

Nau Mai haeri mai ki te pae tukutuku o
Te Rōpū Waipira Whakapōauau o Aotearoa
WELCOME TO THE ALCOHOL DRUG ASSOCIATION NEW ZEALAND

0800 787 797
alcohol & drug
helpline
10am - 10pm, 7 days



EDITORIAL:

From the Chairperson:

You will be aware that the Alcohol Drug Association has undergone recent changes in management with both Paul Traynor and Bronwyn Bindon leaving our employment. I thank them for their contribution and especially acknowledge the valuable work done by Paul Traynor. ADA wishes them well in the future.

ADA is currently reviewing its management structure and going through a re-employment process.

I wish to thank those people in the Alcohol and Drug

field who have been supportive in this time of change. I also wish to acknowledge the ADA staff and volunteers for their commitment and patience during this time.

I will keep you informed of our progress via the ADA Connection and AandD Link.

Pam Sharpe
Chairperson ADA Board

FROM THE CONSUMER ADVISORS DESK

Hi to you all.

The progress in our service to both providers and consumers in the last two months has been both rewarding and challenging at the same time. Some areas are developing quickly, others slowly.

The areas we see progress in are that providers are now asking our advice on specific issues, which is a good move forward. Consumers are going well although the numbers attending the groups fluctuate. A standout occasion for both of us was attending a Consumer Advisor Hui held in Wellington in May where the "National Alcohol & Drug Consumer Network" was

formed. This is an exciting development for the consumer network.

We are just in the throws of receiving the last of the consumer survey questionnaires back, not a bad response just over 80 from 400 sent. So we will be analysing these soon and will let you know the outcomes.

All in all this has been a busy and productive time for us.

Cheers for now **Lynn and Peter**
Consumer Advisors

The Alcohol & Drug *Helpline*
0800 787 797

UPDATE

VICTORY COMMUNITY HEALTH CENTRE INC: A JUNE 2003 REPORT

Tena koutou katoa

It has been a quiet few months of late as we have awaited to present our final submission to the Nelson Marlborough District Health Board (NMDHB) through its Community and Public Health Advisory Committee (CPHAC), which we did on 10 June 2003. We felt reasonably positive about the outcome in that all of the committee voted for the submission to be sent on to the NMDHB meeting on 1 July 2003.

Our submission, in brief, was asking the members of the NMDHB to seek out ways of facilitating their requirement to access After Hours in order to acquire a site Section 88 (the permit for a doctor to practise). We proffered the suggestion that the Emergency Department (ED) might be a means to this end as so far, despite nearly two years of attempting to gain admission to the Nelson After Hours roster, we had been unsuccessful in bringing about any such fruitful discussion.

The Nelson Mail has picked up on the story since last year and this has been useful in that the stances of Nelson City Care Ltd and ourselves has been clarified in public. Perhaps this was not the most satisfactory way of reaching some understanding but we are quite comfortable with it as it has been a means of us being quite accountable to the community that is supporting us.

How can you help us? We would like you to support our submission by attending the Public Forum section of the next NMDHB meeting on 1 July 2003, at 10.15am.

If you can come could you please email Briar at breлма@clear.net.nz or phone her on 548 2856

Within our organisation there have been a few changes. Murray Mochan had to step down as chairperson for health reasons and we wish him a speedy recovery. Leanne Curtis is now Treasurer and Briar Campbell-Maaroufi is now chairperson. Leanne and Briar are sharing the secretarial role. We continue to meet on the second Monday of each month at the Victory School staff room at 7.30pm.

Also we would like to express our thanks to Pip Jamieson and Keith Preston for the work they did for us in March. We have, unfortunately, had to curtail the contract as we had no surety from the NMDHB or doctors as to our future. However, hopefully a solution will be found through resolve and we may look instead at employing our own future manager proper! We are nearly there so ...keep praying!

Kia ora katoa

Briar Campbell-Maaroufi (Chairperson)

ALCOHOL & DRUG HELPLINE

It is 'all go' on the Alcohol & Drug Helpline these days. The Helpline continues to grow and has, in fact, shown a one hundred per cent increase in calls over the last year. Looking back to when the Alcohol Helpline started, we took an average of 5 calls a day in the first year of business.

Five years later we were receiving an average of 30 calls a day, and one year later it is not uncommon to receive 85 calls a day. This is primarily due to the introduction of a "queuing system" on the phones. This means that callers are placed in a queue rather than being asked to call back because the lines are busy. There has also been a huge response to the television advertising for the "Had Enough" Campaign. The 700 video packages have all been sent out and another 100 have been printed so far. While there has been no official advertising of the Drugline, calls to the Helpline regarding cannabis have increased one hundred per cent, and Methamphetamine calls by four hundred per cent, over the last six months.

Up until recently, the Helpline was manned by two Brief Intervention workers from 10am to 6pm, Monday to

Friday, and volunteers from 6pm to 10pm, Monday to Friday, with volunteers only, manning the phones throughout the weekends. Due to the increase in Crisis calls and the overall complexity of calls, a Brief Intervention worker and a volunteer will now man the phones, every shift, seven days per week, as of the 1st of July. A further workstation has been installed to enable yet another worker to man a third phone at identified peak times.

The 28th of June sees the commencement of training of volunteers. This signals the start of our open group style of training. The new format will allow people to enter training immediately, once they have been approved, instead of having at times, a three-month wait.

We would like to say that, as Co-ordinators, we are very pleased and proud of how well the Helpline staff, both paid and volunteer have risen to the challenge of the many changes and pressures the Helpline has experienced in recent months.

Andrea Curtis
Clinical Co-ordinator

Alison Dann
Helpline Co-ordinator

UPDATE

TREATMENT WORKS JUNE 2003 – BEST PRACTICE SYMPOSIUM

As part of Treatment Works Week, the National Treatment Forum hosted two symposiums on Best Practice. In Christchurch Amanda Wheeler, RADS CRRC, spoke on applied research and an audit tool; Philip Siatoga, a consultant living in Christchurch, spoke about practitioner competencies for Pacific AOD workers and Pam Armstrong, Mental Health Manager, Northern Health Service spoke to a model on developing and implementing Best Practice for Maori. Joel Porter, Clinical Director of Mental Health Services, Hamilton, asked 'what is Best Practice?'. Joel summarises his presentation below .

At best, Best Practices in the addiction field can be understood as the principles and processes that clinicians, researchers, educators and managers utilise to inform their decisions about therapy, research, education and management. And, depending upon the context or paradigm employed by a give clinician, researcher, educator or manger, Best Practice may be understood and implemented quite differently. From a clinical perspective, Best Practice in a harm reduction-focused program will embrace different perspective than that of an abstinence-focused program. I am not implying that

one view is better than the other, it only means that we are looking at two very different paradigms of treatment.

Regardless of theoretical, cultural or spiritual perspective, the centerstone of Best Practice in the addiction field is to "First, do no harm". The safety, protection and provision of helpful services are the sole responsibilities of the practitioner and agency. To this end, Best Practice can be upheld by ensuring practitioner competencies and program evaluation. The establishment of DAPANZ and the national emphasis on workforce development are big steps towards ensuring practitioner competence. Ongoing program evaluation is a critical component pursuing Best Practice from a agency perspective. Since we are all human and prone to error and personal biases, it is imperative that we continually examine quality and efficacy of the services we are providing to people. In that way we can take inventory of service and keep doing the things that are helpful and stop (or modify) the things that are not. I heard it said, "That to not incorporate program evaluation is a like playing golf in the dark. You could make a great shot, but have no idea where the ball went".

COUNSELLORS, CONSUMERS & COMMUNITIES

In the pursuit of professionalism, with its concomitant attributes of accountability, the AOD field has undergone major changes in the last decade, many of them very positive - some not so good. While accountability had been discussed frequently long before the beginning of the decade, nothing was put into place to make that goal a reality, including funding.

Changes have been made and now a variety of accountability systems are in place and sometimes give the appearance of competing with each other for dominance. Where there should be compatibility, there is often dissonance. We have evolved from voluntary to mandatory certification. In 1993, as a product of the field itself, a set of AOD standards came into existence that was specific to our work. The auditing tools for compliance were formalised and turned over to independent agencies for the actual audits - again these initially were voluntary. These AOD Standards coexisted and often vied with Mental Health and Health & Disabilities Standards for applicability. Work went on for years to identify the gaps and close them between these guidelines. Some agencies were required to comply with all three Standards. Then, independent of these three, came the DHB with its own auditing procedures - many of which were apparent duplication of the processes inherent within the previously

mentioned standards. One would think this would not be a problem, as being in compliance with one should make it easier for being in compliance with the others. However, this has not proven to be the case, as the process of compliance within each set of standards requires different responses. The recent work by Standards New Zealand Committee for AOD to combine the AOD, Mental Health and Health & Disabilities Standards into one objective should simplify things - at least that's the objective. Time will tell.

What has been the downside to all of this work? William L. White, MA, Senior Research Consultant at Chestnut Health Systems in the U.S. and author of *Slaying the Dragon*, a history of Addiction Treatment and Recovery in America, has recently written an excellent article for *The Counselor Magazine* discussing some of the changes encountered in the U.S., many of which reflect those encountered here in New Zealand. In his article he states:

There are growing calls to rebuild the connecting tissue between treatment and recovery and to rebuild the relationship between treatment agencies and local communities out of which there were born (White, 2002). There are also concerns that the role of the addiction counselor is being corrupted by an inordinate preoccupation with

UPDATE

regulatory compliance and financial profit (and the resulting paper processing) rather than on transforming lives. ... when the addiction counselor was an outreach worker and a community organizer, and when the community was both the "client" and the treatment program.

The Ashburton Community Alcohol and Drug Services, Inc., (ACADS), has a unique arrangement that has proven to be somewhat of an effective counter to the trend of a growing separation from the community itself. ACADS, in addition to the traditional clinical processes (assessment, referral and aftercare) has missions, which include work in Health Promotion and Youth Work /Services. Alongside of these services are an Intensive Outpatient Programme, separate Men and Women support Groups, plus being the host agency for a variety of independent specialty groups, i.e. OA, AA and, soon to be initiated, GA. Others are being considered. Health Promotion allows ACADS to present the remainder of its services within the community with a "softer face" - the same can be said for the work with Youth.

In pursuit of linkages and dialogue with a variety of community entities, its "consumer" base extends well beyond "former clients of the service who are in recovery from those conditions that can be found on the far end of the continuum - those who suffer from dependencies". Prevention and tertiary treatment co-exist and, in fact, provide a symbiotic relationship that enhances the mission of each. However, even in this close-knit community the current regulatory changes are causing stresses and strains.

What ACADS, and other agencies in New Zealand, are trying to address more effectively are people with problems that fall far short of this extreme. Consequently, our "consumer" base includes those individuals who are not attached to any formal "recovery" group or philosophy.

Recently the South Island Shared Services Agency Limited and the Canterbury District Health Board produced a document that was reviewed by a group of South Island Stakeholders at a meeting sponsored by ALAC in Christchurch. The purpose of the document and the review was expressed as:

...to develop a plan for the development of specialist alcohol and other drug treatment services in the South Island over the three years ending 30 June 2006 within the resources available.²

This 61-page document is far too comprehensive of a review to go into a great deal of detail. But, certainly, in

the opinion of this writer, there are a couple of interesting points that addresses the points made supra. For the first time, Family Members begin to gain official recognition as important elements within best practice treatment approaches, instead of something that "is recommended" and are now gaining status as "consumers" themselves. The inclusion of family/whanau members receiving treatment themselves, with or independent of the AOD client is welcomed and broadens what has been the focus of what constitutes a "consumer".

Another addition that aids in re-enforcing community is the Review's goal of "increased aftercare/re-integration services utilizing a social work/community support work model".³ Again, the "consumer" network is expanded.

Many Maori and Pacific Island professionals, and their agencies, frequently have a better appreciation for the broader aspects of the term "consumer" than non-Maori groups. This certainly became apparent during the discussion held by the New Zealand Standards Committee on AOD Standards and at the time of the SISSAL review meeting itself.

Overall the SISSAL produced document is a far-reaching piece of work. While agreement to all of its recommendation is yet to be reached, the effort itself needs to be applauded.

Much has happened over the past decade to ensure the communities of New Zealand receive AOD services that reflect the best in terms of clinical best practice performed by competent professionals. However, thus far the emphasis in terms of accountability has split our efforts in terms of the amount of time and resources spent on meeting the needs of various regulatory agencies at the expense of those we serve in the community.

"Consumers" must be re-defined and refocused to ensure our specific communities are being appropriately represented.

Jere Bun (Director, ACADS)

¹ White, William, *The Road not Taken: The Lot Roots of Addiction Counseling*, **Counselor - The Magazine for Addiction Professional**, April 2003, Vol. 4, A Health Communications, Inc. Publications Deerfield Beach, Fl. USA, pp 22&23.

² Rout, Paul, *South Island Alcohol and other Drug Services, Review, Document Two, Discussion of Key Issues and Proposed Service Development Objectives for DHB Consultation*, SISSAL, PO Box 3877, Christchurch, 6 May 2003.

³ Ibid, p. 4

The ADA CONNECTION is the official newsletter of the Alcohol Drug Association New Zealand.

Contributions including letters are welcomed. Submission does not guarantee publication. Contributors enjoy all reasonable liberty in the expression of their views. Views so expressed do not necessarily represent those of the ADA.

Articles from Connections can be reprinted as long as acknowledgment of the source is given.

All correspondence, inquiries, address changes and ADA membership subscriptions should be made to:

ADA

PO Box 13-496, Christchurch.

Phone: 03-379 8626. Fax: 03-377 5600.

Email: ada@adanz.org.nz

Office: Level 1, Latimer View,
215 Gloucester Street Christchurch.

www.adanz.org.nz