

Cutting Edge 2004

CONFERENCE PROCEEDINGS

An annual treatment conference on alcohol, drug and addictive disorders,
Convention Centre, Palmerston North

2 ~ 4 September 2004



ALCOHOL ADVISORY COUNCIL OF NEW ZEALAND
Kaunihera Whakatupato Waipiro o Aotearoa

CUTTING EDGE 2004 PROCEEDINGS

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ACKNOWLEDGEMENTS

I would like to sincerely thank those who helped me to bring together, and disseminate the wealth of information from this year's Cutting Edge conference.

Meg Harvey

Proceedings Writer

1. EXECUTIVE SUMMARY

The place to improve the world is first in one's own heart and head and hands.

(Robert M. Persig)

- ◆ Cutting Edge 2004 was held at the Palmerston North Convention Centre in Palmerston North on September 2, 3 & 4
- ◆ Three hundred and thirty-nine delegates attended the conference
- ◆ The theme of this year's conference was Integration
- ◆ The keynote speakers were Moe Milne from Te Moemoea in Matawaia, Duncan Raistrick and Gillian Tober of the Leeds Addiction Unit, United Kingdom, Michael Baigent from Flinders University in South Australia, Martin Kennedy of Christchurch, Joan Zweben from San Francisco, USA and Tamasailau Suaalii-Sauni of Auckland

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 four years there has been an increasing opioid presence at the conference as well as Problem Gambling, with the inclusion of psychiatric comorbidity as a feature 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 Māori and Pacific 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 went extremely smoothly, with Lisa and Lindsay having efficiently organised conferences in Nelson (2002), Waitangi (2003) and now Palmerston North (2004).

3. SUMMARY OF THEMES

The theme of Cutting Edge 2004 was Integration. While the overall theme was of the integration of the fields of Alcohol and Other Drugs (AOD) treatment and Mental Health, there were many other areas to include in this integration such as gambling and smoking cessation into addiction, coexisting disorders, the place of Māori/Pacific Island/Asian dedicated treatment services, integration of pharmacotherapy and psychotherapy in treatment, integration of family work with an individual-based approach, and the integration of basic sciences and research with clinical practice. The theme was well reflected in both presentation titles, content and the sheer variety of topics seen.

Culture remains a vital part of the Cutting Edge conference and there was excellent representation from Māori, Pacific Island and gay/lesbian/bisexual groups. It was great to hear how services are (or should be) tackling the issue of making sure all New Zealanders are cared for. This year saw an even stronger number present from the gambling field, with presentations covering problem gambling, brief intervention, the families of problem gamblers and the relationship between gambling and foodbank access! We even had a paper that integrated addiction issues around Problem Gambling in gay/lesbian/bisexual groups.

Methadone and opiate addiction again had a strong presence. Topics in this area covered barriers for care, GP authority and addressing psychiatric disorders. Starting to make an appearance amongst the presentations was the topic of amphetamines. As the use of "P" and other amphetamines reportedly grows steadily in this country the field are responding in sharing their experiences.

The refreshing variety of topics that rounds out Cutting Edge each year continued in 2004 with the inclusion of presentations on substance abuse and brain injury, the Land Transport Act, post traumatic stress disorder, spirituality, drug policy, adolescent drug use, and pregnant and parenting clients.

4. KEYNOTE ADDRESSES & PLENARY SESSIONS

KEYNOTE ADDRESS #1: Integration: A Māori perspective (Moe Milne)

The first keynote speaker for 2004 was Moe from Northland. She has been involved in AOD and Mental Health for many years and in many roles, with an underlying passion for Māori rights. She wears many hats in a range of organisations and has a large family.

As she flew into Palmerston North she likened the land to what the people of the area must be like – calm, with a quiet confidence and order. Up north, where she is from, there is lots of bush and rolling hills, which also reflects the people.

She noted that her talk was from her Māori perspective. The outline of her presentation was to look at the historical and political impacts and past to present developments of integration. Her definition of integration was to combine the parts into a whole. She sees this as a positioning of power. She presented several dictionary definitions of integration, including:

- To bring or come into equal membership of a community. An example of this is the Treaty of Waitangi, but we are still a long way from realising the full potential of this
- To end racial segregation, i.e. who has the power to decide what the rules are
- To complete by addition of parts. She wants us to see what Māori integration models are and take them on board

At this point Moe had to bring out her glasses and made a side note acknowledging ageing, identifying her grey hair as “White Stripes” she had earned and wore proudly.

She raised the issue of assimilation noting integration has often been underpinned by asymmetrical power issues. She feels Māori have been a major casualty of integration in

the past, consigning them to the bottom of the heap. One example is language – in 1900 90% of Māori school entrants spoke Māori then language suppression occurred and by the 1960s only 26% did (language is just one example – land is another).

There is no service yet that takes note of the effects of the political climate on the health and wellbeing of Māori. AOD robs Māori of world standing and in the Pakeha world there is a loss of Mana. Moe cited the example that alcohol was used as currency to in part payment for land in the early days. Alcohol has become entrenched into some subcultural groups in Te Ao Māori. Moe was one of the early ones to highlight the impact of alcohol on Māori. There used to be a crate of beer given as a thank you at end of meetings, which they tried to change – and the thank you became cigarettes instead. There is quite an economic subculture in Māori based around cannabis too.

Moe presented a framework for treatment, identified as – Whanaungatanga in practice and consisting of the following processes:

1. Tuku, the process of letting go
2. Tangi, the cleansing through tears
3. Whanaungatanga, support of whanau
4. Whaikorero, the talk, discussion, linking of whakapapa, history
5. Nehu, the burying/closure
6. Hakari, celebration of life
7. Takahi I te whare, laying ghosts, bad karma to rest
8. Po Whakamoemoe, negotiating agreed support systems/people
9. Whakahoki ki te kainga, being taken back home
10. Kawa Mate, final closure

She questions whether new integrations in service delivery will take whanau into account. Much of the debate about integration in services at the moment is about power (status). Moe also noted that concentration on comorbidity can contribute to losing sight of the patient – integration would help this with everything being dealt with within a holistic framework. It is necessary to take an historical and political perspective including the failure of policies to integrate the needs and aspirations of Māori and the impact of policies on health and wellbeing with respect to issues of loss.

The presentation ended with a Waiata, after which Tuhakia Keepa asked a question about individuals wanting to acknowledge their culture. Moe thought it was about choices – what the consumer wants in their whanau. She was also asked when are we going to get there? Moe feels we are ready to integrate as a nation.

KEYNOTE ADDRESS #2: Substance Use in Mental Illness (Duncan Raistrick)

Duncan was from the Leeds Addiction Unit in the United Kingdom. He has been a psychiatrist and researcher in the addiction field for about 30 years.

The presentation started with an introduction by Ian MacEwan, who first thanked and acknowledged ALAC. Ian discussed Duncan's love of fast cars and Coke Cola. Duncan set up and heads the Leeds Unit (an hour from Coronation St). He is one of the most respected thinkers, leaders, and speakers who works in AOD in the UK.

Duncan started by thanking everyone for the welcome and for being invited. He gave a brief view of what is going on in the UK at the moment. There has been an audit into unexpected deaths and drug use under way, which had the support of the government. There was also drive from addiction services for this. Addiction services have led the way in a number of ways, e.g. self-help groups. This audit has given the impetus for developing models of service provision for people with coexisting disorders as the review highlighted gaps between Mental Health and Addiction services.

In terms of substance use in mental illness, Duncan started with lifetime prevalence and odds ratios of mental illness and substance misuse (Kessler et al, Archives of General Psychiatry 1994). His main point was the diversity in numbers as related to each drug and mental illness, which indicates diversity in the issue. Looking at where the problem is located he noted that basically there is a lot more comorbidity in psychiatric settings than addiction settings (Miller & Fine, Addictions in Psychiatry 1997).

Making a diagnosis is very difficult for a number of reasons:

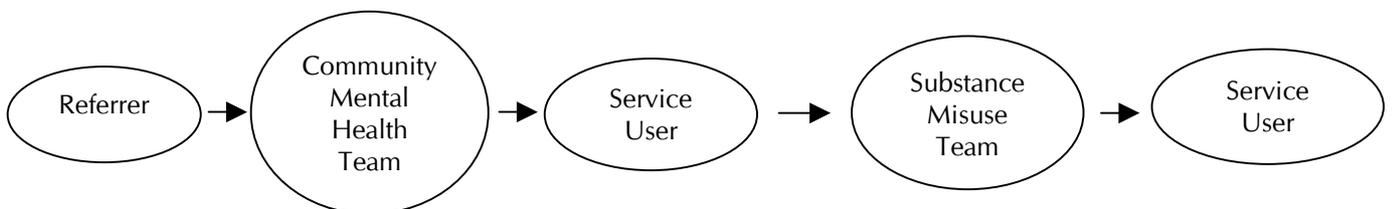
- Transient symptoms versus syndromes (intoxication, withdrawal, situation related)
- Substance induced disorder – harder to unravel (it used to be that if it was drug induced the symptoms would go away quickly, but is more complicated than that)
- Coexisting mental illness and addiction

The implications of comorbidity discussed included:

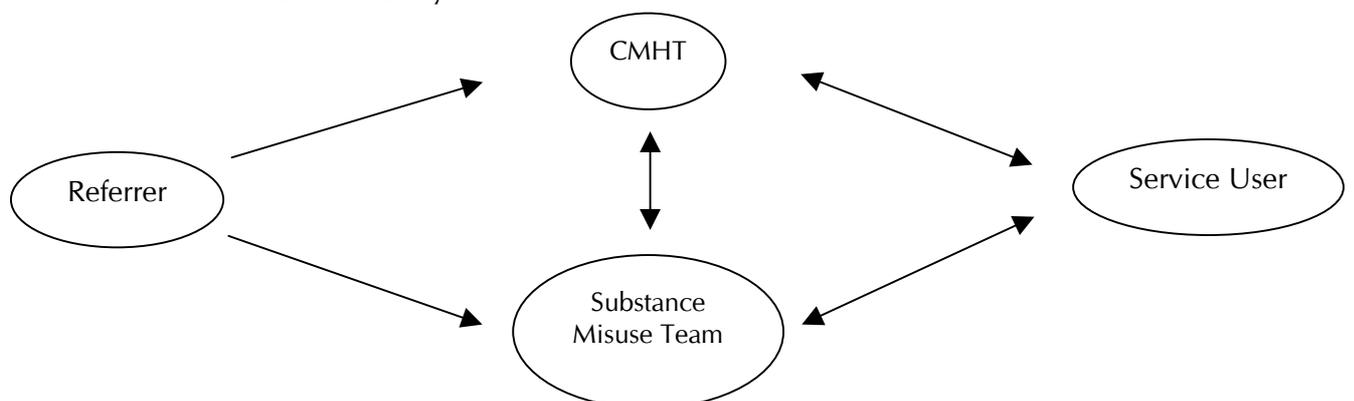
- The overall outcome is poor
- Increased severity of psychiatric symptoms
- Increased violence
- Poor compliance with treatment
- Poor housing and social circumstances

Duncan then went on to discuss a number of different models of treating comorbid addiction problems and mental illness.

The first was a Serial Services model, where the client is treated in sequence by the differing agencies –

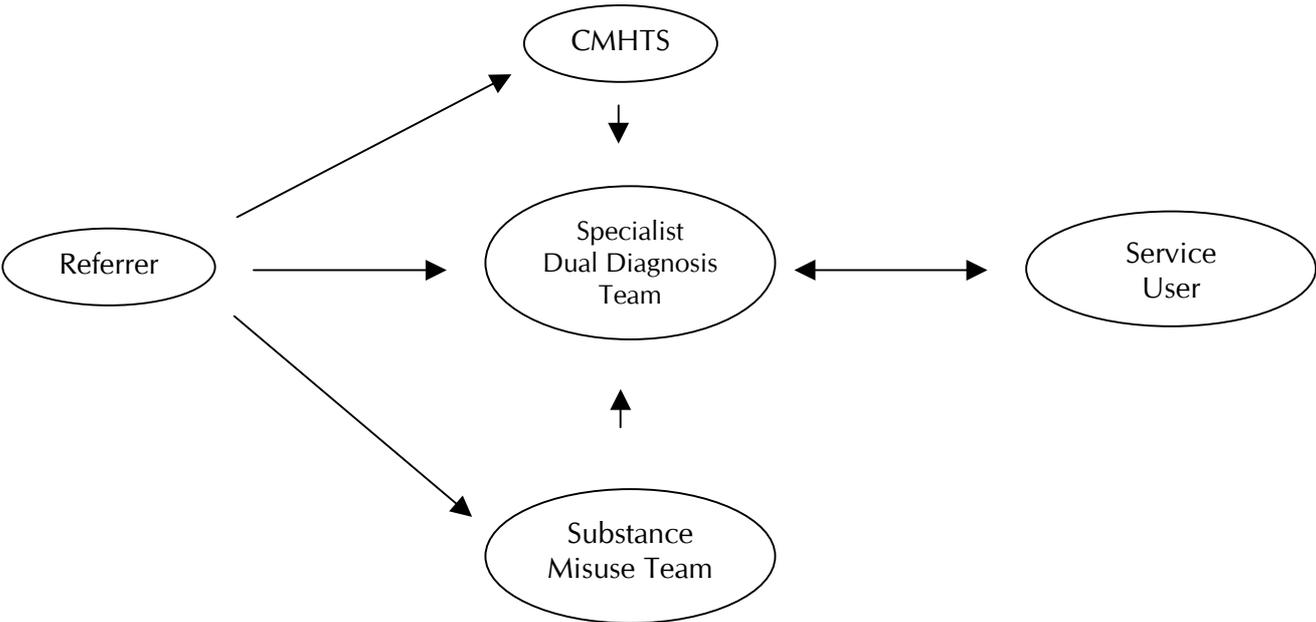


Then a Parallel Services model, where the client receives treatment for substance abuse and mental illness concurrently –



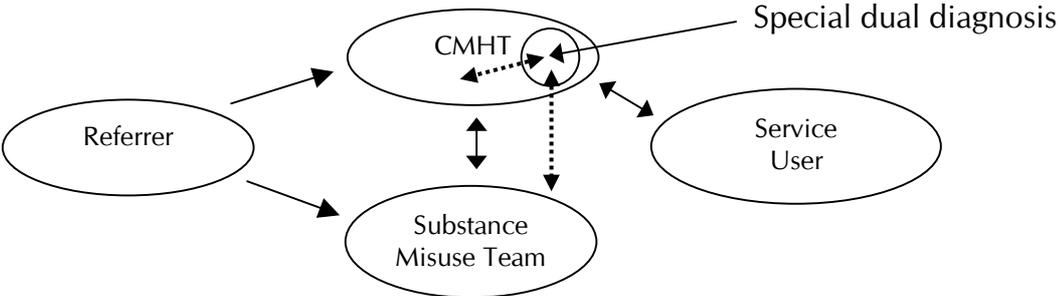
Duncan felt that neither model really makes sense and both should be rejected. He noted that dysfunctional thoughts such as, “I feel tired and flat on the medication” or “I feel great and energetic when I use” represent psychological interwoven problems.

The next model he presented was an Integrated and Dedicated Service model, where substance use and mental illness services are joined by a dedicated dual diagnosis service –



He saw this as a viable model, but we would need to think carefully about the Specialist Dual Diagnosis Team workload.

The final model Duncan discussed was a Shared Care Services one. This is the preferred model and the one they are working on in Leeds.



In “carving up” the territory he suggested a grid consisting of high to low mental illness and high to low substance use with local services identifying clients who would be in each quadrant, including clients who could enter either door and get their needs met well.

Duncan asked the question what does the addiction team bring? He feels the answer is a lot:

- Good information
- Skilled use of psychosocial interventions
- Ability to supervise and work with Mental Health teams
- Links to addiction psychiatry for diagnosis and pharmacotherapies
- Links to addiction wrap around service

The cognitive behavioural approach to treatment appears to be the most affective. This is what they use in Leeds with a workbook. The Workbook has eight milestones with small repetitive messages until milestones are achieved. It covers the issues/questions:

- How do AOD affect me?
- How do AOD affect my mental health?
- Identifying a support network
- Activating the support network
- Improving communication
- Increasing pleasant activities
- Thinking about relapse prevention strategies
- Coping with high risk situations

In training they have found the didactic approach to be a big mistake and that more basic drug education is needed. Supervision problems they have encountered include:

- Organisational barriers – middle managers
- Overestimated ability to assess substance misuse
- Low self-efficacy
- Therapeutic pessimism
- Varied skills mix
- Overestimated enthusiasm of staff

An NHS staff survey of therapeutic attitudes highlighted issues such as role adequacy, role legitimacy, positive expectation, self-efficacy, therapeutic attitude, and support. Doctors were not interested in getting involved, health care assistants were most enthusiastic, and Nurses were in between.

Duncan concluded that the key tasks are:

- To get organisational level commitment
- To devise a service model to do the existing work more effectively
- Agree on operational plan and care pathways
- To implement staff training in an motivational style and evaluate

We need to keep doing what we are doing, but more effectively.

The presentation finished with questions around stigmatisation, counsellors versus clinicians in dual diagnosis, where to allocate funds in dual diagnosis and discussion of the Māori model of wellness in relation to dual diagnosis.

KEYNOTE ADDRESS #3: The Treatment of Amphetamine Dependence (Michael Baigent)

Hailing from South Australia, Michael is a Senior Lecturer in Psychiatry at Flinders University as well as being a Senior Specialist with the Drug and Alcohol Services Council. His main area of research is coexisting substance and mental illness disorders. Currently he is looking at the effects amphetamines have on psychiatric disorders and this was the topic of his keynote address.

Murray Hunt introduced Michael and noted that the rest of day had been a good lead into this talk. Amphetamine type stimulants have gained a lot of growth and publicity of late. Recently nine million methamphetamine tablets were seized from lava lamps.

Michael noted that he had been worried about coming over from Australia, but once we retained the Bledisloe Cup he felt safer. He had enjoyed the warm welcoming powhiri experience in the morning. He observed that the answers around amphetamines are not there, so he was just going to give us a framework regarding amphetamines. Michael divided his talk into drug effects, problems and management.

A. Drug effects

Methamphetamines:

- Are sympathomimetic
- Block reuptake and increase the release of dopamine and nor-adrenaline
- Have lesser effects on serotonin
- Increase the actions of nor-adrenaline peripherally

Amphetamine type stimulants:

- Are increasingly fashionable
- Are problematic in Thailand, Japan, Australia and the Philippines
- Are used recreationally, occupationally (sex workers, musicians (classical), drivers, hospitality industry), for weight control, and produce abuse and dependence

The typical methamphetamine problem user in Australia:

- Is male and aged around 24 years
- Uses 1-2 times a week, with a 50% likelihood of injecting
- Has a duration of use of 6-11 years

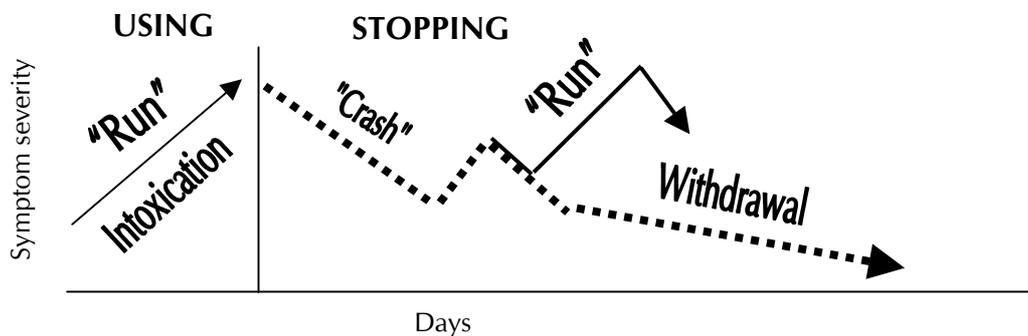
Intoxication is dose related:

- There is autonomic arousal (pupils dilate)
- Users can be excited, elevated, talkative, frankly psychotic, unable to sleep, and irritable
- There can also be repetitive movements like teeth grinding

Small acute doses in the drug naïve, improves cognitive functioning especially memory.

B. Problems

Below is a typical cycle of amphetamine use and cessation.



This diagram is from *Whoa To Go* by the Australian Government. This cycle can often and easily be confused with many psychiatric illnesses. Symptoms of depression and anxiety with paranoid delusions often make it impossible (cross-sectionally) to identify a substance induced illness from a primary mental illness.

There is rapid acute tolerance to amphetamines, particularly cocaine. The mechanisms this works through are metabolic changes, pharmacodynamic changes and behaviour. Behaviour sensitisation is the opposite to tolerance and can lead to users becoming more prone to psychosis with amphetamine use. Methamphetamine neurotoxicity may produce subtle frontal lobe deficits (e.g. on Stroop like tasks) and may explain persistent behaviour changes seen even after drug cessation.

Neuroimaging shows that essentially the nerves that utilise dopamine are damaged and reduced in number in long-term amphetamine users (like Parkinson's syndrome). The nucleus accumbens appears to be effected (Volkow et al 2001, Sekine et al 2001). Volkow (Am J Psych 2004) has shown some recovery in some areas is possible.

Michael pointed out that instead of the usual cute Speedy Gonzalas image of amphetamine users, it is actually more like the aggressive and chaotic Tasmanian Devil.

C. Management

Most research has been done for cocaine. No drugs have been found to help cessation/rehabilitation.

Antidepressants increase neurotransmission action and may decrease craving, but so far there have been no well designed controlled studies. MAOIs were used for some amphetamine users (in 1970's). Lithium has been found to be unhelpful. Similarly, dopamine antagonists have not helped. Some benefits have been seen with psychosocial interventions, but again there are few rigorous scientific studies.

Michael's final reflections were:

- The toxicity of the drug is helpful in making users want change
- Clients often think they have adult ADHD
- Engagement is difficult (clients are often chaotic)
- Clinicians need to have a long-term perspective and expect ups and downs. Remember the human life cycle (20s interested in staying awake all night – 70s not)
- In withdrawal management Olanzapine and Mirtazapine are helpful, but they just help the symptoms
- Treat aggressively with what ever means available to alleviate psychiatric symptoms
- Induced psychosis normally resolves rapidly

He concluded that:

- Each client has their own use-by-date
- Management is essentially experimental
- Abstinence should be the aim

Questions included asking about how to manage false adult ADHD wanting Ritalin? Michael won't manage adult ADHD as he thinks only 10% of those diagnosed have it, plus they are usually using 10 times the normal dosage for ADHD. There was also query about people using methadone, who for their crash period become injecting amphetamine users. He noted there is more mixing of the drugs today, but also snobbery between the two groups.

KEYNOTE ADDRESS #4: Alcohol and Other Drug Addictions: Can DNA Make a Difference? (Martin Kennedy)

This year's keynote speaker from outside the Alcohol and Other Drugs field was Martin. He is a geneticist from the Christchurch School of Medicine and Health Sciences. Martin has worked here and in the UK and is now looking at the genetic aspects of mental illness.

Martin gave an excellent presentation about understanding addiction at a molecular level. He started by thanking the organisers. As the conference had been approaching he was getting more and more concerned and nervous. Then that morning in the paper he saw the headline, "Calm down, anxiety is all in your genes" and was feeling much better. In fact much of Martin's talk was about how misleading the media headlines around genetics are.

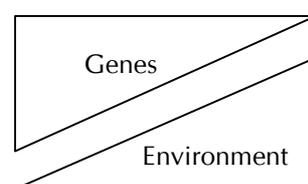
Martin's talk covered: Genes 101, Complex disorders 101, Are there genes for addiction, What might they do, How will we find them and What might they be used for?

1. Genes 101

The Body is made up of cells, which have a nucleus, which have chromosomes in which DNA (which carries genetic information) is housed. This produces a very ordered, well packed structure. At this point Martin showed some really interesting slides of chromosomes. He also emphasised that genes contribute to biology not directly to behaviour.

2. Complex disorders 101

In terms of the contribution of genetics and environment, the combination is complex and can vary as displayed in the diagram below.



For example, cystic fibrosis is largely genetic, while coronary heart disease is half and half and AIDS has a small genetic contribution and large environmental one. Addiction probably has at least a third genes contribution.

Simple illnesses are from mutated genes that will pass through families. More complex disorders have a number of genes that are not necessarily mutated. We are all at risk of some thing as we all have damaged genes.

3. Are there genes for addiction?

Genetic influences are on the *vulnerability* to AOD disorders. The pattern of incidence in families and the population comes from three types of studies – family studies, twin studies and adoption studies. Familial inheritance of alcoholism is well established. There is increasing research to suggest that drug use disorders are also familial. There is an eight times risk for drug disorders in relatives of a person with a drug disorder, but clearly environmental influences play a major role as well.

Identical versus non-identical twin studies illustrate the effects of genes. Since identical twins share more common genes than non-identical twins, if there is a genetic effect to drug use you would expect to see higher rates of it in identical twins. In non identical twins the rate of alcoholism is 10-15% , while in identical twins the rate is 30-40%. Twin and adoption studies indicate significant genetic influence on vulnerability to alcoholism. Animal models of addiction are increasing in sophistication and provide more evidence of genetic influences.

4. What might they do?

There are candidate 'addiction' genes. These are likely to function in brain reward systems, the endogenous opioid system, through drug metabolism and many others ways. Some will no doubt be surprising.

5. How will we find them?

The Human Genome Project is an international project to identify every base pair in the human genome and is now publicly available. This project has really facilitated the

work of individual researchers, but we still only understand the function of about 5% of genes. Other studies helping in the process are association studies and linkage mapping, as well as animal models. Martin noted, however, that it is a huge leap from finding a potential region in a chromosome to finding the actual gene responsible.

6. What might they be used for?

- New avenues by which to explore the biology of the condition
- Research tools
- Basic research about understanding the condition
- Improved medication (tailored treatment or new drug leads)
- Risk prediction, though Martin thinks this will be unlikely

Can genes make a difference? Martins answer – YES

- It can improve biological knowledge
- Be used in and as research tools
- Help tailor therapeutic drug use

Martin believes that when they are located there will be significant overlap in mental illness and addiction genes (or in the genes that contribute to these conditions).

One of the first questions Martin was asked was whether he sees gene research effecting changes in practice or for consumers? He thought not any time soon, but that it will eventually lead to changes in practice. Martin was also asked about nature versus nurture being studied in isolation and whether understanding evolutionary theory would complement the two to be seen together. He didn't have an answer and sees a big chasm between the clinic and the research lab, but believes the lab is an investment in the future of the clinic.

The next question was whether behaviour can produce genetic deficits, which Martin thought unlikely, except for cancer. He pointed out that living is carcinogenic and damages genes. Martin was also asked about measures of heritability in different populations, but found this difficult to answer given our shared inheritance and migratory inheritance. He was also asked if we inherit more from our mothers or

fathers – we inherit from both. The final question was if there was an increased risk of a child with two alcoholic parents developing alcoholism. Martin said there will be an elevated risk. He doesn't think we will ever get accurate enough information to test for addiction at birth. We will need wider family information to really make decisions of risk.

KEYNOTE ADDRESS #5: The UK Alcohol Treatment Trial (Gillian Tober)

This keynote was preceded by an introduction to the study by Doug Sellman of the NAC, the main message of which was that Motivational Enhancement Therapy (MET) is an effective treatment for alcohol dependence.

Doug talked about Brief Treatment Project that was based on a WHO study, which found 5 minutes of therapy was better than 0 minutes, but 15 minutes was no better than 5 minutes. Doug also discussed Project MATCH which found no difference between Cognitive Behavioural Therapy, Twelve Step Facilitation or MET. Overall in the BTP study there was a significant reduction in drinking in all groups. MET was significantly better at reducing relapse or heavy drinking compared with non directive reflective listening. There was no difference between Non Directed Reflective Listening and no further counselling. The conclusion was that MET is effective and supportive non-directive counselling not effective.

Gillian also hails from the Leeds Addiction Unit in England, where she is Deputy Clinical Director. She is a psychologist and currently running the Training Centre in the United Kingdom Alcohol Treatment Trial, on which she gave her address.

She was pleased to be back (having been a keynote speaker at the first Cutting Edge). She could see how much we've grown and diversified as a field. AOD training is a subject close to her heart. She has been training people in delivery of addiction treatment for some 20 years. Training people for this trial was one of the greatest experiences in her professional life.

The basis for their work came from the observation of the glaring omission in Project MATCH of a social approach. They wanted to compare other approaches with treatment involving social networks, i.e. Social Behaviour and Network Therapy (SBNT). So they designed a multi-centre trial of treatment for alcohol problems in the British Treatment System. They were building on Project MATCH and involved centres around the UK. They did a randomised trial involving multi-site clinical settings investigated the effectiveness of two psychosocial treatments – SBNT and MET. It consisted of 8 sessions of SBNT versus 4 sessions of MET.

It was mainly an effectiveness trial to possibly find a treatment more effective than MET. It was also to see whether there was a treatment that was more cost effective. She wanted it to be pragmatic and applicable in the average service, so they tried to be as inclusive as possible. The exclusions were being under 16 (legal issues), not able to read and write (the assessment was based on this), uncontrolled psychotic illness or cognitive damage, the lack of follow-up contact details, alcohol not the main problem and of were already receiving treatment.

Therapists were recruited widely, following the submission of a video of themselves using MET. They were randomised to either giving MET or SBNT. Seventy-two attended the first three days of training. They were all trained in MET and SBNT then supervised giving treatment and their competence was assessed. There were 52 successful therapists involved in the trial (nurses, counsellors, doctors, social workers, therapists, and occupational therapists).

The main measures were: drinks per drinking day, percentage days abstinent, LDQ (Leeds Dependency Questionnaire), APQ (Alcohol Problems Questionnaire), liver function test (same as Project MATCH to be able to compare), GHQ28 (General Health Questionnaire), and the SF36.

They recruited 742 participants: 74% male, 95.6% white, 1/3 with no educational qualification, 35% employed, 5% retired, and 41% single. At 3 months they had a follow-up rate of 93%, and at 12 months of 83%.

On average participants attended just over 2 sessions of MET and 3.6 sessions of SBNT. Over baseline, three and twelve months the percentage days abstinent increased significantly, number of drinks per day significantly reduced, but there was no change in liver function. There was no difference between the MET and SBNT. Harmful drinking reduced continuously over follow-up. The conclusion was that SBNT is equally effective to MET.

In terms of cost effectiveness SBNT is more intensive so they compared MET and SBNT on the cost of treatment, savings to society and effects on individual drinker.

SBNT cost more, but also saved more resource dollars than MET. Every £ spent on treatment saved £6. They concluded that both had more savings than costs.

The implications of this study are that SBNT adds to the repertoire of effective treatments and the project has shown demonstrable benefits to services from clinical trials. They found that different people will be better at giving one treatment than other (often based on the passion they have for a particular therapy).

Gillian encouraged people to think positively about being involved in these kind of trials in your own service.

The initial question to Gillian asked why therapists were not suitable. Gillian noted that a proportion were not competent. They also had a number of drop outs for various reasons including an outbreak of pregnancy, high turnover, some decided it was not for them, clinicians not liking to be randomised, and some were resistant to changing the way they did counselling. Gillian was also asked if there was any variation in training professions. Her only note was that doctors most likely to complete training.

KEYNOTE ADDRESS #6: Mental Health and Addiction Treatment Systems: Philosophical and Treatment Approaches & Issues (Joan Zweben)

Joan had come from California to talk to the conference. She is a clinical psychologist as well as a Lecturer in Psychiatry at the University of California, San Francisco. Joan has extensive experience in AOD in residential and outpatient services and also methadone.

Following Gillian Tober's address (on training in the UK Alcohol Treatment Trial), Joan noted the importance of high quality supervision for improving treatment. Her work looks at solving problems at a systematic level to give clinicians skills to work with complex clients. Joan spent 18 months integrating Mental Health and AOD services. She identified historical issues of mistrust in the US between consumers and health professionals, as well as barriers to care, such as fragmented systems and that providers expected to collaborate, but funders don't. What is needed is joint interagency policies and a commitment to righting the impropriety of excluding persons with coexisting disorders.

In terms of licensing and certification Joan sees what is needed is a comprehensive framework for program licensing and site certification or specific programs that are exempt from existing requirements. It would also be good to remove regulatory barriers that discourage providers from serving this population and create incentives through adequate reimbursement.

Training also needs mechanisms to cross-train professionals and to continuously develop the skill base of non-credentialed workers as well as taking into account comorbidities. It also needs to align all elements of the system to promote mastery of content that has been defined as important. Finally there is a need for regular clinical supervision. Joan noted a need for individualised treatment planning, and assertive outreach. She also sees the need to identify basic competencies in assessment and treatment.

Joan sees barriers to addressing psychiatric disorders as:

- Mistrust of professionals
- Not having good diagnosticians
- Belief that TC or 12-step will fix everything

- Resistance to/misunderstanding about medications
- Inappropriate expectations about time course
- Attitudes about chronic illness affecting stance towards relapse

The barriers to addressing AOD use are different:

- Failure to recognize and assess
- Minimizing the role of AOD use
- Toxicology screens not readily available
- Lack of understanding of, and respect for, the self-help system
- Medications: some physicians over prescribe, mis-prescribe, and medications can cloud diagnosis
- System barriers

Joan went on to discuss some guiding principles, especially noting that there should be no wrong door to open for service users accessing services. She noted that assessment and referrals must be consistent with this principle. She suggested creative outreach to promote engagement and that both the staff and the programme be flexible. She argued that the philosophical differences between harm reduction and abstinence are not helpful and should be seen as a continuum in relation to where a person is at. Joan then talked about three treatment models – addiction only services, dual diagnosis capable and dual diagnosis enhanced services.

She also discussed the difficulties in distinguishing substance abuse from psychiatric disorders. Issues include:

- The wait until withdrawal phenomena has subsided (usually by 4 weeks)
- Physical exam, toxicology screens
- History from significant others
- Longitudinal observations over time
- Constructing time lines: inquire about quality of life during drug free periods

The full version of slides from Joan's presentation can be found on the website – www.ebcprp.org

KEYNOTE ADDRESS #7: Thinking Beyond Description: To Think and Walk the Culturally Appropriate Talk? (Tamasailau Suaalii-Sauni)

Originally from Samoa, Tamasailau is now a Lecturer in Sociology at the University of Auckland and completing her PhD. She is also involved in Pacific research and was until recently the Co-Director of the Pacific research company, Pacific Research and Development Services Ltd.

Tamasailau began by giving warm Pacific greetings to all – Talofa lava, Fakalofa lahi atu, Malo e lelei, Kia orana, Taloha ni. Nisa bula vinaka. She thanked the organisers for the invitation to present this keynote. She was honoured by the invitation.

Through her engagement in various Pacific social and health service research projects over the years, she has met a number of people within the field whose knowledge and commitment to the Pacific Peoples in New Zealand has been enriching and humbling for her. Their work has helped to keep her own work grounded. Having mixed with many of the field at the conference, she was reminded of how important it is to have such occasions like this where people of the same spirit can connect or reconnect to keep our mahi (our work) real.

As a Pacific social and health researcher/evaluator cum academic, the question of how one might measure or evaluate cultural appropriateness in service delivery, is one that has become more and more pronounced as governments continue to emphasise the need for evidence-based services and service policies.

In the fields of Pacific Mental Health and Pacific AOD and gambling, knowing how to language the need for cultural appropriateness in different ways so that the need can be impressed on key, but quite different stakeholders (i.e. practitioners, policymakers, clients, families, researchers) is imperative. Whilst that sounds quite straightforward, knowing how one might do that exactly is extremely difficult (both theoretically and at a practical level).

Being able to develop a culture of integration where people no longer have to rely solely on their own personal networks to make connections with others in related fields and where the infrastructures of services across different sectors demand efficient referral processes, is something that is long overdue. Developing culturally appropriate services, whether the service is Pacific or non-Pacific relies on the development of this culture of integration.

For funders the talk is couched in 'outcomes/performance indicators' speak. For service providers, the talk is more about 'rapport building', 'assessment' and 'treatment interventions'. For clients and their families, the talk is about simply 'getting well'. No longer is it important only for researchers or evaluators to know these different language frames or emphases. With integration it is necessary, at least in Tamasailau's opinion, for all these groups to know these frames, or at least to be made aware of them.

Six percent of the New Zealand population is Pacific and this is made up of many ethnic groups including Samoan, Tongan, Niuean, Cook Island, Tokelauan, Fijian and Tuvaluan. Most are urban based and it is a young population. There are improving employment rates though low educational achievement. Pacific People are disproportionately represented in violence statistics.

There are no reliable prevalence estimates for Pacific psychiatric morbidity, though findings suggest Pacific Peoples' Mental Health status is similar if not better than the national population. Tamasailau talked about some preliminary findings from the National Mental Health and Wellbeing Survey. Pacific Peoples are low users of state Mental Health services. Traditional healers are still utilised. Barriers to Mental Health service utilisation are cost and culturally related.

Proportionally, Pacific drinkers are less than total national drinkers, but drink at the same frequency levels. Pacific drinkers drink more when they do drink and often drink to get drunk. Pacific drinking patterns are more harmful than those of the national population. Alcohol plays a social role similar to that of food in Pacific societies. Pacific

Peoples suffer more problems from other people's drinking compared to the total population. Tamasailau also discussed more ethnically specific data around drinking.

In terms of tobacco Pacific men smoke more than women. Over two-thirds of Pacific People believe smokers are risking harm. A third of the respondents had used cannabis, 17% in the last 12 months. More males than females used cannabis and the mean age was 17 years. The other most commonly used recreational drugs were stimulants, LSD, mushrooms and morphine. Only a very small proportion used these other drugs and they were mostly male. In their survey 23% of respondents had tried Kava, 8% in the last 12 months. Kava was drunk mostly at Kava clubs then at home and then at ceremonial occasions.

Thirty-nine percentage of men and thirty-eight percent of women reported having gambled. Cook Island Māori women gambled the most and reported the most worry over gambling. Overall a low percentage reported their gambling caused them problems.

Tamasailau then asked how we can use this information to understand cultural appropriateness and provide culturally appropriate service delivery. The first step is to look at what cultural models of service delivery are available to Pacific services. Currently there are eight possibilities:

- The Wellness model
- The Illness model
- The Fonofale model
- The Te Vaka model
- The Faafaletui model
- The Strands or Pandanus Mat model
- The Strengths-based model
- The Traditional Healing model

The most commonly used of these is the Fonofale model, which incorporates environment, time and context. Tamasailau also talked about the Nurses' Cultural Safety Model and the Pacific Health Charter. She also discussed how other cultures' models

could be applied to the Pacific People and offer a different perspective. There also needs to be a movement from Pacific models of health belief to service delivery.

Tamasailau believes to develop cultural appropriateness in services there needs to be:

- A meeting of minds and spirits
- Transparency and accountability in systems adopted
- Understanding of where services meet and differ
- Recognition of past developments and present contexts
- Solid theoretical and empirical support for future developments
- Appropriate “linguaging” skills

She notes that all the above requires explicit movement and safe spaces for describing what it is, explaining how it is and for suggesting how it can be. Tamasailau concluded that we have some tough questions to ask ourselves about cultural appropriateness, however, to stay real to our mahi they have to be asked.

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

Terry Huriwai opened the session with Kia Ora and thanked us for coming. He then introduced the Associate Minister Damien O’Connor and talked about his involvement in problem gambling, problem drinking and problem smoking. The Minister then acknowledged previous meetings and the importance of its work. He talked about what work has begun in government in curbing problem addictions, i.e. banning smoking, increasing levies on alcohol, the importance of modelling good behaviours to our children, and the importance of intervention. He also spoke about the new initiative of Workforce Development by the National Addiction Centre.

He praised the efforts of the Mental Health Commission, the Blue Print targets and HRC supports, and the work involved in the National Drug Policy.

The Minister also identified a number of areas in need of further work or support. These included the need to address the escalating integration of drugs and crime, and the

integration of addictions, e.g. smoking with drinking with drugs. He also talked about the problems of drugs and alcohol in the workplace, the financial costs of addiction to the family, workplace, labour, welfare, health and socially. He pointed out that treatment of people needs to be comprehensive, when and where they need it, as well as integrated with other help. Finally, he commented on how the conference will be covering a wide range of subjects, which can be integrated and help the government achieve its aims and lead them into the future.

PLENARY SESSION #2: Workforce Development Plenary (Ian MacEwan, Kirsty Maxwell-Crawford, Simon Adamson, Doug Sellman)

Ian MacEwan was the first to speak in this plenary session. He talked about the National Addiction Treatment Workforce Development Programme (NATWDP). Our workforce has been in our hands as to how it develops and Consumers have often been involved in this. We could have just been part of the Mental Health Workforce, but due to lobbying from us we are our own mistress.

Now is the time we need to talk, discuss, and listen to how we see ourselves developing from here. What is it we do? What is unique? How do we see where we want to go and where we are going to get our workers from? Most important to the field at the moment are recruitment issues. Ian extended an invitation to all to feel part of this process. The NAC is ensuring the Ministry gets the strategy document, but all of us must ensure what that strategy is.

Kirsty Maxwell-Crawford was next to take the stage. She opened with a Pepe in Māori. She spoke about Te Rau Matatini (TRM), which is working on developing a national strategic workforce plan for Māori in Mental Health.

The aim is to strengthen the Māori Mental Health workforce by:

- Policy
- Career opportunities

- Extending and expanding workforce
- Excellence in clinical and cultural practice

TRM was launched in 2002 at Massey and is now an independent Trust with a Governing Board.

Their workforce projects include:

- Promotion of Māori Mental Health careers
- Closer alignment of education and health
- Māori Mental Health career pathways
- Training
- Mental Health in primary healthcare
- E-workforce development
- Development of a National Māori Mental Health strategic plan
- Māori child, adolescent Mental Health workforce development
- Orientation
- Placement guidelines for Māori tertiary students

The plan is strongly influenced by research, literature, and reference groups. They are taking an evidence-based approach. The plan is called Ria Pua Wai Te Ararau and the four sections can be found on their website – www.matatini.co.nz. The vision of the next 10 years is to significantly increase Māori working at all levels of Mental Health services.

Simon Adamson, of the National Addiction Centre was next to speak. He talked about the 2004 National Telephone Survey. A random selection of 275 dedicated AOD workers are to be interviewed by phone. So far 150 interviews have been done.

As compared to the 1998 phone survey the sample has the same gender ratio and roughly the same ethnic mix. There are significantly more people staying longer in the field and the average age of workers has increased. The percentage who have an AOD qualification has risen from 47.4% in 1998 to 56.7% in 2004. Similarly the percentage with an AOD postgraduate qualification has risen from 2.8% in 1998 to 12.8% in 2004.

Simon concluded that we have an ageing workforce that is more experienced. In service training is widely available and workplaces seem supportive of ongoing training.

Finally Doug Sellman, also of the National Addiction Centre, talked about the National Addiction Treatment Workforce Development Project (NATWDP). He is pleased, as are all the team, that Ian is leading the project. He thinks the field has an inclusive feel as did the conference. Doug is also delighted to be developing a strong relationship with TRM.

Doug talked about the draft NATWDP and where it is going. He discussed the objectives for organisational development, infrastructure, recruitment and retention, training, research and evaluation. He then asked a series of questions about what was wanted from the plan. He also presented a series of vignettes based on NTOP data to illustrate who we are seeing as a workforce. Currently the primary goal of NATWDP is to enhance the well-being of people with addiction-related problems in Aotearoa New Zealand, through improving the clinical competence, leadership and public standing of the national addiction treatment workforce. Two of the biggest issues are stigma and the way it effects public standing and that there needs to be more emphasis on nicotine dependence.

The first question asked of the panel was if they felt that the move to workers being more professionally qualified was cutting a lot of potential workers out (e.g. recovering people and past offenders). Ian answered and pointed out that in the past we have tended to throw the baby out with the bath water, but are trying not to do that now. All agreed that this is an issue that needs to be addressed.

Another question centred around how further training now was a lot more technical and that the older workforce doesn't like this. Was there any motivation and support for people to continue training (especially with computers)? Kirsty noted that TRM has supports in their system to help with technical skills (and language too).

PLENARY SESSION #3: Problem Gambling – Looser Pays! (John Hannifin)

The main point of John's address was that the money for treatment of problem gamblers comes from gambling venues (casinos etc), so the loser (in gambling) literally does pay for their own treatment.

John has a 20 year history in the AOD field and for the last 8 years he has been closely associated with the Problem Gambling field. The Problem Gambling Database has been centralised and largely driven by John. He sees gambling as a sure way of getting nothing for something.

Nowadays in the Problem Gambling field the gambling industry (casinos) and Problem Gambling Committee are working together. In the beginning the Problem Gambling Committee and the Gambling Industry and Problem Gambling Service Providers and the Problem Gambling Purchasing Agency were all working in a series of disconnected relationships.

John thought that too many people were on the same beaten path, so he decided to try something different. The mission was to provide help for those currently suffering from gambling problem and eventually health promotion. They went about this by focussing on creating access to services through contracts for new clients.

They started by contracting three agencies for national mainstream coverage: the Problem Gambling Helpline, the Problem Gambling Foundation and the Salvation Army Oasis gambling service. The focus is on outcome of service and thus the follow-up of clients is essential. They found that 75% of clients followed-up had improved. Grant Paton-Simpson has set up a database that gives immediate feedback on the Problem Gambling client base and this computer system is now in all services.

In regard to Māori Problem Gambling services (Te Heienga Waka o te Ora Whanau) there are many national Māori initiatives underway including:

- Iwi are mandating services in local areas (starting to look at gambling generally not just at Problem Gambling)

- Focus on community development, health promotion and intervention
- National co-ordination and development through Te Heienga Waka o te Ora Whanau
- National Māori prison project
- Working with Māori organisations

The Asian Problem Gambling population is also a growing concern. One survey showed 6% of Problem Gambling clients are Asian, though a GP survey estimated the figure closer to 12-14%. As with Māori, their needs have to be addressed in their own ways. Initiatives to address this population include: a national team placed with the Problem Gambling Committee, Asian language speaking clinicians and national services particularly in Casinos. Similar issues are arising with Pacific Island groups and country and ethnic specific clinician and services are required, e.g. Samoan with Samoan. A more educational and community approach is also needed.

John then talked about some of the statistics involved in Problem Gambling in New Zealand. In 2002/2003 Kiwis lost nearly \$2 billion on gambling. There are around 22 – 25,000 gambling Pokie machines in the country. From 1997 to 2003 Problem Gambling services saw 13,592 face-to-face clients and the Helpline had 25,000 new customers. In all, over 33,000 received help for a gambling problem.

Work that is now underway includes competencies for workers being developed as well as standards for agencies. There are also health promotion initiatives in progress. The Public Health work plan has woven the threads of Pakeha, Māori, Pacific Island and Asian communities and pointed out that we all need to work together as well as separately.

A number of research projects into Problem Gambling are also underway including:

- The socio-economic impacts
- A Dunedin longitudinal study
- Why do people gamble in New Zealand
- The effect of Naltrexone on gambling
- The effect on children of problem gamblers
- The effect on women whose partners gamble

Client's progress is the basis of the whole thing. John believes we should be aiming at normal practice, not best practice as normal practice should *be* best practice. He also talked about further data, which is available from the Helpline.

In terms of future directions John would like to see:

- Screening and targeted help
- Integrated care (as part of follow-up)
- Public Health being left as an orienting perspective, as this is a social problem
- Organisational independence (at the moment John finds it easier to work with NGOs than DHBs)

Finally John mentioned three models for treatment of Problem Gambling for us to consider:

- Consumer protection and rights
- Community development
- Addiction

5. DAY ONE OF THE CONFERENCE

CONFERENCE OPENING:

Whilst the weather was nothing to be pleased about, it was excellent to come together as a field again. We are fortunate as a sector that we have an annual opportunity for nearly half of our workers to converge and network, exchange ideas and gain support from each other. In a field that is undergoing a number of changes, and which is very fluid at the best of times, it is important for those working with AOD clients around the country to be able to connect face-to-face. The Palmerston North Convention Centre was a wonderful venue for this reconnection. It was centrally located – most importantly near a number of superb places to purchase coffee.

The conference was started with a Powhiri which was led by Mana Whenua. This was followed by the address from the Minister.

SUMMATION OF DAY ONE:

This year saw the biggest Cutting Edge ever with nearly 340 delegates from around the country. Groups of AOD workers catching up with each other could be seen all around Palmerston North for three days.

The first day of the conference had only one streamed session in the afternoon. The rest of the day was made up of keynote addresses. Damien O'Connor as at Waitangi in 2003 represented the Ministry of Health at the Powhiri and spoke about issues and problems facing the AOD sector. This was followed by addresses by Moe Milne on a Māori perspective of integration and Duncan Raistrick on substance use in mental illness. During the lunch break several meetings were held including the Psychologists, the Doctors, the Drug and Alcohol Nurses of Australasia (DANA), and the Alcohol and Drug Consumer Meetings.

After lunch was the only streamed session of the day, which had topics varying from the families of problem gamblers through Māori AOD models to the integration of substance abuse treatment in schools. Following a break for afternoon tea the day wound up with a presentation from Michael Baigent on the Treatment of Amphetamine Dependence.

The end of the day saw the launch of Kina Families and Addictions Trust as well as the DAPAANZ AGM, Kina Families and Addictions Trust AGM and the AChAM Supervisors workshop.

The day, and conference, ran very smoothly and was kept well to time. Once more the amount of effort Lisa and Lindsay (the conference secretariat) and the organising committee put into setting up the conference was evident. The Palmerston North Convention Centre staff were extremely professional and helpful and the facilities superb.

SELECTED PRESENTATIONS FROM DAY ONE:

◆ Weaving Together Communities and Individuals (Famke Van Laren/Cynthia Orme)

It was great to see the number of papers on gambling at this years conference. The presenters noted that while clinicians assist in providing a clearer understanding from a clinical perspective, the Public Health team is at the heart of communities. They also pointed out that gambling is easier to hide than AOD: with gambling you often don't know what you've got into. They feel the need to bring Problem Gambling much more out into the open.

The reasons they listed for using a Public Health perspective with gambling were:

- To offer an integrated approach
- To address quality of life of families and communities, e.g. the TAB that applied for a liquor license just so they could put Pokies in
- To emphasise harm reduction strategies

Not everyone who comes through the door is ready to stop gambling (like abstinence versus reduced drinking).

Problem Gambling has a lot of impacts, which in turn have a lot of spin offs:

- Work and study
- Personal
- Financial
- Legal
- Interpersonal
- Community services

Public Health can cover all these areas.

They use the ABCDE model of Community Health Promotion Action for Gambling:

A = Awareness

B = Building networks and coalitions

C = Community development

D = Developing resources

E = Evaluation

Public Health workers and clinicians need to work hand in hand. The main aim of health promotion in gambling is to inform, mobilise and support communities in taking their own action with regard to Problem Gambling. It is the Problem Gambling Foundation that is taking this Public Health approach. It is all about motivating people.

◆ **Once Were Warriors But Never Were Drinkers (Paul Robertson)**

Paul is currently working for the NAC and is based at the Māori/Indigenous Health Institute (MIHI). He opened his presentation with consideration of the construction of reality. He suggested reality could be seen to be made up of “the truth”, defined as objective, neutral, unchallengeable and independent of socio-historic context, or ,what he described as the “as if truth”, identified as subjective, discursively negotiable and contingent on contextual variables. It was suggested that both versions potentially provided a stable and predictable basis for reality, but “as if truth” provided great scope for critical consideration of phenomena.

Paul then described his research, a qualitative evaluation of 11 Māori men's experience of addiction and treatment, in which discourse analysis was applied to a number of in-depth interviews. The primary aim was to identify how participants used discursive resources, or language, to present themselves in terms of being Māori and experiencing addiction. The qualitative nature of the research precluded generalisation of the results, but did provide an in-depth consideration of the korero of the participants. Paul emphasised that the objective was not to verify the truth of participants' reports, but rather to allow analysis of the ways in which they used particular language to present themselves as Māori and as 'addicts in recovery'.

When presenting the results Paul noted that Māori had historically been cast in a negative light in relation to drinking, such that many of the participants seemed to associate being Māori and alcohol use as naturally co-occurring. This association was clearly evident in colonial times within notions of the "drunken savage" being common and has been illustrated more recently within "Once were warriors" type stereotypes. The results of interviews suggested, however, that a number of the participants had turned negative stereotypes on their heads via narratives which associated Māori tradition with sobriety, the maintenance of boundaries and abstinence. In doing so they repositioned Māori culture and, by association, themselves as Māori, as being separate from alcohol use and addiction. Alcohol and other drug related problems were thus recast as external to Māori, rather than an intrinsic part of who they were. Paul noted that although there were some limits to such cultural tradition based narratives like these, they did have potential for contributing to a foundation for addressing addiction related problems. He proposed that greater attention needed to be paid to understanding how the 'talk' of recovery might be associated with the 'walk'.

◆ **Integration of Substance Abuse Treatment into Schools – Would it Work?**
(Mirjana Vilke/Kevin Ronan)

Before they started talking about their project the presenters felt there were three important things to discuss:

1. Youth drinking habits
 - Prevalence (from the ALAC Youth drinking monitor) showed there were some decreases, but also a lot of increases – particularly in binge drinking and the amount drunk
 - ALAC's The Way We Drink looked at current New Zealand drinking (in young and adults) and found New Zealand is still quite tolerant of drinking
 - APHRU also has a lot of research on the increasing drinking of youth

2. Youth Health – A guide to Action. This is a policy level factor focussing on the health of young people. It emphasises a holistic approach, with goals on measurable improvements in health.

3. Te Taihere Hauora, which is a Health Promoting Schools World-wide movement. It began here in the late 1990s and sees school as part of a wider community supported by parents and services and community.

Facts:

- Young people are drinking heavily and using cannabis
- Measures for young people are required from prevention to residential rehabilitation

Schools have traditionally been regarded as the best place for delivery of drug education. Furthermore, there are now a lot of kids in the middle – they have no access to professionals, but have issues that need to be dealt with.

In their study:

- They asked about attitudes to, and knowledge of, youth drug use, the treatment available to them and whether interventions in schools was a good idea
- The first port of call was School Counsellors
- They sent a questionnaire to all their colleagues in New Zealand
- They had 130 responses of which 122 were valid

Forty percent thought treatment options were reasonable for youth, while 60% disagreed. Forty percent thought regular AOD intervention in schools was a good idea. Thirty percent thought it would be good sometimes and twenty percent thought often.

- Who was most appropriate to deliver this intervention?

Guidance counsellors	65%
Teachers	50%
AOD Counsellors	76%
Youth Worker	51%

- What are the potential benefits of AOD interventions in schools?

- Easy access
- Increased understanding and knowledge of drugs
- Reaches all kids
- Professionals a more 'familiar face'
- Professional services regularly available
- More information for teachers
- Schools are sometimes the only place that care about kids
- Harm reduction strategy
- Peer and family support
- Bringing the reality of the large percentage of youth using to the school setting

- Drawbacks cited were:

- A lot said, but nothing done
- Level of training required
- Schools under resourced
- Privacy
- Normalising drug use behaviour
- Time constraints

The presenters concluded that school based, limited range, AOD interventions are worth exploring. This will need proper training, but could be empathetic and timely.

◆ **Me Whakahaere Katoa, Kaua e Whakarerea: Include Everything, Don't Leave Anything Out (Dick Johnstone)**

Dick feels he is about empowering Māori. He was brought up by a Māori godfather. His personal history involves being a theatre director and working in the Māori addiction field as well as a history of alcoholism.

His presentation was about models available to treat Māori with AOD problems. He noted that with colonisation the Māori models of health moved from wellness to illness. He noted several Western models, such as AA, Step, harm reduction, which he feels show little regard for local culture.

The remainder of Dick's stunning presentation then comprised of outlining theories of treatment with the background of local Māori artists. These models included:

- Whare tapa wha
- Hinengino – mind and emotions
- Whanau
- Mauri life force
- Tinana – body
- Wairua – spirituality
- Powhiri Poutama
- Rangi Matrix
- Maslow's hierarchy of needs
- Life transitions model
- Kete model
- Nga Pou Mana
- Taukumekume
- Muriwai Wanaga
- Whakamana
- Empowerment model
- Te Wheke
- Harakeke
- Kahuikaumatua/Kuia model

Dick's conclusion on the best model to use was - Just use everything! However, there does need to be a return to inclusivity and Māori holism as well as non Māori holism.

◆ **Māori AOD Models: What's Being Used in the Addictions Field? (Mike Goulding/Terry Huriwai)**

Mike and Terry presented on the work they have been doing talking to Māori practitioners about what they do. Their aims have been to:

- Identify models and frameworks of treatment
- Consider the extent to which these models could be applied to gambling

Their rationale is based on:

- National Strategic Framework
- Gambling Act 2003

The project has had three phases. Phase one consisted of a literature review, defining the group and preliminary contact. Phase two was preliminary interviews with organisations and Phase three was further interviews. In all 48 practitioners from 20 organisations in 13 regions were interviewed.

The models they came back with are:

- Te Whare Tapa Wha (Four sided house, balance and inter connectedness)
- Powhiri/Poutama
- Te Wheke
- Whakamana – empowerment

The concepts of the models are the same, but the way practitioners used them made them individualistic, leading to the creation of a perhaps "Super model" with the elements of:

- Kahui Ao
- Tatou
- Dynamics of Whanaunatanga
- Ma Te Wa
- Awhi

They hold the belief that the efficacy of the models is very important.

6. DAY TWO OF THE CONFERENCE

SUMMATION OF DAY TWO:

The second day of Cutting Edge didn't show much improvement in the weather. As usual this was the busiest day of the conference with many presentations and meetings going on. The morning started bright and early with Martin Kennedy's fascinating and excellent keynote address on alcohol and drugs and DNA. After morning tea Doug Sellman gave some background to the UK Alcohol Treatment Trial in preparation for Gillian Tober's interesting and very relevant keynote on the training initiatives involved in the UK trial. This was followed by Joan Zweben giving a presentation on Mental Health and addiction treatment systems before we broke for lunch.

There was just one streamed session in the morning in between keynote addresses. The streams covered a wide variety of topics including opiate detoxification, integrating Māori and Western philosophies of treatment and brief intervention approaches for gambling.

As is traditional lunchtime was taken up with the Treatment Research Interest Group's AGM as well as the Pacific Peoples' meeting and the Māori workers' meeting.

Post lunch were the second and third streamed sessions of the day as well the poster session. The streamed sessions reflected the diversity of the conference as well as the theme of integration. Presentations covered: amphetamine induced psychosis, post traumatic stress disorder, brain injury and AOD, treatment delivery the Pacific way, needs of Lesbian, Gay and Bisexual clients, sexual identity and gambling, spirituality and addiction, integrating legislation and drug policy, social behaviour and network therapy and addressing psychiatric disorders in methadone patients.

This year the poster presentations were given a raised profile and many delegates were encouraged to present in this format. Topics covered in the posters included: Correlates

of Self-Reported Treatment Outcome, The Dual Diagnosis Intensive Outpatient Programme, A Partnership Approach to Client Follow-up: A Workforce Development Issue, CADS Community and Home Detoxification Service, Rehabilitation Studies at Massey University, Working With Offenders in Prison, Te Rau Matatini, Living with People with Alcohol and Drug Dependency: The Partners Experience, General Understanding of the Term 'A Standard Drink', Factors Affecting Youth Retention in Alcohol and Drug Treatment, Continuing Care: Integration of Services at the Christchurch Bridge, as well as And Can We Check Your Gambling? A Project to Further Validate the EIGHT Screen. A significant number of the poster presentations can be found in the 2004 Cutting Edge Research Monograph and consequently are not reviewed in these proceedings.

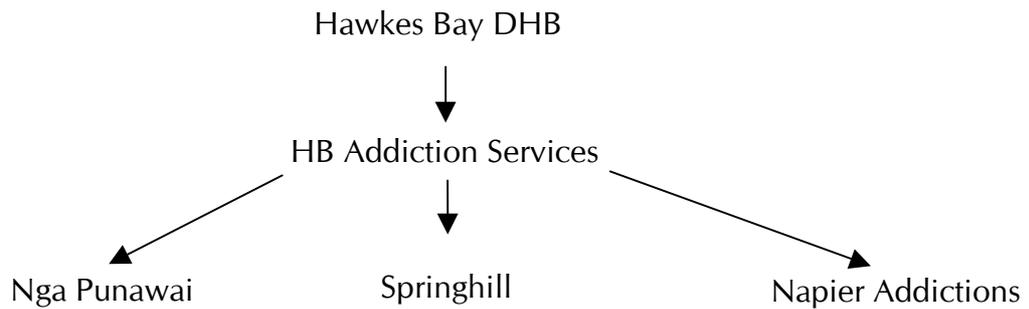
The final keynote of the day was the valuable presentation by Tamasailau Suaalii-Sauni about the Pacific journey in AOD. The day ended with the launch of the ALAC Guidelines for Alcohol and Drug Services Working with Women. The Guidelines were developed by the ALAC Southern Regional Office. The Alcohol and Drug Women's Advisory Group were also involved in this project.

SELECTED PRESENTATIONS FROM DAY TWO:

◆ Integrating Whanau, Hapu, and Iwi Philosophy with Western Models of Practice in the Alcohol and Drug Field (Matt Marsh, Anthony Whaipakanga, Waina Pene)

This presentation was introduced by Dason Hita and was highlighting the integration between Māori and Western philosophy, in particular within their service 'Nga Punawai Aroha' (Hawkes Bay DHB – Māori Addiction Services). A karakia was offered and mihi mihi of presenters.

Waina talked about how she returned to her grandparents home as a child. Her Grandad told Waina she was going to do great things when she grew up – this planted a seed of destiny. Kara Bill & Auntie Rury were influential in planting seeds of destiny to develop Nga Punawai Aroha. The structure is -



Nga Punawai offers:

- One-to-one Counselling
- Court reports
- Whakamahana
- Poutama
- Matariki Te Whare Tirahanga Māori (prison)

The team then sung a Waiata:

E tama I whanake
 I ata o pipiri
 Piki nau ake ki tau
 Tini I rangi e puta
 Ra nei koe e tama
 Ite wa kaikino nei
 Te korikori kia tae atu
 Koe ki te wai ahu puke
 Io tupuna kia wetea
 Mai ka te tapuni tau
 Whaingā hei kahu mo
 Hou ki te whakare wanga taua.
 Au, au, aue

It was written in 1700's for twin sons in fear of bloodshed and death in their future. It was used symbolically to represent that we are still fighting today in Te Ao Hurihuri to

integrate the knowledge from our ancestors with that of our Western learning. It's about embracing Apirana Ngata's Whakatauki.

Matt then spoke about how the Western and Māori philosophy is used with tangata whaiora – Matt was able to honour his tau iwi and Māori heritage with this model (Kanohi ki te kanohi to Fruit salad) - "2 worlds hand in hand".

Te Whare Tapa Wha (TWTW) has a structure that gives safety to us in the whare with four strong walls. If we destroy any walls – the roof/structure would not be as strong as it could be.

They then gave an outline of the development of the model. Kaumatua Tapuna Te Hira said that Taha Wairua is the starting point to wellbeing. They also discussed increased obesity and resulting illness, the high usage of psychiatric services and the large percentage of children living in broken homes. Mason Durie compiled these concerns to give the full picture of TWTW.

They use TWTW to establish understanding for Tangata Whenua of:

- Wairua
- Tinana
- Hinengaro
- Whanau

They ask Tangata Whenua to list how these taha are nourishing or neglecting from their lifestyle and what could be done to strengthen their taha. The outcomes were that when Tangata Whenua have self-assessed and drafted their own goals they are more likely to be achieved!

Other models used include Poutama, Powhiri, Kapahaka along with Western models (CBT, methadone, sport, model of change, interactive drawing therapy). All staff are trained in both philosophies and Western tools/methods are used to enhance Māori philosophy. These were all framed within TWTW.

The presenters concluded that we can ground people primarily with TWTW, but we can add strength to our walls with Western models. However, it is more difficult to reverse this without 'squashing' TWTW and forcing it into a small Western box (which is not as holistic).

Whakaariaori is used by Nga Puna staff to soothe Tangata Whenua who feel Whakamauiui to ground them and their Whakapapa at the start of the day. The process was demonstrated with three volunteers. This involved facing east towards sunrise with soothing natural music played while breathing and performing Tai Chi like movements while the leader explained the ori ori.

The mauri was gathered from Rangi and Papa and released to whanau, hapu, iwi. All bad was released and good brought back to Tangata Whaiora. All four sides are honoured then we can talk about the joining of all cultures. We bind these in a holistic sense and join people together.

Dason opened the floor for questions and Major Tahapeehi congratulated the team and questioned whether services are provided to rangatahi. Matt replied that it was more difficult to get into single sex schools, so co-ed schools are serviced. They were also asked about their view of fitting TWTW into the West and Anthony explained it's too hard to fit a holistic picture into a smaller picture (e.g. Western model). When asked who looks after the wairua of the tangata whaiora Kaumatua explained that whanau should look after whanau, but Kaumatua assist.

◆ **D.I.C.E. Therapy: An Integrated Brief Intervention Approach to Gambling Disorders (Paul Schreuder)**

Paul presented his "DICE" model of an approach to inter-personal therapy in relation to gambling problems. DICE is an acronym for Deliberate, Intensive, Comprehensive and Empowering and proposes a particular way to integrate strategies like motivational interviewing with other cognitive behavioural therapeutic interactions. Paul emphasised the need to design interventions to fit with the seemingly increasing trend towards brief therapy in the current reality of service delivery. The ideas were recently published as a book chapter.

The audience particularly appreciated the musical performance as the speaker is also an accomplished musician, who put his therapeutic notions into a song.

◆ **Getting the Framework Right - Integrating Legislation and Drug Policy (Nandor Tanczos)**

The first thing that Nandor noted was that alcohol is not in the Misuse of Drugs Act and has its own legislation. He then covered the Acts for alcohol, tobacco, inhalants (there is none), and opioids.

He ran through parts of the Act heading to the conclusion that we need a alternative Misuse of Drugs Act. It needs to be reality based, all recreational drugs should be under one banner and it needs to address human rights issues. Nandor feels we need to stop making distinctions between what is socially acceptable or not and instead base decisions on evidence.

Nandor proposes having three classes:

1. Class A - high level of restriction. Possible to search without a warrant for trafficking or possession
2. Class B - medium level of restriction. B1 similar to A, but B2 less strict.
3. Class C - low levels of restriction. C1 would be R18, only on licensed premises and not promoted. C2 would be R18, available without a license, but carrying warning labels. C3 would have no age limits and restricted promotions.

The legal ramifications would be in the first instance to provide help for people rather than immediate legal consequences. He would encourage educational opportunities for minor use.

Guiding any framework should be:

- Care
- Consistency
- Control of issues

◆ **Treatment Delivery the Pacific Way – An Exploration into Delivery of Alcohol and Drug Services for Pacific Peoples in New Zealand (Ata Samu)**

Ata talked about the exploration into AOD treatment interventions for Pacific Peoples – the Pacific arm of the ADOPT project. It provides feedback at a national level from Pacific Services.

1. Introduction

There are 200,000 Pacific People in New Zealand, which makes up 6% of the New Zealand population. There is a greater presence in urban centres. They are trying to keep their culture while living in a Western culture, which equates to tension, which in turn means changes in family and community structure and can therefore lead to problems with alcohol. Some services are currently using Pacific models.

2. The Programme

The overview was to explore the process of delivering treatment to Pacific People across New Zealand. This involved:

- Interviews with clinicians (on their opinions – 31 interviewed in total)
- Interviews with clients and families

The Pacific People interviewed did not agree with, or make sense of, the ALAC definition of assessment as it talks of individuals and not social, familial and cultural contexts.

3. Findings

It was found that services were using the usual forms, but with Pacific People they adapted forms to the Pacific context to include:

- Timeline
- Family tree
- Fonofale model

There were concerns around the DHB forms used. It was noted that Pacific history and tradition is oral, not written. Pacific People talk about issues then fill in forms (whereas

Western protocol is the opposite). This lack of cultural focus on forms produced barriers to relationship building, so clinicians needed to adapt their practice to this. Treatment was best seen as another stage in helping.

Current interventions being used include:

- Pacific approaches
- Spiritual approaches
- Palagi approaches

The aim has been to capture key Pacific values. These include Spiritual (dreams), Christian values and prayers. These are commonly used by young New Zealand born Pacific clinicians.

Palagi approaches are viewed as quite different with their strength based approach, e.g. MET. Pacific are less medical/disease models or DSM based. Since Palagi approaches are not holistic (body only) they need to integrate Palai and Pacific approaches. How we approach the client is crucial, particularly with a holistic approach and involving families.

The holistic approach is not a uniquely Pacific approach, but a human approach involving:

- Spiritual
- Mental
- Physical

E.g. Fonofale model and The Paridamus mat

Clinicians also see involving families as very crucial. Getting families at the onset of treatment to aid recovery is important. Stories provide meaning and cultural implication is difficult to do, but it is happening.

So there is a Pacific way, but it is mediated by funding requirements and reporting requirements of services. There is added stress from the differences in resourcing and

service structure with DHBs and NGOs. One significant finding is that Pacific ethnicity is important in the treating clinician.

4. Recommendations to date:

- Nation-wide assessment system that is Pacific sensitive
- Holistic approach needs to be reflected
- Involve families
- Ongoing training for Pacific workers

This presentation covered just phase one of project. Phase two will interview clients and their families, while phase three will be the findings from stages one and two and final recommendations.

◆ **Integrating the Needs of LGBTTF Clients into A&D Services (Diana Rands/Tania Pritchard)**

This presentation was a follow-up from last year's Cutting Edge talk about what they are doing for lesbian, gay men, bisexual, transgender, takataapui and fa'afafine (LGBTTF) clients.

Who are they? A diverse community:

- Sexual needs met by same sex partner
- Negotiating the process of self-recognition, identity etc
- Confronted with wide spread homophobia

Their clinical needs are:

- Therapeutic relationships
- Environment, staff and literature
- Dealing with guilt and shame so need to be in an environment ensuring growth
- Needs to be in line with the Mental Health Standards

How?

- Physical surroundings
- Recruitment of gay friendly staff
- Safe for staff to be gay
- LGBTTF in leadership positions
- Assessment
- Counselling protocol (never assume heterosexuality)
- Training

The programme they have developed to aid in this process is called Rainbow Recognition. It involves:

- Expressions of interest
- Receiving information
- Signing a declaration
- Completing a checklist
- Receiving Rainbow Recognition poster

The programme has been implemented at CADS South. Initial response was reserved, it was perceived that people felt they needed to be experts. Some discussion of the programme followed and it was stressed that senior management support is very important.

♦ **The Integration of Spirituality into Addiction Treatment: The Salvation Army Bridge Programme and the Recovery Church/Fellowship Phenomenon (Ian Hutson)**

This presentation was about the Salvation Army Bridge Programme and the Recovery Church phenomenon. The Salvation Army mission statement is to care for people, transforming lives and reforming society. It has an evangelical Christian background with social aspects. The Bridge's mission statement is – safe, integrated, high quality service.

Factors behind the emergence of the Recovery Church and fellowships include:

- A desire to provide a more dynamic and relevant spiritual experience. At times it could be very secular then move at others times to extremely religious so they were looking for more consistency
- Linkage to external church or other groups was apparently not meeting the needs of most clients
- Not meeting spirit needs of clients adequately

Some needs commonly identified were:

- A safe place to explore one's faith
- An atmosphere of honesty and acceptance
- Incorporating 12-step concepts and the AA 'culture' (a spiritual journey already happening)
- A relevant and accepting place of Christian worship (some wanted to go where faith was okay)
- Inclusive involvement and participation
- Honest, sharing, AA, NA, bible reading

How they developed the Recovery Church and integrated spirituality into the Bridge:

- Daily spirit lifter – morning meditations (prayer, reflection)
- Weekly spiritual awareness – exploration of spirituality (very open)
- Recovery church attendance – voluntary or mandatory
- Alpha groups

The Recovery Church has grown nation-wide:

- Auckland recovery church commenced in 1995. Its attendance was 20 and is now approximately 120 (only 25 of those 120 are actually assessment clients)
- Twelve Recovery Church groups around New Zealand
- Attendance is estimated at 500 in New Zealand in any given week
- Some Recovery Church groups primarily cater for non AOD people (they feel it is more real than anything else they've found)

They have had 2-3 Recovery Church camps with 120 people. It becomes a community that people come to with family involvement.

The kinds of people attracted to Recovery Church are:

- People in recovery looking for a spiritual home
- People who want to explore their faith in a safe environment
- People who want a faith that is 'earthed' in real life (honesty!! Really important)
- People who want family members involved

The Auckland Recovery Church sees its aim as:

- To assist recovering people on their faith journey of spiritual and emotional healing
- To discover the love of Jesus in a safe, accepting environment
- To empower people to carry the message to others

Ian was asked a question about there being any one thing that stood out as making the Recovery Church so popular. He felt it was the inclusiveness, honesty, and that the Salvation Army had chilled out as a Christian organisation. One audience member commented that it fits well with Te Ha Māori. Ian was also asked if it is fundamentally Evangelistic. He thought yes and no and pointed out that some call it fellowship and not church to avoid these connotations. Ian noted they do explore new possibilities in the liturgy, but this was a new, scary and exciting journey.

THE CONFERENCE DINNER:

*Live in such a way that you would not be ashamed
to sell your parrot to the town gossip. (Will Rogers)*

The staff of the Palmerston North Convention Centre did an amazing job of transforming the main conference room into our dining hall for the conference dinner. Most delegates managed to attend and we all seem to be finally learning to remember our name badges! With over 300 people attending dinner it was a full and bustling occasion. Tim

Harding (aka Funk DJ Superfly) acted as MC for the evening and kept everyone thoroughly entertained and in order. The opportunity for some extended catching up and chatting amongst colleagues was most welcome and the conversational buzz was steady. The meal consisted of a range of salads, hot foods and tempting desserts.

As the conference prizes were presented on the final morning of the conference, it left the only formal part of the dinner as presenting the thank you gifts to the keynote speakers. A special presentation was also made to Tony Poynter for his years of service in the AOD field and Tony gave a fascinating speech in reply. From here the evening quickly moved into the musical arena with the band "International Rescue" starting up soon after the formalities were over. There was plenty of dancing going on and many smiling faces whirling around the dance floor.

7. DAY THREE OF THE CONFERENCE

SUMMATION OF DAY THREE:

The final day of Cutting Edge 2004 provided us with slightly better weather. As usual the delegates slowly made their way to the conference and gained enough energy for the final haul as the day progressed.

The presentations for the day started with the Workforce Development Plenary with Ian MacEwan, Kirsty Maxwell-Crawford, Simon Adamson and Doug Sellman. After this the morning was taken up with two streamed sessions. Presentations in these sessions included: genetics of DNA, AOD and morality, Adolescent recreational drug use, early intervention, an analysis of intermediate outcomes in the treatment of drug addiction, integrating AOD practice into a code of ethics and integrated services improve outcomes for pregnant and parenting clients. The final presentation of the day was John Hannifin's plenary address on Problem Gambling.

SELECTED PRESENTATIONS FROM DAY THREE:

◆ Te Hikoi Maramatanga on "Integrative Process" (Major Tahapehi/Sue Fielding)

Major opened the presentation with a short Korero & mihimihi. Sue also began with a mihimihi. Acknowledgements were made to supporters and funders. Te Hikoi maramatanga is translated to mean the journey of enlightenment. Tohunga Tikanga was explained by Tokoro Waikata.

The four elements of Te Whare Tapa Wha (Wairua, Tinana, Hinengaro and Whanau) make up the elements of Te Hikoi. They envisage these four elements especially with their youth. A young person exists within a whanau who awahi that person to grow in sound mind, body and spirit.

The model of Te Hikoi has:

- Community involvement and inclusion
- All rangatahi included with the aim of equipping them with tools towards mental health, sexual health, personal development and effective communication with positive role modelling, motivation and aspirations

There were evaluations at baseline, after the programme, and 12 months later. The aim of Te Hikoi was to assist youth to develop skills and knowledge for tomorrow. Another aim was to engage whanau to effect change of home environment at the same time. The rationale was to provide a programme that is effective, sustainable, and increases knowledge and resiliency in youth.

The model has been influenced by an informal questionnaire that was completed by the community in Huntly, in which 94% of respondents said there was an AOD issue. This was along with Mauri Ora (Durie 2001) which outlines:

- Positive Māori development and cultural affirmation
- Inclusion of community/whanau
- Public Health approach
- Community health approach

All of which is about embracing a holistic perspective.

Issues that the community saw as relating to young people were:

- Availability of substances
- Self-esteem
- Whanau dynamics
- Boredom
- Suicide

They adopted a community action approach to engage all people in the community in order to have a positive impact. All of them got out there and did it. Te Hikoi is characterised by its reliance on:

- Positive role models - Hikoi to selected marae
- Tawera Nihau and other key players (including ex-addicts and convicts)

- Mentors - young people from community doing normal things. They are committed to Te Hikoi and in it for the long haul
- Relevance - rangatahi like it and therefore engage
- Story telling - where did I go wrong, shared by everyone. The opportunity to learn from other peoples' mistakes
- Parent story telling - both positive and negative elements of being a parent, sacrifices and joys to be shared with kids
- Open invitation over kai - reflecting together at night, bringing whanau together
- Changing the environment - increasing communication and skills between rangatahi and their parents/whanau

By giving young people skills it will:

- Increase self-esteem
- Provide connectedness
- Strengthen resiliency

Thanks were given to both Māori and non-Māori services, and key stakeholders/individuals involved. The presentation finished with a waiata.

◆ **Integrating A&D Practice into a Code of Ethics – Have DAPAANZ Achieved This?**
(Ann Flintoft/Martin Woods)

Martin started by talking about just what a Code of Ethics is. His definition included such things as: a short collection of standard principles and practices, how to behave, what to do, how to treat other people, moral values, principles, rules, directions for moral actions, value systems, and rules organised into hierarchy. They comprise thinking, feeling, and choosing behaviour. They can be professional values or moral agents for those involved in process of moral decision making.

He went on to talk about the history of Codes of Ethics including the Hippocratic Oath. Now there are hundreds of Code of Ethics, which are the product of extensive consultation and debate. They encapsulate desirable moral values of all members, but

are not the same as Codes of Conduct. They are more of a moral mission statement for the good of the public and practitioners. They can be categorised into:

- Inspiration/aspirational codes (virtue directed)
- Prescriptive codes (duty directed)
- A difference between two imperatives

How do they work?

- Mainly are brief
- Serve as collective recognition by members of profession
- Serve as guide or reminder
- Are amendments to provide good focus for discussion/review of practices

Issues that arise with Codes of Ethics:

- Controversial - many critics
- Useful as a reminder to those associated with the code of what is expected of those members
- May not be useful if an opened ended and reflective thing
- Sociological significance
- Reflection of professionalisation - reflecting obligation to society
- Guidelines often seen as inconsistent and unacknowledged

Why bother with Code of Ethics?

- Protection for professionals
- Protection for clients
- Easier to resist unethical pressures
- No shame or guilt re practice
- Obligation of fairness

Strengths and weaknesses

- Educate about professional responsibility
- Discipline
- Inform public about nature and role of profession

What should be included in a Code of Ethics?

- Articulation of underlying assumptions
- Measure to ensure adherence
- Encouragement of scholarly work
- Oppose prejudice
- Forbid unethical research
- Encourage reporting of violations
- Widely disseminated

Ann then talked about the DAPAANZ Code. She is on the executive of DAPAANZ and everyone was handed out a copy of the Code.

A survey on how people were finding the code showed:

- Some familiarity
- Found useful when applied, but still getting used to it
- Used for boundary issues and duty of care

Uniqueness about AOD field?

- Moral decisions about morally viewed diseases
- Number of consumers - supports, boundaries and relationships often part of discussion
- All practitioners have own AOD use/role models
- Confidentiality (illegal actions, unsafe situation, stigma)
- Competence (limitations, beyond assessment and decision, specific populations, spiritual needs, ongoing education, practice development)

The workshop then broke into groups to discuss the Code of Ethics and the issues that had been discussed.

Ethical issues that arose were:

- Privacy
- Confidential versus safety

- Duty of care
- Boundaries
- Familiar financial gain
- Paramouncy of child care
- Educational training - learning ethics
- Cultural ethics - whananatana versus ethics (issue of whether related or not, tauwi - not acceptable)
- Discussions with client around issues of confidence

♦ **AOD Treatment and 'Morality': The New Pejorative (John Caygill)**

John describes himself as an oddbod from the mainland. He had been impressed with the opened and relaxed style of presentation at this conference. What John is suggesting is that moral arguments are not necessarily unreasonable, and moral dynamics not necessarily separable from issues of well-being or processes of treatment. His purpose was to comment on a sociological phenomenon, not to invite panic.

He started with a quote from Peele (2000) on the scientific study of addiction without a moral view,

“The scientific study of addiction has strongly opposed value considerations in addiction, regarding these as remnants of an outdated, religious-moral model. Behaviour therapists, experimental psychologists, and sociologists hold this view in common with disease theorists who have championed the idea that a moral perspective oppresses the addict and impedes progress toward solution for alcoholism and addiction.”

John noted that even on our own AOD link morals and facts get mixed up and debated. He distinguished the difficulty in even defining morality. John talked about Morality as explanation, intention and purpose or responsibility (accountability) and morality as societal codes of right and wrong, good and bad.

The AOD field is used to models that cite reasons for drug use. Morality is the oldest model, but now has been overtaken by more medical or biological models. However,

even complex models still maintain deterministic characteristics. Culture is acknowledged as a factor. Biology is not a factor in some societies that value nondrinking, such as some Jewish cultures, where it is about moral ideals and not biological ones. John noted that the shift in the moral view of drinking can be seen as part of a transformation in social thought grounded in social life.

John discussed at length the impact that moral views on drinking and drug use have on stigma and the turn around effect that this stigma then has on the moral view of drinking. He notes that judgmental perspectives that regard addiction as shameful are potentially damaging to individuals and counter-therapeutic in producing stigma. He sees stigma as invalid, punitive and disempowering.

John also talked about the way in which counselling often encourages clients to take an essentially moral view of their lives. He went on to discuss how different treatment approaches (e.g. the Twelve-Step programme and Motivational Interviewing) utilise this fact.

In conclusion John noted that alcohol and drugs are “morally-loaded” substances with the potential to challenge social functioning. He stated that conclusions that pertain to specific behavioural hypotheses often leave unaddressed the many personal and social difficulties or dilemmas that include a moral element and are so characteristic of problematic substance use. Scientific findings may inform, but often don’t resolve moral debates, nor supplant a moral frame of reference. John noted that there is a crucial difference between attributing responsibility as a moral naming act versus as a treatment-purposive act, to facilitate a therapeutic shift.

◆ **Coexisting Alcohol and Drug (AOD) and Mental Health Problems: What are the Support Needs of Alcohol and Drug Professionals Working with this Client Group? (April Matthews)**

This research is being conducted as part of a Masters at Auckland University and is supported by ALAC. It is qualitative research with AOD professionals from the Auckland

region being interviewed. This study focussed on the perspectives and needs of AOD workers as most of the current work is based in the Mental Health setting.

There is evidence that while the incidence of AOD clients with coexisting disorders is high clinicians working on both sides of the divide feel ill-equipped and often hold negative attitudes and express frustration about clients with coexisting problems.

This study wanted to look at the needs of AOD workers dealing with clients with coexisting disorders, establish if they have appropriate skills and knowledge and identify barriers to providing optimal care. The study proved to be time consuming, very demanding and with poor outcomes. Interviews were on average an hour and a half long.

Key findings were that:

- AOD workers support best practice
- Clients still get bounced from one service to the other
- Abstinence is still a requirement before access to Mental Health services thus setting up a abstinence versus harm minimisation dilemma
- There is a lot of stigma in Mental Health towards AOD clients
- AOD workers focus primarily on AOD problems
- AOD sector is carrying more and more of the Mental Health load as Mental Health admissions get stricter

April noted that services need specialist resources within AOD and improved relationships between AOD and Mental Health staff. Training is also required in personality disorders, crisis management and assessment for Mental Health issues. However, these training needs have to be supported within the workplace.

Consumers noted that they would prefer one person to cover their needs and often feel unable to access services themselves. Stigma was also an issue with consumers stating they would rather be identified as AOD consumers than Mental Health ones.

These findings raised a number of questions. April recommended that we need to re-orient services to the clients needs and develop stronger partnerships and links with Mental Health as well as strengthening our Mental Health knowledge and skills in the AOD workforce. She concluded there needs to be support at the clinical and the system level.

◆ **Treatment Failures or Success Stories? An Exploratory Study of Short Term Treatment Attendance (Justin Pulford)**

Justin presented the latest findings from his ongoing study examining the extent, and meaning, of early treatment exit, which has traditionally been considered a sign of treatment failure. With a representative sample of CADS clients divided into three groups according to how long they had attended, Justin was able to show that those leaving treatment early typically explained their decision as being due to having achieved sufficient improvement in their presenting problem. This explanation received further support from findings showing equivalent levels of satisfaction across groups, and comparable two-month outcomes. Interestingly, many of these clients attributed major benefit to that of significant others. Justin ended his presentation by calling for a “positive rhetoric” to replace the negative interpretation most usually invoked for clients leaving treatment early. This raised the issue of the importance of education regarding “what treatment is”, negotiating, and developing clear idea of the client’s expectations and also addressing the issue of “ not turning up” /exiting treatment at the beginning.

◆ **Illegal Leisure - The Normalisation of Adolescent Recreational Drug Use (Gavin Cape)**

Gavin thought his presentation might push a few buttons, but would also stimulate some discussion.

He started by noting changes in drug use we have seen in recent years including:

- Increased drug use in the young
- The lowering of the age of initiation
- Increase in drug use amongst women
- An increase in availability

This is a world-wide phenomenon as observed by WHO. However, Gavin does not believe that children are being corrupted by scourge of drugs as is often purported.

The recreational use of some drugs has become normalised (Gavin concedes this is a controversial view). In this he is referring to cannabis, amphetamines, nitrates and possibly LSD and MDMA. He is not talking about heroin, cocaine, daily dependent use or chaotic polydrug use.

Wolfensberger (1972) stated that the great majority will have tried an illicit drug by age 18 and 25% of 18 year olds will be regular users. This is supported by data from the Christchurch Health and Development Study. Gavin pointed out that he was not saying it is normal to take drugs or that all adolescents will.

In terms of research in the area Parker, Aldridge and Measham carried out a five year prospective longitudinal study (SPARC) of 14-18 year olds in the UK from 1991 to 1995. They found that it was not the nature of adolescence that had changed, but the experience of growing up. Much greater access to the media and information at an early age contributes to this.

Gavin also discussed a number of other normalisation theses:

- The availability of soft drugs is much easier. There is a freedom of choice mentality. By 15 years the majority of SPARC survey had been offered illicit drugs and by 18 nearly all had been
- There had been a sustained increase in drug trying. In 1995 50-60% had tried drugs. There is no longer a sub-culture of drug users. There is now equal male and female use and no socio-economic effect. Drug trying is not associated with delinquency, low self-esteem or poor education. Drug *trying* is normalised
- Only a small group become regular users and this was usually associated with the dance culture
- Adolescence these days are more drug wise. Even abstainers have a lot of knowledge
- Drug taking is seen as a choice – a freedom of choice
- Leisure now defines the individual not work activity. In addition, adolescents don't see the law as having much to do with their choices

Gavin then discussed how risk taking is now seen as a life skill. The transition to adulthood starts earlier and goes on longer producing a 'semi-dependency'. Success and failure are seen as individual performance and not related to structure in society. Growing up is more complicated and thus more risky. Adolescents are being more economical with the truth with their parents. There is greater individual responsibility thus peer pressure is less of a key factor. Drug taking is a rational decision – rational hedonism.

Gavin's end statements to ponder were:

- The inconsistent regulation and response to drug use is confusing for adolescents
- Harm reduction versus primary prevention
- Separation of alcohol from recreational drugs
- The lack of disclosure to parents and doctors, because they just won't understand it is recreational
- Lack of knowledge regarding harmful effects and combination of drugs. They realise the difference between swallowing and IV use and see IV use as delinquent
- Rational policies and research are obscured by the ideologically led 'War on Drugs' stance

The media (and politics) typifies the adolescent drug user as delinquent and chaotic, however, most young people's drug use is different to that portrayed in the media and policy. In 1989 of drug related murders in New York 96% were structure related and not directly from the drug. There is no longer a voice of youth culture. We promote adolescents to be rational, self-reliant individual members of society, but then tell them they are too young to make decisions.

Gavin concluded that he sees these changes as an encouraging view of adolescence and how they grow up and change.

◆ **Integration of Mental Health Practitioner into Mental Health (Debbie Biggar)**

In this presentation Debbie talked about the experience of integrating an AOD worker into a Mental Health service. The need for this was identified early and then discussed

with senior Mental Health management. In October 2003 Debbie was employed as an AOD worker in the Mental Health service.

The current key tasks focus around:

- Relationships
- Assertive follow-up with appointments
- Assessments and recommendations
- Relapse prevention
- Group work
- Education and support for clients, Mental Health clinicians and other services involved
- Preparing clients for exit to the community
- Referrals to other services

The challenges of integration that they noted were:

- Lack of local data
- Service descriptions/contracts
- Extent of needs
- Mental health view of AOD
- Client centred approach
- Clients too unwell to engage
- Wearing two hats

They have seen some positive results since October 2003. Before that date AOD and Mental Health clinicians were an unknown quantity, there was erratic attendance, low referral rates, delayed referrals and poor post-inpatient attendance. Now they have seen the de-stigmatisation of AOD and Mental Health services, regular attendance, an increase in referrals, timely referrals and reliable post-inpatient attendance.

Feedback from the staff includes that:

- There is a more comprehensive package of care and treatment with in- and out-patient services using a harm reduction model

- Access to rehab has increased through the referral process and liaison
- There is improved communication between the services and a continuity of interventions through to the community
- There is improved assessment and recommendations with specialist aid

From here Debbie sees the need for further training for staff, a community-based relapse prevention group and a community Mental Health AOD practitioner.

◆ **The Road to Recovery: An Analysis of Intermediate Outcomes in the Treatment Of Drug Addiction (Alexandra Gordon)**

Alexandra described a qualitative methodology which sought to explore the treatment-related recovery experiences of clients undertaking multiple treatment episodes. Ten residents of a 12-step based residential programme, all of whom had undergone at least three previous treatment episodes, were interviewed. Nine themes emerged. They were described as “sequential intermediate outcomes” in that they were identified as steps towards recovery which typically occurred in order, and were seen to be part of an as yet ongoing process for the participants. These themes reflected the narratives to which the men had been exposed at their current 12-step programme, but at the same time it was highlighted that there were features external to this paradigm, a reflection of the researcher’s care to continually remind the participants to consider experiences from previous treatment in addition to their current programme. Lively discussion was stimulated from this presentation, with the audience mostly reflecting the view that the methodology had been able to shed real light on complex, and evolving, phenomenon.

CONFERENCE CLOSING:

This year the conference prizes were presented at the end of the conference, to ensure presentations on all three days were eligible. Tracy Fearn won the John Dobson Memorial prize for the best presentation on an opioid topic for her paper on “GP Authorisation: Creative Thinking to Encourage GP Participation in Methadone Treatment Programme”. The John O’Hagan prize for the best presentation by someone under the

age of 35-years was won by Ata Samu for her paper "Treatment Delivery the Pacific Way – An Exploration into Delivery of Alcohol and Drug Services for Pacific Peoples in New Zealand". This year also saw the inauguration of the DAAPANZ prize for a practitioner presentation/review of their work. There were two joint winners: Dick Johnstone for "Me Whakahaere Katoa, Kaua e Whakarerea: Include Everything, Don't Leave Anything Out" and Ken Branch with "A programme for People with Coexisting Traumatic Brain Injury and Substance Abuse".

The poroporoaki was excellent and involved a number of waiatas. This process once again ensured Cutting Edge finished on a positive and meaningful note. The final lunch gave a ample opportunity for relaxing, networking and farewells.

Finally the process of 339 individuals making their way home began. Many a delegate could be spotted in the Palmerston North airport that afternoon and evening. Now another year of hard work, innovation and integration lies ahead until we all meet again...

Our imagination is the only limit to what we can hope to have in the future.

(Charles F. Kettering)

8. CUTTING EDGE 2005

- ◆ Cutting Edge 2005 will be held in Dunedin.
- ◆ It will run from Thursday to Saturday, September 8, 9 & 10.

