dapaanz
fostering excellence in addiction practice

BULLETIN

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Tuhia ki te rangi
Tuhia ki te whenua
Tuhia ki te ngakau o nga tangata
Ko te mea nui
He tangata, he tangata, he tangata
Tihei Mauri Ora

We hope you are all safe after a very shaky and stormy time. Our aroha to those who have been affected.

We are still buzzing from the 21st Cutting Edge 2016 conference – Celebrating Transformation. It was a great opportunity for the addiction sector to network, gain fresh inspiration, learn about innovative thinking and practice in addiction intervention and to develop skills. This year, we had an excellent line up of speakers, and with Professor David Best as a real highlight and setting the scene for a strengths-based approach to celebrating recovery. This bulletin has a major focus on the conference, so check out the articles. You can also go to our website to check out the audios of David Best, Mike King and Ian MacEwan.

To help foster excellence in addiction practice, we have begun providing regional workshops so that members have good, skills-based and accessible training. Keep an eye on our website for training opportunities or contact us if you have a particular training need in your region. We are currently offering training in working with trauma (in partnership with Matua Raki), ethics and boundaries and co-existing problems. We are also happy to discuss other training needs.

Please check out the 'notice board' for other important dapaanz updates.

If you would like to submit anything in the bulletin please send to sue@dapaanz.org.nz with 'bulletin' in the subject line or contact me on 04 282 1809 to discuss. We are committed to providing a place where your voices are heard, where issues are raised, where controversy is explored and your excellent work celebrated.

Don't forget if you are in Wellington – pop in and see us at Level 5, 342 Lambton Quay (in the AMI Plaza).

Nga mihi
Sue

Consumer Story

My experience of suboxoned

By Sammi

Recently I made the decision to contact the Opioid Treatment Service (OTS) about getting help with an opiate addiction that I have been struggling with for a number of years. My aim was to remove the illegal element of my addiction and to stabilise my use and life.

I struggle with anxiety and this has been a driving factor in my drug use. I had been using methadone and substituting alcohol and other drugs when I didn't have enough methadone. I wanted to go on a small, regular dose of methadone as it is the drug I have regularly used and am already aware of how it affects me. The doctors and clinicians said I was a good candidate for suboxone and explained that it was a better drug in the way that people usually experience a clear head and there is little risk of overdose which is a risk with methadone. Also, they said it would be a quicker process becoming established on it (titrating), and that OTS were more comfortable giving takeaway doses so there would only be a three month period of zero takeaways as opposed to six months for methadone. I agreed to start suboxone.

On day one, I went into the OTS and was given 2mg and told to come back in two hours – I was then given another dose. The aim with suboxone is over three days to increase it until a therapeutic dose is achieved (when the patient is stable and the craving and physical withdrawal symptoms of the opiate are gone).

On the second day my dose was increased in the morning first and then again two hours later. On the afternoon of the second day I was feeling tight in the chest, shaky and speedy. I had a bad night with little sleep and elevated anxiety. I was also very nauseous.

On the third day the clinicians put these symptoms down to my dose being too small and increased it. I felt okay for the first hour or so but then started to feel extreme anxiety, tightness in my chest, was very shaky and emotionally on the verge of a panic attack. I discussed this with the doctor and she suggested that it may just take a bit more time to stabilise.

I went home and continued to feel mentally and physically bad. The plan was for me to pick up my dose from the chemist for the next three days. I woke up on Friday morning feeling very unwell and questioning if suboxone was going to be right for me. I was so freaked out by my experience from the previous days that I decided to not pick up the suboxone and that I wouldn't

be continuing with it. I kept thinking the effects of this drug are worse than methadone withdrawal and I would rather hang out than continue with suboxone!

The following Monday I was started on methadone, which so far has been a positive experience. My anxiety has reduced because I'm not always worried whether I will be able to get enough methadone to cope and feel well. I have also managed to reduce my alcohol consumption which was one of my aims. I feel that now I don't need to constantly worry about sourcing, paying, rationing. I have time and energy to focus on enriching mine and my family's lives.

The 21st Cutting Edge Conference

This year's Cutting Edge conference was held in Rotorua, 7-10 September. The theme 'Celebrating Transformation' highlighted transformative practice for individuals, families, organisations and communities.

Around 470 delegates attended from across a wide spectrum of addiction-based roles, including practitioners, managers, policy makers, researchers, service users and peers. Delegates gathered to hear of new practice and research findings and to network and share ideas about what works in transforming the lives of people affected by addiction.

Session One – Professor David Best

Recovery as an issue of social justice and social inclusion

We were privileged to have Professor David Best, Professor of Criminology in the Department of Law and Criminology at Sheffield Hallam University and Associate Professor of Addiction Studies at Monash University, Melbourne. He gave two keynote presentations (and a Saturday workshop) around the importance of group connectedness to recovery.

On Thursday 8 September Professor Best's topic was Recovery as an issue of social justice and social inclusion.

He argued that recovery is a fundamental marker or measure of a society. How inclusive and re-integrative societies are around marginalised populations and people in recovery indicates the wellbeing of the community as a whole.

At the heart of his message was that the recovery process is individually driven but collectively determined. Its success depends upon a series of concentric circles that includes people's networks, their communities and social structures.

Existing research

The average duration of a journey from first use to stable recovery takes around 27 years. This means there are many opportunities for early intervention, harm reduction and change.

Someone's first use of a psychoactive substance first occurs typically between 10-13 years of age so there's a huge window of opportunity (four-five years) for change before people experience significant problems which typically happens around age 20 or 21. Within another eight-nine years they begin to engage with treatment services.

The next critical window is the first five years of abstinence. The chances of someone relapsing is between 50 and 70 percent within the first year of abstinence but if they maintain sobriety for five years, that likelihood drops to around 15 percent.

"In fact, we can judge the quality of a community by how well it treats, integrates and restores its most stigmatised and excluded."

This developmental pathway model is known as the multigenic theory, but Professor Best said we need to combine it with what we call the social-genetic model because we now understand that recovery happens not within people, but between people. It's an inter-personal phenomenon and few successfully do it alone.

He said there is overwhelming evidence for three things that are essential to recovery. First, housing is fundamental. You cannot recover without a safe place to live. Second, people who go to mutual aid groups do better than people who don't and the more actively they participate, the better they do. Third, peer-delivered interventions are highly effective.

"So, society must come up with ways in which a person in recovery can be reintegrated and connect with groups around them. In fact, we can judge the quality of a community by how well it treats, integrates and restores its most stigmatised and excluded," he said.

"And that is where the ideas of social justice and social contract become important. It is not just down to the person trying harder. It is down to everybody to be the champions of reintegration."

Professor Best quoted Johann Hari who wrote in Chasing the Scream that the opposite of addiction is not sobriety. In fact it's human connection.

"The ultimate pathway to recovery is connectedness and the ultimate goal of every drug and alcohol worker is to help people find meaning and a positive identity not based on stigma and exclusion."

"You are better off having addicted people in recovery in your community than people who have never had an addiction problem in their lives."

He spoke about the recent Glasgow and Birmingham Recovery Studies, in which he was involved, and which showed that two things most affecting recovery were how much time people spent with other people in recovery and how much meaningful activity they did together.

Recovery is not a zero-sum game

Professor Best said that what may surprise some is that people in recovery actually achieve better quality of life scores than those who have never been addicted.

"Of people in active recovery in the UK, 79.4 percent actively participate in their local community. For the general public that figure is just 39 percent. So people in recovery are more than twice as likely to be active community connectors. You are better off having addicted people in recovery in your community than people who have never had an addiction problem in their lives.

"So the purpose of recovery is not to get people back to where they started. It's to get them to a positive growth point where they become an asset to the community. And this is not achieved by one 45 minute session every fortnight where clients have magic dust sprinkled on them.

"Studies show mutual aid groups work because they lead to better coping skills, stronger motivation, better general friendship and better support. And through positive change in their social networks people gain access to social opportunities they would never have had before."

Stigma

In 2013 an American study (Phillips and Shaw) looked at a social distance measures and found people who were actively addicted and people who were in recovery were more stigmatised than the other two groups in the study: obese people and smokers.

A similar study by Sheffield Hallam University also looked at the stigma around certain groups and found there were only slight differences in acceptance of groups who were in recovery (e.g. child sex offenders and drug/alcohol users) meaning that the average person finds it difficult to believe in recovery and the possibility of social reintegration.

Professor Best therefore challenged the audience to carry the message far and wide that recovery really does take place and that it's fundamental that we increase pathways of reintegration.

"These people need 'collective recovery capital' – the professionals, systems, structures and processes that will enable reintegration. This includes access to jobs, houses, specialist treatment etc. These are the areas in which society either excludes or re-integrates people."

Informal social control

Belonging to groups doesn't just promote a sense of positive identity and change. The more people are bound into pro-social groups, the bigger the price they will pay for breaking their rules, values and norms. Professor Best said this is called 'informal social control' and that it becomes a significant positive and protective factor.

"The extent of a person's recovery will depend on the access they have to social support and the access that social support has to broader community connectedness and values.

"So the role of the addiction worker is first to build the required basic skills such as self-esteem and coping, and then to link people in with champions, mentors and peer guides who will in turn link them into positive community assets."

Session Two – Professor David Best

Recovery and social identity

On Friday 9 September Professor Best's second presentation looked more closely at what being a member of a group means to people in recovery. He said that as a person's identity and how they present themselves changes from an excluded identity to something more positive they begin engaging with the world as a different type of person – and this is as much about the group as it is about the individual process of change.

"With their roles, values and norms groups provide a new lens for looking at the world and the more a person immerses themselves in the group the more value that group has for them."

He said the sense of belonging groups provide is critical to psychological wellbeing.

"We know group belonging decreases feelings of isolation and helps build self-esteem. But the more, and more diverse groups you belong to, the better. In fact studies show it's better for your long-term wellbeing than anything else you can do, including stopping smoking or drinking. So this is hugely important."

Professor David Best (second from left) with Cutting Edge attendees Suzy Morrison, Nathan Frost and Vanessa Caldwell

Not all groups are equal

Professor Best said homelessness and addiction studies now show that not all groups are equally good and that groups with no access to social resources or positive status and wellbeing are detrimental to quality of life and health.

"The amount both society and an individual value a group will determine how well it will contribute to self-esteem and quality of life."

He also said it's important to note that those belonging to a wide range of groups had better social outcomes than those just belonging to one type of group such as a 12-step programme.

> *"The strongest predictor we have of how people change their substance use after leaving a therapeutic community is the extent to which they have changed from an addict identity to a recovery identity."*

"What works for a 12-step programme such as Alcoholics Anonymous is not turning up for meetings. It is active participation and immersion in the group that works. The more central you become in the group, the more you will abide by its rules."

The social identity model of recovery

There is a typical tipping point post treatment when people have what's called a 'torn identity'. Part of them is being pulled back to their using friendships and networks and another is looking positively towards the future. So Professor Best said one of the most important things a clinician can do is provide access to groups and networks that will help tip that balance, and assertively engage them with the pro-social group.

"One of the important things they will become exposed to is the role model who is experienced with recovery who serves as someone a person can aspire to be like. These role models serve as bridges that will help get people over that tipping point."

He said the strongest predictor we have of how people change their substance use after leaving a therapeutic community is the extent to which they have changed from an addict identity to a recovery identity.

"So what we've hypothesised is what we call a 'transitional identity'. We don't want people to be professional long-term 'recoverers'. What we want is for people to transition to normal everyday aspirations. Recovery is a powerful identity to have but it shouldn't be forever. We would worry about people who are still attending 90 meetings in 90 days after 10 years in 12-step programmes because they haven't done that transition to 'normal identities'."

Social networks and recovery

Professor Best discussed a Melbourne study he is involved in that is mapping social identity change among 150 young people in specialist treatment, following them through their treatment and back out into the community. The aim is to measure their social connectedness and belonging.

People were asked to map out the groups they belonged to and to classify the people in those as either active/problematic users, occasional/recreational users, non-users or people in recovery.

"What our pilot found was that there was a sort of 'penny drop' moment as people realised just what their social networks looked like and were able to identify the groups that were likely to have a detrimental effect upon their recovery. It was helping people realise what they had to do in terms of their social networks."

> *"Those who tried to isolate themselves, getting rid of their using friends but not replacing them, suffered massive declines in psychological health and wellbeing."*

He said those who are socially isolated need to be positively asserted towards recovery-focused groups and people engaged in multiple heavy-using groups need to be moved away from them, even if they include family – which they often do.

In a second study of 309 individuals entering one of five therapeutic communities in Australia, the primary groups identified at the start of the study were family groups and using/drinking groups.

"One purpose for the study will be to monitor how things change for these people during their therapeutic community time and beyond. Will there be a correlation between those who continue to associate with those groups and with extent of relapse?

"What we have found from a recent Youth Cohort Study of 150 young people in Melbourne was that those who return to their old networks relapse, almost exclusively. To fit in with a social network as a young person you will engage in their behaviours.

"Those who tried to isolate themselves, getting rid of their using friends but not replacing them, suffered massive declines in psychological health and wellbeing.

"Only those who maintained the same number of groups they belonged to but transitioned from using groups to non-using groups had significant reductions in substance use and offending."

Professor Best concluded by saying that, irrespective of any individual interventions you do, the world is fundamentally social and the groups you belong to will have at least informal rules about what it is acceptable to do, and they will largely determine how you interpret the world and yourself – and how well you recover.

You can download recordings of these two presentations at: dapaanz.org.nz/cutting-edge-celebrating-transformation-

The hidden epidemic in Australia – a family's perspective

We were also privileged to feature as a keynote speaker Kim Ledger, Australian businessman and father to the late Oscar-winning actor Heath Ledger.

On Thursday 8 September Kim told the audience he was here through Scriptwise, an organisation founded in Australia to raise awareness around misuse of or addiction to prescription medications. Kim is the Patron of Scriptwise.

He said Australians and New Zealanders share a common history and culture, for example as ANZACs and in terms of sports such as rugby, cricket and netball. But the other thing we have in common is high rates of misuse of or addiction to prescription medications. Australia has some very basic statistics around this, while it seems New Zealand has very little data, and that needs to change in both countries.

"This is a broad-based problem and it's completely non-discriminatory. It's almost a sub-culture. It's frightening and damaging; ruining families, relationships and work environments. It can destroy business performance and it fills it out hospitals," he said.

Statistics

In Australia in 2012, 83 percent of all drug-related deaths involved opioid prescription medications. In 2011 overdose deaths in Australia exceeded those killed on the roads. Between 1992 and 2012 the number of units prescribed increased from half a million to 7.5 million, with a 32-fold cost increase to the Government in terms of subsidies. Between 2002 and 2008 there was a 152 percent increase in Australian oxycodone prescriptions alone.

In a recent Australian survey, 65 percent said they would tell their GP about an addiction to opioids or prescription medication, but 13 percent said they wouldn't speak about it to anyone at all.

"Twenty-five percent of Australians admit to using opioids every month and each year we lose more than 450 people to prescription drug use. It's difficult to track, monitor and understand. There's a lack of awareness and education and it can happen to anyone. In fact I had no idea that someone could die through using these substances."

Heath

Kim said Heath had been constantly active from his childhood into his early adult years.

"He thought he was bullet-proof and this sort of thinking can lead to absolute brilliance in young life, or to unmitigated disaster.

"If I can save just one life or change the direction of one life by bringing this matter to the fore then I will have done my job."

"The weeks prior to his passing he was in perfect health but then he caught pneumonia filming night shots. One night when he really needed to sleep in preparation for a meeting the next morning he took Ambien tablets in combination with his prescription medication for pneumonia. Nine hours later he was dead."

Kim learned of the death through news reports. In fact, everyone else seemed to learn of it before the family did. And the world went crazy around them with reporters and press vans and chaos in the street so that they felt like they couldn't catch a breath. It was months before the madness abated and the family could begin the grieving process.

But Kim says that though their situation was unique, there are many families facing the same bewilderment about the death of their seemingly healthy child from mixing prescription drugs.

"So now in my role as Patron of Scriptwise I talk to multiple families who face same personal tragedies. If I can save just one life or change the direction of one life by bringing this matter to the fore then I will have done my job."

Stigma and speaking out

He said there's a stigma attached to prescription medication where people fear they will be labelled junkies or be seen as having no worth or willpower.

"Well, we'd like to say to all of you who know somebody in this situation or maybe you're heading towards that situation yourself, that there is no silver bullet or magic fix. But you need to be compassionate with these

Kim Ledger with dapaanz Executive Director Sue Paton before speaking at the Conference

people. It is a disease and a medical problem. You need to encourage these people to speak out about it to their friends and family because so many are reluctant."

At the same time he said doctors need to be educated about the dangers of prescription medications and the new drugs that are available that may provide a pathway to help people through the situation and slowly come off their addiction. He'd also like to see some sort of real time monitoring in place which allowed doctors to see those who might be "shopping" for prescription drugs.

Another thing he said is that perhaps a proportion of the vast amount of money we spend retrospectively around the world trying to fix the problem could be spent starting to educate kids about this.

"From my own business experience I can tell you that kids coming through to the learner driver centres are best educated from the backseat of the car. They're like sponges soaking up what their parents do behind the wheel. The same thing applies where we start to talk about prescription medication at the lowest level and allow the kids to almost re-educate their parents through the next couple of generations.

"But the most important thing is to get it out into the open and discuss it. Heath was a beautiful boy, but there have been too many beautiful children lost this way."

Dr Denise Blake

Residing in no man's land – transforming adoption landscapes

Another keynote speaker on Thursday was Dr Denise Blake from the School of Psychology at Massey University. She spoke about adoption's important relevance to addiction treatment and began by describing a little brown-skinned girl who typified the many problematic stories of adoption.

This little girl was placed with a white family and raised to be somebody she was not. At night she had to listen to the alcohol-fuelled parties and each day she had to sweep the floor because there was no vacuum cleaner. She began sniffing glue at 13 and ended up living on the streets taking serious drugs.

"I have been privileged to have heard many similar stories as I've written a PhD on the social practices of closed stranger adoption in Aotearoa, which is where a child is placed in a family that is unknown," Dr Blake said

There were 12 participants in her research. Nine were Pakeha and three were Māori. They came from a variety of economic backgrounds and 10 had problematic alcohol and/or drug use at some stage in their lives.

Context of adoption in Aotearoa

Dr Blake gave a quick overview of how we have come to this problematic position with adoption.

After the Second World War, men were coming home from the battlefields sterile because they had contracted sexually transmitted infections or been injured. Women were having babies out of wedlock as there was no contraception and to be born illegitimate was a fate worse than death. Inevitably the Government encouraged adoption which would redeem the mother and protect the child from her 'immoral influence'.

"There's no language for telling people what it's like to not know the blood that runs through your veins or to yearn for a mother you don't even know really exists?"

But the people taking the babies wanted to be sure their emotional and financial investment would be protected and that the birth families couldn't reclaim the child. So in 1955 the Second Aotearoa Adoption Act was introduced

which advocated closed stranger adoption. All birth history was permanently sealed as if the child had been born to the adopting parents.

This meant the child's identity was instantly transformed to that of the adoptive family and these children were now living a lie in terms of who they were. One research participant described this as like "having a big fat secret hanging over her head". Most spoke about feeling second best in comparison to others.

As time went on it was found that adoptees were over-represented in prison and clinical populations with alcohol and drugs being implicated in both. Specific disorders included attachment problems, struggling to form relationships, fearing rejection, not knowing who you are and feeling like you don't belong.

All adoptees have been found susceptible to adopted child syndrome, which has symptoms such as pathological lying, theft, arson and disregard for others. Fortunately not all develop it.

Often, when the justice system deals with these people their symptoms are acknowledged, but rarely is the fact that adoption is a contributing issue.

No man's land

Dr Blake said No man's land describes the adoptee's experience of feeling they belong nowhere and to no one.

"You are considered the same as non-adopted people so there's no language for telling people what it's like to not know the blood that runs through your veins or to yearn for a mother you don't even know really exists?"

As Aotearoa New Zealand came of age, however, adoptees and interested parties began lobbying Government over the human rights violations of constructing somebody to be who they weren't. This led to the 1985 Adult Adoption Information Act which enabled adoptees to apply for their original birth certificate. But there was also a veto clause meaning any interested party from either family could refuse contact.

"Despite this, reunions became possible – but they are necessarily complex experiences. Sometimes the siblings are excluded because the birth mother doesn't want them to know. Birth mothers can be carrying deep emotional guilt and sometimes there's finding out that you are a product of rape. There is no manual to help navigate these emotionally charged reunion relationships.

"So, how do adoptees negotiate a world of belonging nowhere and standing in-between? They numb the pain."

As one research subject said, "Alcohol and drugs were the only thing that gave relief, and this led me down a particular path."

Another said, "Cannabis use was about retreating, but alcohol was about destruction." He wanted to destroy himself because he didn't feel like he belonged anywhere. One more said, "Alcohol and drugs provided a sense of completeness that had eluded me all my life."

Coping

Dr Blake encouraged those working with adoptees to understand this and provide a way for adopted clients to transform their experiences.

"I use the metaphor of hybridity, the grafting of one plant onto a different root stock. That's a bit like adoption, grafting one person into another's family tree. A person can be both adopted and from a birth family.

"This approach allows adoptees to claim their place on the margins and to take up strategies of acceptance. A hybrid transformational space recognises just how amazing adoptees are.

"We've got to give adoptees the tools to cope with the problematic identities and the complex relationships; to have something to hold on to as they find their sense of place; to negotiate their experiences in healthy ways as we work with them to heal and minimise the pain."

Dr Blake said her research goal was to encourage those in positions of power, such those in the sector, to recognise that adoption problematically transforms people's lives; to understand that alcohol and drugs are a way to cope with a compromised identity; and to understand how legislated and social histories shape who we are.

She went onto describe her story of struggle as an adoptee and particularly identified the importance of having a counsellor who "believed in me before I believed in myself."

Dr Blake said health professionals who understand the implications of closed stranger adoption for people who have been subjected to this social practice can enable adoptees with alcohol and drug problems to unpack the relationship between adoption experiences and alcohol and drug use to help heal experiences of dislocation and loss.

Ian MacEwan

How to fall in love with your client and not lose your job

On Friday the conference was privileged to hear from keynote speaker Ian MacEwan, addiction practitioner and former Executive Director of dapaanz. Ian gave sound advice, from his own knowledge and experience, about the ethical complexities that accompany addiction treatment – especially when feelings for your client are involved.

A young woman is referred to a practitioner working on his own. She has a history of coercive and disturbed behaviour and demands sex of the practitioner – threatening him with false disclosure to Police and media if he doesn't agree. In a state of panic, he complies. He tells his supervisor who supports him and encourages him to take it to his professional organisation. The association deliberates and decides to take no further action. Is this right?

After providing this example Ian said that addiction treatment is among the most values-based of all professions.

"Typical ethical dilemmas for us involve circumstances where clients' confidentiality rights clash with our duty to protect others from harm; or our desire to protect clients' rights to self-determination clash with our duty to protect a client from self-harm. Other issues include responding to clients' gifts and social invitations; managing 12-step meetings we and a client both attend; and managing boundaries when we and our clients live together in small communities," he said.

> *"This is about the time when someone new to the profession discovers what a strange occupation it can be!"*

"We and our managers must be concerned about the risk management implications of our ethical decisions and actions – and particularly the possibility of complaints

alleging professional misconduct. It is not a trivial risk. Indeed there is an industry arising consisting of lawyers who will assist people in laying complaints on the grounds that optimal treatment has not been delivered."

Confidentiality

"A bus driver has been referred to you because he was found impaired by alcohol at work, He makes the decision with you to be abstinent. Meanwhile his wife had gone to another practitioner saying he is still drinking and that he is violent. She is frightened and doesn't want the practitioner to disclose why she has come to the service. The practitioner breaks confidentiality and calls you.

"What do you do with that information?" Ian asked.

"A client comes in and says they have raped somebody. Do you go to the police? Well, no, because as practitioners we are bound by confidentiality. This is about the time when someone new to the profession discovers what a strange occupation it can be!"

Ian said the only time we can breach confidentiality is when a client threatens to do something that could harm someone else but that this ethical boundary line needs a lot of care and thought.

"What if they're threatening to embezzle money or defame somebody in an inflammatory blog post? What if that somebody is your colleague?"

But he said being a treatment practitioner was not all about rules and boundaries. There are also the domains of outcomes and values.

Outcomes and values

He said treatment is all about outcomes which are an ethical issue.

"Are we making a difference and can we see positive change? Are we doing what we're trained to do or are we doing what the evidence tells us works?

"It's important because the sector is being increasingly exposed and questioned; again, often with the help of lawyers. This is why we must be careful that the treatment we provide is sound, effective and evidence-based."

Ian said Values is another area of ethical behaviour in our field.

"Should we be satisfied with just helping clients to deal with the effects of their addiction? Or should we be striving to heal clients' damaged spirits, helping them regain their soul and vitality?"

> *"The relationship with the client is magical and intimate when engagement works. The most important thing we have to offer is ourselves as people – more important than our skills and knowledge."*

He said that while therapies like Cognitive Behavioural Therapy are emphasised in our training, they may not be enough for the many clients presenting with more complex, trauma-based issues we are increasingly seeing today.

"These people do not respond well to six or eight weekly 45 minute sessions. So this is an ethical issue. Of course

treatment is compassionate but all too often it is too brief and too temporary."

When feelings occur

So what should we do when we fall in love with our clients? Ian said this is not really something addressed in current training.

"The relationship with the client is magical and intimate when engagement works. The most important thing we have to offer is ourselves as people – more important than our skills and knowledge – so we should not be surprised if emotions become aroused. It's not common, but having feelings for your client can occur."

But he said this is not a cause for shame and it doesn't mean you've somehow become de-skilled. However, what you do with those feelings is vital – and that's to do exactly what you tell your clients to do. Talk about it. This should probably first be done with your supervisor, who should be your ally and champion.

"You will also have to talk to your line manager at some point because you're going to need a strategy for transferring that client to someone else. Line managers should also be supportive and understand that this is not a cause for shame. And if you don't have a supervisor or line manager find somebody, such as a colleague, with whom you can talk about these important things."

Then what?

Ian said there's not a lot of wriggle room. A romantic relationship with a client is too much of a breach of client practitioner boundaries and we have a duty of care to provide protection and focus them on treatment goals.

"Sometimes a practitioner will give up their job and set up life with their client. Perhaps there have been times when this has worked but I haven't seen it. The roles of practitioner and client cannot be combined. What if the client relapses? What role will the ex-practitioner play then?"

Ian finished by addressing the sector's need to foster a culture where practitioners who make mistakes are supported and not condemned. Mistakes should be seen as an opportunity to learn.

"It distresses me that sometimes staff are punished or dismissed for relatively moderate boundary breaches when there could have could have been better ways to deal with the situation.

"Making mistakes and not being excellent are not unethical. However, we do have a moral obligation to do our very best for our client; to be diligent, reliable, careful, prepared and informed."

The inner critic

One of the last keynote speakers at the conference was Mike King, once well-known as a Kiwi comedian, but who now travels the country sharing his personal story of addiction and working to help youth embark on their own positive journey in life.

The problem

Mike started by saying the number one driver of addiction, anxiety, depression and suicide is not fear, pain, poverty or trauma. In fact it's the inner critic; "that little voice in our head that drives us mad".

Mike's journey through drug use and mental health problems started with self-esteem issues at school, mainly due to self-perceptions around his appearance. He'd have constant conversations with the inner critic in his head and these were almost always about what other people were thinking of him.

"I used to look at the positive kids in the room who seemed to have everything I didn't have. They had friends, were always laughing and had wonderful gatherings. I thought it would be so cool to be popular like that, but the inner critic constantly assured me I would never be good enough to fit in with them."

But Mike did become popular when he discovered he was naturally funny. His ability to entertain allowed him to join the popular crowd, but he said this was Day One of his downfall because he began basing his self-esteem on the approval of other people.

> *"Alcohol was a game changer for me and it's a game changer for most people who have addictive personalities. It gave me three things I didn't expect..."*

But Mike says the popular crowd soon became bored with his jokes and started using him to make fun of other kids so they could have a laugh at their expense.

"I knew this was wrong, but I couldn't stop myself because the alternative was being kicked out of the group. So I did it. My biggest fear then, and it's the biggest fear of our children today, was to be isolated.

"The irony is I knew these kids didn't like me, but I didn't care. I'd rather be with a group that didn't like me than be sitting inside my own head beating myself up for being a loser.

"It's the same reason women often don't leave violent relationships. The alternative is worse, and that is the power of the inner critic – telling you how useless you are, that you're never going to amount to anything and that no one likes you."

By the time he was 13 Mike says there was a war going on inside his head and a war going on in his life. Money was tight and there was constant friction at home – except for on Friday and Saturday nights when there'd be friends over and the alcohol would flow. Mike began to associate alcohol with fun.

"Alcohol was a game changer for me and it's a game changer for most people who have addictive

personalities. It gave me three things I didn't expect. It gave me false confidence; it numbed the pain of criticism; and, most importantly, it shut the conversations up in my head."

He said living with those voices is like being in a room with a crying baby and the only way to stop the baby screaming is to get drunk.

"It gives you a little break from yourself, but unfortunately, when you wake up in the morning the baby's crying even louder and you've got a headache. Of course the only thing that gets on top of this again is more drink."

So by the time he was 17, alcohol was no longer freeing Mike from despair. In fact it was driving him deeper into it. That's when the other drugs started in what he calls his relentless pursuit of temporary happiness, and the downward spiral continued.

The solution

Mike said that if as a young person he'd been able to open up about his insecurities with the significant adults in his life; if he'd not been forced to hide behind that staunch 'harden up' Kiwi attitude; if it had been okay to talk about his problems with his significant adults; then he might have been saved.

"But because I had to hold onto my problems I was an alcoholic and drug addict for 30 years. The best part of my life, including my three kids when they were young, I don't even remember."

> *"We've got a young generation coming up now who are getting their self-esteem through the approval of other people, and these are the most likely candidates for addiction."*

According to the Ministry of Health 20 percent of our population will have a major depressive episode at some stage of their life associated with addictive behaviour. But Mike said the sad thing is that 80 percent of those people will never ask for help.

"They won't ask for help because they're worried about judgement and what other people will say. They're worried about job prospects and looking weak – everything associated with what other people think.

"This is what drives the inner critic, what forces us to push the loved ones away. I don't want to appear weak so I'll put on my mask."

The Government currently spends 1.4 billion dollars on mental health and addiction services but Mike said 80 percent of that money goes on the 20 percent of the population who have a problem. However, no money is spent on the 80 percent who have no idea what mental health or addiction issues are, but whose judgemental attitude has the greatest effect on the 20 percent.

"So I think we need to start working with society, encouraging people to open up and talk about their problems. This should already be happening at least in intermediate schools; creating empathy and arming our young people with tools to open up and talk.

"We need to normalise having problems and stop telling our kids off when they make mistakes. Mistakes are normal and if you want your kids to talk about their problems, you need to start talking about yours.

"We need to be the role models. We've got a young generation coming up now who are getting their self-esteem through the approval of other people, and these are the most likely candidates for addiction.

"Resilience comes through making mistakes, and kids can only learn from their mistakes if we give them permission to make them."

Article

Removing Barriers to Recovery / Hepatitis C Treatment

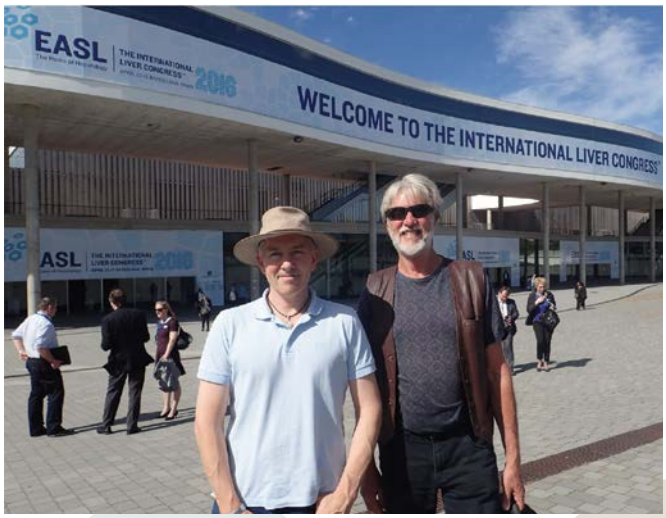
By Naomi Wickens

In New Zealand about 50,000 people have chronic hepatitis C (Hep C). Only 50 per cent of these people are aware they have the virus. Between 60 per cent and 70 per cent of those infected with chronic Hep C will go on to develop chronic liver disease. (Hepatitis Foundation NZ)

In June 2016 Pharmac announced that they would be funding two new treatments for Hepatitis C. These are two of the new direct acting anti-viral medications (DAAVs);

- Harvoni for those with severe liver disease
- Viekira Pak (for those with genotype 1 (there are 5 other genotypes)

57% of diagnosed New Zealanders have genotype 1 which leaves 43% of people with no treatment options currently funded by Pharmac unless they have severe liver disease. (Pharmac June 2016).



James Freeman (left) and Greg Jefferys, founders of the Fix HepC Buyers Club attending and presenting research findings at the 2016 International Liver Congress in Barcelona.

By proving the generic DAA treatments to be as successful as branded treatment, Dr. James Freeman defined a clear role of generic medicines in Hepatitis C treatment area.

Although this is a significant advance in New Zealand a lot of people will not qualify for treatment; they do have the option of access to generic medication rather than waiting for Pharmac funding.

The reason that the treatments are restricted is the cost of the drugs. The global pharmaceutical company Gilead Sciences is charging exorbitant prices for medications that can be produced cheaply. Gilead is charging $1000 a tablet for Harvoni when the actual cost is $1 a tablet. As a result of this over charging, India has produced generic versions of the medications at a fraction of the cost and with exactly the same outcomes.

Costs of DAAVs around the world

- Canada $80,000
- US $94,500
- UK $39,000
- Europe $50,000
- India $900

There are about 150,000,000 people who suffer from Hep C in the world; it is a huge global health issue. The new medications are extraordinary in their effectiveness with cure rates over 90%. Gilead could have been the heroes in the story but their name is now vilified and associated with massive corporate greed.

In Australia the Fix HepC Buyers Club was established based on the model shown in The Dallas Buyers Club, set in the mid-1980s concerning HIV medications (starring Matthew Mconaughey). The Fix HepC Buyers cub aimed to streamline access to the new medications, at affordable prices and including quality control measures. Generic medications were sourced in India and Bangladesh. Many New Zealanders are choosing to use this Buyers Club to access the generics rather than wait for Pharmac to fund more treatments. The New Zealand Hepatitis Foundation now endorse the generic medications acquired through reliable sources, a further significant step in New Zealand.

If your doctor is negative about generic drugs despite all the evidence that they are getting exactly the same result, find another doctor. Remember the whole process is legal; you are doing nothing wrong.

The first step is to register for the Redemption e-trial which you will find at this link:

http://fixhepc.com/getting-treated/how-to-do-it/buyers-club.html

Hepatitis C and OST Services

There are over 5,000 people in NZ on OST programmes. The majority of these people have chronic active Hepatitis C. A number of these people are 'baby boomers' born between 1945 and 1965 and have had the virus for up to 40 or 45 years. These clients have often failed earlier treatments for Hepatitis C and were put off treatment altogether due to severe side effects. They resigned themselves to languishing with Hepc for the rest of their lives and have become so inured to the effects of Hep c they accepted this as their 'norm'. Now that there is a cure it is really important that these people begin treatment as soon as possible as delaying treatment places people at risk of liver disease. OST services should assist their Genotype 1 people to be ready to start treatment from 1 October when GPs are able to prescribe it.

For those with genotypes 2 to 6 and any person wanting to explore their treatment options information needs to be given about the generic medications so that they can, in discussions with their doctors, make decisions about the most appropriate treatment for them.

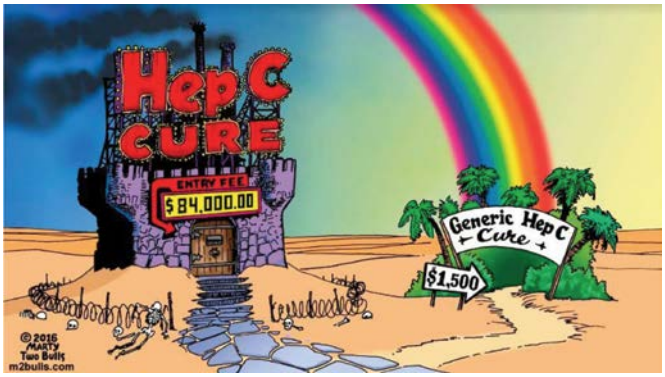
Check the files and ensure that people have had a fibro scan, a viral load, genotype testing, complete blood counts and liver function tests. Check that your current medications do not interact with the new treatment at this link: http://www.hep-ruginteractions.org/checker

There are no restrictions applied to people who inject drugs as they are a priority population for Hepatitis C treatment. Injecting drug use should not be a criterion for restricting access to the new medicines. Basic harm reduction practise around not sharing injecting equipment is important.

As the medication is taken about the same time every day for three to six months, a good reminder system is recommended (e.g. pill boxes marked with the days, a blister pack or an alarm on a cell phone. Some people may be happy to take their medication with their Methadone or Suboxone at the pharmacy.) For those on Suboxone there are potential side effects to be aware of.

Older OST people are now presenting with a myriad of other health problems, some linked to Hepatitis C. Living with a chronic illness leads to depression, lethargy, poor motivation and, if they experienced the brutal earlier treatments, a cynical attitude towards mainstream health services. In addition, the stigma attached to Hepatitis C becomes internalised and people living with Hep C may have lower self-worth and have reconciled themselves to living with HepC. As people recover from the effects of hepatitis C they are in a much stronger position to review their OST treatment and more energy and motivation to consider change.

Not everyone has a computer or access to one. Not everyone is confident navigating websites. Consider having a password protected computer available for people to use to register with the Redemption trials and



to order their medications through the Buyers Club. Ensure people have the following information:

- blood tests to confirm active hepatitis C infection (PCR Positive)
- genotype (strain) you have
- Fibro scan results
- Viral load
- Liver Function and full blood count
- A prescription from a New Zealand Doctor or specialist.
- You need approximately $2300NZD. Borrow from a family member, put it on a credit card, discuss with Work and Income, get a month's work; do whatever it takes!

Personal Experience of a cure from HepC

A friend attended a presentation on the new direct acting anti-viral drugs in March 16. She encouraged me to look into treatment. I thought oh here we go again another round of some horrible drugs with horrible side effects and wasn't keen. I found my way to the fixhepcwebsite and soon changed my mind. I learnt about the Buyers Club in Tasmania and about Greg Jefferies and Dr James Freeman. I rushed out and got the Dallas Buyers Club DVD and watched it. I checked out the process on the fixhepc site and registered for the Redemption Trial.

I needed a New Zealand prescription to start the process. I was worried about being able to get this and expected my GP to say I need to see a specialist. To my surprise he had just read an article in the Lancet about the new drugs and was all for it. However, he did want specialist oversight. I had a long standing specialist appointment the next week. I had not met the specialist before and he was amazing. He said I will open and close your file because this script is all you need from me.

So I walked out with a script feeling happy. I scanned and emailed the script to fix hep c and then booked a phone appointment with a doctor attached to the Buyers Club based in India. This doctor asked a bunch of questions about my general health history, and if I had any questions. Basically he said I was good to go. I then transferred $2300NZD to the fix hepc bank account and was told to expect the drugs to arrive within 2 weeks or so.

I was given a tracking number and was able to track the parcel from India to Singapore to Auckland then to Wellington. A week later there was a knock at the door and a courier handed me the parcel. I burst into tears and then I took a tablet. It was so easy.

Other than a surge in energy during the first few days I had no side effects. I had a blood test on day 6 and the

viral load in my blood had dropped from 1.3 million to 480. By four weeks it was undetectable. Twelve weeks after the end of treatment it remained undetected; this means I am officially cured (sustained viral response).

After living with Hep C for about 40 years, this was life changing. I have more energy, do not get as tired, and can do more in a day than I had been able to do before many years prior to treatment. A lot of people describe it as a fog lifting; and this is how I felt. I still get tired, but it's a normal tiredness, as opposed to a crushing exhaustion.

The ease with which I got access to the meds was extraordinary. It was almost as easy as walking into a pharmacy. It is lifesaving treatment; saving the country untold money by avoiding transplants and severe liver disease down the track.

All the contact I had with the Fix HepC Buyers Club was positive. The doctors share a compassionate and ethical regard for human life and could not have been more helpful. Australia may not get everything right when it comes to their Kiwi neighbours but they got this right.

Anyone born between 1945 and 1965 should be tested for Hep C

Part four – OST Perspectives

Another perspective

By Nathan Frost
Special Projects Advisor

New Zealand Society On Alcohol & Drug Dependence

This series of articles present OST consumer perspectives and provide a vehicle to influence and inform critical thinking and best practice in OST in NZ. If you've had experiences as a consumer of OST you'd like to share, please email me at nathanfrost@nsad.org.nz for an interview

Recently published New Zealand guidelines for OST practice, '....strongly endorse a path that moves away from a maintenance-treatment model and towards client-led, recovery-focused treatment.' (Ministry of Health. 2014. New Zealand Practice Guidelines for Opioid Substitution Treatment. Wellington: Ministry of Health)

Despite this, the OST consumers interviewed for previous articles in this series have talked about their experience of OST services as functioning primarily within maintenance dose dispensary roles. These consumers felt services failed to fully understand the importance of supporting their wider physical, emotional and social needs. Jane's story of receiving little real backing from her service provider when deciding to count down off suboxone (both during the count down process and in the early first days, weeks, and months opiate free) raised contentious issues around an OST service's duty of care in providing- when requested- supportive pathways out of opiate dependence. But, there is another group of OST consumers who experience real benefits from remaining on maintenance doses of opiate substitution. This article focuses on what client-led, recovery focused treatment means to them.

For this interview I am talking with 45-year-old small business owner Dave. Dave contacted me for this interview because he felt his experience of OST was completely different from the stories shared so far. It is likely that his perspective is one shared by many other OST consumers. Dave, who has no interest in getting off methadone, felt it was really important to have his story heard.

What were the circumstances that led you to seek out opiate substitution treatment?

I started using hard drugs in my early twenties - you know like shooting up morphine and home-bake that kind of thing- and for me I loved the way it made me feel. It was like the best antidepressant in the world and I remember thinking to myself after that first shot, where have you been all my life! And so I plunged head first into a love/hate affair with the gear. I loved the way it made me feel but I hated what I had to do to get the money to score.

Fast forward ten years and I'm fresh out of jail for the fourth time, using again and I know that if I carry on like I am, I'll be back inside in no time. So I hauled my arse into the clinic and got on the programme.

How long have you been receiving OST?

I've now been on the programme for 12 years, best thing I ever did. Methadone has given me my life back. Today I run my own successful business, pay taxes, and raise a young family. I can't remember the last time I've had any dealings with the police, its just been so long since I've had to walk in that world.

How has your experience of OST services been?

Well it has gotten better over the years but I'd be lying if I said I didn't have some serious problems with the clinic in the early days. I was sick of the junkie world, I went on methadone to put some distance between me and that world. But then you're forced to get your script once a month from the clinic, forced to turn up at short notice for random urine tests, its this constant message that you're a drug addict who needs to be under the thumb. And you see people you don't want to see in the waiting room, its that constant reminder you know. And even worse, you have to drink your dose in front of the pharmacist every bloody day for months. And again, you see people you don't want to see and there's deals going down that sort of thing. Even after I got takeaways I still had to go to the pharmacy three times a week. Its

impossible to make plans to travel anywhere or have any kind of flexibility in life when you're tied to your local pharmacy like that.

The other thing I had to deal with in the early days at the clinic was a doctor's insistence that I was depressed and needed antidepressants. Well of course I was depressed I was fresh out of jail, my life was shit and I had another habit which I was fuelling with behavior that was going to get me sent right back to jail. But its always the same isn't it? Lets conveniently ignore all of those social life issues and talk about the chemical imbalance in your brain. So I got put on an antidepressant that interacted with the methadone in such a way that it turned me into a zombie. I couldn't get out of bed before midday! When I raised these concerns with the doctor I was assured it was only an adjustment period and that things would even out. They didn't! So I actually did some of my own research and found out that the particular antidepressant I was on had a really toxic contraindication with methadone. There is something wrong when you are ignored and have to undertake your own research to prove a point. Get on the methadone, you'll get your life back they said, no, you'll sleep half your life away on a toxic combination of drugs and be ignored when you speak up for yourself! Well that was my experience anyway. My mood has improved over the years on par with my quality of life.

Things got better for me when I got onto GP authority. I didn't have to go to the clinic to get my scripts any longer, and the frequency of trips to the pharmacy decreased as well because my GP trusted me with takeaways far more than the clinic ever had. My GP actually listened to me too and was interested in what I had to say about my treatment. GP authority has really helped me feel like I've created some distance from my old life. Today I go to my GP, I sit in the waiting room with all the other normal human beings and I leave with a prescription just like everyone else.

Do you ever entertain thoughts of becoming opiate free?

Yes of course. Anyone who's hooked on dope is lying if they tell you they've never thought of getting off. I've tried several times in the past, and hung out in jail too. For me I'm the kind of person who'll make my mind up and just tough it out through all the withdrawals only to get bored and think stuff it and pick up again. These days I don't really think about getting off, I've been on the methadone for so long now I can't really see any reason to go through all of that when chances are I'll decide I just want to be back on it again anyway. Its just become a fact of my life I guess.

What do you think a client led recovery focus OST service should look like?

Well everyone is going to have a different opinion on that - I mean that's what 'client led' should mean shouldn't it - a service that tries its best to meet the needs of individual clients rather than forcing a one rule policy across the board? For me recovery means stability. It means not going to jail, not sitting around in clinic waiting rooms or queuing at pharmacies in the morning with other junkies waiting to get scripts or dope. It means recovering my dignity, feeling like a normal person, and doing all those normal civilian things straight people do. Run my business, raise a family, watch my kids play sport in the weekends all of that stuff. So client-led for me means anything that makes it possible to live as normal a life as possible while on methadone without fear of stigma or discrimination. To me I am living recovery today.

Well that is all we have time for today Dave but before we go, any final thoughts you'd like to add on what OST services could be doing better for their clients?

Healthy life opportunities, housing, employment, all the things that get a person out of that narrow rut of being a junkie. The problem with drug addiction is that people get so close to the coal face they stop being able to see anything other type of life. So services that promote fresh life opportunities are essential.

Ethics and Consequences

Authors – Sierra Ryland and Amelia Goodall

At the recent annual dapaanz conference, one of the workshop groups discussed ethics and the disciplinary processes that can arise from a breach of ethical obligations, usually through a complaint from a client. Lawyer Sierra Ryland offered a legal perspective, and this article summarises the main points from her presentation.

Complaints can come unexpectedly and be costly and emotionally taxing to deal with. Knowledge of your obligations and the potential fishhooks can help to avoid complaints. It is also important to seek legal advice if you are confronted with a difficult situation or find yourself the subject of a complaint, so that it can be dealt with as smoothly as possible.

What are my obligations?

As a member of dapaanz, you are required to comply with the dapaanz Code of Ethics. This Code outlines core ethical principles, which promote respect, safety, client rights, and professional practice and behaviour.

Some of the main obligations include acting professionally and maintaining the integrity of the client and counsellor relationship. The most common complaint that we see is where the counsellor has disclosed private information to another person or agency, often inadvertently or out of a genuine concern for his or her client.

Complaint processes

When a complaint is laid with dapaanz it will be investigated and dealt with by its internal disciplinary procedure which is set out in dapaanz's Constitution.

You will be given a copy of the complaint and offered an opportunity to respond. As time frames for responding are usually quite tight, it will be important to deal with the process straight away – this means notifying your insurer as soon as possible as well and considering whether you need legal advice.

At the conclusion of the disciplinary process, dapaanz is able to make a range of orders. It can suspend or deregister a member, issue a warning, place the member on probation or issue a statement. You are able to appeal the decision.

If you also belong to another regulatory body, for example the New Zealand Psychologists Board or the Medical Council, then dapaanz is able to refer the matter to that body. These regulatory bodies are set up by the Health Practitioners Competence Assurance Act 2003 ("HPCAA"). The HPCAA provides mechanisms for dealing with "health practitioners" who are incompetent and a risk to public safety. However, the HPCAA only applies to some practitioners including psychologists, doctors and dentists.

The relevant regulatory body will have its own internal complaints procedure through which it will deal with the complaint. At the conclusion of its investigation, the body can make a number of orders as provided by the HPCAA including an order for a competency review of the practitioner, a review of the scope of the practitioner's practice, or counselling of the practitioner.

If the matter is very serious, in that the practitioner may be guilty of professional misconduct, the body can prosecute the practitioner in the Health Practitioner's Disciplinary Tribunal ("HPDT"). A charge in the HPDT can be costly to defend and may result in cancellation of the practitioner's registration. However, it is rare that matters proceed this far and in 2014-2015 there were no hearings.

Even if you are not a "health practitioner", you are still obliged to follow the privacy principles in the Privacy Act and Health Information Privacy Code. The Privacy Act governs agencies' use and disclosure of personal information. Generally, agencies (which includes individuals) are obliged to let clients see their own health information, with some exceptions; for example, where disclosure would be prejudicial to the client's physical or mental health. Refusal to disclose information without good reason, even when this information is only held in your mind, will be a breach of the Privacy Act.

The other side of privacy is of course keeping clients' health information confidential, and only disclosing it with good reason.

Breaches of the privacy principles can lead to a complaint being made to the Privacy Commissioner. The Commissioner has its own investigation process which will involve a formal response from you. If the Commissioner finds that a breach of privacy has occurred, then it will encourage conciliation between the parties usually by recommending that compensation is paid to the victim and an apology is made. While the Commissioner has no power to enforce these recommendations, if a settlement is not reached between the parties it can refer the matter to the Human Rights Review Tribunal.

In exceptional cases, disciplinary proceedings could result. For example in 2013, a nurse who illegally accessed details of a patient's pregnancy termination and then texted another person about it, was suspended from practice by the HPDT.

Advice

The various ethical and legal obligations coupled with the range of disciplinary processes that apply to counsellors can be a minefield to navigate. For example, we discussed at the workshop whether it was appropriate to take clients out for a coffee, or attend a celebratory AA meeting with them. The answer will turn on whether the client is aware that this will tell others that you are counselling them and whether your presence will have a therapeutic purpose. However, you must always consider whether your client could misinterpret your actions as something more than counselling.

It is important to seek legal advice when you are faced with a tricky situation in your practice, to safeguard against potential complaints. Legal advice at the right time can save further expense and disruption down the track. Some medical malpractice or professional indemnity policies will contribute to such legal costs.

It is also advisable to seek legal representation if you are faced with a complaint. This is to ensure that you properly respond and comply with all parts of the disciplinary process. Your insurance policy will usually cover your legal costs for this.

An insurance broker can advise on insurance products, including professional indemnity and medical malpractice cover.

For more information on health law, privacy and disciplinary issues, please contact Sierra Ryland:

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Sierra Ryland, Senior Associate, DAC Beachcroft New Zealand

Sierra is a general insurance litigation lawyer in DAC Beachcroft's Wellington office with over 7 years' experience as a commercial and civil litigator and in dispute resolution. She specialises in a number of areas including professional indemnity insurance and medico-legal defence work.

Amelia Goodall, Solicitor, DAC Beachcroft New Zealand

Amelia Goodall is a solicitor in DAC Beachcroft's Wellington office. She specialises in insurance and civil litigation.

DAC Beachcroft New Zealand is a specialist litigation and dispute resolution practice with offices in Auckland and Wellington. We focus on insurance, professional liability and the health sector.

Notice Board

Have you set up your online login?

Thanks to those who have set up their login profile on the website! It is great that we have had a good response to this. If you haven't already done so – can you please do so? Once you have set up your profile you are able to check when your renewal date and change your personal details online. It is also important because it provides us with the ability to report on anonymised demographic data of the workforce, track trends in the workforce and identify development needs.

Employer survey

We recently undertook a survey of employers to find out whether there is alignment between the dapaanz Addiction Intervention Competency Framework, employer's expectations of staff, and the professional pathways into the addiction workforce - including the dapaanz registration process. There were 54 respondents and the findings of this process will inform future developments.

Education committee

To help our members choose robust education courses we are undertaking a major proactive review of addiction courses to be listed on our website as endorsed by dapaanz as teaching to our competencies. This review is nearly complete and you can check out which courses we are currently endorsing on the website. If you have already started a course that has not been endorsed (or is still going through the process), don't worry we will honour that qualification that you have started in good faith.

Indemnity insurance

You may have noticed that there is now a box you can tick on online application and renewal forms – if you are interested in being followed up for indemnity insurance. We highly encourage you to consider this. Indemnity insurance will protect you against legal costs and claims relating to your practice. You cannot rely on your organisation's insurance to cover you and indemnifying is important step in the professionalization of the addiction treatment workforce.

Hoe Tahi Addiction Scholarships are now open!

The Te Rau Matatini, Hoe Tahi Addiction Scholarships are now open. If you are working in addiction treatment and are planning to study next year you may be eligible for a scholarship. Go to teraumatatini.com/hoe-tahi-addiction-scholarship

Fees 2017 from 1 December 2016

Category	New Applicant	Renewal
Standard membership	$110	$110
Student membership (non-salaried full time student)	$50	$50
Provisional registration	$300	$300
Registered AoD or PG practitioner	$320	$320
Associate Practitioner	$300	$300
Support Worker	$200	$200
Accredited clinical supervisor (for dapaanz registered practitioners)	$100	$100
Accredited clinical supervisor (not a dapaanz registered practitioner)	$210	$210

In the interests of quality control – dapaanz moved the supervisor renewal process to yearly from June 2016.

From 1 December 2016 those renewing will incur an annual renewal fee. You will not be required to go to annual renewal until your next renewal for accreditation is due. At your next renewal we will also be aligning your supervision renewal with your membership/registration renewal date – so that you will only need to renew for both categories once every 12 months.

Addiction Research Bulletin

November 2016

Welcome to the Addiction Research Bulletin, November 2016

Welcome to the November 2016 Addiction Research Bulletin (ARB). Matua Raki brings you this resource, in conjunction with dapaanz, offering insights into recent research activities that have relevance to the addiction sector in New Zealand. We hope the ARB will increase your awareness, understanding, appreciation, implementation, utilisation and critiquing of addiction research. Please feel free to share it with others.

If you would like to publicise an event, piece of research, award or activity, or contribute to this publication in any way, contact klare.braye@matuaraki.org.nz.

IN THIS ISSUE

This quarter the bulletin has a special focus on the Cutting Edge Conference held in Rotorua 7-10 September. It highlights the oral and poster presentations that offered research findings or perspectives. With the focus on 'celebrating transformation' and the wonderful stories shared at this event, I was heartened to hear of the multiple uses of research, providing the 'evidence' to support a local initiative or providing backing to an idea. It is always encouraging to see how research findings can so effectively inform service delivery for tangata whai ora and whānau

Cutting Edge Conference

The 2016 Cutting Edge Conference attracted more than 400 participants from across the spectrum of addiction-based roles: practitioners, support workers, service users, policy, management, primary care, public health and researchers. They gathered to share ideas and initiatives that highlighted transformative practice for individuals and families, organisations and communities.

While presenting research findings was not the primary intent of this conference, research invariably found its way into many presentations. For some this was drawing on best practice evidence to develop service delivery; for others it was exploring a modality used in one area of health and adapting it to another. Research can also be used to affirm what is 'known' or anecdotally reported, and I think David Best's presentations highlighted how research not only provides the 'evidence' too much of what we think is effective within our own treatment and community settings, but also how it offers encouragement, affirming the value of much of the mahi currently being done in Aotearoa.

The following reports offer a snapshot of the research that was presented at the conference. Further information on each of the presentations can be found by either contacting the researcher/practitioner directly or by sourcing their presentation at www.cmnzl.co.nz/cutting-edge-2016/presentations/.

Matua Raki

Recovery as an issue of social justice and social inclusion

Professor David Best; Professor of Criminology, Sheffield Hallam University, UK; Associate Professor of Addiction Studies, Monash University, Melbourne.

Social justice is a marker of a society. How we deal with the needs of the vulnerable and the excluded are indicators of social justice, and recovery (whether from addiction or mental health) is a marker of the soul of a community.

We know that recovery is a long-term journey that is often characterised by lapses, crises and a very slow process of growth. Almost nobody can do this alone and, for most people, the support of family and the emergence of new social networks are critical to that journey. Social networks provide 'social capital' in the form of both practical resources and help when the person is struggling as well as a new set of values, norms and beliefs that will help support the journey to recovery.

By transitioning from 'using' networks that themselves are often stigmatised and excluded to positive networks, the individual may find they have access to greater resources in the community. New friends and peers are able to open doors to opportunity – for houses, jobs, college courses and so on (as well as providing motivation and drive). This is what we call the social contagion or spread of recovery, where one person is welcomed into a recovery network and they in turn become part of the process of helping and giving back.

This growth helps create a 'therapeutic landscape' of recovery. The number of people in recovery grows and becomes more visible and so changes the context and the community. But this spread and growth of a recovery-friendly landscape cannot happen without the openness and acceptance of the broader community.

And this is the point about 'community recovery capital'. It is down to all of us in two ways. First, we must have a personal commitment to inclusion and we must be willing to accept people in recovery as worthy of being our neighbours, colleagues and friends. If we do not and harbour hidden views that people can't be trusted or should stick to their own neighbourhoods and networks, we are acting as barriers to recovery. The second point is that we have a duty to challenge stigma and exclusion when we see it in others.

Those in long-term recovery are more likely to volunteer and to actively support their own community than people who have never had a drug or alcohol problem –they are 'better than well'. Recovery is a huge challenge and, for those who manage it, something that we should all celebrate. It is part of a social contract that allows complete reintegration. People in recovery alone can do this, but they cannot do it alone.

Obstacles, benefits and learnings from the implementation of PCOMS

Laurie Siegel-Woodward, Problem Gambling Foundation

"Outcome measures" and "results-based accountability" (RBA) are increasingly utilised in reporting to quantify progress and service efficacy. One measure, the Partners for Change Outcome Management System (PCOMS), has been widely validated and used in New Zealand and internationally. The Problem Gambling Foundation (PGF) first implemented PCOMS eight years ago using it with 4055 clients between 2010-2014. Significant shifts in the culture of the organisation, have been experienced placing consumers' voices at the centre of everything they do.

RBA asks:

1. How can we measure whether our service users are better off?
2. How can we measure whether we're delivering services well?
3. How are we doing on the most important measures?

Multiple studies conclude that the client's perception of the therapeutic relationship is the best predictor of outcomes, and client involvement is the centerpiece of a strong relationship (Project MATCH Group, 1997; Babor, T.F., & Del Boca, F.K 2003). PCOMS was developed to measure these things with a four-question scale at the beginning and end of each therapeutic session.

PCOMS measures (Q3 above) the therapeutic relationship; how well the service is being delivered according to the service user (Q2) and change between sessions to determine whether clients are better off (Q1).

There are some obstacles to implementing PCOMS including cost, access to trained supervisors, and reticence from professionals. Ongoing training can be time-consuming and expensive. Supervisors and practitioners may have concerns that PCOMS "reduces people to numbers", that employers can use feedback against the practitioner or that excessive power is given to the client.

The benefits however are wide. For funders, PCOMS provides quality assurance. By measuring progress in every session, PCOMS identifies improvement (or not) early on, allowing for adjustment. PCOMS keeps the interventions focused on consistent goal-setting, and reduces treatment duration, encouraging discharge once the client maintains effective scores. For the organisation, PCOMS streamlines supervision and assists with service planning. Clients self-select in supervision. Those who aren't progressing are prioritised for discussion instead of relying on practitioner opinion and highlighting clients who are at risk of dropping out, self-harm, relapse, etc. Scoring trends can aid service planning noting which interventions are most effective for specific client types. Patterns within a practitioner's caseload can highlight training needs. For clients, the graphed changes in

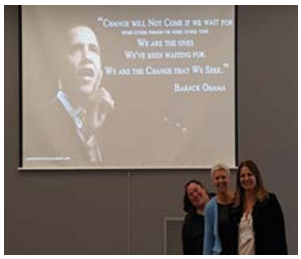
scores provide visual motivation and reflect the work done with and by them. Privileging the client's voice empowers the client as the expert.

Learnings are that implementation requires organisational preparation. There must be buy-in from the front-line to the board level. Commitment to PCOMS-specific supervision is critical. While PCOMS is not a model, it does rely on the premise that the client is the expert, which may require a clinical philosophy shift. What practitioners cite as cultural reluctance for a client to give honest critical feedback generally sits with the practitioner's own resistance.

Partnering for Outcomes Foundation Aotearoa oversees the integrity of PCOMS. With its increased use within New Zealand, service efficacy can be compared meaningfully across sectors using a common language.

This work contributed to Problem Gambling Foundation being award the Matua Raki Workforce Innovation Award

Sensory modulation: invaluable skill based tool or misuse of addiction resources?



Vicky Totua (RN, BHSc Nursing, PGdipEIM), Karen Fraser (DipPhys), Karen Henke (RN, DAPAANZ Pract. Cert & Supervisor); CADS Auckland

Sensory modulation is an emerging modality within mental health settings (Bundy et al., 2002; Champagne, 2000) in both the national and international arenas. A sensory modulation trial was commenced through Medical Detoxification Services at Waitemata District Health Board with the approval of the Community Alcohol and Drug Services Clinical Governance. Sensory modulation was available within the detox inpatient unit for clients experiencing symptoms of substance withdrawal and/or emotional dysregulation. This was used in conjunction with education-based support around the use of sensory tools within the sensory modulation room. An individual treatment approach was created acknowledging the different preferences of clients.

An evaluative audit was undertaken of client completed self-evaluation forms to determine whether sensory modulation is a useful therapy tool during medicated substance withdrawal and thus an invaluable skill based tool – and not a misuse of addiction resources. Initial analysis of results indicated a significant improvement in client mood and an increase in self-efficacy through the development of skills that assist in self-regulation.

A self-reporting feedback form was completed by 136 people after using the sensory room. More than half of these used the room for more than 20 minutes. Improved mood was noticed by 128 people, one person recorded a decrease in positive emotions and seven people recorded no change, positive or negative, in their mood. The average feeling on entry to the room was 4.4/10 which increased to 8.1/10 on exit.

This brief evaluative audit lends support to the growing area of clinical practice in the management of emotional and behavioural dysregulation within addiction settings. Sensory modulation has been implicated in regenerating natural dopamine production and decreasing distress associated with substance misuse and/or withdrawal. Further research could lead to the improvement and/or development of addiction services moving into the future and a proposal is underway to look more closely at the impact of sensory modulation within the field of substance use in New Zealand.

Vicky, Karen and Karen were recognised for their work and presented with the 'New and Emerging Researcher Award' by Matua Raki.

Management of clients with alcohol related brain injury – a literature review and suggestions for transformation and improvements to current services

S Lustig; J Mellors; J Deihl; S Dillon; M Chapman; J Simms; Community Mental Health, Addictions and Intellectual Disability Services, Hutt Valley DHB). susana.lustig@huttvalleydhb.org.nz.

The Addiction team at the Hutt Valley Community, Mental Health, Addictions and Disability Services [CMAID, 3DHB] identified that no services currently meet the specific needs of clients with Alcohol Related Brain Injury [ARBI] and no appropriate assessments, standardised treatment procedures and/or protocols are in place. There are no prevalence data in New Zealand representing this cohort. Clients with possible ARBI are often left undiagnosed, misdiagnosed or undertreated. The pending implementation of the Substance Addiction (Compulsory Assessment and Treatment) Bill provided an opportunity for the team to design a local 'Best Practice Evidenced Based Treatment Model'.

The team conducted a literature review to inform the development of a treatment model for clients with ARBI. From 11 documents gathered, three were selected based on their content and relevance: The Wicking Project, Australia (2011); The Wirral Study, England, (2011), and The Fife Pilot, Scotland (2012). Each identified a lack of available services and treatment and undertook

pilot studies exploring specialised treatment facilities, diagnostic criteria, specialised assessments and tools. Both positive and negative results associated with treatment models within hospital and community settings where identified.

This project highlighted the need for similar services to be developed locally for people with ARBI. Each study provided insights that that could best be applied in a New Zealand context, in developing a 'Proposed Model of Treatment'. A specialised service would provide a holistic approach to care using a multidisciplinary team trained in the treatment of ARBI. A poster including findings and the 'Proposed Model of Care' was presented at the Cutting Edge Conference in Rotorua in September this year.

'Where to from here' proposals for the project include: the development of a 'pilot database' capturing potential ARBI clients presenting to services and providing fundamental prevalence data; treatment outcomes; and prognosis. This data can inform local and national government initiatives to support the development of appropriate services for clients with ARBI. At the DHB service delivery level, use of standardised assessment tools will contribute to appropriate identification and diagnosis of ARBI.

Specific training in cognitive assessments is recognised as a need. At a regional level, the findings of the project continue to be presented to local management along with recommendations for suitable development of services for this client group.

Amohia e huringa (Transformation)

Takurua Tawera & Saul Waihape; Downie Stewart Foundation – Moana House Programme

Saul Waihape, with the korowai of Takurua Tawera, presented his story of recovery. Saul's kōrero from a research perspective fits a qualitative design, solidly grounded within the principles and methodologies of kaupapa Māori theory.

Saul appropriately opened his kōrero with a mihi whakatau, greeting everyone and explaining his iwi connections to Ngai Tūhoe and Ngāti Kahungunu (Kaupapa Māori research framework). Takurua (Supervisor) informed us of his designation in Te Whare Moana, as a pou whakahaere, and described how their men are, in the main, referred from Te Whare Herehere (prison). They have long offending and imprisonment histories, addiction issues, co-existing mental and physical health issues, gang affiliations, limited resources to travel to Moana House and few clothes or personal belongings. They often struggle when they first come to Te Whare Moana as they learn to realise that the kaupapa isn't punitive but rather treatment focused. It's about manaakitanga.

Saul (Research kaupapa) described being a state ward when he was one, sent to boys' homes when he was 10, and imprisoned by the time he was 17. He said prison was a way of life for him and the only saving grace he felt he had was when he participated in kapa haka and te reo Māori. He said it brought "light and pride" into his otherwise hard, abusive and violent existence. Although he became a gang member he soon challenged his leaders, resulting in charges for assault and more prison time. After his last incarceration and when the time came to look at what he was doing for reintegration the only place that would take him was Moana House. He had no expectations of Moana House, having been in the "system" for 30 years and involved in many interventions that didn't work for him.

Saul (Research intervention) reported that what assisted his transformation was not only the kaupapa Māori models used in Moana House, but also the encouragement to explore "key principles" of whakatauākī and other facets of te ao Māori to apply to his life and whānau. Saul said the therapeutic kaupapa gave him a pathway he was able to follow, understand and implement, enabling him to leave the "real dark place" he'd lived in for decades.

He said that when he returned to the community he initially felt "lost". It was different and abnormal not having an expectation that he would predictably relapse and return to prison. Saul realised he needed to receive ongoing manaakitanga from Moana House. Together they set up telephone calls, a return visit to the facility and "skype therapy". He said he's gained "heaps" from watching 'Ted Talks'.

Saul has been in the community for one year, relapse-free (Research outcome and post research). He's enjoyed being with his partner and connecting with whānau and is pleased he's taking the kaupapa he's learnt to another level to help him in his maintenance and recovery.

This is a story of transformation; a case study of resilience, recovery and manaakitanga; an example of the principles of kaupapa methodology in action.

An innovative youth focused approach to addressing addiction

Deb Fraser and Tangi Noomotu; Director and Clinical Coordinator, Whakaata Tohu Tohu/Mirror HQ

Mirror HQ presented a poster capturing the key elements from its formative evaluation report (2016). Mirror HQ is a service funded through the Prime Minister's Youth Mental Health Initiative. The evaluation verified that the service specifications have been implemented as required and that Mirror Services had established Mirror HQ as a standalone Coexisting Problem (CEP) enhanced service. Mirror HQ provides CEP AOD services for young people aged between 12 and 22 years through its multi-disciplinary and multi-skilled team.

The title of the poster was How we measure up and featured a whakatauki in Māori and English: "He hui whakatau i te mana o te tamaiti a te whakakotahitanga o nga whenua o tea o" or "Human kind owes to the child the best it has to give". This is something Mirror believes in very strongly, and it underpins the approach taken across all its work.

The team identified words depicting the service and set these in a spiral in the centre of the poster. Behind these

words are hands reaching out and helping, and reaching out for help, knowing this happens both ways. The poster has a kowhaiwhai on the side with meanings including growth and potential.

Here are some key findings from the evaluation and how Mirror aligns with best practice:

Youth friendly	Evidence based Interventions
• Youth participation in design, delivery, brand identity • Services offered in settings of higher needs • Increased mobility • Increased flexibility of service • Meeting unmet need • Contribution of peer support.	• Service is CEP capable • Individual, whānau and group interventions matched to need • Integration of culturally based interventions for Māori and Pacific youth • Connection with treatment agencies.
Collaboration and integration	**Developing the workforce**
• Coordination and integration with primary care • Discharge/transition planning to primary level services • Focus on prevention/ early intervention services • Identifying and responding to emerging youth needs.	• Frameworks used to identify CEP skill gaps • Emphasis on CEP workforce development • Cultural supervision • Clinical practice leadership to southern region • Training mentoring, support to other agencies • Contribution to sector development.

Residing in No-man's Land: Transforming adoption landscapes

Dr Denise Blake; School of Psychology, Massey University

The 'closed stranger adoption' period was legislated between 1955 and 1987 in Aotearoa/New Zealand. During this time, approximately 80,000 adoption orders constructed adoptees as if born to legally married adoptive parents. Adoptees were taken from their birth mothers, given an adopted identity and the birth history was permanently sealed. The practices of adoption were claimed to have little effect, adoptees being positioned the same as non-adopted peers.

In this way, particular adoptive experiences are excluded from everyday language that enables citizenship in a non-adopted world. While in this inarticulate space, adoptees belong nowhere and to no one; they return to their place of birth, a no-man's land, where they are neither born to the birth family, nor as if born to the adoptive family. Being raised as someone you are not and denied access to a family of origin has consequences for all.

Adoptees are overly represented in clinical and prison populations throughout the world. A plethora of research represents the psychological effects associated with the lived experiences of adoption. Some of those psychopathologies include identity diffusion, psychic homelessness, Adopted Child Syndrome and problematic alcohol and other drug use. Research largely ignores the social power relations that govern an adopted identity, instead focusing on using adoptees as a tool to theorise heritability of disease or disorder.

The Adult Adoption Information Act (1985) came into effect after years of lobbying by adoptees and other interested parties against the human rights violation of being forced to be someone you are not. This legislation overturned the strategies that prevented access to birth origins allowing adoptees to access their original birth certificates and making reunions possible. These reunions however are often highly charged and complex, and adoptees have no guidelines to help navigate reunion relationships.

This research explores the implications of adoption practices on the lived experience of adoptees and the way in which adoptees use alcohol and other drugs to cope with their tenuous position in no-man's land, the space in-between. People in positons of power, such as health professionals, need to recognise the effects of adoption and provide a transformational space in which to challenge taken-for-granted knowledge about adoptees and adoption practices within Aotearoa/New Zealand, and beyond.

Practitioners should unconditionally engage with adoptees and listen to their lived experiences so adoptees can find acceptance about the human right violation of being removed from their family of origin. Adoptees should be supported to find a way to cope with the tensions in their identity and the complexity of the triad adoption relationships. This work challenges a pathological lens that locates problematic alcohol and other drug use within the adopted subject, addresses social power relations that enable adoption practices and recognises that adoptees are truly remarkable people for living on the margins. It enables the possibility of a hybrid identity where adoptees can be both born to and as if to born so that they can move towards healing their stories of exclusion and loss.

Upcoming research event

Addiction Nurses Symposium

27 March 2017, Hamilton

The annual Addiction Nurses Symposium provides an opportunity for nurses working with people who use substances to hear about national initiatives and best practice; to share their ideas and innovations and to network with like-minded clinicians. www.matuaraki.org.nz/workforce-groups/addiction-nursing/155