



It's not what you do, it's the way that you do it.

By Deirdre Richardson

Does it matter when working with people who have co-existing disorders?

Over the last 100 years an increasing number of therapeutic models and interventions have been developed to assist people in coping better with life. Comprehensive reviews of research in the field of psychotherapy have found that no



Artist, Daniel Ormsby

one approach is ultimately superior to any other (Hovarth & Symonds, 1991). A similar trend has emerged in the substance use field e.g. Project Match. In response, rather than compare treatment modalities another avenue of investigation has been to look at pantheoretical concepts found to be important in treatment process and outcome. One such variable is therapeutic alliance defined as a collaborative relationship between the client and the therapist that consists of an emotional bond and a shared

presumption regarding the tasks and goals of the treatment endeavour (Connors, Carroll, Di Clemente, Longabough & Donovan, 1997: 588). Extensive research in the psychotherapy field has consistently found therapeutic alliance to be related to outcome (Martin, Garske & Davis, 2000), this also having been reported in pharmacotherapy studies (Krupnik, Sotsky, Simmens, Moyer, Elkin, Watkins, & Pilkonis, 1996).

There is also a growing body of literature investigating therapeutic alliance in relation to substance use disorders. It is of particular interest in that people with substance use disorders are traditionally a challenging group to treat as they are more difficult to engage in treatment, often have poor motivation, have poor retention in treatment programmes and tend to have poor social relationships. (Meier, Barrowclough & Donmall, 2005). These difficulties are exacerbated as a high proportion of people diagnosed with substance use disorders experience a co-existing mental health disorder (up to 70%) often resulting in multiple and more complex problems.

To date, research supports the relationship between therapeutic alliance and treatment engagement and retention. The relationship with treatment outcome is less clear, with therapeutic alliance linked to improvements in early treatment but not with post treatment outcomes. However, variance in the range of research methodologies, patterns of drug use and treatment employed make overall conclusions tentative. (continued page 2)

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Here again

It feels as if we have just come back from the last Christmas and New Year break, where did the year go, and what has been done? Well a lot actually! Not all of what has been done is what the addiction sector wanted – some of it acceptable but could be improved, and some we just groan about because it seems just a waste of precious resources and energy.

The Health Select Committee recommended that BZP and related substances be classed as C1 making it illegal to make, export, sell and use. The bill passed and is now law. The outcome was celebrated by some and accepted with reservation by those who know that illegal drugs do not necessarily disappear. There were also those who were horrified i.e. the people who made great profits from the sale of BZP.

The Government's announcement that there was to be a complete review of the Misuse of Drugs Act was much more exciting for most in the Addiction Sector. Less exciting and somewhat deflating was the outcome of the Liquor Review as it had the potential to have much greater impact on the effects of one of the top three most harmful drugs.

And more recently from all reports, the Cutting Edge and APSAD Conference was fabulous, disseminating a vast amount of useful information and linking many services and people to feed into the complex multifaceted Addiction Sector.

Among many tasks, there is still the Nationwide Services Framework Project to work through, the HPCA Act (Health Practitioners Competency Assurance) issue to resolve, all fraught with a multitude of intricate details that must be considered and worked through. So for next year, and the next..., the pace of policy change will continue while treatment services continue their day job: offering treatment and support to those with alcohol, drug and gambling problems and that – although at times we do not feel like it – there IS much good that comes from that work, so take note you are all fabulous and you should celebrate it.

We at ADANZ wish everyone all of the components that make a wonderful holiday and the energy to enjoy all the pleasures that go with it. To you, your whanau families and friends the best of wishes, take care and have a wonderful start to 2008.

Char Macpherson
Editor

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continued

Over the next five or so years I hope to add to this body of research by investigating the role of the therapeutic alliance in treatment for clients who have substance use disorders, and for clients who have a co-existing disorder (alcohol dependence and depression). This research is being undertaken as part of the Treatment Evaluation of Alcohol and Mood (TEAM), a national study being undertaken by the National Addiction Centre (Sellman, Adamson & Deering, 2006) and also by utilising data available from the Brief Treatment Programme (Adamson, Sellman & Dore, 2005). Some of what I hope to find out is whether the therapeutic alliance is linked to treatment outcome (for this population) and also the role therapist and client characteristics play in this relationship. For those of you working directly with clients this may provide further insight into what is of greatest benefit when working with clients – perhaps what should you do more of and perhaps what less. Of key importance is that the findings are likely to be more applicable to the New Zealand population compared with research undertaken overseas. So if you are still reading Connections in 5 year time – watch this space...

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HPCA Act – Seeking a Solution

The HPCA (Health Practitioners Competency Assurance) Act is under review in three stages; the first, information gathering, stage has started, and Drug and Alcohol Practitioners Association Aotearoa NZ DAPAANZ has made a submission towards this.

The Addiction Treatment Leadership Day (ATLD) in October included a discussion on progress and the current situation with regard to the HPCA Act and its implications for the addiction treatment workforce, and in relation to DAPAANZ's stance on registration of the AOD work force under the Act.

For a profession to be registered under the Act, key conditions need to be met:

- The work force concerned must want and agree to be so registered
- There must be a potential or real risk to the public from the practice of that profession's members
- It needs to be accepted that a profession's coming under the Act is in the public interest
- The profession needs to be unique, distinguished from others by functions, roles, practice and competencies.

The positive and negative implications of becoming subject to the Act need to be identified, considered and weighed up by all concerned.

Negative issues like pay differentials, the hierarchy effect between disciplines which are registered and those not, and between those practitioners individually registered versus those unregistered need to be put against positive

recent moves such as the letter (widely known about and appreciated by the sector) to DHBs from Janice Wilson, and the slackening of pressure caused by the imminent review of the Act, its intent and current ramifications in practice.

DAPAANZ has for some time been considering whether to seek registration of its members as a distinct profession under the Act. It has approached other similar groups contemplating becoming registered but no agreements have been reached with any of them. One possibility is that several professions can make separate applications to be registered, not under separate Accreditation Boards but under one common Board, thus reducing costs and complexity.

In a preparatory move, DAPAANZ is drafting an application for accreditation so as to be ready to move forward if the outcome of the review of the Act is such that makes this appropriate, and should its members agree on this action. At the ATLD it was pointed out that if AOD Practitioners were to come under the Act, DAPAANZ would lose its regulatory and accreditation functions, as these would pass to an Accreditation Board. It could, however, still remain a sector membership body.

It was further noted that addiction treatment practitioners participate in a uniquely varied range of practice modes and models. There is also uniqueness in the multiplicity of skills required for effectively intervening with or treating AOD issues; this very complexity could be the unique identifier of what differentiates AOD Practitioners from e.g. Counsellors or other disciplines or practice groupings.

Submission information and contact details for the Ministry of Health can be found on the back page.



IIMHL Exchange and Conference

The International Initiative for Mental Health Leadership (IIMHL) is a joint endeavour of the National Institute for Mental Health in England (NIMHE), the Substance Abuse and Mental Health Service Administration (SAMHSA) of the US and the Mental Health Directorate of the Ministry of Health (MOH) New Zealand, intended to facilitate the sharing of best practices and to provide needed support and collaboration for leaders of mental health services to develop robust managerial and operational practices.

To date, four IIMHL Leadership Exchange and Conferences have been held, and support has been provided in the form of scholarships to assist leaders who work in mental health to attend. In 2005, New Zealand hosted the exchange and conference and, in 2006 these were held in Scotland. This year's programme was held in Ottawa, Canada, 27-31 August.

The Ministry of Health engaged Te Pou to manage the scholarship process. Debbie Fraser, Manager of Dunedin's Mirror Counselling Service and Youth Day Programme and Cate Kearney, CEO, ADANZ, Christchurch were two of the 10 scholarship recipients who attended IIMHL 2007. Of the 50 New Zealand delegates there were three addiction sector delegates, the third being Tim Harding, CARE NZ.

When asked for comments on the conference Cate reported that the IIMHL was at the Chateau Laurier, Ottawa, and it was a real chateau – large, ornate and very French. The conference was a two day event with over 500 delegates. The opening ceremony on the Wednesday evening was led by the First Nation people with expert drumming and dancing demonstrations. The conference had a mixture of presentations: at times information that was micro or operational rather than macro or debating the issues of leadership. As ever, the discussions over breaks were as valuable as sessions. The second day of the conference was the main attraction with the Canadian Prime Minister opening the day and launching the Canadian Mental Health Commission, also promising substantial new funding to the mental health sector.

Cate's exchange was with the Sacred Heart Centre, a 128 residential bed and detox centre in Michigan. Day One focused on the intricacies of the USA funding system with opportunities to meet with provincial and state funders.



Debbie Fraser and Cate Kearney

Disclaimer and Contact Information

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While US health care is entirely privatised there is minimal funding available for the "indigent", these who are poor and without any health insurance. Over lunch discussion evolved to service-led advocacy, where like organizations work together to lobby for the people they serve versus the problem of limited federal, state and provincial funding and 'ticket' clipping at every exchange of funds. Day Two focused on electronic patient management systems: a very complex system tracking payments and recording inputs as allocated by insurance companies.

In between conferencing and exchanges, people had opportunities to brush up on their French. My colleagues dined out in Ottawa and ordered crocodile. I watched as they appraised the taste and texture. Not something to seek out again: the consensus was that crocs may be good for many things but perhaps not as a gastronomic delicacy.

More information on the IIMHL Leadership Exchange and Conference can be found at www.iimhl.com/

Future IIMHL scholarships will be advertised on the Awards, Bursaries and Scholarships page on the Te Pou web site.

Nationwide Services Framework Project Mental Health and Addictions Sector

What is the purpose of this project?

This Ministry of Health sponsored project aims to develop a framework for the comprehensive review of current and new nationwide service specifications for the mental health and addictions sector.

Within this framework, a cycle of sustainable revision of the nationwide mental health and addictions service specifications will be commenced. This project will also recommend a revised service coverage schedule to the Ministry of Health, referred to the Minister of Health for approval. This project is a requirement of the Te Kokiri Action Plan.

How is the project structured?

The project has key sponsors at both Ministry of Health and DHB level. It is being led by two part-time project managers: Roz Sorensen (NDSA) and the other .5 position is expected to be filled in the near future. The Te Kokiri Working Group will provide a governance function for the project.

A multi-stakeholder group has been established known as the Project Reference Group. This group will consult with their stakeholder group and bring stakeholder feedback to meetings to inform project processes. Furthermore, they will support and guide project development activities to achieve overall project outcomes.

Task specific groups will also be established to work on specific service specifications at a more detailed level.

Tasks completed and underway

A stock take of service specifications in use in 20 DHBs was carried out in September 2007. Feed back was considered at a recent project reference group meeting. The feed back included the need to reflect the current direction of the mental health and addictions sector as described in Te Tahuu and Te Korkiri including pathways to recovery and resilience; a focus on ethic needs as well as their clinical needs. Other issues to be taken into account include spiritual needs, family/whanau and the different understandings of mental health, wellbeing and recovery.

The establishment of a tiered framework for the service specification for mental health and addictions sector is underway and is expected to be ready in December 2007.

There will be meeting minutes and newsletter updates distributed on various networks to keep people up with the progress. The project is expected to be completed with a final report in September 2008.

How can I participate?

A member of the project reference group would be keen to communicate with you regarding your feedback on the aspects of review. Meeting minutes and newsletters will be available to keep you up to date with progress.

Email contact details

Cate Kearney (ADANZ) cate.kearney@adanz.org.nz
Roz Sorensen (NDSA) roz.sorensen@nds.co.nz



New Service in the North of the South

The Able Tasman National Park is a special place and its town of Motueka is where you will find Te Whare Hauora o Te Āwhina Marae. Rochelle Curtis is Acting Manager and she describes the Marae services below.

Te Whare Hauora o Te Āwhina Marae

As our name indicates, Te Āwhina Marae was created as a place that openly welcomes all people to come to learn, seek shelter, find hospitality, and get health advice and much more.

We are a Kaupapa Maori Health Service, who seeks to guide and support our whanau on their journey to wellbeing.

Te Whare Hauora currently employs six health workers. Hauora services currently running successfully are:

- Alcohol and Drug Services
- Whanau ora Service
- Mental Health Support
- Peer Advocacy Support
- Aukati Kaipaipa – Quit Smoking Service

(Photo by www.motuekaisite.co.nz)

Staff at Te Whare Hauora are well trained and educated in their appropriate fields. On the team we have a registered nurse, a certified mental health support worker, a qualified counsellor and two qualified smoking cessation coaches.

Te Whare Hauora staff Rochelle, Nellie, Nicola, Jackie, Kerry and Sean, work together for the overall wellness for clients and whanau. We are a holistic team working within the Te Whare Tapa Wha model. We strive to offer the best service to whanau. We believe we are a team who talk and strive to have balance in our personal as well as our professional lives.

As a service we can provide the following:

- A friendly multicultural environment
- Clinical expertise within our services
- Support services
- Counselling
- Education and health promotion
- Kaupapa Maori services.

All our Health Services are FREE and available to ALL people of Motueka and the greater Nelson Bays area.

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Alcohol Drug Helpline calls from the South Island regions

Each year the Alcohol Drug Helpline gets thousands of calls from all over New Zealand. From July 2006 to June 2007, there were **15,180 valid calls** to the Helpline with 17,765 queries about alcohol or other drugs, indicating some callers discuss more than one substance.

Often there are regional variations in types of drugs used and types of support offered e.g. when looking at the Helpline data, most calls received about methamphetamine are from the top half of the North Island. Over the past year we have explored regional variations as the impact of ALAC's Culture Change campaign gains momentum: the latest round of advertisements have often tagged the Helpline number.

We have compiled from our 2006/07 Annual Report a breakdown of South Island calls by drug type and by helpline response for the six South Island DHBs. We note that at times the Helpline receives regular calls from a small number of repeat callers. The statistics presented have been adjusted to account for any increase in drug type calls that are attributable to a single individual.

Primary Drug: Number of calls by South Island DHB area

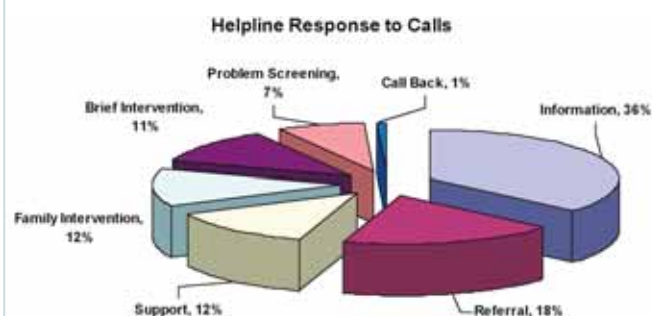
DHB Area	Alcohol	Benzo	BZP	Cannabis	Meth	Opioids	Total
Nelson/Marlborough	310	4	12	78	34	27	557
West Coast	187	2		14	13		235
Canterbury	1571	99	73	378	143	201	2893
South Canterbury	93		2	20	13	7	171
Otago	752	20	21	67	22	23	997
Southland	247	6	6	94	10	7	423
Total	3160	131	114	651	235	265	5276

Primary Drug: Percentage of calls by South Island DHB area

DHB Area	Alcohol	Benzo	BZP	Cannabis	Meth	Opioids	Total
Nelson/Marlborough	56%	1%	2%	14%	6%	5%	557
West Coast	75%	1%	0%	7%	7%	0%	235
Canterbury	54%	3%	3%	13%	5%	7%	2893
South Canterbury	54%	0%	1%	12%	8%	4%	171
Otago	71%	2%	2%	8%	3%	3%	997
Southland	58%	1%	2%	14%	3%	2%	423
Total	60%	2%	2%	12%	4%	5%	5276

Alcohol is the most commonly called about drug, followed by cannabis, then opioids. Even after adjustments are made for regular callers, the West Coast and Otago DHBs still have the highest percentages of calls where alcohol is the problem. Similarly adjusted Nelson-Marlborough and Southland DHBs have the highest percentage of calls where cannabis is the problem and Canterbury has the highest percentage of calls where opioids are the problem.

Helpline Responses to callers from the South Island DHBs



Callers to the Helpline have received a variety of services: some callers will receive more than one e.g. often a brief intervention call will be paired with information.

While information calls are the most common, almost a fifth of calls result in a referral to an AOD service, while 11% and 12% respectively are immediately offered a brief or family intervention.

For all calls received from concerned others in all South Island DHBs, the most commonly called about age group is those aged 35-44, followed closely by 45-60, then 25-34. For the whole of the South Island, the average age of a person identified with cannabis as a problem is 25 years. However, a quarter of all calls about cannabis are regarding users who fall in the 12-18 years of age bracket, then 18-24 year olds at 24%. Primarily these calls are from parents concerned about their teenager's cannabis use.

The Alcohol Drug Helpline is a national 0800 information, referral and intervention service operating 7 days a week from 10am – 10pm. The Helpline provides confidential information, insight and support with any problem callers have about their own or someone else's drinking or drug use.

Carol Randal, Training Coordinator and Peter Cornes, Quality Manager
Alcohol Drug Helpline: 0800 787 797

Diary Notes:

Health Practitioners Competence Assurance Act – Survey

Closing date for submissions is Friday 21 December 2007

The operation of the Health Practitioners Competence Assurance Act 2003 (the Act) is required to be reviewed as soon as practicable three years following its commencement. This is a statutory requirement set out in section 171 of the Act. September 18th, 2007 marked the three year anniversary of the commencement Act.

In order to collect information on the operation of the Act and thus identify any issues and potential solutions, the Ministry of Health has prepared a survey document. A copy of the document can be found on the Ministry's web site www.moh.govt.nz/moh.nsf/indexmh/hpca-identification-issues-solutions-consultation-oct07.

The document presents information on key provisions of the Act and poses some questions. The topics covered by the survey document and the questions posed are by no means intended to be an exhaustive or restrictive list. They are intended to provide context and stimulate thought to help respondents comment on the operational issues they perceive to be impacting on the public, practitioners and service funders/providers. Following collation and analysis of the information collected the Ministry will formulate a discussion document which will pose recommendations in respect of the way in which the Act is operationised. The discussion document will be circulated widely for comment.

If you have any questions or would like to meet to discuss any aspects of the survey document, the review or the operation of the Act generally, please contact Ryan McLean, Policy Analyst, Health and Disability Systems Strategy Directorate, Ministry of Health, PO Box 5013, Wellington. Telephone: (04)496 2245.

Information on a range of scholarships and application forms can be accessed from the DAPAANZ web site: www.matuaraki.org.nz/scholarship.php

Addiction Treatment Leadership Day

2008 Meeting Dates

13 March Christchurch
3 July Auckland
6 November Wellington

Addiction Summit

10-12 July 2008, Melbourne, Australia

For more information contact summit@pacificcmc.com
www.pacificcmc.com.

"Harm Reduction 2008: IHRA's 19th International Conference"

11-15 May 2008, Barcelona, Spain

www.ihraconferences.net – the new web site for more information and updates.

Benefits and butts

It is always good to see reports about clubs and pubs complying with the new regulations and banning smokers to outside areas. However, there have been a number of unfortunate results associated to the new no smoking regulations in Australia.

In an effort to cater to smokers who have been caste outside, some club and bar venues have been replacing healthy areas, such as family facilities and sport focused facilities, with smoking areas. One club in Melbourne removed a squash court and replaced it with a beer garden and new smoking area rather than doing improvements to the courts.

A tavern had a play area for children with swings and slides in an internal courtyard, they removed the kids stuff paved it and turned into a smoking area. And to add salt to the wound, some venues with pokies were getting tax breaks for their efforts, explaining that new outdoor smoking areas actually benefited the community – what's that about!

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alcohol drug association new zealand

