



Treatment works, but do we have enough services?

By Cate Kearney, NCAT

The Addictions sector is a vibrant and growing industry and that is due in large part to the consumers who access our services; their numbers are growing as is the range of substances they use. Or is the idea of increased demand only our perception?

Mark: 1 of 3 current ALAC television advertisements



As we lack data to determine whether numbers of referrals and admissions to services are growing nationally, we rely on reports from services and workers.

Recently at a Christchurch LOAD meeting there was a mix of highly motivated and engaged alcohol and other drug workers and allied professionals who reported increased waiting times due to both workforce issues and increased referrals and self-referrals. There were requests from services to be patient with those agencies that had lengthening waiting times.

The Alcohol Drug Helpline has tracked an increase in referrals to AOD services as a result of the ALAC social marketing television campaign from on average eight a week in May 2007 (no TV campaign) to 15 a week in May 2008 (one month into TV campaign). With new programmes such as Effective Interventions and the increased presence of the Primary Health Strategy, we are in little doubt that service demand is growing.

So is treatment service growth increasing to match demand? There has been some increase overall in the national expenditure on treatment services, yet vastly more resource has been allocated to supply control through Customs and through the Criminal Justice system.

Of interest, in election year there is increased rhetoric about crime and punishment, recently accompanied by the getting tough on drugs message. While some parties may see this as an easy fix to the problem, the addictions sector would like to know where is their health policy on treating people with addictions? Where is any political party's policy on alcohol and other drugs?

Recently in The Press, the Christchurch metropolitan newspaper, a former drug squad police officer who had found a new career as an educator on Methamphetamine, made the claim that "the current justice and treatment system is a mess. The emphasis is on deterrence rather than cure. Treatment services are a patchwork of charity, private, Church and state schemes anyway. (Continued page 2)

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It's all working

Taking a stand: applause for ALAC

The recent Alcohol Advisory Council's (ALAC) social marketing campaign has highlighted the reality of binge drinking in New Zealand. They have taken a stand and presented New Zealanders with some challenging images that can not be brushed aside. The television advertisements have impact! They are bold and confronting about how some New Zealanders actually use alcohol. People have been taken out of their comfort zones.

Rather than inspiring complaints to the Advertising Standards Authority ALAC should be attracting congratulations. ADANZ applauds the strength of the stand that ALAC takes on the important issue of binge drinking; they have provided a lead in challenging New Zealand's binge drinking culture. The early benefits of the current TV campaign has been that people are calling the Alcohol Drug Helpline seeking help. Based on the feedback from callers to the Helpline, these ads have been a powerful motivator for some drinkers who had wished to minimise the problems associated with their drinking. We look forward to seeing the next stage of the campaign.

Advocacy and Peer Support: smoothing the way

Over a year ago the Canterbury DHB took the initiative and funded the Addiction Advocacy Service for the Canterbury area; to date the only one in New Zealand While still in its infancy, anecdotal reports suggest that people who might have stopped their treatment because of stigma or difficult situations have been supported to work through the issues and get back to focusing on their treatment.

We know that treatment works, we celebrated it a few years ago with Treatment Works Week so following the lead taken by the Canterbury DHB, should we ask ourselves: would treatment retention improve and therefore treatment outcomes improve if Peer Support Workers were available in all 21 DHBs?

This edition of Connections highlights consumer services, looking at the future of consumer services, the input into service development by consumer advisors and also the vision for the future development of the Addiction Advocacy Service.

Char Macpherson, Editor

(Treatment works continued)

There is not a coherent national service to match the scale of our substance-abuse problems."¹ While there are inaccuracies in his story, especially in relation to the patchwork of services and a lack of a coherent approach, there is one element of truth: we do not have enough services to match the national increase in substance misuse problems and treatment is not prioritised over punishment.

We know treatment works. For every \$1 invested in addiction treatment programs there is a return of between \$4 and \$7 in reduced drug-related crime, criminal justice costs, and theft. When savings related to health care are included, total savings can exceed costs by a ratio of 12 to 1.²

And yet the addiction sector in New Zealand remains largely under-funded. This is not due to current funding policy or to individual DHB's but is an historic fact related to long-term under-funding.

The Addictions sector resource is approximately 10% of the Mental Health budget. While no-one in the Addiction sector advocates for a reduction in mental health funding, it is time that the addictions treatment sector saw improvement in funding, without impinging on national targets for the overall funding of Mental Health services.

And what is the impact on the addictions workforce when service need increases? The 2004 National Addiction Centre Workforce Survey showed that we are an aging sector (from 1998 to 2004 the average age of the workforce increased from 42 to 47), but the good news is that years in the sector had significantly increased (from 5.8 to 8 years). Post graduate qualifications had increased from 5% to 13%. Those that identified their drinking status as "ex-drinker" declined significantly to 27% from 36%. At present we do not have a picture of our current workforce. An updated picture of the Addictions Workforce is due to be made available by Matua Raki in late 2008.³

So in election year, perhaps we can try something new and different. We could either individually or collectively in our DHB's, lobby local politicians in regard to the benefits of treatment, its cost effectiveness and the commitment of our workforce. We can do more: all we need is more resource and recognition of the fact we know well: treatment does work.

1. <http://www.stuff.co.nz/thePress/4475713a19743.html> The Press: Saturday, 12 April 2008, The demon P
2. <http://www.drugabuse.gov/newsroom/06/NR7-24.html>
3. <http://www.matuaraki.org.nz/index.php?id=60>

The Misuse of Drugs Act: Grist for the Mill

By Char Macpherson, Editor

The review of the Misuse of Drugs Act is an opportunity for everyone to seriously consider a number of options regarding how drug use is perceived and how the resulting harms from use can really be reduced. The initial requests for feedback at the early stages of the review have already drawn some comments which are definitely grist for the mill.



It has been strongly noted that this is the time to take advantage of the opportunity to bring up and discuss a wide range of ideas. Can we come out from behind the safety of our desks and at the very least, have a conversation that begins with – what would happen if...? Seriously consider options that may be outside of the square. In doing so, New Zealand can continue to take the lead in changing how we and the world could really reduce the harms from drug use, at an individual as well as at a global level.

It was suggested at the Addiction Treatment Leadership Day in March 2008, that the review presents an opportunity to consider removing the use of all drugs from the justice system and to place such use with in the public health system; to include alcohol and tobacco as drugs, and to consider the wider implications of criminalising drug users.

Alcohol and Tobacco

It is made clear in the terms of reference¹ that the Commission will not be making recommendations in regard to the regulation of alcohol and tobacco. This point attracted strong comment. It was highlighted that these two drugs are legal, the most widely used, and lead to the most harms for individuals and society and that a 'first principle' review such as this should include alcohol and tobacco or wait until it can. It is time for the outdated moral argument for the licit/illicit distinction of alcohol and tobacco from other drugs to be addressed.

Does Prohibition Work?

Do we need to experience a paradigm shift? A paradigm shift occurs when the current theory stops working or answering the questions. Does prohibition work?

Prohibition has been in place in most countries for many decades. Despite this however, drug use continues to rise in New Zealand and around the world. The United Nations 10 year goal to eliminate all drugs globally by this year, 2008, illustrates that prohibition does not work. America's 'war on drugs' has not worked. New Zealand's position is one that supports human rights and endorses an international position for harm minimisation. Any Act related to drugs and their misuse should at least reflect this position.

More Grist

The Act must continue to include and overlap the health system and the justice system unless drugs are made completely legal. Decriminalising the use and possession of drugs has the possibility of reducing many of the harms. The number of people who are criminalised could be reduced. It is suggested that shifting misuse from a criminal focus to a health focus and with harsher restrictions in place to control supply, more people would seek treatment. During the thrill seeking and experimental stages of adolescence there would be more opportunity to reduce ongoing contact with criminal groups using diversion to treatment rather than incarceration or punitive consequences.

(continued page 4)

(Misuse of drugs act continued)

If drug use was decriminalised it could also be expected that parents with young children would be more likely to seek treatment earlier. Parents, particularly mothers, can be fearful that their children will be removed from their care or that they may be convicted or imprisoned if identified as using an illegal substance or that they will be judged harshly because of an addiction to an illegal substance.

Over all the stigma of addiction treatment is likely to be reduced if misuse of drugs is placed in a health and treatment framework rather than a criminal one.

The Mill

No one is saying that these are the answers; they are just ideas for solution focussed dialogue. Let's Debate and discuss these gnarly issues, not just go with the status quo because it is less time consuming or cost effective. At Addiction Treatment Leadership Day, over coffee, during Cutting Edge and LOAD meetings around the water cooler, in the tea room, are all ideal forums in which discussion can take place, make notes send them off to the Law Commission: com@lawcom.govt.nz

Allison Bennett 04 9144834 Val Sim 04 9144814

Web sites for more information are: New Zealand Drug Foundation <http://www.nzdf.org.nz/>; The UK's Transform Drug Policy Foundation <http://www.tdpf.org.uk/>

1. <http://www.lawcom.govt.nz/ProjectGeneral.aspx>

Impressing the CEO

By Ian MacEwan

So, you want to know how to impress your CEO. Well, here are some guidelines extracted from an overseas AOD NGO staff manual: The impulse which often comes to the inexperienced staff member to ask the CEO what to do recurs more often when the problem is difficult. You will succumb to it only if you do not know your job. It is your job to advise your CEO what he ought to do, not to ask him what you ought to do. He needs answers not questions. Your job is to study, write, restudy, and rewrite until you have evolved a single proposed action – the best one of all you have considered. Your CEO merely approves or disapproves and then your views become his views simply by signing his name. Do not worry your CEO with long explanations and memoranda. This may result in more work for you, but more freedom for the CEO. This is as it should be.

Yes, yes, yes, I want to be a CEO.

Elm Tree Lodge

Elm Tree Lodge is a unique community facility that operated for 35 years, offering a safe environment for people addressing alcohol or other drug problems. After closing in 2005 due to a lack of funding, this community house was officially reopened on 30 May and plans to be open to residents by mid-July.

The Right Honourable Jim Anderton officiated at the opening. The Elm Tree Lodge trustees thanked him for his commitment and support in retaining this house for the people of Christchurch. They also thanked The Canterbury Community Trust, ALAC, Te Rito Arahī, Salisbury St Trust, the Christchurch Alcohol and Other Drug services and the past residents, staff and trustees of Elm Tree who had all participated in finding ways to retain this service.

The service will be open for referrals in Mid July for:

1. People who have completed a treatment programme and seek aftercare
2. People engaged in treatment either at a day programme or similar
3. People who have completed detoxification and await the next stage of treatment e.g. waiting for admission to residential services.

The House philosophy will have components of a therapeutic community with house traditions; rituals around caring for the house and stocking the house, shopping, cooking and cleaning rosters. Residents will be encouraged to take responsibility for their own recovery, to follow through on their care plan, and will be supported through this by a Community Support Worker.



Elm Tree Lodge

ALAC's Pacific Spirit Conference: Winds of Change 8 - 9 May Auckland

By Carol Randal, Alcohol Drug Helpline, Training coordinator

Arriving at the Mangere Centra to a wonderful buzz of delegates and live music, I had no inkling of the rollercoaster of laughter, tears and inspiration I, as one of few palagi present would ride for the next two days.

A Youth Symposium held the day before, brought remarkable and moving drama and song to the conference. Tears were shed as this talented, insightful group of young people portrayed the tragedies occurring in families and communities through alcohol abuse.

The mantra of the conference was the chant 'me no change, you no change, me no change, nothing change'. Representatives of most of the islands of the Pacific were present, and content focused on why there must be change in the community's approach to alcohol and drug use, and consequently, to treatment programmes.

ALAC CEO, Gerard Vaughan welcomed and acknowledged dignitaries from Oceania, introduced the Pacific Reference Group (PRG) and outlined how thinking in respect of alcohol in pacific communities has moved, as a result of the feedback from PRG. Issues are not just about the individual; a strengths-based approach is best; abstinence is a valid choice; as is harm reduction and identification of the specific needs of Pacific people.

Su'a William Sio, MP, emphasised that with 30% of the Pacific population aged less than 14 years, focus must be on the role of youth as the leaders of tomorrow. He challenged youth to dream big dreams.

TUPU, the pacific island treatment service of WDHB, showcased their assessment/process tool, the matalafi matrix, in dramatic form. Keynote speakers, psychiatrists Frances Agnew and Siale Foliaki, Barrister Sandra Alofiavae and Youth Worker Allan Va'a were interviewed by Pale Sauni, a gifted facilitator and with extensive knowledge of the AOD and MH sector.

Multiple messages (too numerous to mention all) came from the workshops; there are many methods of working in the AOD field, one size does not fit all, core family values need reinforcement, fathers need to be more emotionally available, research counts – without it the dollars don't flow, leadership is the mantle – not a position, the way to leadership is through service, education and treatment services must be experience and evidence-based.



I left the conference with my palagi head full of song, hope, the wisdom of others and enormous respect for the realism, skills and commitment of the participants and their willingness to confront the challenges they face in their communities.

Disclaimer and Contact Information

Connections is the official newsletter of the Alcohol Drug Association New Zealand, funded by the 6 South Island DHBs.

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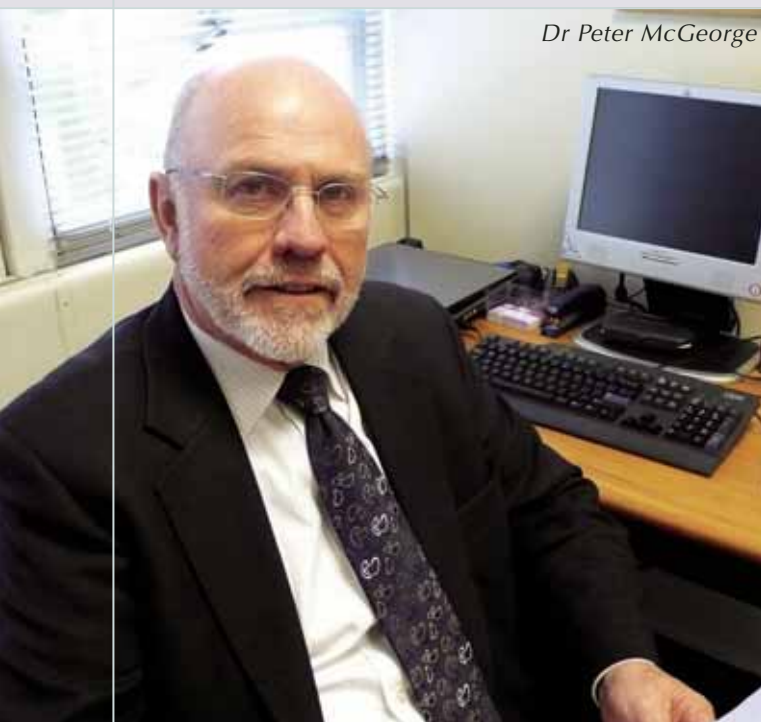
Office Address: Level 1, Latimer View House, 215 Gloucester Street, Latimer Square, Christchurch.



New Commissioners for Mental Health Commission

Peter McGeorge, Ray Watson and Bice Awan have been appointed as Commissioners. Each appointment is for three years.

Peter McGeorge has been working part-time as the Chair Commissioner since January 1 2008, replacing Ruth Harrison who finished in the role at the end of December 2007 and has been confirmed as Chair. His position is expected to become fulltime later this year.



Dr Peter McGeorge

Dr McGeorge is a child, adolescent and general psychiatrist who has extensive experience in the development and delivery of mental health services in New Zealand and Australia.

Ray Watson brings extensive clinical, leadership and governance experience within the health sector, particularly mental health. His iwi affiliations are Kai Tahu and Te Atiawa. Previously chief executive of the Ngai Tahu Development Corporation and chief executive of Lakeland Health in Rotorua and Taupo, Mr Watson has also held a number of senior management roles at Lakeland Health, Canterbury's Healthlink South Mental Health Services, Otago's Mental Health Services, and at Cherry Farm Hospital.

Ray Watson



Bice Awan also brings extensive leadership and governance experience. She is currently the chief executive of the Skylight Trust, an organisation that provides support for children facing all kinds of change, loss and grief, and she has more than 30 years of involvement in the public, private and consulting sectors in the United Kingdom, Canada and New Zealand.

Bice Awan



The Mental Health Commission's General Manager, Selwyn Katene, welcomes the appointments.

The Commissioners set the Commission's strategic direction, confirm its annual work priorities, monitor its compliance and manage its finances and any business risks that may arise.

The term of the Commission was due to end in 2007 but has recently been extended under the Mental Health Commission Amendment Act 2007 until August 2015.

The future for Consumer Services

Anna Taylor, Team Leader Consumer Services.

Both in New Zealand and overseas we are seeing a growth in the development of consumer services, in particular peer support and advocacy services. It could be argued that current treatment options and drug policy do not adequately address the needs of AOD users and society as a whole. As a result consumer services fill a gap, attempting to ensure that consumers have their needs met, providing a voice for families, and advocating for change.

The consumer team in Christchurch is proving to be a valuable addition to the AOD workforce and one which has yet to reach its full potential. Comprising of two advisors and the addiction advocacy service it offers consumer participation to treatment providers as per standard 9, with advocates offering peer support and advocacy to address a wide range of issues impacting on client's treatment.

The emergence of new substances requires the AOD sector to be flexible, creative and innovative to meet the needs of substance users, both problematic and recreational. As well as more widely contributing to reducing the harm associated with AOD use for family/whanau and community.

Consumer participation is crucial to service development. Within the workforce, consumers offer personal experience, drive and enthusiasm that is hard to match. They offer peer representation and advocacy at a level that is not achievable by professionals employed in treatment settings.

Services delivered by consumers provide checks and balances for the sector, illustrate need and respond to new and ever changing drug scenes. In order to survive these services must work with and be supported by the mainstream AOD sector and government policy. The future success of this workforce is dependant on financial support, training initiatives and a commitment to best practice.

This area of consumer services and workforce development will grow with support and dialogue from within the sector, respecting difference with the knowledge that one size doesn't fit all.

"Big Picture" The vision for Consumer Advisory

By Marc Beecroft and Margaret Bates
South Island Regional AOD Consumer Advisors

The vision of the South Island AOD Consumer Advisors is to ensure effective consumer participation in all AOD treatment services by establishing strong regional consumer groups. These groups are in place and are flourishing. It's time to take consumer participation a step further and develop Consumer Groups within Services.

Marc Beecroft



As Regional Advisors we want to work directly with service providers to develop these groups and their leadership. These consumer groups must have a meaningful relationship with the service and we need services to take the lead in supporting their development. Services could:

- Identify potential leaders for the consumer group
- Develop a terms of reference for the group's function and relationships within the service
- Develop a job description for the group leader
- Provide access to suitable training for the group leaders
- Provide financial support for the group leader to perform their role.

This is about upskilling the next generation of consumer leadership in a constructive and collaborative way. New skills and knowledge opens the door for individual consumers to expand their sense of self and what they have to offer their family and community. It provides the service with the potential for innovative practice based on the personal experiences of those whom they are there to serve.

Advocacy and Peer Support Services

By Nikki Smith, AOD Consumer Advocate

There are a number of initiatives that I think the Addiction Advocacy Service could do to further develop, or take a leap of faith with: The peer support aspect of what we do is in its infancy. I think it's crucial that we create a base for consumers to come to, discuss ideas and get involved. In effect I guess I'm talking about a drop in centre – but something far over and above the sharing of copious cups of coffee on a defunct couch. There are consumers out there who want to run support groups but need some backing to do it – that could be us. There are people who have learnt a wealth of knowledge about recovery that want to share it with others who're filing in behind them – do it at our place. I'd like to see us have a hand in supporting consumers to up-skill themselves so that they can act autonomously and pursue their ambitions – so we need someone on board to organise some meaningful training for those who want it.

So I think ideally our service needs to be a stand alone, consumer driven service in order for this to happen. A peer support hub and an advocacy service. Speaking of which, one of the things that I'd like to see is for us to actively advocate for people who are currently using but not seeking treatment. We are all aware of discrimination that people face everyday particularly those with addiction problems. We all need advocacy at some point in our lives whether at the doctors, hospital, WINZ; the forums for advocacy and peer support are endless.

Peer services have the 'know what it's like' credibility. People may not be ready for detox or rehab but may be ready for harm minimisation and in all areas of life secure housing, correct benefits, safer AOD use to name a few. Peer support allows for this flexible approach and incorporates mentoring and relationship building which can bring about positive change.

As a final thought, it'd be useful if we could clone our service so that consumers from all over the country can get the support and advocacy that they need and deserve.

Diary Notes:

INVOLVE 08: Relate:

'Quality relationships and young people'

2 - 4 July, 2008

Michael Fowler Centre, Wellington, New Zealand
Details www.involve.org.nz

2008 International Addiction Summit

10 - 12 July, Melbourne, Australia

A Climate for Change - Advancing Theory, Research, Policy and Practice in Addiction and Post-Summit Professional Development Workshops. Information and online registration are available at: www.addictionsummit.org

Alcohol and Other Drug Related Brain Impairment

1 - 3 September, 2008, Melbourne, Australia

Visit www.arbias.org.au or www.bia.net.au for information. Alternatively, email events@adf.org.au or telephone +61 (03) 9278 8137

Cutting Edge 2008

4 - 6 September, 2008, Christchurch

<http://www.chmeds.ac.nz/departments/psychmed/treatment/conference.html>

1st Global Conference on Methamphetamine: Science, Strategy and Response

15 - 16 September, 2008, Prague, Czech Republic

More info <http://www.globalmethconference.com/>

2008 Joint Conference with the Travelsafe Committee of the Queensland Parliament and the Australasian College of Road Safety

18 - 19 September, 2008, Brisbane

Submit an abstract go to the following link for info brochure <http://www.acrs.org.au/srcfiles/ACRS-Seminar-Qld-Feb-08LoRes.pdf>

Mental Health events

Mental Health Foundation Calendar of events web address <http://www.mentalhealth.org.nz/page.php?p=47&fp=6&sp=>

