Cutting Edge 2005

CONFERENCE PROCEEDINGS

LOOKING BACK TO MOVE FORWARD:
CELEBRATING 10 YEARS OF CUTTING EDGE

An annual treatment conference on alcohol,
drug and addictive disorders,
The Dunedin Centre,
8 - 10 September 2005

Principal Sponsor
Alcohol Advisory Council of New Zealand (ALAC)

CUTTING EDGE 2005 PROCEEDINGS

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Proceedings Editor
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1. EXECUTIVE SUMMARY

Far away in the sunshine are my highest aspirations. I may not reach them, but I can look up and see their beauty, believe in them, and try to follow where they lead.
(Louisa May Alcott)

- Cutting Edge 2005 was held at The Dunedin Centre in Dunedin city on September 8, 9 & 10

- Three hundred and fifty delegates attended the conference

- The theme of this year's conference was Looking back to move forward: Celebrating 10 years of Cutting Edge

- The keynote speakers were Paraire Huata from Christchurch, Charles Waldegrave of Lower Hutt, Nancy Petry from the United States, Ross McCormick of Auckland, Rod Jefferies of Canada, James Bell from Sydney and Lita Foliaki from 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), Palmerston North (2004) and now Dunedin (2005).

3. KEYNOTE ADDRESSES & PLENARY SESSIONS

KEYNOTE ADDRESS #1: The Power of P (Paraire Huata)

This inspirational keynote speaker was introduced by Tuari Potiki as a man who is a trainer, instigator, teacher, mentor, friend and someone who is passionate about AOD issues.

Paraire, who is of Ngati Kahungunu descent, led the audience through a humorous yet deep examination of the cultural/clinical split in AOD and mental health services. To begin with Paraire commented on the lack of "new faces" in the audience indicating the need for the sector to support the new and especially young workers coming through by allowing them the space to come to the conference, even if that was at the expense of our own attendance. This led into a discussion of "The Dichotomy of Diagnosis and Mental Health: A social conundrum" whereby the notion of language as a powerful tool to both motivate and inhibit social change was addressed. He also discussed the clinical/cultural dichotomy in terms of talking about what works. Based on the power of language Paraire pointed out that what works is being able to "make the connection first". He discussed the emotional reaction we have to words and how these are culturally based in terms of worldviews that guide our interpretations. In particular, he pointed out that we are conditioned to only hear language that is important to us. As such we need to be aware of our own culture as well as the culture of other people, to see both where we and our interpretations are coming from as well as where others and their interpretations are coming from. According to Paraire the cultural/clinical split is "not about what we do and how we do, it is about what we do naturally and how we can do better with it".

KEYNOTE ADDRESS #2: Developments in the Treatment of Pathological Gambling Over the Past 10 years: What Needs to Happen from Here? (Nancy Petry)

Professor Petry's keynote address was divided into three sections:

- Symptoms and correlates of pathological gambling
- Treatment
- Emerging Issues

Part one of Nancy's presentation was directed at the symptoms and correlates of pathological gambling including providing a general background of pathological gambling. Gambling was defined, the many types of gambling were explained (from poker games to animal races) and the three types of gamblers were described with Level 1 type gamblers being those who participate in social gambling, Level 2 gamblers involved in at risk gambling and Level 3 gamblers those defined as compulsive gamblers.

The second section of the presentation described the treatment currently available for pathological gambling including pharmacotherapy, inpatient, self-help, marital/family, psychoanalytic, cognitive, cognitive-behavioural, brief interventions and natural recovery. Nancy reported on some results of a new treatment study she was involved in that was based on cognitive-behavioural treatment (CBT) principals. The researchers found that in general the pathological gamblers recruited into the study decreased gambling upon entering treatment and those who were involved with Gamblers Anonymous had overall better outcomes. Additionally, not only did patients assigned into the CBT group do better than those who weren't, but greater participation in the CBT was associated with improved outcomes.

The third and final part of the address was devoted to issues that remain associated with problem gambling. These include ongoing issues around diagnosis, assessment and the long-term efficacy of treatments. One of the most problematic issues evident in pathological populations is that despite the large numbers and devastating effects of

disordered gambling, very few problem gamblers seek or receive services. Professor Petry suggested that even brief intervention (5 minutes either by phone or in person) appears effective in reducing problem gambling, especially amongst less severe non-treatment seeking patients.

The large audience responded enthusiastically to Professor Petry and utilised her expertise on pathological gambling by asking a number of questions that generated some excellent discussion.

KEYNOTE ADDRESS #3: Addiction Treatment of Indigenous People: A Journey From There and Back Again (Rod Jeffries)

Rod entitled his talk The Power Of S (Spirit). Rod is a practitioner and a healer of the spirit. He began with the message that we need to listen to our children and our youth. He noted that teaching and learning are gifts of the heart. What we have learnt to do is go to our heads where it is safe and that we need to go to our hearts where the people are. He talked about youth, who are lost. They are lost from their family, their identity, and their sense of belonging. Most importantly, they have lost their SPIRITUAL CORE – their rituals, their language, their land. What we need to do is teach our children what flows from the core (the spirit). Children form a circle from our spirit.

He then asked for volunteers to bring items of value (that were special/valuable to them) to the front of the hall and place in a circle. From there he asked for volunteers who felt that they were still children to surround the valuable items. He asked for mothers to then come up and circle the children. Grandmothers then followed, Grandfathers after that, the protectors who closed the circle. He asked each group what it felt like - safe, secure, caring, nurturing, wise, purposeful, old, proud.

He then asked the same groups to form another circle beginning with the Fathers, followed by the Grandfathers, then the Mothers, and then the Grandmothers. The children were then asked to go to the back of the hall and wander aimlessly around the

room. The same questions were asked of how it felt – directionless, loss of purpose, sad, grieving, jobless, angry. There was no spiritual and cultural connection.

To form effective treatment models we need to make our own cultural models with the focus on connection.

KEYNOTE ADDRESS #4: The Role of Primary Care Practitioners in Alcohol and Drug Screening and Interventions – and the Changes in the Last Ten Years (Ross McCormick)

Professor Ross McCormick introduced this talk with an overview of the literature examining brief intervention screening. From this literature he concluded that we have a reasonable understanding of the "what and why" of brief interventions, but are less clear about "who" should do brief AOD interventions and "how" they should be conducted. Subsequently, he described the research he had engaged in at the Goodfellow Unit at Auckland University to overcome the "who" and "how" barriers. The TADS programme provides training for a range of professionals about screening and brief interventions and they are currently training about 1500 people a year. This training not only covers AOD related issues, but all lifestyle issues throughout New Zealand from a variety of professions. Ross described how this programme has shifted from a focus on "screening" to "beginning a useful discussion" that leads on to further discourse and intervention. Ross explained that in comparison to needs around brief interventions recently identified in the UK, New Zealand is leading the way in brief intervention training as the TADS programme, which has been running for seven years, is already providing such information in NZ.

KEYNOTE ADDRESS #5: Cultural Competencies in Healthcare for Pacific (Lita Foliaki)

Lita Foliaki, who works as a project manager in Pacific Health for the Waitemata District Health Board, gave a passionate presentation (with support from Jemaima Tiatia, a

recent doctoral graduate) about cultural competencies in healthcare for Pacific Peoples. This presentation conveyed the importance of having services work with Pacific populations in a culturally appropriate manner. In discussing the importance of humility and respect and the role that these play in Pacific culture Lita explained some of the important issues to be addressed. This was further illustrated by her exemplars of how mental health workers can work alongside Pacific People to engage them in a meaningful and appropriate manner. She reiterated the importance of being knowledgeable about Pacific worldviews, acknowledging the priority given to experience, legitimising authority and not undermining families.

KEYNOTE ADDRESS #6: Reflections on the Dismantled and Reconstructed Social Democracy in Aotearoa, New Zealand (Charles Waldegrave)

Charles Waldergrave comes from an eclectic background and currently leads the Family Centre Social Policy Research Unit and is joint leader of the New Zealand Poverty Measurement Project. In this keynote he presented an overview of the New Zealand poverty measurement project as an illustration of the effects of social and economic policy on poverty in New Zealand. A main part of this overview related to how the poverty line was determined in this project. Based on international definitions and on information collected from focus groups in New Zealand, the researchers determined that the poverty line should be set at a 60% cut off based on income. Based on this definition, in 1993 20% of all New Zealanders and 33% of New Zealand children were deemed to be living below the poverty line. The researchers concluded from these figures that the size of the problem was manageable, but the issue was the political will to make changes. Since 1999, with the arrival of the Labour Government, this team has tracked the progress of poverty reduction in New Zealand. Overall Charles concluded that progress had been made, which he doubted would have been seen had the National Government remained in power. He reiterated, however, that there was still progress to be made.

KEYNOTE ADDRESS #7: Ten Years of Change in Addiction Treatment (James Bell)

This presentation reviewed the last twenty years of addiction treatment in Australia. In 1985 a survey identified an increasing number of individuals presenting with heroin addiction with the added concern of HIV amongst injecting drug users. At the Australian Drug Summit in 1985 treatment was reformed away from the abstinence model towards "harm minimisation", and an increase in funding for expansion of methadone treatment, with additional funding for research and treatment with the establishment of national research centres and hospital-based Drug and Alcohol Units. The implications of this new paradigm were "technocratic", pragmatic and an empirically based solution to a social problem; with a mainstreaming approach to drug and alcohol treatment. However, this was a challenge to the then prevailing paradigms of faith-based individual recovery in specialist services with little mainstream connection. The balance had shifted from a "moral" to a more "medical" approach. Towards the last 1990's this brought a more "optimistic" phase of sustained expansion of treatment with long-term maintenance and adequate dosing. The improvement of access became a highest priority, and treatment was de-regulated with a rise of primary care and private clinics. Training of doctors was also introduced.

From 1996 – 2000, when heroin was cheap and very plentiful, there was a rapid increase in people using heroin. At the same time methadone maintenance programmes were of a poor standard and many people were dying methadone deaths. There was a subsequent backlash towards zero tolerance policies, with rapid detoxification programmes and treatment was re-regulated. It was felt that from 1985 - 2000 the treatment system behaved like a dysfunction client e.g., instability in mood, affect and self-image, poor short-term memory, and keeps making the same predictable mistakes.

Then in 2001 there was a re-dress towards social conservatism and an emphasis on personal responsibility, which meant the balance between "moral" and "medical" was tilting back. There was the establishment of the Chapter of Addiction Medicine within RACP, and the setting up of a training programme in Addiction Psychiatry and an

increase in research within universities. There was also the emergence of the National Evaluation of Pharmcotherapies for Opioid Dependence (NEPOD), which has conducted numerous valuable studies, whom are competing in the international addiction treatment market.

In closing Dr Bell presented a current climate of increasing social conservatism, and emphasis on individual responsibility and moral clarity. There has been an increase on empirically based, professional, client-centred approaches to treatment and now, a good acceptance of Addiction Medicine within mainstream services.

PLENARY SESSION #1: Opening Presentation (Pete Hodgson / Tahu Potiki)

Please see Day One for the summary of this presentation.

PLENARY SESSION #2: Treatment Outcomes for Women in Specialist Women's AOD Services (Cate Kearney)

Cate began by introducing her talk, which was providing an up-date of the last ten years of her work. She began as the Women's Co-ordinator at CADS in Christchurch. The history of her project came about from her work at CADS and with women through the treatment centres and concern about the future of AOD treatment for women. Traditionally alcohol treatment has always been for men.

An overview of the emergence of women's treatment history was illustrated by a) Eugenics/America's experience from the 1870s to 1950s; b) women having been invisible to services; c) the Women's Health Movement in 1970's through mental health literature; d) the identification of women's needs and; e) the emergence of women as specific to AOD treatment population.

The underlying issues concerning women were a) that women were under represented; b) treatment models were not applicable to women; c) stigma, shame and guilt; d) co-existing disorders e.g., depression and; e) physical health issues. Cate also discussed access to services: in the 1980s men to women ratio presenting to services was 10:1. This has been reduced to 3:1 in 2003. These figures are now extended to include drugs as well as alcohol.

The current outcome study for treatment services in Christchurch included aims to gather characteristics of the female population, gender-specific issues, and treatment outcomes. It also investigated the degree of Post Traumatic Stress Disorder (PTSD) and whether having PTSD influenced the treatment outcome. The study included four dedicated services in Christchurch in 2003. The study design included an interview of women who entered treatment within the first ten days of treatment, with a follow-up interview at four and ten months following treatment. The results showed there were 32 women who took part, the average age was 35 years, with 96% being Pakeha and 9% being Māori. Fifty-six percent of the sample were single, and 75% had children. The main drug of choice was alcohol. Interestingly, 85% experienced physical and bodily pain. Half of the sample had a diagnosis of PTSD above 5 on the diagnostic scale. At follow-up the severity of dependence had dropped to 14%.

Cate's conclusions were that although there was limited resources for women the study showed an increase in treatment outcome. Future service provision should include the development of community services for women, women co-ordination and use of women-led treatment models.

PLENARY SESSION #3: ALAC Presentation (Ian Scott)

Ian's talk was on alcohol and the public health – our responsibility…your responsibility? He noted that his talk was more planned around free association than a steady plan. In his 37 year career Ian has worked as a GP and in palliative care among other things including being a student in Dunedin. Ian has been with ALAC since 2001, as well as

working at CADS in Auckland. He noted that at points during his talk he would be wearing his ALAC "hat" and at other times would be talking of his own opinion.

From Cutting Edge in Napier (September 11, 2001) this conference has been challenging to him as a member of ALAC as they have changed their emphasis and role in the treatment sector and decided not to fund treatment and to use the money for new initiatives. They have continued to support Cutting Edge and other events such as early interventions shows.

Ian talked about some of ALACs history – it was established in 1976. The 2000 Amendment Act meant it was part of a new era of encouragement and promotion of moderation (among other things). More moderation – less harm. No other country has a statutory body like ALAC.

In his non-ALAC hat Ian pointed out that we struggle with the issues of the alcohol industry, regulation of alcohol advertising, the age of purchase and the enforcement of the laws relating to alcohol. In 1999 we lowered the drinking age. New Zealand has four times the number of liquor outlets that Australia does – Ian questioned whether changes have come from a vested interest?

In talking about the industry Ian noted that any engagement comes with risk. Beneficence should result in public health gains (increase in resources, additional expertise or expansion of audience). There are many risks increasing with trade off – dominance by the better resourced. We must remember that harm from alcohol is seen as a consequence of individual choice, it is also an inherent quality of the product itself. In regard to advertising there is potential for fostering harm.

It was noted that the media often confuses age of purchase with drinking age. ALAC believes the new law (lowering the age) has some merits, but needs to be part of a comprehensive programme addressing our drinking culture. Enforcement of our laws seems to not be a priority. A third of premises in Dunedin recently served under age

drinkers. A similar thing happened on Waiheke Island, but because it was just before Christmas it was deemed unfair to close those businesses.

We know about the New Zealand drinking culture – it's not the drinking, it's the getting drunk (ALAC advertising campaign). We can't legislate to change behaviour, but social norms can be changed with support. ALAC promotes a three pronged drive:

- Supply control
- Demand reduction
- Problem limitation

This will be not just through ads on TV, but also with the police, other groups and ourselves in the treatment sector.

Following Ian's speech there was a question about the variety and potency of alcohol content today – Ian noted that ALAC wanted all alcohol clearly labelled with the number of standard drinks it contains, but the industry has not been so keen.

PLENARY SESSION #4: Raising the Drinking Age (Matt Robson)

Matt Robson began by clarifying that the focus of his presentation was not on the drinking age, but on the purchasing age of alcohol in New Zealand. In highlighting his political position he pointed out his reputation for upholding universal human rights as well as advocating for early intervention and integrated programmes to help turn the tide against crime. In a call for wanting policy based on evidence not ideology he highlighted two questions that he believes need to be answered in relation to the debate on changing the alcohol purchasing age. What is the empirical evidence associated with national and international changes in alcohol retailing laws and what is the empirical evidence on the effect of lower purchasing ages on young peoples' health? After a brief discussion about the monopoly of the liquor industry on public awareness about alcohol and the obvious luring of the youth market through alcohol advertising Matt provided some answers to these two questions. He reported statistics indicating increased alcohol

involved road crashes, increased teenage drinking, and increased levels of alcohol being sold to underage purchasers (combined with inconsistent policing on this issue).

Matt acknowledged that the proposed bill before parliament was not the only answer to all these problems, but suggested that it was diverse enough in its brief that it would be able to have some impact on a range of issues. Specifically, he mentioned the increase in age able to purchase, limits being placed on television liquor advertising, and the power to prosecute those caught selling alcohol to minors. Finally, he ended with a political plea as he acknowledged the need for him to be returned to parliament in order to prevent the bill being killed in its tracks.

4. DAY ONE OF THE CONFERENCE

CONFERENCE OPENING:

Claire Aitken, the chair of the Cutting Edge Organising Committee and Programme Director of Moana House greeted delegates and invited kaumatua Pat Ruka from Whitiki Maurea in Auckland to open the Cutting Edge 2005 conference with karakia (prayer). This was followed by the himene 'Whakaaria Mai'. Claire then introduced Tahu Potiki, the CEO of Te Runaka o Ngai Tahu, who followed with a mihi to all delegates on behalf of mana whenua (local iwi). After welcoming delegates, Tahu continued his address by talking about the word 'chrysalis' and how this word to him meant 'a metamorphosis' or 'a change from one state of mind to another'. Tahu connected this korero to his own personal journey of graduating from the programme at Moana House and his change in state of mind from "believing in nothing to believing in something". This personal experience gave Tahu a deep belief in the possibility for change to occur.

Tahu's own personal 'chrysalis' introduced the main message of the presentation - 'change'. Tahu noted that the journey to initiate genuine sustainable long-term change takes a great deal of time and incredible commitment, but that this is necessary to facilitate required institutional change. Tahu believes that institutions could be the most effective agents for social change if run properly and that change needed to be in the context of a vision to create healthy, wealthy and proud communities. Tahu outlined several initiatives, which have been implemented to achieve this vision for the people of Ngai Tahu, including the distribution of settlement funds and resources into Ngai Tahu families to enable them to save for the future/their retirement or to buy their own house, the distribution of funds to the cultural and social life blood of the iwi to enable the transmission of values to future generations and the distribution of resources to local economic iwi development. He highlighted the success story of Whale Watch Kaikoura, a Mãori-owned enterprise, which has been a major contributor to the rejuvenated economy of Kaikoura and the significant current unemployment rate of 0%. Tahu

strongly advocated that a long-term view to change is essential, not just acceptable, to sustain development among the iwi of Ngai Tahu.

Tahu noted that alcohol and other drugs (AOD) posed a great risk to adolescents in today's society and that approximately 10% developed ongoing problems with AOD into adulthood. He wanted to ensure that Māori were not in that 10%. In conclusion, Tahu posed a question about whether it was possible to make a change within individuals. The answer being "of course" however, these changes can often be fickle or temporary. More important was the need to make genuine systemic institutional change to facilitate long-term change in the future. A waiata for Tahu was performed by the whanau of Moana house at the conclusion of his speech.

The Powhiri was followed by the address from the Minister. Claire introduced Hon. Pete Hodgson, MP for Dunedin North, who proceeded with his presentation. Mr. Hodgson indicated that he had two speeches, which had been prepared earlier for this address, however some of the things Tahu had said in his speech had resonated greatly with him and he would instead like to endorse and talk to these points.

Before he continued, Mr. Hodgson welcomed delegates and encouraged them to soak up the wonderful atmosphere of Dunedin. He also thanked and acknowledged Claire and the Organising Committee for their wonderful organisation of the conference, acknowledged overseas visitors and guests to the conference and also acknowledged Annette King, Damien O'Connor and Jim Anderton for the roll out of the Government's health policies. Finally, he addressed Moana House and acknowledged the wonderful work they do in the community and have done for the conference. He spoke of his personal connection to the programme in undertaking a Te Reo Māori language course through Moana House.

Mr. Hodgson went on to label Tahu's comments on the systemic wellbeing of people as "masterful". He spoke of the high child poverty rate in New Zealand and believed that Labour's 'Working for families' scheme would see the child poverty rate in New Zealand drop substantially. Mr. Hodgson believed that we are doing well, but not well

enough and that the future of our country would depend on everyone having the opportunity to participate and be included as part of our society. Mr. Hodgson admitted that he had gained just a small knowledge of alcohol and drugs in his role as a constituent MP, but one thing that he was very sure of was the linkage between poverty and one's own ability to address addiction. He concluded by stating that the issues that delegates faced as an AOD field/sector made a systemic contribution to the wellness of New Zealand's society.

Both speakers were happy to answer questions and Doug Sellman of the National Addiction Centre asked about the Government and Labour's commitment to the addiction sector. Mr. Hodgson replied that Labour was aware of the 'cinderella status' of the sector and remarked that this was the only area of health that was ring-fenced for funding and that their inclusion of problem gambling for funding was deliberate, indicating their commitment to the integration of this area within the addiction treatment sector. Another question from the audience asked of the part that the law plays with our clients and was it really useful to commit clients to prison for behaviour related to AOD. Tahu believed that both the police and law makers played a role, but essentially thought that communities and agencies connecting in meaningful dialogue would provide leadership to implement and use social policies properly.

Claire Aitken presented both speakers with a beautiful taonga carved from Oamaru stone.

SUMMATION OF DAY ONE:

Year by year Cutting Edge continues to steadily grow in size. This year we had over 350 delegates from all corners of New Zealand including a waiting list. Dunedin provided a delightful venue for the conference – an attractive town with a great buzzing energy. The Dunedin Centre was an extremely professionally run centre with spacious rooms, excellent catering and the chiming bells of St Pauls next door! Throughout the conference Moana House and other local artists mounted an art display on the walls

around the hall morning and afternoon teas were held in. This beautiful and often moving art was a wonderful accompaniment to the conference.

The first day of the conference had one streamed session in the afternoon. The rest of the day was made up of keynote and plenary addresses. As detailed above Pete Hodgson spoke at the opening of the conference. After morning tea he was followed by addresses by Paraire Huata on the Power of P and then Cate Kearney on treatment outcomes for women in specialist women's AOD services. During the lunch break several meetings were held including the Psychologists, the Doctors, the Social Workers, the Nurses, and the Alcohol and Drug Consumer Meetings.

After lunch was the streamed session of the day, which had topics varying from the development of Māori AOD services through mental health and AOD to alcohol and pregnancy. Following a break for afternoon tea the day wound up with a presentation from Nancy Petry on developments in the treatment of Pathological Gambling over the past 10 years. For the first time the conference dinner provided the final event of the day (see below).

Day one, and the conference, ran smoothly. Once more the efforts that Lisa and Lindsay (the conference secretariat) and the organising committee had put into setting up the conference was evident.

SELECTED PRESENTATIONS FROM DAY ONE:

- **Cultural Supervision Kawa and Te Tiriti (Khyla Russell)**

In this very interesting presentation Khyla highlighted the difference between cultural supervision and cultural advice. She defined cultural supervision as "a process by which cultural awareness, sensitivity, and safety are actively encouraged" and stressed that this should be a two way discussion that should not be focussed on deficit perspectives of Māori. Nor should it just focus on providing cultural advice for the unknowing practitioner who sees the issues s/he is having with a client as related to their being Māori. She also strongly advocated that those people who provide cultural supervision

should be properly trained and stressed that we should not be continually looking to kuia and kaumatua to take on this role in an untrained capacity as it often places them in a very unsafe position. Given this position Khyla issued this wero to all working with Māori: "to make possible better tailored treatment, whose mode of delivery is informed by te Tiriti and acknowledges the place of tikaka – a - iwi (Tikanga) as part of the service provision".

- **A Ton of Help: A 100 Years of Addictions Work in The Salvation Army and the Alcohol & Drug Treatment Field (Ian Hutson)**

This year Rotoroa Island, the Salvation Army residential programme, will cease to operate. To get to this point was a painful and significant journey for the organisation. There is also a mixture of pain and excitement when they see what they could do now. There is currently a book being written about this journey. The Bridge and the AOD sector have not valued its history as much as it perhaps should have. The NSAD have, however, written a small history recently.

The Salvation Army was founded in England in 1865 (in the context of the Industrial Revolution) and came out of an era of strong evangelical Christian social concern. It was also connected to the Temperance movement. William Booth's book "Darkest England and the way out" in 1890 signalled the move of the Salvation Army to what is today – evangelical and about social concern.

The Salvation Army has been involved in AOD from early on, starting with the idea of "Deliverance for the Drunkard". There were farm colony's and country or city homes. Drunkenness was seen as a habit not a disease. The country homes were compulsory confinement through the justice system. City homes were more like half-way houses.

In New Zealand the Vagrant Act (1866) used the term "habitual drunk" to describe people who had been abusing alcohol for more than three months and had three court appearances related to alcohol. Our rate of drunkenness was three times that of Britain – as was our rate of conviction. There have been queries as to whether this was a crime wave or a control wave? It became clear something more than throwing people in

prison needed to happen. This prompted the 1906 Habitual Drunkards Act, which in turn produced Rotoroa Island (1908). The programme was long-term abstinence (usually 2 years) and promoted healthy living – employment, diet and spiritually. It operated through the depression and two World Wars. All before AA came to New Zealand.

The AOD field in New Zealand developed further with the advent of AA in the late 1940s/50s. The National Society on Alcoholism was established in 1953. A watershed occurred in 1956 with a conference on the care of alcoholics where for the first time the idea of disease found a voice. Also it saw a shift away from seeing this as a justice issue and more social work. Since that time there have been many heroic stories of volunteerism and advocacy. The history becomes a little fragmented, but highlights include the start of ALAC in 1973. In 1980 only 10 of 29 hospital boards had AOD services.

Over time the Salvation Army models of treatment have encompassed:

- Emerging elements of various disciplines
- Goal of addressing the spirit, physical, psychological and social
- 12 steps being evident (but not in the forefront) and psychotherapeutic models
- Mixture of treatment with a heavy dependence on Superintendents (Directors)
- Loosely based on Minnesota model
- Raise and fall of the residential model

Issues the Salvation Army now face include:

- Abstinence versus harm reduction
- Business versus clinical
- Quality standards and accreditation
- Women, Māori, Pacific Island, family/whanau, youth, consumer participation
- Reduction in residential beds
- Twenty-one DHBs and the risk to the AOD voice
- AOD under the mental health umbrella

- **Te Atea Marino - The Development of a Māori AOD Service 1995-2005 (Joanne Haitana-Evans / Billie Jean Paita)**

Joanne Haitana-Evans (Ngati T□wharetoa, Te Ãti Hau Nui-A-Paparangi, Nga Paerangi) and Billie Jean Paita (Nga Puhi) began their presentation by acknowledging the people of Waitaha, Kati Mamoe and Ngai Tahu - the local iwi. They also thanked their koroua for their support at the conference and made special acknowledgements to others who had supported them and the development of Te Atea Marino. Joanne then explained the significance of a whakatauki (proverb) which encapsulated the kaupapa (ideals) of Te Atea Marino:

Ka rere te karekare o te moana,
Ka whangai te mauri o te ora,
Ka ora ai Te Ao Hurihuri.

As the waves continue to ebb and flow,
As life-force is nurtured,
So wellness continues in the turning world.

She acknowledged that even though the service had been through much development, the values, processes and tikanga (practices, protocols and customs) of the service had always remained true. Joanne and Billie Jean's presentation aimed to provide an overview of the development of Te Atea Marino, a Regional Māori Alcohol & Drug Service, during the past 10 years. The service currently provides a range of services to Māori and their whanau throughout the Auckland metropolitan area.

Joanne and Billie Jean started by providing details of the physical location and the organisational structure of the service and proudly displayed a photo of Te Whanau O Te Atea Marino. They then explained that the genesis for the idea to develop a Māori service came about in 1993 from a group of Māori alcohol and drug workers who were working in isolation from each other in Auckland, but who would come together once a month to share stories and experiences about working in the field. Some reasons behind the development of the service were: to centralise Māori resources, to put into practice

Treaty obligations of partnership and equity, to acknowledge colonisation and oppression as a source of 'illness' and to identify ideological differences between Western methodologies and Māori approaches. Joanne and Billy Jean elaborated further on the latter by identifying differences between Māori and Western ideas of creation, models of health, paradigms around healing and treatment, and ideas around whanau and the presence of hallucinations experienced by some tangata whaiora/clients.

The presenters then went on to explain the guiding principles of Te Atea Marino before talking the audience through a timeline showing the development of Māori services within Regional Alcohol and Drug Services (RADS) in Auckland. Under the leadership of Harry Pitman and Te Puea Winiata, a centralisation of Māori workers occurred in 1998 and there was the formation of a Regional Māori Service based at CADS South. In 1999, this was renamed Te Atea Marino and over the period of the next year, the service moved twice to arrive at their present location. Highlights during the development included the pooling of a talented and skilled workforce, accreditation of the service in 1999, employment of Tohunga (healers) to enhance Tikanga Māori and an acknowledgement of dual competencies required for staff - both clinical and cultural.

Joanne and Billie Jean also identified challenges that the service had encountered in its development and solutions that had been proposed to counter these issues. Finally, they outlined some of the future directions for the service, such as a change of focus from individual counselling to whanau and group work, implementation of regular Kaupapa Māori supervision for clinical staff and fortnightly Whakatau (welcomings) for tangata whaiora/clients and their whanau, the beginning of a Saturday group and for staff to be supported by the organisation to learn Te Reo. The presentation concluded fittingly as it had started with the guiding whakatauki of Te Atea Marino.

- **Ten Years of Transition in AOD - The Salvation Army (Lynette Hutson)**

The small room was full for Lynette's review of how the Salvation Army addiction services have been reshaped in the past ten years. There has been a real shift. They are not trying to reinvent the wheel.

The Salvation Army has centres throughout New Zealand from Kaitaia to Invercargill. There are Bridges, Oasis and supportive accommodation. The main centres are Wellington, Christchurch and Auckland. Some services that were around 10 years ago have completely disappeared. This could be perceived as having gone backwards and a loss of services, but actually now the Salvation Army is much broader and better prepared to be responsive to people. They are on the edge of learning about all this. They now operate to match the approach with the person – it's not one size fits all anymore.

The work hasn't got any easier. Clients are more frequently viewed with their environment – respect and values empowers people more.

Ten years ago services were completely residential, that has now changed. All programmes were done the same way with a lack of flexibility. Then two reports were produced 10 years ago around Wellington residential services and gambling. This lead to the establishment of the quality improvement working party. The beginning of the new model was in Hamilton, which was the first programme to be contracted as a day programme. Putting the existing residential programme into a day programme translated, but was not perfect. So they started thinking about the whole context.

For the Salvation Army, it was hard to start thinking in terms of harm minimisation and not just abstinence. It was good in the end, however, as it gave people options. Then within residential programmes they started to give people the option of being day clients. Then they could see people do the programme and learn during the day and then go back to their environment at night and the weekends and practice what they were learning.

Wellington then also moved the residential programme to a community based option. The feedback from the community was that this was irresponsible. It took a real mind shift for them (and the rest of the field) to accept this move. They found quickly that it actually worked – particularly for women. It was very positive overall, but with some

pain in the learning. In 1997 the Dunedin Bridge opened and is now a residential and day programme.

Around this time dialogue (within the Salvation Army and externally) developed further. Questions were asked around strategic planning frameworks. It was emphasised that responding to the poor and vulnerable was really important to them. This involved a process of consultation across the country with all staff. The lead person was Dr Judith Christianson. There was a strong belief in working in partnerships with people.

There were four parts to the new process: the context of the Salvation Army, 12 steps (which clients wanted), partnership (biculturally and with the client), and a community reinforcement approach (seeing the person within their environment). This all meant making the most of brief interactions in the context of the clients lives. We need to realise our time with clients is just a blip in the whole of their lifeline. Ongoing support is needed. An unexpected success story has been Recovery Churches, which are more relaxed than the average church and very interactive. They are very popular, while not being forced on anyone.

New developments for the Salvation Army include working with women and children, Otago rural services and the Auckland reconfiguration. They are also developing Oasis Gambling Services, which are proving to be a real learning curve.

Lynette summarised the themes of the past ten years for the Salvation Army as:

- A changing level of client need (more complex and higher, e.g., dual diagnosis)
- Changing health environment
- From one size fits all to packages of care
- Client as partner
- Internal focus to person in context of their environment.

- **Service Promotion in AOD Agencies (Diana Rands / Michael Bird / Robert Steenhuisen)**

This presentation given by Robert Steenhuisen provided an overview of the process that CADS Auckland has engaged in to rebrand all its services into one easily identifiable package. Robert presented the steps that they went through and the issues that they identified that need to be addressed in order to provide a service that could easily and adequately be accessed by all clients needing to use the service. Some of the issues identified were that the services offered were underutilised, in some instances there was low productivity, double handling of clients and inadequate resources to promote each of the different services run by CADS Auckland. To solve these issues they decided they had to change a mindset from "we're a great service if you can find us" to "we're ready here to help you". They designed the "When You're Ready Campaign" and presented information about the success that this campaign has produced with regards to increased referrals and productivity. Robert also presented some advice for other agencies wanting to make such changes and suggests that agencies: get professional advice; run promotional activities from the top; one point access is vital; and focus on the positives.

- **Guidelines for Alcohol & Drug Services Working with Women (Eileen Varley / Pen Walkinshaw / Fiona Owens / Anila Paul)**

In 2004 ALAC launched the Guidelines for Alcohol and Drug Services Working with Women; Policy to Practice. This well attended presentation chaired by Sue Paton featured four representatives from CADS units who spoke about the development and subsequent implementation of the Guidelines into mainstream services.

The Guidelines grew out of work done in 1990 with treatment issues specific to women with alcohol and other drug misuse. Some years later the topic was revisited in order to further progress service development particular to women.

The speakers outlined a number of the processes employed to develop the Guidelines with consultation with both consumers and the sector being pivotal to the process. For example, one CADS manager said that the development of the guidelines emerged by employing four key strategies. These were:

1. Producing a discussion document that was distributed widely and often at in-service, business and specific meetings
2. Monitoring outcomes, e.g., "not achieved, partially achieved or fully achieved"
3. Identifying change e.g., what needs to change and how can this happen
4. Reviews at six and 12 months.

What emerged from the many meetings and hours of consultation was a best practise Guideline that was simple, practical, straight forward and easy to administer. It focuses on treating female consumers and their family and whanau with respect and acknowledges the need for flexible service delivery around issues such as childcare. It takes into consideration the need to work with other agencies, to address issues such as shame and guilt, poverty and unemployment, abuse and neglect and co-existing disorders.

The largely female audience participated in open discussion invited by the speakers, asking and answering questions as well as providing comment.

- **Te Ari Ari O Te Oranga (Paraire Huata / Claire Aitken)**

After Paraire Huata's insightful and entertaining keynote presentation earlier on day one, there was a full house for his presentation with Claire Aitken, Programme Director of Moana House. Paraire and Claire's presentation drew on some of the work they have done this year as part of a contract, which was a joint venture with the Health Research Council, the Ministry of Health and the Moana House Training Institute. Some of the work was also presented in collaboration with the National Addiction Centre. The focus of the presentation was the topic of 'Te Ari Ari O Te Oranga' or 'Co-existing disorders'.

Paraire and Claire's presentation was rolled out in a role play/audience participation style, which was thought provoking, comical and very engaging. Paraire and Claire, both taking on the role of people working with tangata whaiora/clients for the purpose of the presentation, started by talking to the audience about a tangata whaiora/client called 'Hone'. Drawing on a familiar face in the audience, Claire picked Pete Mellars to stand up to represent Hone. Claire posed the question to the audience that Hone looked

like someone who was "well built and probably went to the gym, so why would he be here at her service?" Secondly, Claire pulled up Terry Huriwai and asked Terry to stand beside Pete. Claire explained that Terry represented Hone's very strong affiliation to his iwi (tribe) of Ngati Porou. Claire continued by picking Te Puea Winiata to stand beside the two others to represent Hone's very strong feminine characteristics, of which Hone was extremely proud. Claire continued to pick three more members of the audience to represent other different dimensions of Hone - showing his skill as a weaver, his ability to sing beautiful waiata and his artistic flair for carving.

Stating to members of the audience that "sitting down on the floor won't save you from being picked to come up", Claire selected yet another helpless volunteer to represent Hone's issues with mood. She explained that sometimes Hone's mood fluctuated a bit and that some of the other 'aspects' standing around Hone were dependent on his mood. Claire continued to select members of the audience to represent other important aspects of Hone, such as: his issues with wairua (spiritual matters), his strong connection with the criminal justice system as well as his connection with his whanau. Claire then explained that Hone's dream was to study at the University of Otago as he was passionate about learning te reo and called on Doug Sellman to represent this aspect of Hone. The reason for Hone being at the service today, however, Claire explained, was his problem with cannabis.

By this point in the presentation, Claire and Paraire had managed to swiftly accommodate 18 extra people up the front of the room to symbolise the many different dimensions and characteristics of Hone. Both presenters in their roles then went on to identify the 'parts' of Hone that they believed they were more capable of working with. "I'm just concerned about whanau. We only get funding for Whanau ora!" Paraire quipped. The role-play concluded with both presenters coming to the realisation that if they worked together, they would be better able to serve Hone as a person.

Paraire believed that the dilemma faced these days is that the more we identify these bits and pieces of a person, the less we see of the whole and whatever comes through the doors of our services these days comes as a complex person. He believed that we

often became territorial as services of our own areas, rather than working in a collaborative manner to serve the people who came to us for help and that each time a tangata whaiora/client was referred on, it diminished their personal mana even further.

Paraire then shared with the audience some of the other findings from working with this contract, such as: the abysmal lack of knowledge around the DSM-IV, the limited uptake of this training by AOD agencies, often claiming a common theme of "we know it all anyway", the distinct mistrust and lack of understanding of the role of psychologists and psychiatrists and the pressure being felt by those in the rural sector. However, he also reported a hunger from people to gain a solid grounding in initial and comprehensive assessment, as well as the cultural concepts involved. His final recommendation was for more putea (funding) to continue to build on the work done in this contract to take it to another level. The presentation concluded with a waiata and Paraire thanking the audience for "flying with Claire and Paraire".

- **AOD Service Delivery at Six CADS Units in Auckland – Evaluating Needs, Choices & Options (Robert Steenhuisen / Wolfgang Theuerkauf)**

Following on from Robert's presentation on the re-branding process undertaken by CADS Auckland, Wolfgang Theuerkauf took the opportunity to present an overview of six of the CADS services, the characteristics of the clients and patterns of service use by these clients. This information was derived from each of the services six-monthly reports. Of particular interest were the attendance patterns of the clients. Sixty-five percent of clients were found to attend between one to four sessions while 5% attended more than 21 appointments. The concern raised by these figures was based on the fact that the number of sessions attended did not necessarily reflect problem severity resulting in a small minority of clients (5%) utilising 20% of all available appointments. These findings raised many issues around where to best place resources, retention, best practice, appropriate treatment modality, dealing with waiting lists, service delivery structure and dealing with those clients who failed to show for appointments.

- **Panel Discussion: The Shape of Women's Treatment Options over the Next Ten Years (Daryle Deering / Deb Fraser / Tracy Potiki / Lynette Hutson / Claire Gilbert)**

Five women all experienced in treating women's problematic alcohol and other drug use were invited to share their vision of the shape of women's treatment options over the next 10 years. Each woman spoke for three minutes and the following is the main points from each presentation.

Claire Gilbert suggested that there is now an awareness that women presenting for alcohol and other drug treatment have a large range of issues over and above their presenting problems. These include living in abusive relationships, raising children (often alone) and problems with childcare. Claire's vision for the future was that the needs that are unique to women be acknowledged by the treatment sector and that clinicians must work differently with women rather than continuing to employ traditional models.

Daryle Deering stated that fewer women than men enter treatment services for a number of reasons including the stigma surrounding alcohol and other drug misuse. Daryle's vision for the next 10 years was that treatment services continue to improve for women. This can be done by asking female consumers what their expectations are of services, what makes it hard for them to enter services for treatment, providing more gender specific information and developing therapeutic relationships.

Tracy Potiki stated that while a number of youth services have been established that cater for 13-19 year-old female alcohol and other drug users, more are needed. Tracy suggested that "one size doesn't fit all" in the delivery of treatment services and that one of the challenges for the future is for non-Māori to explore how they engage with Māori consumers. Her heartfelt vision was a simple one; that Māori do not use alcohol.

Lynette Hudson highlighted that women are relational beings and that for women to benefit from alcohol and other drug treatment programmes, relationships must be worked into their recovery. Lynette provided a brief overview of the current day and residential programmes established by the Salvation Army. She also announced that a

funded programme specifically aimed at women and their children was just about to open at the Wellington Bridge. Lynette hoped that during the following 10 years a number of similar programmes would be established.

Debbie Fraser stated that treatment services available for women must cater for a range of additional needs, over and above their alcohol and other drug misuse. These included physical and sexual abuse and other mental health issues. Family involvement in the treatment process for women was essential, but to date had been neglected. Deb's hope for the future was the development of more skilled treatment workers encompassing a wide range of skills from delivery of appropriate interventions to providing information on legal issues.

The general theme to emerge from these discussions is that women entering treatment services have a number of challenging issues beyond problematic alcohol and other drug behaviour. Treatment providers must establish and implement programmes that specifically address these issues. The enthusiastic audience rightfully acknowledged the vital contributions to the sector being made by each of the panellists.

THE CONFERENCE DINNER:

One cannot think well, love well, sleep well, if one has not dined well.

(Virginia Woolf)

This year's Cutting Edge conference dinner was exceptional in two regards. The first was the shift of the dinner to the first night of the conference as a welcoming event. The second change was that for the first time in ten years the dinner was "dry", with no alcohol present. This was done as a mark of respect for the number of workers in the field who are maintaining sobriety.

The dinner was in the Dunedin Town Hall, a spectacular venue with a very grand atmosphere. Nearly all delegates turned out to celebrate the tenth year of Cutting Edge

and Ian MacEwan kept us in line through the evening. The evening began with the launch of the ALAC Cultural Concepts.

This was closely followed by the Haggis ceremony, which acknowledged the Scottish heritage so strong in Dunedin. The Scotsman who lead it was an interesting and humorous character, but had nothing on the knobbly knees of Gavin Cape and keynote speaker James Bell, not to mention the full kilt of Fraser Todd. An entertaining event to say the least, with the haggis being quite tasty for those who dared.

Then the real treat began with the buffet meal. The chefs of the Dunedin Centre had done a wonderful job of providing a variety of delicious choices. There was lots of lovely seafood and beautifully carved fresh meat. The vegetarians among us were thrilled that they had a separate vegetarian table put aside for them. The range and taste of the desserts were an exceptional end to a delightful meal.

With the conference prizes being presented on the final morning of the conference, it left only a couple of speeches from Tuari Potiki and Doug Sellman reminiscing on the past ten years of Cutting Edge conferences to finish the evening.

5. DAY TWO OF THE CONFERENCE

SUMMATION OF DAY TWO:

As in previous years the second day of Cutting Edge was the busiest and packed with presentations. The morning started bright and early with Rod Jeffries emotive and innovative keynote address on addiction treatment and indigenous people. We then moved straight into a stream of workshops on topic varying from cognitive-behavioural therapy for gamblers to the Healing Our Spirit Worldwide covenant. After morning tea a series of keynote and plenary addresses were started off by Ross McCormick discussing the role of primary care practitioners in AOD. He was followed by Ian Scott of ALAC talking about public health and alcohol. The morning concluded with a talk from Lita Foliaki and Jemaima Tiatia on cultural competencies in healthcare for Pacific.

As is customary lunchtime was taken up with the Treatment Research Interest Group's AGM, where the new name was officially changed to the *Addiction* Treatment Research Interest Group. Additionally, there were meetings for the Pacific Peoples', the Drug and Alcohol Nurses of Australasia (DANA), and the Māori workers'.

Post lunch was the second streamed session of the day as well the poster session. The streamed session reflected the diversity of the conference as well as the theme of "Looking back to move forward". Presentations covered: innovative interventions in a rural setting, family inclusive practice, serum methadone levels, cultural competencies and Pacific Peoples, a Kaupapa Māori intervention programme, minimising the impact of teenage AOD abuse, methadone and benzodiazepines, the role and voice of consumers, learning to stay Māori in un-Māori places, interim methadone prescribing programme, and respecting the consumer experience.

This year the poster presentations were integrated with afternoon tea to give delegates a real opportunity to mingle and talk. Topics covered in the posters included: the future of nursing in AOD, a profile of New Zealand AOD clients, initial results from the National

Telephone Survey of Māori AOD workers, multisystemic therapy, treatment outcomes in a youth dedicated therapeutic community at Odyssey House, attributions for AOD among socially anxious individuals, problem gambling interventions certificate, the effects of naltrexone on craving in people with pathological gambling, ten years of providing residential service, Rainbow Recognition Audit Tool, knowledge about IV drug use in the CADS workforce, Treatment Evaluation of Alcohol and Mood (TEAM) study, arrest referral scheme, WelTec AOD studies programme, NAC postgraduate programme, herbal highs and party pills.

The last keynote of the day was the interesting and political presentation by Charles Waldegrave about the dismantled and reconstructed social democracy in Aotearoa New Zealand. At the conclusion of Day Two the DAPAANZ AGM was held as well as, for the first time at Cutting Edge, a 12 Step meeting as an opportunity for consumers.

SELECTED PRESENTATIONS FROM DAY TWO:

- **Kia Angahia Te Taki - To Face the Challenge (Pat Ruka)**

Pat Ruka acknowledged mana whenua (local iwi) and all present before starting his presentation titled 'Kia Angahia Te Taki - To Face the Challenge'. His presentation was a call for us all to face the challenges that drugs and alcohol present today in our communities. Pat talked of the 160 years that have brought about the disassemblement of the Māori way of life and provided a historical context to illustrate where Māori have come from, what Māori are today and where Māori are going. Pat believed that people needed to know where they have come from to understand what they are today and to understand directions for the future.

Pat started by talking about how Māori believed that the universe evolved out of Te Kore, Te Po and Te Ao Marama - 'out of the nothingness, into the Night, into the World of Light'. It is in the Night that we have the coming into being of Rangi and Papa (Sky Father and Mother Earth) and their children and the struggle of their children to

overcome the darkness and move into the World of Light. It was in this place, a place with reason and knowledge, where Māori became self-reliant.

Fourthly, Pat talked of Te Ao Māori, a place where Māori culture and knowledge, which has been cultivated over eons of time, resided. This knowledge is known as matrilineal knowledge or knowledge passed on by kuia (grandmothers) as kuia are the ones who hold knowledge about whakapapa (genealogy) and are protectors of the tikanga (practices, protocols and customs) of a marae. Pat compared this model where kuia hold certain knowledge and kaumatua awhi (support) kuia to the slightly different model used by Rod Jefferies in his presentation whereby the males of a family were the protectors.

Next Pat spoke of Te Ao Hurihuri (the changing world) where the arrival of the Pakeha culture fragmented and distorted the matrilineal knowledge and in response, this knowledge went underground. He then talked of Te Ao Pakeha, a time where Māori went from living as whanau, hapu (sub tribes) and iwi (tribes) to living as communities and belonging to churches. These changes in lifestyle, Pat explained, showed how over the last 160 years Māori had learnt to adapt. Pat went on to talk of the next stage called Te Ao Mamae, where the distortion and fragmentation of this knowledge had given birth to suicides, drug and alcohol abuse and a major underlying problem of a loss of identity for Māori. Pat believed that we should go back to whakapapa, whanaungatanga (establishing connections), karakia (prayer) and powhiri when working with iwi and Māori. He believed we needed to pay tribute to the people we were working with and mihi (greet) them and the identity that they bring with them. He also believed that we needed to point Māori back to the positive places of their ancestors.

Finally, Pat talked of a time where cultures can learn to work together (Te Ao Kotahitanga), likely times of imbalance with any new beginnings (Te Ao Whawha), and a time where we will be able to 'get the right mix' to provide a balanced service for tangata whaiora/clients (Whakaranua). He explained how the services that he was connected to (Whitiki Maurea, Maurea, Te Atea Marino and Moko) were slowly starting to bring their services together in this way to become a one-stop shop to help Māori.

In conclusion, Pat talked of Te Ao Turoa - a world where work ethics and outcomes must be robust, open and above reproach so whanau can access healthcare and get the best possible outcomes available. His presentation concluded with a waiata by Te Whanau O Te Atea Marino.

- **Peach Pie in the Hokianga - Innovative Interventions in a Rural Setting (Molly Walters / Isobelle Dalton)**

Aunty Molly and Aunty Belle were as inspirational delivering their presentation as they were the previous night at the Conference dinner leading the line-dancing. Introduced by Khyla Russell, the two women started their presentation by singing a song. Simply known as "Aunty", Molly and Isobelle are champions for change. Trained in brief intervention, motivational interviewing and other addiction related training, they also bake a mean peach pie.

The basis of their "opportunistic intervention" revolves around korero, sharing knowledge and kai. They maintain that regardless of whether someone enters the marae via the front or the back door, food helps form a relationship. When people cook and eat together they talk. And the good kai encourages people to come back to not only eat, but to continue talking. During the presentation the Aunties shared with the audience a number of philosophies including the importance of:

- Coming together, engaging your community collaboratively to create a well community
- Sharing knowledge, with knowledge being a gift to be shared
- Taking the opportunity to help whanau
- Only Māori can repair Māori
- Eating well

The large audience responded enthusiastically to Aunty Molly and Aunty Belle by acknowledging with enthusiasm their programmes and asking a number of questions.

- **"Methadone Maintenance": An Outdated Concept (Tom Flewett)**

This presentation given by Tom Flewett attracted a large audience that spilled out into the corridor. Tom began his presentation by questioning if methadone maintenance treatment (MMT) was not only harmful, but unethical. When methadone treatment was introduced 40 years ago, it was envisaged that it would provide a short-term treatment for opiate dependency. MMT gave hope to patients, practitioners and society, however four decades later Tom argued that MMT is actually causing harm by being the only known treatment that promotes the maintenance of an illness by simply controlling dependence. Tom questioned the definition of MMT by stating that while the research avoids defining MMT, it is a political term widely used to encompass all forms of treatment with methadone, and the term is widely used by service providers and users alike.

Tom ended the presentation by highlighting a number of examples that challenged the effectiveness of MMT including:

- Cochrane Review challenges the myth that MMT has a positive effect on criminal activity
- Perpetrates the absence of treatment for comorbid disorders that occur in up to 80% of opioid dependent patients in New Zealand.

Tom's presentation generated a great deal of discussion and questions. While a proportion of the audience clearly did not support his views, they appreciated the passionate discussion it generated.

- **Wāhine Tupono: A Kaupapa Māori Intervention Programme (Ruth Ann Herd / Dianne Richards)**

Ruth Herd (Hapai Te Hauora Tapui) of Te Atiawa descent and Dianne Richards (Oasis Centre for Gambling) of Kai Tahu, Kati Mamoe and Waitaha descent presented their evaluation of Wāhine Tupono: a Kaupapa Māori Intervention Programme for Māori wāhine with gambling problems/issues. Ruth and Dianne explained that an explosion of women with gambling problems in South Auckland prompted the development of

Wāhine Tupono. The programme has been going for a period of two years and attracts women mainly through word of mouth, however, most referrals are received via mainstream services. The evaluation of the programme consisted of two years of process evaluation combined with qualitative interviews with six group participants aged between 40 and 55 years and five programme developers - all Māori wahine. The evaluation is forming part of an education thesis being undertaken by Ruth, which also examines the schooling experiences of Māori women.

The Wāhine Tupono programme uses the Powhiri Poutama framework, developed by Paraire Huata, which is based on the stairway to knowledge and the welcome ritual that takes place outside the front of a marae. The various stages of the framework were explained throughout the presentation. The presenters explained the first stage titled 'Whakatau' and the processes that were followed when women arrived at the group, including having a kai, karakia (prayer) etc. Wāhine often shared their negative experiences of mainstream settings at this session. 'Mihimihi' was the second step in the framework where women were encouraged to begin to tell their own life stories and truths without fear. The use of narratives, personal testimonies and life histories also formed the basis of the methodology for Ruth's thesis.

The third stage explained by presenters was 'Whakapuaki' or 'Revealing' - a stage of preparing the wāhine to let go of things that enable transformation. To do this, the programme used a variety of models that empowered people. The next stage talked about was 'Whakatangi' or 'Weeping' where the wāhine claimed the right to weep and cleanse themselves and others with dignity and respect and 'Whakaora' or 'Cleansing', which was the stage to begin to acknowledge healing and strengths through weaknesses. This was also the stage at which interviewing for the evaluation occurred.

'Whakaratarata' or 'Celebration' was the next step on the framework and was where the wāhine began to acknowledge their new knowing that had come from their journey. Feedback about the programme from participants who had reached this stage was very positive. Presenters explained that the next stage of 'Whakaoti' or 'Consolidation' was really the beginning of new journeys for both wāhine and workers, embodied in

different initiatives, such as the designing of new programmes, community empowerment and attempting to redirect policy. A final stage that had been added to the framework for the purposes of the programme was 'Wananga' or 'Discussion', which detailed challenges that the programme had faced in relation to dependences on funding. In response to this, E Tū Wāhine Pono was formed in August 2005 with the aim not to take any community funding, which is indirectly obtained from the Gambling Foundation. The presenters concluded with a waiata presented to them as a taonga from the wāhine of the programme titled He taonga tuku iho.

- **Inclusive Practice – Involving Significant Others in Alcohol and Drug Treatment (Marika Orosz / Gary Gunning)**

This presentation by Maria Orosz and Gary Cunning, Clinical Supervisors of CADS Central and The Auckland Methadone Service, outlined a framework of inclusive practice that they have developed for their own use that ensured that significant others were involved as integral parts of the treatment experience. The presenters quickly pointed out that they see their framework of inclusive practice as different from family therapy. They discussed the rationale for inclusive practice as being based on greater client satisfaction, improved client response in terms of clients getting better quicker, positive effects on significant others and the wider community and because it is a requirement of the Mental Health Standards and Practitioner Competencies. In discussing the implementation of inclusive practice in their own services the presenters reported that in general clinicians rated the use of inclusive practice highly, but also stated that there were many barriers to implementing such a practice. Steps to overcome these barriers included: non judgmental listening, providing information and knowledge, counsel re: coping, and social support in terms of interagency collaboration.

- **No Hea Koe / Where am I From? (Deb Fraser / Blondie Lewis / Piripi Matthews)**

Deb, Blondie and Piripi started their presentation by introducing themselves and their roles at the Mirror Youth Day Programme (MYDP). The MYDP is a comprehensive drug and alcohol day programme provided within a kaupapa Māori framework and a therapeutic environment. The programme is situated in Waitati, north of Dunedin, and

provides eight places for young people aged 13-17 with moderate to severe alcohol and drug issues. Deb oversees the programme as the Kaitiaki (Manager), Blondie is the Kai Oranga Hau Ora me Kaiwhakahaere (Co-ordinator) and Piripi works as a Kaimahi Haere Maia (Outdoor Educator) with the programme. Before continuing, they acknowledged the group of young people from their programme who had come through to support and be part of the presentation.

Next they introduced the mission statement of the programme - to assist children and young people to respect and value themselves and others. Then Deb provided a brief history of the day programme, from its beginnings in 2001 to the development of the kaupapa Māori framework in 2002 and relocation to their present site in Waitati in 2004. She stated that the aims of the MYDP were to provide young people with a safe environment to make positive changes and with the opportunity to address the challenges they faced in their life due to substance use/abuse. Deb also talked about the different members of staff at the MYDP and the proposed plan to pilot a social work position in 2006.

Deb then provided some statistics on rangatahi (youth) who use the service, explaining that young people were referred by youth services from a variety of different sectors (education, mental health, AOD, social services) and that the young person had already undertaken an AOD assessment and had been matched to the programme. One hundred and seven rangatahi have attended the MYDP - 41% have completed the programme, 13% have graduated (attained all goals and improved behaviour), 15% exited within the first week or two, 13% were stood down on first entry and then re-entered at a later date, 11% self-discharged and 7% absconded or went under the care of CYF. Some of the positive activities that rangatahi had taken up after discharge included: a return to schooling (30%), training programmes (22%) and work (9%). From 74 of these attendees, 55% were Māori, 38% were non-Māori and 7% identified themselves as of Pacific Island origin.

Blondie continued the presentation by explaining some of the specific components provided within the programme, such as the use of a phase system to measure progress

and an individual case plan for counselling. She also gave brief explanations of the groups that the rangatahi took part in, namely karakia/check in, te hikoi wairua, personal power, creative expression and adventure therapy. Piripi expanded on the latter, explaining how his role was to take the rangatahi out of their comfort zone and into the outdoors and provide them with challenges to overcome. Other happenings at the MYDP included: different educational opportunities, vocational assistance, lunchtime meals every Thursday that whanau were invited to, camps, hui and hangi with whanau, graduation and celebration.

The presenters acknowledged that there were also many challenges that the programme faced, but that their hope and aim overall was to make the rangatahi feel safe and invite them to share their hearts and puku (where Māori believe emotions arise from). At this point, Blondie acknowledged Takarangi Metekingi who before his untimely passing, was the kaumatua for the programme and commented how he was "still part of the whanau".

To finish the presentation, Blondie introduced a young man from the group of rangatahi to speak about his experiences with AOD. Jaime, of Ngai Tahu affiliation, gave a very personal and candid talk about his troubles with drugs and how it had impacted on his life, family and friends. He talked of his entry into the programme in 2004, how he felt safe there, how the programme opened the channels for him to learn about his whakapapa and how the programme supported him back to school. He now attends the programme part-time and has goals to be living independently and to become a music teacher. The presentation concluded with a waiata created by the group of rangatahi. Both Jaime's contribution and the waiata provided an awesome ending to the session by Deb, Blondie and Piripi whose combined commitment and dedication to the kaupapa of helping youth affected by AOD was strongly evident throughout the presentation.

- **Minimising the Impact of Teenage Alcohol and Other Drug Abuse on Whanau Members (Michael Bird)**

This interesting presentation drew on the data gathered from 18 two-hour video interviews of family members of teenagers who had experienced severe alcohol and

other drug abuse issues. Snippets from seven interviews were presented in order to provide the audience with a window into the everyday lives of these families that had been severely effected by teenage drug abuse.

From the outset Michael stated that this anecdotal research was needed to stimulate discussion around the provision of treatment options that included families and whanau. When the parents, the teenage users and their siblings were interviewed, a consistent theme emerged by way of a number of similar comments being made. In general parents said:

- They feared losing their child to alcohol or drugs
- They often felt isolated
- Numerous challenges to their parenting were experienced
- Their family fell apart
- Teenagers often drink to "forget"
- Confusion often reigned in the family
- Siblings were effected
- Alcohol and drugs effect many families; not just lower socio-economic families

When the teenage users were interviewed the most common statements made by them included:

- Most teenagers use alcohol and drugs
- Most teenagers know their limits

A large passionate audience enjoyed Michael's presentation and acknowledged this by asking many questions and sharing with him their experiences of similar situations.

POSTERS:

- **The Future of Nursing in the Alcohol and Other Drug Field (Moira Gilmour)**

Where will nursing be in ten years time? Is the Nurse Practitioner role acknowledging the expertise of the AOD nurse? Substance dependence is having an increasing impact

on individuals, families/whanau and communities in New Zealand. The practice of the alcohol and drug nurse caring for clients with AOD issues is challenging. AOD nursing practice rather than being under the directive of physicians and hospital policy is becoming increasingly autonomous, supported by a wider multidisciplinary team. The nurse is aware of being accountable and responsible for decision making, which requires ongoing reflection and questioning of the care offered to clients. The nurse practitioner framework is a way of advancing the role of the nurse practising in the alcohol and drug field. Opportunities of the nurse practitioner in improving the role of experienced nurses are being documented. The nurse practitioner framework gives a broad scope for nurses to specialise in the alcohol and drug field whilst remaining clinically focused. The nurse practitioner role recognises there are a number of skilled nurses working within the mental health/alcohol and drug multidisciplinary teams with advanced clinical skills. To highlight health care needs and provide services that meet the identified needs of often complex and stigmatised people, the scope of the nurse practitioner role encourages nurses to forge working relationships with a range of health services, and encourages nurses to conduct research in the alcohol and drug field within the New Zealand context.

- **Nursing in Alcohol & Drug Services: Present & Future (Daryle Deering / Julia Davies / Jodi Shoobridge)**

Health workforce legislation changes together with a national emphasis on workforce development are impacting on the alcohol and drug treatment workforce. The Health Professional Competency Assurance (HPCA) Act (2003) requires nurses to have a defined scope of practice, based on undergraduate preparation and registration and to meet competency requirements for ongoing registration. Alongside the introduction of competency-based practice has been an increased emphasis on Professional Development and Recognition Pathways (clinical career pathways) and the introduction of the Nursing Council credentialled Nurse Practitioner role, extending the clinical career pathway. A 2004 National Telephone Survey (NTS) of a representative sample of alcohol and drug workers in New Zealand undertaken by the National Addiction Centre, found that 16% of workers identified as nurses and were the largest professional group, next to counsellors. The contracted interviewers asked respondents who

identified as nurses whether they would be willing to participate in a more in-depth follow-up interview. The purpose of the interview was to gain an understanding of the present role of nurses working in alcohol and drug services and their views on future roles, including that of Nurse Practitioner; professional development needs; barriers to working in the field and undertaking post-graduate study and professional body affiliations. This poster reported key results from the survey and implications for nursing practice and workforce development.

- **A Profile of New Zealand's Alcohol and Drug Treatment Clients: Results of the 2004 National Telephone Survey (Simon Adamson / Doug Sellman / Paul Robertson / Karen de Zwart / Daryle Deering / Fraser Todd / Mark Wallace-Bell)**

The 2004 National Telephone Survey of the alcohol and drug workforce gathered brief data on a representative sample of 383 clients seen at services throughout New Zealand. This data reveals the continued dominance of alcohol and cannabis as primary substances of concern, but also the increasing presence of amphetamine misuse since the survey was last undertaken in 1998. Clients are now older, less likely to be Pakeha, and less likely to be attending residential treatment. Significant interactions between these variables are highlighted. The implications for treatment delivery of this changing profile are discussed.

- **Initial Results for the National Telephone Survey of Māori Alcohol and Drug Workers (Paul Robertson / Tami Gibson / Simon Adamson)**

A national telephone survey of the alcohol and drug treatment workforce has recently been completed. This survey not only replicated a survey carried out in 1997, but also provided the opportunity to run a parallel survey that was focused on Māori alcohol and drug treatment workers. The latter focused on issues specifically relevant to Māori, including the application of tikanga in clinical settings and training issues for Māori workers. The present poster presented some initial results from both the main national telephone survey and the Māori telephone survey to provide a snapshot of the current Māori workforce. Māori workers continue to make up a significant portion of the workforce, but the results of the survey indicated that this group has specific training and professional development needs not readily addressed through 'mainstream' strategies.

The poster concluded with some initial discussion of specific issues for Māori and implications for workforce development strategies.

- **The History of the Development of Māori Alcohol and Other Drug (AOD) Services and the Māori Addictions Workforce in Aotearoa/New Zealand (Tami Gibson / Paul Robertson / Terry Huriwai / Suzanne Pitama)**

In response to a call from attendees at the Cutting Edge Māori Caucus, held in Palmerston North in September 2004, this research project was developed to record the history of the development of Māori AOD treatment services and the Māori addictions workforce in Aotearoa. Attendees at this hui agreed that it was time for the Māori AOD field to "know the whakapapa and go forward". In-depth interviews were undertaken with identified key informants to the project. The project aims to broadly review historical and social developments that have shaped the development and provision of alcohol and other drug services to Māori in Aotearoa. Initial findings of the project are to be presented.

- **Testing Effectiveness of Aboriginal Appropriate Family Structured Intervention (FSI) to Empower Indigenous Families to Succeed in Respectfully Guiding Resisting Alcohol Dependent Loved Ones to Rehabilitation - Before Hitting Bottom (Deborah Dupré)**

Australian AOD rehabilitation programmmes require addicted people to ask for help. Most Chemical Dependents cannot ask for help because of the disease's hallmarks, Denial and/or Delusion so never receive treatment and continue harming self and others. Most people want to assist loved ones with Addiction to recover, but lack skills to succeed. Australian Aboriginal low mortality mainly relates to alcohol. Throughout Australia, Aborigines consistently request interventions that heal affected loved ones and their families rather than control and contain. In shear exasperation from a problem out of control, some Indigenous communities use "tough love" banishment interventions, turning "unwanted" tribal members into a caste of "walking dead." The Alcohol Education and Rehabilitation Foundation funded research based on Dr. Vernon Johnson's FSI, Dr. Walter Scanlon's supporting research and Deborah Dupre's 14 years of FSI practice with Indigenous U.S., Australian and Ni-Vanuatu clients. FSI is pre-treatment that rapidly, gently and respectfully breaks denial and motivates clients to

treatment. It is generally only available for those with private health care and in developed countries. Culturally modified FSI, “Family Healing Circle” were tested in the impoverished community, Halls Creek, Western Australia with four Aboriginal families adversely affected by a resisting, harming Alcohol Dependent family member. Tests proved effective in participants "getting power back" to support their family member to rehabilitation. A domino effect occurred. In three weeks, sixteen Alcohol Dependent adults and youth were committed to rehabilitation with nine at-risk children. Family Structured Intervention (“Family Healing Circle”) pre-treatment works and is a human right, the Right to Rehabilitate.

- **Multisystemic Therapy (MST): A Community - and Family-based Approach for Challenging Youth in New Zealand (Nici Curtis)**

MST is a time-limited, intensive and individualised home-based treatment model that effectively reduces challenging behaviour in adolescents (e.g., severe externalising behaviours) by targeting the multiple risk and protective factors associated with such behavioural problems. Using an ecologically valid, strength-based approach, MST empowers caregivers to develop the necessary skills and competencies to achieve positive, sustainable changes in the young person’s behaviour. Over the past 25 years MST has been shown to effectively reduce challenging youth behaviours across multiple replications and over a wide range of clinical presentations, service providers, and community settings. This poster first presented the theoretical and empirical basis of MST, including the extensive quality assurance process that is a crucial component of the treatment model. The structure and service delivery of MST was presented and case examples were provided to illustrate the primary components of MST treatment. They also discussed the dissemination of MST in New Zealand, along with follow-up treatment outcomes. Finally, they also discussed proposed future directions in the research and development.

- **Treatment Outcomes in a Youth Dedicated Therapeutic Community at Odyssey House, Christchurch: An Introduction and Overview (Victoria Ravenscroft / Ria Schroder)**

In recent years the Odyssey House Youth Programme in Christchurch has expanded from a day programme to a day and residential programme. This poster provided an overview of this new extended programme and an overview of a study that is being conducted to evaluate the outcomes of this programme. This study aims to measure and assess a range of outcomes of alcohol and drug treatment for youth at Odyssey House, Christchurch. Approximately, eighty young people will be invited to participate by completing a series of structured and semi-structured instruments in a face to face interview format at admission into the day or residential programme, at six weeks, 12 weeks, six months and 12 months following admission. In addition, factors will be explored as to what might improve the length of time young people who are referred for treatment engage with and stay in treatment, as well as whether the treatment helps youth to mature in their personality thus improving their outcome.

- **Attributions for Alcohol and Drugs Among Socially Anxious Individuals in a Non-clinical Sample (Robin-Marie Shepherd / Professor Robert Edelmann)**

This poster examined reasons for use of alcohol and drugs among a population of socially anxious university students. Previous research has suggested that the socially anxious self-medicate by use of alcohol and drugs although it is unclear whether it is social anxiety per se or related symptomatology which is linked with such behaviour. The present study extends the self-medication hypothesis, examining alcohol and drug use by assessing attributions for such use in addition to ego strength in relation to anxiety, depression, and social anxiety. It was hypothesised that social anxiety and lower ego strength would be related to increased use of drugs and/or alcohol use as a means of alleviating social fears with comorbidity additionally contributing to self medication. The results are generally in line with the hypotheses. Those who reported drinking alcohol and using drugs to cope in social situations scored higher on measures of social anxiety and lower on ego strength.

- **Problem Gambling Interventions Certificate (Mary Anne Cooke)**

Soon Abacus Counselling and Training Services will commence offering a level 4 NZQA accredited course entitled Problem Gambling Interventions Certificate. This 40 credit course has four modules that will offer a wide range of practical and theoretical skills through self-directed and evaluative learning when considering intervention procedures for problem gambling. The course aims are: to develop confidence and skills in understanding why someone would develop a gambling problem; to recognise a gambling problem and how you would approach someone who is showing the signs; and to promote understanding about problem gambling behaviour and awareness of the approaches used in brief problem gambling intervention. The recent transfer of treatment and public health service for problem gambling to the Ministry of Health and the commencement of private health organisations (PHO), means clinicians and public health promoters within the substance-oriented addiction/mental health field and general health providers are needing to become familiar with problem gambling detection and develop brief intervention skills for the populations they serve, as problem gambling is now seen as a health risk, which has a propensity to co-exist with other mental and physical health issues. This course is able to accommodate these needs. For those considering employment or who are already working in the problem gambling field in positions such as face-to-face counselling, telephone counselling, health promotion and host responsibility, limited academic opportunities in problem gambling learning exist to augment their career choice. This course would offer specific credentials towards professional development in this field.

- **Is a Wider Intervention Approach the Way Forward for Problem Gambling Service Providers? (Alison Penfold)**

In 2003 at the Problem Gambling Symposium, some ninety practitioners from the field of problem gambling treatment were surveyed as to their perception of the importance of various treatment components. In addition, information was provided on a practitioner and client survey that incorporated a review of therapy delivered/received for those with gambling problems, and additional help that clients would prefer in future treatment delivery. These views were elicited from the then substantial majority of the problem gambling practitioner workforce, providing an important baseline discussion

for clinical intervention. As a part of a workforce analysis project, contracted by the Ministry of Health, Abacus has met with all current clinical problem gambling treatment providers to consider whether the findings of 20 months ago remained current. Information has been sought on whether services considered that a much wider intervention approach remained appropriate, that incorporated aspects such as budgeting, stress management and liasing with organisations such as Work and Income. Information on all other forms of treatment and support that is offered to those with gambling problems and their family/whanau was also gathered. Consideration was given to the cultural appropriateness of a wider intervention approach, and what ongoing training needs and resource implications there would be if services were adopting this model. The results of this project were reported on, along with addressing what the interface with alcohol and other drug workforce development may be. The implications of how this may guide future planning around workforce development was also considered.

- **The Effect of Naltrexone on the Craving in People with Pathological Gambling (Dominic Lim / Doug Sellman)**

Pathological gambling can be conceptualised as an addiction disorder even though it is presently classified as an impulse control disorder under the DSM-IV classification systems. Amongst its addictive features is the phenomenon of craving, which is reported in many who suffer from the disorder. Naltrexone has been used as an anti-craving agent in alcohol dependence disorder and its efficacy in pathological gambling has been demonstrated in some studies. The project studied the effect of Naltrexone on the craving in people with pathological gambling. Twenty-eight participants with severe gambling problems with a mean DSM-IV score of 8.7 were recruited. They were trialled on a placebo-controlled, three-weeks single-blinded lead in, six-weeks double-blinded cross-over trial. The results from 24 completers showed a significant placebo effect. However, the reduction in the mean craving scores as measured by the Obsessive-Compulsive Gambling Scale (OCGS), the Gambling Urge Questionnaire (GUQ), the Gambling Craving Scale (GCS), the Gambling Symptom Assessment Scale (GSAS) and the Yale-Brown Obsessive Compulsive Gambling Scale (YBOC-PG) were no different when 50mg or 150mg of naltrexone was given. However, the changes in the craving

scores between the participants on either 50mg or 150mg were not statistically significant.

- **The Outcome of 90 Alcohol and/or Cannabis Dependent Clients Following Intensive Residential Treatment in Canterbury (Michael Baker)**

Clients (107) entering three intensive residential treatment programmes in Canterbury were consecutively approached from May 2000 to March 2001 for inclusion in a study to investigate the effectiveness of intensive residential alcohol and drug treatment with a Twelve-step component. Clients (90) were recruited as follows: 38 Bridge; 22 Hanmer; and 30 Te Aroha o te Hauangiangi (Taha Māori). Participants were first interviewed within 10 days of starting treatment, using a structured survey covering demographic, clinical, drug and alcohol, as well as spirituality and Twelve-step related questions. Six months later participants were reapproached to complete a related set of questions. It was found that 37% of the sample was female, and the mean age was 36 years. The sample was comprised of 37% Māori and 5% of other Pacific peoples. The participants with a DSM-IV diagnosis of Alcohol Dependence were 93%, 63% were dependent to cannabis, and 59% had diagnoses of Major Depressive Disorder. Fifty-seven participants completed treatment, and 75 were successfully followed-up, at which time 22 were completely abstinent from alcohol and drugs. There were significant improvements at follow-up in the means scores of the Leeds Dependence Questionnaire, the Beck Depression Inventory, and measures of alcohol and cannabis use. Mean component scores of the SF-12 Health Inventory did not improve. The best predictors of outcome for the sample were age (i.e., younger participants tending to do worse) and affiliation to a support group (i.e., a 12-step fellowship, church or Marae) on entry to treatment.

- **"Not Just A Bed – A Complete Service" - Ten Years of Providing Residential Services (Johnny Dow)**

The Higher Ground Drug Rehabilitation Programme is a 12-Step based programme, which has provided residential services for over 20 years to people who are severely dependent on alcohol and other drugs. This poster mapped the changes that have occurred over the last 10 years within this residential programme. The poster highlighted the various components that make up a residential service and how these

components are implemented to provide an effective programme for the clients. The poster looked at how over the last 10 years the landscape has altered through health regulations and funding requirements and how these changes effect a residential service. The poster also addressed the significance of choice through a range of services for clients and the place residential services sit in the continuum of a harm reduction model. Contained within the topography of treatment is the Therapeutic Community. People in a Therapeutic Community are members, as in any family setting, not patients, as in an institution. The poster illustrated the importance of this model in working with the severely dependent client.

- **Clinical Characteristics of Clients Entering the Odyssey House Christchurch Adult Residential Therapeutic Community (Hatarei Peka / Ria Schroder)**

Since 2001 Odyssey House Christchurch has been conducting an assessment of the Therapeutic Community run for males 17 years and over with severe substance dependence and other difficulties. An important aim of this study has been to determine the extent of health problems experienced by the men entering this Therapeutic Community. While the information generated is primarily for clinical purposes, it also provides an opportunity to monitor trends and improve the impact of treatment on this difficult to manage client group. This presentation provided an overview of the physical, psychological, social and emotional health of the 150 men who have entered this programme over the last four years. In addition, preliminary data about initial changes in general health (SF-36), psychiatric symptoms (SCL-90R) and personality (TCI) was discussed in relation to indicators of promising outcomes for this group of men who were shown to be seriously ill on their admission to the therapeutic community.

- **Treatment Journey (Look & See) (Don Graham / Wayne Owens)**

In late 2003 CADS (Community Alcohol and Drug Services, a division of Waitemata District Health Board, Auckland) acquired the Mount Eden, Auckland clinic of the Hanmer organisation. This presentation explored the difficulties and opportunities concerning the dichotomy of harm reduction/minimisation and abstinence based treatment encountered by this merger. At the extreme, harm reduction/minimisation is construed as maintaining the addictive pattern and the misery associated with it, while

the abstinence model expects the client to be abstinent "cured" before the client engages in treatment. If the client is unable to maintain abstinence he is labelled as having failed. Looking back to move forward was a process that enabled a simple but effective strategy to enhance the treatment journey for clients, which has been called 'Look & See' that has allowed clients to look back to move forward. Treatment journey is a preparation in the continuum of treatment that explores the option of abstinence. It is based on the client's narrative with an underpinning client-centered, motivational group process, where all options are legitimate. Client engagement, safety and risk are paramount. Over four weeks with two one and a half hour sessions per week clients undertake their own A&D assessment, framed around the predisposing, participating, perpetuating and protecting aspects of addiction, with a self-diagnosis using the DSM-IV substance dependence criteria. The process concerns discovery and choice without onerous labelling with on-going support providing a meaningful and rewarding experience that develops self-efficacy through empathy creating hope and a sense of spiritual well being. *Don Graham* is a contract clinician for CADS Mount Eden. He was with the organisation when it changed from Hanmer Clinic to CADS Mount Eden and facilitates several groups including The Look and See IOP Pre-entry group, which was the subject of this presentation.

- **Rainbow Recognition Audit Tool - Have You Completed Yours? (Diana Rands)**

The issue of meeting the needs of what has been identified as an 'at risk' population - Gay Communities (i.e., lesbians, gays, bi-sexuals, transgender, takataapui and fa'afafine LGBTTF) has been raised at the last two Cutting Edge Conferences. Meeting the needs of LGBTTF clients falls directly under cultural competency, and as such, is an auditable issue for AOD services. Earlier this year a self-monitoring 'Rainbow Recognition' audit tool was sent to AOD services nationwide. Each service was invited to complete it, and send it back within a 3 month period. Twenty out of 125 services initially responded indicating that they would be keen to audit their service. This presentation covered: the results and findings of the Rainbow Recognition audit, the organisations who responded, benefits to these organisations, difficulties administering the audit, and a case study on the 'guided audit' training run at Odyssey House Auckland. A recommendation was then presented as how to further this project.

- **Kia Ora - How Can I Help? (Peter Jamieson / Bronwyn McGregor)**

Ten years ago the Alcohol Helpline began as a pilot covering the Christchurch area. Proving its worth the Alcohol & Drug Helpline now has funding from ALAC and the Ministry of Health allowing this expansion (Alcohol & other Drugs). The Helpline is here to support your work in your areas of Aotearoa New Zealand. The A&D Helpline can offer support to callers at any stage of the Continuing Care continuum.

- **Injecting Confidence & Knowledge about IV Drug Use into the CADS Workforce (Sheridan Pooley / David Cranston)**

In looking through the resources from the manager of the local needle exchange, it occurred to the authors - how much do CADS clinicians know about IV drug use and safe injecting? Not just the ones who work in methadone services, but all staff: case managers, AOD clinicians, counsellors, doctors, nurses, social workers, etc.? After all, all kinds of people inject all kinds of drugs, all kinds of substances. If a client tells a clinician they've been using an injectable substance, what would the clinician's response be? Would the clinician be confident in discussing injecting with a client? What harm minimisation information would they give the client? What if the client had infected IV sites? It was assumed all the staff were IV literate, but is this a valid assumption?" This is an example of a consumer-driven project where the Consumer Advisor works with CADS staff to ensure responsiveness to the needs of IV drug using clients. Amongst the various outcomes of the project, one of the most significant has been the improved active working relationship with the local needle exchange.

- **An Evaluation of Cognitive Functioning in Individuals on Methadone Maintenance Treatment and the Interrelation with Treatment Compliance (Susan Yates)**

Methadone Maintenance Treatment (MMT) is the most commonly used treatment option for individuals who are dependent on opiates. However, outcome studies show that compliance with treatment regimes and retention is poor (estimates place retention on MMT as low as 40%). Reasons for poor treatment compliance and retention have been investigated in numerous studies. These studies suggest a number of possible predictive factors, however, there is little consistency in the findings. More recently it has been

suggested that cognitive deficits might be a factor in compliance and retention in treatment given that higher levels of cognitive impairment have been identified in the drug and alcohol population. However, as yet this has not been systematically examined and no research has until this point looked into this connection between cognitive abilities and adherence and retention to treatment. The present research set out to examine the cognitive abilities of those currently attending present Methadone Maintenance Treatment (MMT) at Community Alcohol/Drug Service in Hamilton in relation to their compliance to treatment. This presentation examined the research conducted to date.

- **Treatment Evaluation of Alcohol and Mood (Team) Study (Doug Sellman / Simon Adamson / Daryle Deering / Karen de Zwart / Julia Davies / Gavin Cape / Murray Hunt / Amanda Wheeler / Alistair Dunn)**

The combination of alcohol dependence and depression is common in people presenting for addiction treatment in New Zealand. Pharmacotherapy offers a significant step forward in treatment. Effective antidepressant medications have been available for a number of decades, but medications that assist with relapse prevention in alcohol dependence (antidipsotropics), other than the long-established disulfiram, have only recently become available in New Zealand. To date, there have been no published randomised controlled trials investigating a combination of pharmaceutical treatments in people with both problems. This poster outlined a multisite clinical trial investigating the effectiveness of citalopram (antidepressant) vs placebo when combined with naltrexone (antidipsotropic) and clinical case management. The five research sites are Whangarei, Auckland, Hamilton, Christchurch and Dunedin. Included in this presentation was details of the methodology, including recruitment of the sample (n = 220), details of the 24 week treatment period, and measurement of treatment outcome. Finally, the benefits of this study for both treatment delivery as well as workforce development were highlighted.

- **Arrest Referral Scheme (Tessa Watson / Peter de Boer / Mitch Rakatau)**

The Arrest Referral pilot scheme, run by Lifelinks and based in Christchurch, is a partnership between the Police and local alcohol and drug services, which uses the point

of arrest as an opportunity for drug and alcohol workers, independent of the police, to engage with problem alcohol and drug using offenders, and help them to access treatment and to ultimately reduce re-offending. These types of schemes have been established overseas in the United Kingdom and Australia and it has been shown that they can have an impact on crime reduction and reducing alcohol and drug use by offenders. NZ Police have decided to trial this type of scheme to see if it can impact positively on crime and crash reduction and community safety. The pilot is running for 18 months, and started on the 31 January 2005. This presentation showed the demographic make-up of the clients seen by the scheme as well as results achieved so far. It also provided information on lessons learnt and key success factors for these types of schemes.

- **The Clinical Process Self Evaluation Project - Stage 2 (Helen Mitchell-Shand)**

In 1998, the then National Centre for Treatment Development (Alcohol, Drugs & Addictions)(NCTD) published the Clinical Process Self-Evaluation Guidelines (CPSE), to assist AOD treatment services in New Zealand to evaluate and improve their practice in accordance with national standards.

Phase one involved introducing AOD agencies to the CPSE Guidelines and assisting them to develop clinical practice pathways reflecting national standards. Helen Mitchell-Shand, a quality consultant and an approved auditor, undertook this work in consultation with Daryle Deering, the National Addiction Centre (NAC) Project Co-ordinator. In 2003/4 a group of alcohol and drug services participated in developing a draft Clinical Practice Framework for Alcohol and Drug Services based on the Guidelines. The framework meets national standards of practice (accreditation and certification), and alignment to the DAPAANZ Alcohol and Drug Practitioners Competencies. Project objectives for phase two were to review and refine the Draft Clinical Practice Framework and present the Project at the Cutting Edge Conference in September 2005; pilot the Draft framework with two alcohol and drug services (one community based and one residential); develop a Clinical Practice Framework CDROM and Implementation Guidelines; identify six alcohol and drug service providers who are willing to trial implementation of the Framework with support from the project leader (limited number of days with the service contributing to the cost of the project leaders

time); dissemination of the CDROM and Implementation Manual via the National Addiction Centre website.

- **WelTec Alcohol and Drug Studies Programme (Raine Berry)**

WelTec is a national provider of quality alcohol and drug studies programmes. WelTec currently delivers Bachelor, Diploma and Advanced Certificate of Alcohol & Drug Studies courses in Te Tai Tokerau, Auckland, Hamilton, Wellington, Porirua and Christchurch. In 2006, in response to industry feedback, they plan to offer several new courses including Opioid Substitution, Group Facilitation and A&D Youth Work, and two new qualifications. The planned additional qualifications are a Certificate in Alcohol & Drug Youth Work (Level 5) and a Graduate Diploma in Addiction Studies (Level 7). The idea for the Graduate Diploma came out of discussions with existing practitioners who would like to upgrade their current qualifications, develop addiction related skills and knowledge, or meet specific competencies outlined by DAPAANZ. Information about WelTec's programmes and enrolment forms were available at the poster presentation.

- **NAC Postgraduate Programme (Fraser Todd)**

The National Addiction Centre's postgraduate programme offers a range of papers delivered nationally that form the basis of postgraduate qualifications. Students may progress from the Postgraduate *Certificate* in Health Sciences (Addiction and Co-existing Disorders) to the Postgraduate *Diploma* in Health Sciences (Addiction and Co-existing Disorders) and on to a Master of Health Sciences and a PhD within the National Addiction Centre. This poster provided information on these papers and courses for those who were interested in enrolling in them.

- **New Drug in an Old Scene: Experiences with Herbal Highs (Mary Paki / Andrew Raven)**

Benzylpiperazine, or "Herbal High" is a relative newcomer to the party drug scene. Currently legal, and obtainable from a wide range of retail outlets, this drug appears to be being consumed by an increasingly large number of New Zealanders. Reports of use

are also increasingly present amongst clients of Addiction Services. This poster aimed to present background information on benzylpiperazine, and on the range of formulations covered by the term "Herbal High". The information was of particular use clinically, with some focus on mental and physical health harms associated with this drug use. The results of a survey, of Addiction Services clients, were presented. This gave some indication of prevalence rates amongst a client group, including a demographic picture, and also presented information on client's subjective experience with the drug. There was a particular focus on health impacts amongst polydrug users, including those on Methadone, and on issues impacting on client's decisions to continue or discontinue use. The introduction of benzylpiperazine into the clinical population, occurring quite rapidly as it has, has been a challenge for counsellors. This poster also presented data on how clinicians have responded, with a particular focus on how they have updated skills and acquired knowledge on the drug. This poster was of particular interest to clinicians working in the treatment sector. Debate regarding the legality of Benzylpiperazine, and other health promotion issues, made this a poster of interest to those working with youth and health promotion.

- **Party Pills - The Low Down on the Latest in Social Weaponry (Dylan Norton)**

Party pills are legal stimulants designed and manufactured for recreational use. Falsely known as 'herbal highs', they have been around for the last ten years though only recently becoming the focus of public attention. Party pill sales have been escalating with around eight million pills sold in NZ in the last three years. Along with this increase in use has been an increase in abuse of these products and clients are now presenting at inpatient and outpatient AOD services with issues relating to their use. Currently new party pill products are being regularly released that offer stronger, longer and different hits. The current knowledge in the AOD sector is therefore struggling to keep up with this proliferation. This presentation aimed to provide comprehensive information about the 'cutting edge' party pills products available. The presentation covered: historical and legal information; information about the different active ingredients; possible contraindications; short/long-term effects; misnomers about Party Pills; the recovery pill aspect of these drugs; and comprehensive list of current products and their ingredients.

- **The Place of Mindfulness in AOD Treatment (Linda Gibson / Ana Ricciotti)**

Linda and Ana would like to extend an invitation to clinicians interested in applying mindfulness practices when working alongside clients with problematic substance use. They'll share their experience of running 'Managing Mood' groups at CADS North. These groups are being developed in response to a perceived need for clients to strengthen their crisis management and distress tolerance skills. 'Light Skills DBT Courses', as they are referred to in mental health settings have been run with a reasonable degree of success for a number of years. At CADS North these light skills DBT courses have been adopted and adjusted to suit the particular needs of this client group. Ana and Linda hoped this presentation would stimulate interest and discussion, which will inform the future running of these groups. Handouts on group content and structure are available for those interested.

6. DAY THREE OF THE CONFERENCE

SUMMATION OF DAY THREE:

As seems to be the way the third and final day of Cutting Edge 2005 was much quieter than the bustle of the previous two days. Dunedin provided us with another glorious blue skied day, though the northerners still needed warm jackets.

The presentations for the day started with James Bell talking about Ten Years of Change in Addiction Treatment. After this the morning was taken up with two streamed sessions. The varied workshops and presentations in these sessions included: methadone and buprenorphine treatment, the therapeutic process of interactive drawing, alcohol policy, a public health approach to gambling, AOD and gambling, nicotine in psychiatrically disordered adolescents, naltrexone and integrated treatment. The final presentation of the day was Matt Robson's plenary address on raising the drinking age.

After prizes and the poroporoaki the Cutting Edge 2005 ended with another delicious lunch from the staff at the Dunedin Centre.

SELECTED PRESENTATIONS FROM DAY THREE:

- **Ideal to Real (Claire Aitken & Moana House Whanau)**

Words are just not able to do justice to the presentation by Claire Aitken and the Moana House Whanau. Despite the apparent tiredness of the group due to the many months of hard work in preparing for the conference and their presentation, the performance of the Moana House Whanau was nothing short of exceptional. Incorporating rhyme, waiata, rap and role-play, the powerful, emotive and raw nature of the presentation, punctuated with down to earth humour at times, moved many in the audience to tears.

The eerie sound of the kōauau (wooden flute) signalled the beginning of the workshop, which Des (Moana House whanau member) followed with a mihi to mana whenua (local iwi) and to manuhiri (visitors) who had travelled to the conference. The first part of the presentation, cleverly played out in rhyming fashion, showed the whanau members and how they were constantly surrounded by stories of addiction, each finding it easy to be involved with this type of lifestyle, but so hard to be different. During this, definitions were read to the audience of the words 'therapeutic', 'community', 'community centre/service' and a strong connection made between the words 'community' and 'whanau'. Making a semi-circle, the nine whanau members of the programme moved to role-playing experiences of being locked up in jail and what they would do when they finally got out. One mentioned this woman he had heard of called "Claire" and a place in Dunedin called "Moana House".

A waiata sung by the group at this point not only illustrated the strength of the voices of the whanau members, but acted as a curtain to indicate a break in 'scenes'. After the waiata, whanau members had moved on from being in jail to role-playing being at Moana House on Christmas Day. A poem read by one of the whanau asked the group to enjoy this day together at the House. A second waiata and scene change brought Claire into the presentation heading group time with the whanau. In this role-play session, whanau members brought to the surface a lot of negative thoughts that they had experienced and often thought about themselves. Des showed his talents by rapping about his experiences with alcohol and drugs.

Claire then provided the audience with some information about therapeutic communities and Moana House. Moana House is a residential therapeutic community, which caters for male offenders in Dunedin. A therapeutic community is one that uses the community as an aid to recovery - in this case, the smaller one of the programme itself as well as the wider community of Dunedin. It started in 1983 as a charitable trust, but really opened in 1987 and graduates run the programme. She stated that the vision of Moana House was "giving you a real chance", but the ideals that drove therapeutic community treatment were not often well aligned with mainstream thinking. Therefore, to bring the programme into the 21st century, adjustments have had to have been made

between ideal and reality as the title of the workshop alludes to. Claire stated auditing and standards as examples of barriers that the programme faced in reality. She also believed wholeheartedly that reality in terms of leadership involved holding fast to the kaupapa (ideals). At this point, a photo of Takarangi Metekingi was shown as Claire asked, "Takarangi, where are you when I need you?" A very emotional waiata followed.

Returning to role-play mode, the whanau members/Moana House touch team explained to the audience their love of touch and how they practiced every Sunday. In competition though, the team had a tendency to get aggressive towards other teams and the ref, while certain other members of the team often showed off and sulked if they were not included or hogged the ball. At a house meeting called by Des, he challenged the whanau to change these behaviours out on the field as these were not behaviours that they aspired to in the House. The final 'scene' of the workshop showed a tug of war scenario with one of the whanau members standing in the middle of a rope and bad 'influences' (other whanau members) pulling from one side and good 'influences' pulling from the other. After a battle, the whanau member breaks through to a new life of freedom, devoid from alcohol, drugs and other troubles.

Nearing the end of their presentation, the Moana House whanau came together for another waiata before launching into a stirring haka, which blew the audience away. This intense finale was then followed by a mihi from each member of the whanau and extended whanau involved in the presentation: Claire, Joan, Des, Chris, Lance, Leo, Te Reo, Te Atua, Dean, Leo Jnr, Poura, Desmond, Piripi and Hone. Hone laid a final wero (challenge) down by asking those in attendance to consider that all tangata whaiora/clients we work with will be at different stages in their own journey. He urged the audience to think about the natural energies we needed to use to ensure that their journey and our journey both was a safe one. The workshop ended with the waiata Io and E Kore Au.

Praise abounded from the audience after the presentation, with many feeling very privileged to have witnessed the session. A final tribute came from Titari Eramiha - kaumatua of Nga Manga Puriri who acknowledged the personal hikoi (journeys) of those

at Moana House, stating his vision for kaumatua to be behind them to support them all the way in their journeys and ending with the comment "may we forever visualise this performance here for the future".

- **Development of the Substances and Choices Scale: Results from Stage 1 (Development Stage) (Grant Christie)**

Grant Christie, Child and Adolescent Psychiatrist from CADS Auckland, presented an overview of the study currently being conducted by himself and a team of researchers to develop a screening and outcome tool for AOD use with adolescents. He outlined the rationale for the development of an adolescent specific AOD screening and outcomes tool in terms of a need to: improve delivery service; raise awareness of substance use problems and increase the focus on AOD interventions; have access to a tool that is suitable in terms of length, cost and content. Based on an extensive review of the literature the Substances and Choices Scale (SACS) preliminary questionnaire was developed. Extensive consultation about items in this questionnaire was undertaken with youth and a range of workers in the mental health, youth health and substance use treatment field before a trial version of the SACS was developed. This trial version was piloted on a community and clinical sample (n = 61). Results showed that the SACS was a relevant and reliable tool for use with young people in New Zealand. The individual items were also shown to discriminate well and testing to date suggests that the SACS will be valid. The next step for the development of the SACS is testing the reliability and validity of the final version of this tool. This stage of the research project is currently in progress.

The vision of the research team is that the SACS will become an integral part of youth AOD and mental health service delivery. Its routine use will raise awareness of substance use problems in services and in the community and improve the delivery of AOD services to youth. In the future it may be used in other parts of the health sector and community including primary health care services and schools.

- **The Natural History Of Nicotine Use And Dependence In Psychiatrically Disordered Adolescents - A Four Year Follow-Up (Karen De Zwart)**

Karen, an assistant research fellow with the National Addiction Centre, presented the findings of the second part of a three part study, which predominantly makes up her PhD thesis focused on nicotine dependence and youth. Karen introduced her study and acknowledged her supervisor, Doug Sellman.

Karen started by presenting smoking prevalence rates among adult patients with mental health problems (55-90%), which are considerably higher than among the normal population (25%). Interestingly, the same studies have not been performed on adolescents with mental health problems, with an estimated prevalence rate to be in the region of 30-60% compared to an estimated daily smoking rate of 11-20% among 14-19 year olds in the community.

Therefore, the aim of Karen's study was to investigate tobacco smoking and nicotine dependence in adolescents presenting for mental health treatment, with two key questions isolated for investigation: what was the prevalence of nicotine dependence of a clinical sample of adolescents at baseline and four years later, and how did the pattern change over this four year period? Karen explained the rationale for the study, highlighting important implications of the research and her thoughts that it was an important area to explore given the considerably high smoking prevalence rates among adolescents in today's society.

The 1998 baseline collection of data involved the administration of a 14 item questionnaire to 93 adolescents aged 13-18 years. The questionnaire sought to determine smoking use in a cascading fashion and clinical files were also used for reference. At follow-up, 59 young adults aged 17-23 years were interviewed. The second questionnaire was far more comprehensive, asking questions about drug use, both legal and illegal, psychiatric disorders, general health and how the service they had been attending had helped them.

Moving to the results of the study, Karen explained that the few studies that had been conducted in this area were fraught with methodological issues due to the various different ways used to classify smokers. Therefore for this study, it was really important to obtain a proxy measure for nicotine dependence, which was done by asking whether the participant had smoked 'at least five cigarettes a day for a month and had smoked in the seven days prior to the interview'. At follow-up, this rate was 67.8% compared with 39% at baseline.

Results around the change in smoking status showed that at follow-up only five participants had quit smoking. Baseline demographic results showed that there were twice as many female smokers as males (69.6% v 30.4%) and significantly more Māori in the sample were current smokers than non-Māori. At follow-up, females were still over represented as smokers (65% v 35%) and the significant trend for more Māori than non-Māori to be current smokers continued.

In conclusion, the results indicated that adolescents with psychiatric problems were 2-3 times more likely to smoke regularly than adolescents in comparably aged community samples. Also young adults (17-23 years) with a current/past history of psychiatric problems were twice as likely to smoke regularly as young adults in comparably aged community samples. Females were overrepresented both at baseline and follow-up and significantly more Māori than non-Māori smoked at baseline and follow-up.

Karen looked forward to finishing her PhD on the completion of the third part of the study, which will explore the reasons why adolescents/young adults were smoking, the reasons behind why some participants took up smoking during the four year period and the reasons for quitting smoking amongst some of the adolescents/young adults involved in the study.

CONFERENCE CLOSING:

As was established last year the conference prizes were presented at the end of the conference, to ensure presentations on all three days were eligible. The first prize to be

presented was the John O'Hagan prize for the best presentation by someone under the age of 35 years. Geoff Robinson of Wellington presented the prize and noted that he had registered late for the conference and was originally told there was no room, however, once he reminded them he had the cheque book for the prizes, they squeezed him in.

The winner of the John O'Hagan prize was Meg Harvey for her presentation "The end of the road: Final results form the project on adolescent cannabis use and cognition". The second prize presented was the John Dobson prize for the best presentation on an opioid topic, which was looking for a commitment to science with real feeling for the people. Myra Duff, who had worked with John, and Doug Sellman spoke of John's mentoring and his belief in therapeutic alliances. They also mentioned how he would simply turn his hearing aid off when he didn't want to hear a conversation! The recipient of the John Dobson prize was David Mellor for his presentation on "Interim methadone prescribing programme (IMPP) – Preliminary results from Dunedin". An honourable mention was also given to David Gilmour for his presentation on methadone and benzodiazepines. The final prize presented was the DAAPANZ prize for the best presentation around clinical practise. Tim Harding noted that there were a lot of fine presentations and input into what we do. The outstanding winner was Claire Aitken and the Moana House whanau for their workshop "Ideal to real". There was also the worthy mention of Trish Gledhill and her work with children in our sector.

Bringing to a close an informative and well organized conference, the poroporoaki began with Claire Aitken asking all members of the Organising Committee to make their way to the front. Claire thanked all members of the committee and made special mention of Lisa Andrews and Lindsay Stringer (Conference Secretariats) who carry an enormous workload in organising the conference every year. Claire also drew attention to Doug Sellman and Ian MacEwan of the committee, who have both decided that 2005 was their last year on the committee.

Ian acknowledged the hard work of the committee, commented on how wonderful the conference had been this year and praised the hard work of those from Moana House.

Claire added to this her acknowledgement of a wider local group in Dunedin who had also helped a great deal. Doug then paid tribute to Ian for his part in developing and supporting this conference and the field.

Finally, Tuari Potiki (Southern Regional Manger of ALAC) acknowledged the National Addiction Centre, the Organising Committee, all presenters and all delegates for their continued interest and passion to work with this kaupapa. He left those in attendance with a final thought: that everyone who walks through your doors is a member of someone else's whanau and we should treat them as we would want our own whanau treated. Ian Hutson performed the final karakia to put to end Cutting Edge for another year.

He is happiest, be he king or peasant, who finds peace in his home.
(Johann von Goethe)

7. CUTTING EDGE 2006

- Cutting Edge 2006 may be held in Wellington
- It will run sometime in September
- Tim Harding is the Chair of the Organising Committee for 2006