about doing this project and being the only papa langi (pakeha). Her husband is Mäori and so she has learned how to work in a marae kitchen as a fruit cutter – this was one of her hats. Today she was talking more about process of the study than results. The brief was about the effectiveness of A&D treatment for Pacific peoples. They needed to find ways of working that were acceptable to participants and a methodology that would gather and analyse high quality data. The cultural requirements for the process were that it was overall transparent, holistic, and collective. The methodological solution was to use grounded theory. This starts with what is important for people. This is for a good reason – it starts from the bottom up.

Karl then talked about the cultural solution. Questions arose such as, which Pacific peoples and professionals should participate, and should there be payment? The reference group ended up with representation from each of the island group communities. This included Tuvalu, Solomon Islands, most commonly Samoa, Tonga, Cook Island, and Fiji. There was a Matua to open each fono (forum) and guide the process "on the day". They had to make sure they had people who spoke each language. It can be politically correct too, but can't get it right all the time. Karl pointed out that times move on.

Helen discussed the theory of the project – symbolic inter-actionism (how do people behave towards each other and what meaning does that have for them). They carried out line by line coding of the transcripts of the fonos. They went in not with a question, but an area of interest. There was some thematic analysis done by the primary researcher.

In terms of strengths and limitations it captures issues important to end users, but the data set is large and time consuming to analyse. Participants find it difficult to think outside the square. Demands for payment compromised the 'research' credibility and reliability. The outcome was that 31 Pacific staff from 13 services identified in the ALAC National Directory were interviewed and staff training has had some development in Pacific Island services. They found that there were clearly identifiable Pacific ways of working with patients. These ways were mediated by the funding arrangements and

reporting requirements of the services. While there were no significant differences between NGO and DHB providers, there were differences in resourcing and service structure. There is not enough time in the current climate of services for rapport building. Helen and Karl noted that it is not enough to just be of Pacific origin to work with Pacific people – they need training. Phase two of this project will be more quantitatively focussed. The presentation ended with a poem of farewell.

- **Pacific Nations clients at RADS – The implications of screening assessment data for clinical practice and service delivery (Bruce Levi & Grant Paton-Simpson)**

Bruce was from TUPU, the Pacific Island service at Waitemata DHB, while Grant is an ex-RADS researcher who now does some consulting for them. Bruce was presenting the results of 418 screening assessments. The screening package that has been used for four years included the AUDIT, Leeds Dependency Questionnaire, Severity of Dependence Scale, level of drug use, and mode of use. Over 7500 screens have been completed and there is now enough Pacific screens for preliminary findings. The appropriateness and language of the screening has been issue.

The biases they have encountered include who completes the assessment and whether clients are seen through the main CADS or TUPU (even within TUPU there were counsellor differences). Pacific is a very diverse category (including NZ born). They tended to be younger, with 23% aged under 20 years and there were fewer female. Alcohol use and alcohol and cannabis use were the main problems. Pacific clients tended to have more alcohol issues than other New Zealanders (in terms of substance misuse). Cannabis was a problem for nearly half of the female Pacific clients (more than other New Zealanders). There were huge numbers of female use, even with increasing age. There was more male use of amphetamine, though this was much lower (for male and female) than other New Zealanders. Most Pacific male clients presented with alcohol as their only problem. There was an increasing trend as they got older to have alcohol problems.

The service implications are that we need to be taking Pacific Nations peoples to a place of wellness. These client's problems are not always the fashionable ones getting media

attention (alcohol and cannabis not amphetamine). The research has shown the importance of more older male counsellors and growth areas around cannabis resources. Additionally the issues of Pacific female youth were highlighted.

- **Assessing client satisfaction with methadone treatment programmes (Daryle Deering)**

Daryle is a Lecturer at the National Addiction Centre in Christchurch with over 25 years of nursing experience. She was presenting results around methadone client satisfaction. The presentation was very positively received. Having previously introduced the Methadone Treatment Index as a measure for use in MMT, Daryle now presented a client satisfaction questionnaire (Treatment Perceptions Questionnaire), which looked very handy.

Issues that arose from her research included the continuity of staff or conversely high turnover, which seemed an important factor in client satisfaction. Partly this appears to be related to the different attitudes/philosophies that each staff member brings to their work, which impacts on the client in the way the staff interpret and manage the rules of the programme. Daryle's work highlighted the need for consumer input. Some audience members pointed out that this is easier said than done.

- **Community Pharmacists – Partners in the care of drug users (Janie Sheridan)**

Janie is an Associate Professor at the University of Auckland. It was fantastic that the A&D field has gained the addition of such an academic from overseas. She contributes significantly to the A&D field.

Janie talked about the experience of community pharmacists with drug users. Chemists find shoplifting and presenting intoxicated more of a problem than violence, which is a rare occurrence. She felt there are many more areas where pharmacist could play a useful role in helping MMT clients, such as dentition, overdose , Hepatitis B , nutrition, constipation, and sleep problems.

SELECTED PRESENTATIONS FROM SESSION THREE:

- **Tobacco smoking in an adolescent psychiatric population (Karen de Zwart)**

Karen is an Assistant Research Fellow at the National Addiction Centre and currently doing her PhD in the area of nicotine dependence. The session started out as an intimate gathering and ended up almost full. The session covered a lot of ground with Karen's presentation on the relationship between smoking cigarettes and psychiatric disorders in adolescents.

Karen presented the results of a study that she and Doug Sellman completed. This was an important study on many fronts. First, it was the only presentation on nicotine dependence at the conference. The study also disputed the notion that people often "self-medicate" emotional illness through cigarette smoking. Although 78% of the adolescents with psychiatric conditions studied had smoked, only 46% of them met the diagnostic criteria for nicotine dependence. Adolescents with a psychiatric condition appeared more likely to smoke when compared to adolescents without psychiatric disturbance. Interestingly, amongst the cohort of adolescents studied, females were more likely to smoke than their male counterparts.

- **Developing a partnership with a mental health service: The Hawkes Bay Addiction service experience (Andrew Raven)**

Andrew is a Senior Clinical Psychologist with the Hawkes Bay District Health Board. He facilitated a lively discussion on addiction treatment in New Zealand. He began by asking the audience, "What is special about addiction services?" Throughout the presentation, Andrew benevolently challenged the audience to look at who we are as a sector, what we do that makes us unique and how we provide the services we do. He also explored how A&D services might interface better with mental health services.

THE CONFERENCE DINNER:

Kei te kamakama te tikanga.
(It is a proper thing to be joyful and full of high spirits)

The warm, relaxed and friendly atmosphere of Waitangi made for another enjoyable conference dinner. Delegates were in full attendance and very co-operative with remembering their name badges. Pam Armstrong did a great job of keeping the evening flowing. Amazingly everyone fitted into the room and the conversation buzz was steady throughout the night. The dinner was a delicious range of salads and hot foods, including plenty of the local seafood on offer. The Copthorne kept everyone flowing past the buffet tables well, though the prelaid tables of dessert around the room proved too tempting for many.

Once again, the Cutting Edge dinner served as the opportunity for the conference prizes to be presented. This year Alistair Dunn won the John Dobson Memorial prize for the best presentation on an opioid topic for his paper on "Minimal Methadone Treatment". The John O'Hagan prize for the best presentation by someone under the age of 35-years was won by Grant Christie for his paper "Do adolescents presenting to outpatient substance use services differ from adolescents presenting to outpatient mental health services?". Both recipients were pleased to have won their respective prizes.

The keynote speakers Eric Broekaert, Lloyd Geering, and Keith Evans as well as Lindsay and Lisa were all presented with beautiful Taonga necklaces. It was great for the conference to show its appreciation with such personal and culturally noteworthy gifts given the location and theme of the conference. We were also treated to a beautiful duet sung by Houpeke and Mere Piripi.

The highlight of the evening was the farewell that had been prepared for Ian MacEwan. While Ian is still active in the field, he has left his long held position with ALAC. There was hardly a dry eye in the house when "Wind beneath my wings" was sung to Ian and

the accolades that followed were very complimentary and very true. Ian was also presented with a handsome Taonga necklace.

The evening eventually got round to some dancing with the excellent band Pulse. A good few delegates enjoyed themselves with a range of foot tapping music until the wee hours.

7. DAY THREE OF THE CONFERENCE

SUMMATION OF DAY THREE:

Saturday, the last day of Cutting Edge 2003, started at the slightly saner hour of 9am. The day was taken up largely with plenary speakers. The audience for the day started small and grew as the day progressed and delegates gathered the energy for the final day of conferencing.

The first presentation of the day was from David Benton on treatment for opioid dependence. This was aptly followed by Geoff Robinson speaking about methadone. After morning tea there was a brief streamed session, which included talks on consumer expectations and brief intervention, the sociological aetiology of addiction, 1-4-B dependence and withdrawal and gay friendly services. The final presentation of the conference fittingly was from Fraser Todd, Takarangi Metekingi and Claire Aitken discussing issues beyond biculturalism.

SELECTED PRESENTATIONS FROM SESSION:

- **Issues for methadone case managers – Enhancing practice (Merlin Curreen)**

Merlin is a Clinical Team Leader with the Auckland Regional Methadone Service. This facilitated forum was a continuation of the forum initiated at Cutting Edge 2002 and provided opportunities for methadone case managers to discuss important issues and share information on methadone treatment practices. The session was attended by 18 people from around the country. Not all were methadone case managers, however, most were and the remainder had a direct association with the management of methadone clients.

Topics put forward for discussion included co-working with counsellors, the counselling case-management mix, Hepatitis C referrals and testing etc, management of benzodiazepine use and/or addiction and group work with a view to withdrawal

support. Other issues mentioned were senior practitioners and the possibility of staff supervision, case-loads and ceilings thereof and burnout.

There was a valuable discussion of the difficulties around case-management and counselling and how this could possibly be utilised to alleviate the burdens of high methadone case-loads. Characteristics required of professionals who work in a methadone setting as counsellors were also discussed. It was felt that management needed to have an active part in determining how a counsellor/case manager mix could function to optimum benefit of all concerned.

The group noted that the referral and funding for Hepatitis C testing varied throughout the country – this possibly being a function of programme size (funding 1000 people in Auckland to have Hepatitis C tests would be a horrendous cost!). The discussion was useful, however, in clarifying the sorts of standards we should be aiming at in assisting clients to ascertain Hepatitis C status and to manage the subsequent outcomes. The final topic they were able to deal with was a discussion of the Auckland initiative recently put into place of withdrawal support groups.

This is the second year that this session has been held and on each occasion, those attending have thought it to be a worthwhile exercise, resulting in the sharing of knowledge and support amongst those who don't normally get the chance to meet in a group. Last year's meeting resulted in the construction of a nationally accepted transfer summary for clients moving between regions and also in the establishment of regional 'hui' meetings, which have taken place in Thames and Auckland.

- **1-4-B dependence and withdrawal: A case study (Catherine Burbery)**

This presentation was delivered by Jeremy McMinn (a Wellington Psychiatrist), a practicing psychiatrist at Capital Coast Health due to the unavailability of Catherine Burbery (a Counsellor with the Wellington Community A&D Service).

The case study was a very interesting one as it focused on the primary drug of choice gamma hydroxybutyric acid (GHB), of which the client used up to 50 mg per day stating

that it helped him to sleep. This made the case a rare one and posed questions with regard to best practice.

Rapport with the counsellor was good with 38 appointments attended in 40 weeks. Over time progress was made with regard to cutting down of GHB use. Both CBT (Cognitive Behavioural Therapy) and MIT (Motivational Interviewing) were used during this counselling. The client however drank more alcohol when reducing GHB use and had difficult narcissistic "have your cake and eat it too" tendencies.

During treatment a variety of medications were prescribed including: Clonidine and Diazepam for withdrawal; Fluoxetine and then Paroxetine (more successfully) for depression; and Phenobarbital for withdrawal. Eventually the counselling was terminated when no further progress was made and the suspicion was that the psychotherapy was satisfying his narcissism.

- **Gay friendly – Rhetoric or reality? (Diana Rands)**

Diana is a Gay Communities Project Worker with RADS. This enlightening report on the work done by Diana and the RADS team identified some key issues. The most important of these was the need for services to identify *how* they were committed to "culturally safe" practices and what these may include for lesbian, gay, bisexual, transgender, takataapui and fa'afa'fine.

Issues identified to consider included physical surroundings, recruitment, staff, leadership, assessment, counselling protocols and training. How these may be addressed was discussed and things such as posters, pictures, publications, advertising of events, staff and partners involvement, awareness of homophobic statements, appropriate greeting of transgender clients, teams discussion on how to handle best orientation issues and training for all staff were some of the suggestions raised.

The outcome of the discussion was that protocols must be in place and observed to truly be culturally safe and that there was an opportunity to accredit these protocols. Diana

stated that this accreditation would need to be developed as an opportunity to involve services in improving there delivery.

CONFERENCE CLOSING:

The poroporoaki was beautifully spoken and ended the conference on a positive note. Once more this year having lunch following the closing gave a good opportunity for winding down and farewells.

Then we all headed back to our home lives and services, hopefully a little changed by the things we had learnt during the conference and renewed by the sharing of ideas and stories among colleagues for three days. All eyes now focused on the future in the field we work in.

E kore a muri e hokia
(There is no turning back)

8. CUTTING EDGE 2004

- Cutting Edge 2004 will be held in Palmerston North.

- It will run from Thursday 2nd September to Saturday 4th September.