Investing in addiction treatment

A RESOURCE FOR FUNDERS, PLANNERS, PURCHASERS AND POLICY MAKERS

National Committee for Addiction Treatment
(NCAT) New Zealand, 2008. www.ncat.org.nz

The National Committee for Addiction Treatment (NCAT) is the national voice of the addiction treatment sector. NCAT provides expert advice on treatment for alcohol, other drugs, and problem gambling.

Investing in Addiction Treatment. A resource for funders, planners, purchasers and policy makers.

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This document is also available on the NCAT (www.ncat.org.nz), Matua Raki (www.matuaraki.org.nz) and Te Pou (www.tepou.co.nz) websites.

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ADDICTION TREATMENT WORKS

There's no doubt that the last ten years have seen major progress in treating addiction, but there's no silver bullet, neither with drugs, alcohol, tobacco nor gambling. Addiction is a complex medico-social problem, hand-cuffed to a society obsessed with consumption. There's no one-size-fits all approach.

Professor Doug Sellman, University of Otago

Key government policies and strategies recognise that treatment is vital to minimising the harms from alcohol, other drugs and problem gambling. When addiction[1] goes untreated, there are significant costs to our society in terms of negative impacts on health, disrupted relationships, financial instability and crime.

Addiction treatment is cost-effective. Reviews are consistent in finding that most addiction treatment yields net economic benefits to society. It is estimated that for every dollar spent on addiction treatment programmes, there is a $4 to $7 reduction in the cost associated with drug-related crimes. With some non-residential programmes, total savings can exceed costs by a ratio of 12:1[2]. Addiction treatment can achieve positive effects on a number of outcome measures, including health status, criminal behaviour, family functioning, mental health and employment.

More people need access to quality addiction treatment. While there is some regional variation in the availability of specialist addiction services, it is estimated that nationally less than 1% of the population is accessing these services. In the period May 2007 – April 2008 the total number of individuals of any age receiving assistance from specialist alcohol and drug treatment services in New Zealand was 22,696 or just 0.5%[3]. NCAT's vision is that the capacity of addiction treatment services at least doubles within the next 3 years to provide capacity to treat 1% of the population who most need addiction treatment and thereby move closer to meeting targets set by government. By extending the capacity and the range of addiction treatment options, more people can access the treatment type that works for them. With a competent workforce, people can access the right treatment regardless of where they enter the treatment system.

Investment in effective treatment must be guided by available evidence. International and local research provides evidence for effective addiction treatment options. In the New Zealand context the value of ethno-cultural approaches in engaging and retaining people in treatment is well-recognised. For those with severe addiction, outcomes are improved if people are engaged in intensive treatment for at least three months[4]. Understanding motivation and working with people to increase motivation are essential components of an effective addiction treatment system.

- Addiction is often a chronic and relapsing condition.
- Addiction does not occur in isolation – mental health, physical health and social problems often coexist with addiction.
- Treatment works and is cost effective.
- The capacity of addiction services needs to at least double to enable those most severely affected by addiction to gain timely access to treatment.
- Treatment works through timely engagement.
- People can require multiple treatment episodes.
- No single approach works for everyone.
- Harm minimisation and abstinence approaches occur within a spectrum of treatment approaches for a spectrum of need.

Each person's addiction treatment journey is unique depending on their health, their relationships, the nature of their addiction and the quality of the treatment received. Evidence suggests that people gain cumulative benefit from a series of treatment episodes and that entry to treatment has an immediate positive impact.

It is essential that a range of evidence-based treatment options is readily available; that treatment is of the highest quality and that options to support early and brief interventions as well as continuing care are enhanced.

1. Addiction is an umbrella term to include alcohol and other drug misuse and problem gambling
2. NIDA National Institute on Drug Abuse 2006
3. ADANZ, source: MHINC, as at 06/08/08. NB: numbers of people accessing gambling treatment and addiction treatment provided by non-government organisations are not included
4. Effective Interventions Unit, 2004; Gowing et al., 2000

NCAT'S VISION FOR THE ADDICTION TREATMENT SECTOR

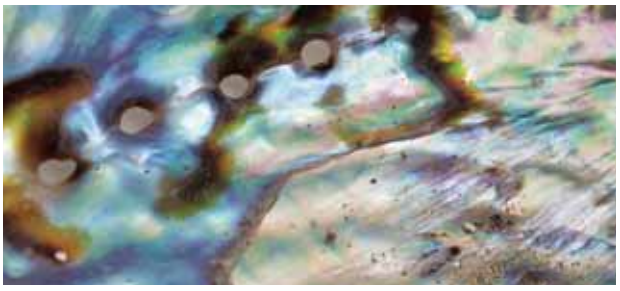
Investing in Addiction Treatment has been developed to provide planners and funders, purchasers and policy makers with an up to date summary of current best practice along with key trends and issues in addiction treatment.

NCAT's vision for the addiction treatment sector includes:

- High quality treatment that is responsive to the needs of consumers, their whanau/families, and the wider community.
- Services capable of assessing and treating co-existing addiction and mental health problems; a skilled workforce providing complementary assessments and integrated interventions.
- A broader range of services to provide treatment for alcohol, other drug and/or gambling problems and increased flexibility in combining treatment options.
- Improved access to treatment i.e. capacity to provide treatment for at least 1% of New Zealanders most severely affected by addiction.
- Readily available culturally responsive services in a range of settings.
- An addiction treatment sector that supports recovery and wellness incorporating both harm reduction and abstinence approaches.
- Strong consumer leadership in treatment planning, delivery and evaluation; a strong consumer workforce with peer support services available in every district health board (DHB) area in New Zealand.

The National Committee for Addiction Treatment (NCAT) is the national voice of the addiction treatment sector. NCAT provides expert advice on treatment for alcohol, other drugs, and problem gambling.

NCAT has a key role in linking a range of stakeholders and providing information, advice and advocacy on addiction treatment issues. The membership of NCAT reflects the work and diversity of the addiction treatment sector, including representatives of the full range of treatment, education, policy and other interests relevant to addiction. NCAT members include service leaders, consumer leaders, educators, representative groups and individuals elected by the sector. Māori and Pacific providers also have representation on the committee. NCAT has strong links with the Ministry of Health, the Mental Health Commission and the Alcohol Advisory Council of New Zealand.



Te Kōkiri: The Mental Health and Addiction Action Plan 2006-2015 (Te Kōkiri) identifies NCAT as a key stakeholder in implementing several action points relating to addiction.

NCAT strongly supports the key challenges identified in *Te Kōkiri* with particular emphasis on supporting improved availability and quality of addiction services to those New Zealanders who are affected by addiction issues.

Improve the availability of and access to quality addiction services, and strengthen the alignment between addiction services and services for people with mental illness, with immediate emphasis on:

- *broadening the range of services that are funded for substance use problems*
- *maintaining and developing responsive and effective problem gambling services*
- *building the expertise of addiction and mental health providers to conduct complementary assessments and treatment planning.*

Te Kōkiri, 2006

POLICY CONTEXT: ALCOHOL, OTHER DRUGS, GAMBLING

Key national policies recognise addiction treatment as an important strategy in the management of alcohol, other drug and gambling related problems.

> *Over the next five years the Government will continue to improve the quality of, and access to, drug treatment services. Treatment interventions are vital to the limitation of problems arising from substance use.*
>
> National Drug Policy, 2007–2012

> *It is important to ensure that services are available and accessible for those that require them wherever they may be in the country.*
>
> Preventing and Minimising Gambling Harm
> Three-year service plan 2007–2010

In recent years in New Zealand considerable work relevant to addiction has been undertaken at the policy level. Key policy statements include:

- Ministerial Committee on Drug Policy. 2007. *National Drug Policy 2007-1012.*
- Ministry of Health. 2007. *Preventing and Minimising Gambling Harm: Three-year service plan 2007–2010.*
- Mental Health Commission. 2007. *Te Hononga 2015 Connecting for greater well-being.*
- Minister of Health. 2006. *Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015.*
- Minister of Health. 2005. *Te Tāhuhu–Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan (Te Tāhuhu).*

These documents support key directions in addiction treatment including:

- More accessible addiction treatment.
- An expanded range of addiction assessment and treatment services.
- Treatment that supports the aspirations of Māori and Pacific peoples.
- Effective, accessible and acceptable treatment options for young people and their families.
- Greater consumer and family participation in treatment planning, design and delivery.
- Alignment of treatment options especially between prevention, primary care and secondary care.
- Further development of inter-sectoral approaches that address the needs of the whole person.
- Further investment in the addiction treatment workforce.

Policy requirements: range and capacity of services

Te Tāhuhu indicates that Government's interest in mental health and addiction has broadened. NCAT strongly supports this shift and anticipates greater emphasis on initiatives targeted at reducing harm from alcohol, other drugs and gambling in public health and primary care sectors, as well as a broadening of the range of services offered by specialist services.

While *Te Tāhuhu* signals a broadening of focus, Government's commitment to implementing The Mental Health Commission (1998) *Blueprint for Mental Health Services (Blueprint)* is reiterated in *Te Kōkiri. Blueprint* sets benchmarks for mental health and addiction service volumes, outlining associated resource requirements, and has guided service planning and funding decisions over the past decade. *Blueprint* states that mental health and addiction services should be available to the 3% of the population who at any given time are most severely affected by mental illness and addiction. This percentage was developed primarily for national and regional planning, and as stated in *Blueprint*, any translation of these figures for requirements at a local level must take into account the local population and its needs.

Currently specialist addiction services have the capacity to provide treatment to approximately 0.5% of the population. NCAT strongly supports the development of initiatives to at least double the current service capacity within the next 3 years.

THE NEW ZEALAND SPECIALIST ADDICTION TREATMENT SECTOR

Specialist addiction treatment is provided in approximately 150 dedicated addiction teams located within the 21 District Health Boards (DHBs) and in 16 large NGOs (some of which are Iwi services). Other addiction specialists work in general mental health, Māori health or services for young people.

There are about 800 full-time alcohol and other drug and problem gambling treatment practitioners. The addiction treatment workforce is multi-disciplinary and includes alcohol and other drug practitioners, problem gambling practitioners, nurses, social workers, psychologists, counsellors, physicians, psychiatrists, occupational therapists, cultural workers and support workers. There is also a small number of consumer and family/whanau advisory and advocacy roles.

People with lived experience of addiction form a significant part of the addiction treatment workforce in this country and the lived experience of addiction continues to inform the development and provision of addiction treatment.

The Drug and Alcohol Practitioners Association Aotearoa New Zealand (DAPAANZ) has emerged as an important professional organisation with 628 of the alcohol and other drug workforce in membership[5]. Workforce development leadership is provided through Matua Raki, the National Addiction Treatment Workforce Development Programme, funded by the Ministry of Health.

A multi-disciplinary workforce is essential to respond effectively to the diverse needs of people seeking help for addiction-related issues. NCAT supports the trend towards registration of specialist addiction practitioners. Services should be encouraged to recruit registered professionals for clinical roles, i.e. practitioners holding DAPAANZ registration or registration with other bodies such as those regulated via the Health Practitioners Competence Assurance Act 2003 and the Social Workers Registration Act 2003.

The National Addiction Centre (NAC) is one of a number of tertiary-based training centres providing training for the addiction workforce. Others include Auckland and Massey Universities, Auckland University of Technology and Wellington Institute of Technology. Moana House Training Institute also offers DAPAANZ-recognised competency-based training.

UNDERSTANDING ADDICTION

Addiction is a complex disorder that is caused by multiple genetic factors interacting with multiple environmental factors. Addiction is often a 'chronic and relapsing' condition.

Addiction is also used as an inclusive term referring to the entire range of harmful, hazardous and dependent patterns of alcohol, other drug use and problem gambling.

The abstinence to addiction continuum

Alcohol, other drug use and gambling can be seen as occurring on a continuum of "use"[6] from no use or abstinence at one end through to severe dependence at the other end. The continuum allows for different levels of treatment to respond to the nature and severity of problems, as shown below.

No use	No treatment required/ Public or population health & prevention initiatives apply
Low risk use	
Hazardous use	Likely to benefit from less intensive treatment options, need treatment but do not necessarily need specialist treatment
Harmful use	
Mild dependence	
Dependence/ pathological gambling	Need intensive, specialist treatment options

Providing a range of treatment options is vital. Different levels of treatment are needed to respond to differing levels of complexity.

Screening and brief intervention can be provided in non-specialist settings by General Practitioners, others in primary care, accident and emergency staff, social workers, community workers, cultural workers and probation officers.

People with more severe problems need access to specialist and intensive addiction treatment options for example withdrawal management, specialist case management and counselling, opioid substitution, intensive day-programmes, residential programmes and therapeutic communities.

5. Matua Raki, 2008
6. In the case of gambling, "use" can be substituted for "activity"

WHO NEEDS ADDICTION TREATMENT?

Addiction treatment services typically provide treatment for people who are moderately to severely affected by addiction-related issues.

People from all walks of life, their families and communities can face addiction-related problems. Addiction often generates despair, deprivation and crime, ultimately affecting everyone.

A major consequence of gambling was a drop in living standards for gamblers and their family/whanau. There was less money to spend on the basics, such as food, clothing and school fees. Interviewees had sold their furniture and stopped buying food. Relationship breakdowns were mentioned due to conflict about gambling, further resulting in reduced standards of living. Cheaper accommodation was often sought.
Centre for Social and Health Outcomes Research and Evaluation & Te Ropu Whariki, 2006

Those needing treatment for addiction-related issues can be at various stages in the development of their problems, from early stages through to severe dependence or compulsion. Some groups are more at risk than others of developing serious problems. Māori, Pacific people and young people are identified as experiencing greater addiction-related harms relative to others. Men are also identified as being significantly more at risk from alcohol and other drugs; gambling appears to affect men and women equally.

Co-existing mental health problems are the rule and not the exception in addiction treatment populations.

Those needing treatment often also suffer from co-existing problems in mental and physical health along with other personal, social, spiritual and economic problems, some of which can be complex and long standing.

Addiction has a ripple effect. As well as affecting the individual, problematic gambling, alcohol and other drug use can be harmful to families and the community. To illustrate: alcohol can be associated with domestic violence and many other crimes; gambling can result in significant financial hardship for a family; injecting drug use can result in blood-borne viruses spreading in the community as a whole.

- Māori and Pacific people experience greater problems related to substance use disorder and dependence. The youthfulness of the Māori and Pacific populations and their relative socioeconomic disadvantage play a key part in this.
- Māori and Pacific peoples are at increased risk of problem gambling. They are also over-represented in deprived areas in which gambling opportunities are much more likely to be located.
- Prevalence of alcohol and other drug abuse and dependence for males are around double those for females.[7]
- Overall twelve-month prevalence of substance use disorder is 3.5% but in males aged 16-24 this rises to 12.5% and in young Māori males it rises further to 22.0%.[8]
- People aged 18-24 years are significantly more likely than all other age groups to have experienced physical assault, sexual harassment, a motor vehicle accident or another type of accident as a result of someone else's drinking.[9]

7. Te Rau Hinengaro, 2006
8. Te Rau Hinengaro, 2006
9. Ministry of Health, 2007

AN OPTIMAL ADDICTION TREATMENT SYSTEM

Increasingly research demonstrates that addiction prevention, education and treatment programmes are effective in saving lives, are cost effective and contribute to reduction of crime and illness.

No single treatment is universally effective for treating addiction.

An optimal addiction treatment system includes a range of treatment options of varying intensity provided in various settings and utilising a range of treatment modalities. An optimal treatment system provides access to screening and brief interventions in a range of locations, outreach services to engage and re-engage people in treatment, "helpline" services, withdrawal management services, out-patient and community based specialist treatment, residential and therapeutic community based treatment. Culturally specific treatment options are readily accessible. Services are competent to meet the needs of those with co-existing addiction and mental health problems. Families are included in treatment and can access support in their own right. Continuing care is available. Services such as supported accommodation, peer-support and needle exchange are available.

Generally more intensive treatment should be provided for people with more severe problems. People with severe addiction problems and those who have mental and physical health problems are more likely to need intensive day programmes and residential and/or therapeutic community treatment programmes of at least 3 months duration.[10]

An optimal treatment system will provide services bases on population needs including culturally specific services.:

- Provide services based on population needs.
- Provide sufficient treatment capacity to ensure ready access to treatment.
- Address local service gaps.
- Deliver equity.
- Provide evidence-based treatments.
- Provide an integrated response to people with complex needs.
- Involve consumers in funding, planning, delivery and evaluation.

The sooner there is an intervention in the course of development of a substance-misuse problem, the more likely a positive outcome can be achieved. Also, the longer a substance misuser attends a treatment process, the better the outcome. Follow-up or after-care is a core component to sustaining recovery.

McCormick et al., 2006

'The [therapeutic community] programme may have saved my life. There's a big chance that I would have ended up inside or dead. I would have just continued to use and do crime. I would probably be living on the streets with nothing under my name, just the clothes on my back.

I was diagnosed with a mental illness, the medications didn't work well and the side effects were bad. I was also using cannabis and drinking and that was making my side effects worse. For about 10 or 12 years I was suffering because my medication was wrong. I put myself in hospital and things just went bad from there. I did burglary while I was overtaken by the drugs and ended up in court. That's when I knew I would have to do something about my life. The judge sent me to treatment and that's when things started turning around for me. All the things I'd thrown away while I was mentally unwell I had a chance to pick them up again. Like my honesty, my eating habits, my attitude. I wasn't perfect, I did play up, I did a lot of things wrong.

[Graduating from the programme] I just felt proud – like Willie Apiata! I haven't had side effects since I've been taking [the new] medication and the urge to use drink and drugs is not there any more. I just don't need it in my life any more. This is the place where it started for me, getting me back on track.' Z.

10. Effective Interventions Unit, 2004; Gowing et al., 2000. Note: research relates to residential and therapeutic community treatment

TREATMENT PHILOSOPHIES AND PRINCIPLES

Approaches to addiction treatment draw on broad philosophies that underpin aims, objectives and practice principles.

Abstinence and harm reduction: both approaches required

Abstinence and harm reduction[11] are two widely adopted approaches to addiction treatment, sometimes distinguished in theory but often blended in the treatment context. A range of treatment options is required and both approaches have their place.

An abstinence approach promotes no gambling or alcohol and other drug use, arguably the safest option. An abstinence goal is often advised for people with moderate to severe dependence. Treatment assists consumers to develop the skills to live an alcohol, drug and /or gambling-free lifestyle.

Treatment informed by harm reduction focuses on reducing harms associated with addiction, including health, social, economic and other harms experienced by individuals, families, communities and society. Harm reduction can be an effective approach for consumers with mild dependence issues or for those with moderate to severe dependence who are unable to achieve abstinence. Pragmatism is an important principle in harm reduction. Treatment is likely to focus on what a consumer is prepared to do "now", with priority given to realistic, achievable goals.

'People move back and forward along the harm-reduction - abstinence continuum which is why no one treatment is going to work for everybody. With the advent of harm reduction I learned how to use safely so managed to avoid contracting HIV. I avoided abscesses, septicaemia and other injecting related problems. And when I entered treatment for the sixth time I was able to stay on methadone for as long as it took to actually make some positive change in my life; to move away from the life of an active addict, to get into training and employment, to develop and maintain healthy relationships, to learn and put into practice new ways of living, including a period of abstinence from all drugs including alcohol, but total abstinence was never my goal.

I enjoy a good wine with dinner, I like having a beer or two on a hot summer's day - but I also recognise that for some people abstinence IS what works for them, so it's important that there are a range of services which fit along that continuum and that people can 'try out' the different approaches until they find what works for them.' S.

Family inclusive treatment more effective

Every person working in a mental health and addiction treatment service encourages and supports families/whānau to participate in the recovery of service users and ensures that families/whānau, including the children of service users, have access to information, education and support.

Ministry of Health, 2007a

There is growing recognition that addiction treatment is more effective when family members are involved. This is more than just keeping family informed and in some cases may require intensive work with a consumer's support systems. "Family Inclusive Practice"[12] is increasingly being adopted as a preferred treatment approach and it is encouraging to see this reflected in the Nationwide Services Framework. Adequate investment is required to support this approach.

Kaupapa Māori and Pacific treatment models have always recognised the family as central to the treatment process and the treatment outcome; working with family in Māori and Pacific addiction treatment services is standard practice. However, services are not always resourced on this basis.

Mental health standards emphasise the importance of involving families in treatment and working with families is recognised as a core competency. Research has shown that alcohol and other drug treatment that involves family has resulted in higher levels of abstinence. There is a need to further develop service delivery models and systems that support the inclusion of family in treatment and to provide training and support for the workforce in family inclusive approaches.

11. Also referred to as harm minimisation
12. For more information on family inclusive treatment in the New Zealand context see: Kina Families and Addictions Trust (2005) Family Inclusive Practice in the Addiction Field

Holistic and strengths-based treatment

Addiction treatment must adequately address people's needs, not just their addiction.

Increasingly addiction treatment embodies a holistic focus combined with a strengths-based approach, incorporating the strengths of the person and their family and viewing the whole person in the context of what it means to be well for them.

The importance of a holistic approach to addiction treatment has always been well recognised within kaupapa Māori and Pacific models of care.

In 2007, 46% of the frequent drug users were 'unemployed, sick or invalid'...

Wilkins et al., 2008

People living with addiction-related problems often face a range of issues including being mentally unwell, homeless, unemployed, disconnected from family and social networks and excluded from many of the activities that make up a quality life-style. Addiction services must strive to address these issues and must be resourced to do so.

"Recovery" can have a different meaning

The principles of "recovery" are acknowledged as essential to underpinning mental health care. In the addiction sector this term has been in use for decades and has its origins in the 12-step approach. In this context it is a term that for many people refers to an abstinent lifestyle within a set of beliefs and traditions relevant to the 12 steps. It is important to recognize the different meanings for the term "recovery." However, many addiction treatment consumers welcome more recent concepts of recovery and internationally there is an emerging discourse in the addiction sector relevant to this.

Developing a vision of recovery - a work in progress

- Recovery is about building a satisfying and meaningful life, as defined by the person themselves, not simply about ceasing problem substance use.
- Recovery involves the accrual of positive benefits as well as the reduction of harms.
- Recovery includes a movement away from uncontrolled substance use and the associated problems towards health, wellbeing and participation in society.
- Recovery is a process, not a single event, and may take time to achieve and effort to maintain.
- The process of recovery and the time required will vary between individuals. It may be achieved without any formal external help or may, for other people, be associated with a number of different types of support and interventions, including medical treatment. No 'one size fits all'.
- Aspirations and hope, both from the individual drug user, their families and those providing services and support, are vital to recovery.
- Control over substance use is a key part of recovery, but is not sufficient on its own. Positive health and well-being and participation in society are also central to recovery.

UK Drug Policy Commission: www.ukdpc.org.uk

'I have been using drug and alcohol services for 15 years. When I was younger I tried residential abstinence based treatment. I never really believed what they told me but took their advice of "fake it till you make it". I am glad I did because I learnt a lot, a lot of the knowledge I gained I still carry today.

I had several goes on the programme, in those days the programme was very punitive, thus, I had no relationship with the staff. I was always trying to keep one step ahead of them, always expecting the worst. The only impact any staff had on me was when they showed me kindness. This I will always remember. Later on I was put with a case manager who worked with me wherever I was at, with her I could be honest, if I had used I could tell her and together we would learn. I did a lot of growth at this time.

Now I am the captain of my own ship and my ship is sailing just fine, I have worked out what works for me, I have found the cure, and the cure is me. I have a holistic approach to my wellness, I take supplements, have a good nutritional plan, exercise, meditate, spend quality time with my friends and I go to counselling. I know where to go to if I need help, when I do go for help I expect the services to work with me where I am at, this is essential.' H.

Promoting consumer leadership and consumer participation in treatment services

The value of consumer leadership and consumer participation in the delivery of addiction treatment services is well recognised. There are two important strands to the development of the consumer workforce:

- Consumers-as-practitioners: A number of addiction practitioners have lived experience of addiction alongside their professional qualifications. This group is represented across a range of roles in the workforce.

- Dedicated consumer roles: There is scope for the continued development and maintenance of dedicated consumer roles (e.g. advisors, representatives, advocates etc) either within services or as consumer-run services (peer support, community workers, etc).

Effective consumer leadership within the addiction treatment sector is not an activity that functions outside of or in isolation from an organisation's management structure. Not dissimilar to the skill and competencies of service manager, consumer leadership can be defined by the necessary skills and ability to influence and successfully operate within an organisational structure while remaining grounded within the consumer world view.

Effective consumer leadership is a role that requires a high level of skill and proficiency and an environment that is supportive and committed to the development of the consumer workforce.

Rhonda Robertson, Matua Raki – National Addiction Treatment Workforce Development

Public health approach

Problem gambling intervention services are funded by the Ministry of Health and are informed by a public health approach.

This comprehensive approach to problem gambling aims to provide services and programmes that cover the continuum of public health (primary prevention) and treatment (secondary and tertiary prevention) services. In keeping with this, there is an emphasis on brief and early intervention and 'follow-up' in the service specifications available for problem gambling intervention services.

NCAT supports this approach and sees opportunities for further developing alcohol and other drug services in line with this.

12-step fellowships

Alcoholics Anonymous (AA), Narcotics Anonymous (NA) Gamblers Anonymous (GA) and Al-Anon (for family members) are examples of widely accessed, internationally available fellowships promoting abstinence and adherence to the 12-steps as a means to recovery from addiction.

The 12-step fellowships do not provide treatment. Groups are informal, accessible and offer a high level of mutual support, social contact and understanding between members, often complementing addiction treatment. Many consumers participate in 12-step fellowships before, during and after treatment.

MULTIPLE TREATMENTS AND COMBINED TREATMENT

Addiction treatment programmes typically provide a mix of interventions and services, rather than a single treatment. Addiction treatment is a process usually involving engagement with different treatment services, often in an episodic manner over a number of years. Easy access to treatment and well-linked treatment services offer the best potential for positive treatment outcomes.

While addiction treatment research often reports the effects of single, specific interventions, in practice, treatment programmes typically provide a mix of interventions and services, rather than a single treatment. Those using services seldom receive only one episode of treatment; some receive many treatment episodes over time.

In New Zealand the addiction treatment sector encompasses a range of treatment types and services, both mainstream and culturally specific, in primary and secondary care settings. An overview of addiction treatment interventions, programmes and modalities is provided below.

Screening and brief intervention

Simple screening is a brief process conducted to determine the likelihood that a person has an addiction-related problem, the presence of related or co-existent problems and whether there is any immediate risk for the person or others.

Screening may incorporate or be followed by a "brief intervention". Research indicates that brief intervention can be both effective and efficient for those with less severe problems. Most of the research on brief intervention pertains to primary or emergency health settings and alcohol use. Evidence to support the effectiveness of brief intervention for other drugs and gambling is emerging. Brief intervention can be delivered in a range of non-specialist settings. Where screening indicates that problems are more severe, practitioners refer on to more appropriate specialist addiction services. Screening tools for alcohol and gambling are well researched and utilised, this is less so for other drugs.

More specialised "remote information and support services" such as the Problem Gambling Helpline and the Alcohol Drug Helpline also provide effective screening and brief intervention, along with other more specialised treatment.

Specialist addiction treatment overview

Specialist addiction treatment comprises a range of interventions, some of which have been extensively evaluated, while others have received only limited attention.

Most specialist addiction treatment programmes deliver a combination of interventions. Some services target particular consumer groups e.g. young people, Māori, Pacific peoples, people dependent on benzodiazepines or opioids. Some provide support for family members whether or not the addicted person is attending treatment.

Outpatient or community addiction treatment services typically provide comprehensive assessment services, pharmacological treatment, counselling, case management and group-based treatment. The focus of treatment is tailored to the person's need and treatment is generally of varying duration[13].

Residential and therapeutic community services also provide comprehensive assessment services, counselling, case management, group-based treatment and continuing care. Some also provide life-skills or habilitation therapy. In the case of the therapeutic community, the community itself (i.e. being part of a treatment community) is a key component of the therapeutic process. People accessing these services tend to have severe addiction-related problems and may have co-existing mental health problems. Evidence indicates that effective intensive programmes are of at least 3 months duration.

Residential treatment for those with gambling-related problems is currently limited and does not need expansion. Most people who might require this level of intensive intervention have co-existing mental health or alcohol and other drug-related problems and can generally access existing addiction treatment services.

Specialist addiction treatment can include a number of treatment components and service types. These are briefly outlined on the following 3 pages.

13. Effective Interventions Unit, 2004; Gowing et al., 2000

Comprehensive assessment

Comprehensive assessment is considered to be essential to determine the best course of treatment. Targeted at those with more complex needs and those who may require specialist addiction treatment, the goal is to determine the nature of the addiction problems, and co-existing problems, including mental and physical health, spiritual well-being, family, social and cultural strengths and issues, offending and legal problems. A full risk assessment is also included.

Pharmacological treatments

The importance and effectiveness of pharmacological treatments is becoming increasingly recognised and incorporated into treatment of addiction and co-existing disorders in New Zealand.

Medications to promote abstinence or prevent relapse to alcohol use include: Disulfiram (Antabuse); calcium carbimide (Dipsan); naltrexone and acamprosate. Naltrexone is also used in the treatment of problem gambling. Medication for assisted withdrawal from alcohol typically includes benzodiazepines, such as diazepam.

Opioid Substitution Treatment

Opioid Substitution Treatment involves the prescribing of medication as a substitute for illicit opioids. Pharmacological treatment is more effective when provided in conjunction with psychosocial treatment, and this is the model promoted in New Zealand. The effectiveness of opioid substitution treatment is well established. Many consumers report significant quality of life improvements. Other outcomes include reductions in illicit opiate use, risk-related behaviours and drug and property crimes and improvements in health.

In New Zealand most opioid substitution treatment is delivered either by specialist addiction services or authorised general practitioners supported by specialist addiction services. Medication is generally administered or dispensed in community pharmacies.

Effective psycho-social therapies

A wide range of psycho-social therapies have been shown to be effective. Evidence-based psychosocial interventions include:

- Cognitive-behavioural therapy (CBT)
- Motivational interviewing
- 12-step facilitation therapy
- Coping and social skills training
- Community reinforcement approach
- Relapse prevention therapy
- Therapeutic community
- Some family-based approaches.

In practice, the delivery of psychosocial therapies is not necessarily discrete. Different therapies often share common components.

Withdrawal management (Detoxification)

Withdrawal from alcohol and from some other drugs can be life-threatening and may require specialist medical management.

Some people require a withdrawal management service, colloquially referred to as "detox" or detoxification treatment. The goal of withdrawal management is to ensure the consumer is supported to withdraw from alcohol and/or other drugs as safely and comfortably as possible. Abstinence is generally the immediate treatment goal. Withdrawal management is not effective on its own in producing long-term abstinence rather it constitutes a first treatment step for those who require it.

Withdrawal management services are provided in a range of settings and with or without medical management. Services can be provided at the consumer's home (e.g. a specialist addiction nurse co-works with the person's GP), in a dedicated community facility, in a dedicated in-patient facility or in a general hospital. Some services utilise complementary therapies such as mirimiri and rongoa during the course of withdrawal.

Assessment and a plan for withdrawal management should be included when people are being admitted to mental heath and general hospital services. Many addiction treatment services can provide consultation and liaison to other health professionals to assist this.

Relapse prevention

Relapse is a significant issue for all addictive disorders.

Relapse prevention is an effective component of treatment and aims to teach people how to identify, anticipate and manage problems and situations that may lead to a relapse. Most specialist addiction treatment incorporates relapse prevention as a key treatment component. It is also an important part of self-management once a person disengages from treatment.

Continuing care (after care)

Continuing care involves providing support so that the gains made in treatment are not lost.

The importance of continuing care is widely accepted in recognition that consumers face a high risk of relapse in the period immediately post-treatment. Continuing care can include relapse prevention, support groups and individual support for those wishing to maintain the changes they have made in treatment. Access to education or training, advisory services, peer support and social networks and employment support may be included.

> *Whether the treatment modality entails abstinence or substitute prescribing, and whether the client enters it via healthcare or criminal justice mechanisms, reintegration into a productive lifestyle will require the availability of services to offer education, training, employment opportunities, the availability of secure accommodation, and the chance to restore positive social relationships with families.*
>
> Stevens et al., 2006

Continuing care is essential for those leaving treatment, finishing a community sentence or moving between the community and custody. There is a need to strengthen links between addiction treatment and other services for example, housing/accommodation providers, employment providers and providers of other health and social services.

Kaupapa Māori addiction treatment

Research increasingly supports the proposition that barriers to engaging and retaining Māori in addiction treatment are reduced by provision of dedicated Māori services.

Kaupapa Māori addiction treatment is consistent with wider aims and aspirations of Māori development in that it is concerned with whānau ora not just symptom relief or management. Addiction treatment based on and within a Māori cultural paradigm may utilise a range of different models, some indigenous to New Zealand and others not.

Kaupapa Māori addiction treatment options have been steadily developing based on evidence that treatment programmes and interventions that are firmly based on Māori beliefs, values and experiences can increase access and retention in treatment. Likewise there is increasing awareness of the efficacy of such programmes.

Such treatment integrates cultural and clinical processes and elements, taking a holistic view of consumers in the context of whānau. Generally, treatment is underpinned by acknowledgment of inter-related elements of wairua, hinengaro, whānau and tinana as fundamental to optimum health and wellbeing for Māori. Optimally kaupapa Māori services are developed, delivered and evaluated by Māori, supported by kaumātua and mandated by manawhenua/iwi kainga.

Kaupapa Māori is a frame of mind and way of working that is congruent for most Māori. Clients of other ethno-cultures may choose to access such services. Treatment is provided in a range of settings and in ways that acknowledge and respond to the variety of experiences of contemporary Māori.

> *Kaupapa Māori is whanau, family, hapu, the ability to connect to a marae, whenua, moana, the chance to be Māori, think Māori, before the system devalues our heritage beyond our grasp. Kaupapa Māori services are about an ancient way forward not a forward way back.*
>
> Jeanette Katene, Kaiwhakahaere, Rangataua Mauriora.

Pacific approaches to addiction treatment

Diversity is a defining characteristic of the Pacific population in New Zealand. The term 'Pacific peoples' encompasses a number of Pacific Island nations and communities who are linguistically, culturally, and geographically distinctive from each other[14]. Young New Zealand-born Pacific people are a growing group with higher levels of need.

Pacific addiction services are underpinned by Pacific values and incorporate Pacific approaches to health and well-being. Service provision is holistic, i.e. inclusive of spiritual, physical, emotional and mental dimensions. Essentially, treatment reflects Pacific ways of thinking and doing. This includes a strong focus on family and recognising the importance of relationships with self, God, family and community, use of Pacific languages and integration of Pacific cultural practices.

In the Pacific services we work from a holistic viewpoint. Cultural awareness and connectedness of staff, family and client (working together) is vital. We use approaches that come naturally to us as Pacific – spiritual, prayer, music and song, story telling - this allows us to engage and connect with families, through our therapeutic intervention. Allowing families to pray (religious beliefs) and bring their spiritual healing through Matua (cultural advisors within the family and/or service) is fundamental for Pacific peoples.

Josephine Gray, Team Leader, Tupu Alcohol and Drug/Gambling Pacific Services

Services for young people

Half of all men aged 18-24 years, and one in three women aged 18-24 years, had a hazardous drinking pattern.

Ministry of Health, 2008.

Addiction treatment for children and young people is an emerging area of treatment. Most treatment for young people with alcohol, drug and gambling issues is provided in community settings that are of varied nature and with varying workforce capabilities. There are some young people's community-based intensive-day programmes and residential treatment programmes and some young people receive addiction treatment through mental health teams.

Research suggests that holistic, strengths-based treatment that incorporates a person's natural social environment, including family, works well with young people. Multi-systemic therapy is an emerging intensive treatment modality.

There is good evidence that a family-based approach to the treatment of a young person with substance misuse can be effective. This approach is an intensive intervention and requires considerable resources and time. Nonetheless, such approaches are well validated and have been associated with significant cost savings in families with complex and multiple problems.

Frye et al., 2008

Development of more accessible and effective addiction treatment options for young people is a priority as is development of addiction treatment skills in other health, justice and education workforces.

The key issues identified for AOD [alcohol and other drug] services are:

- A lack of clarity on whose responsibility it is to provide AOD services for children and youth, which leads to gaps in access
- A lack of AOD services for children and youth
- A limited recognition of AOD issues in mental health services
- Limited awareness of the extent of and appropriate interventions for comorbid mental illness and substance use disorders
- Limited understanding of the extent and nature of the problems of fetal alcohol syndrome in New Zealand.

Ministry of Health, 2007b

14. Cook Island Māori, Fijian, Niuean, Samoan, Tokolauan, Tongan and Tuvaluan peoples are the seven main ethnic groups in the Pacific community in New Zealand

TRENDS IN TREATMENT NEEDS

Co-existing problems

Te Kōkiri signals the need for a concerted response to address disparities in access to services for people with both mental health and addiction-related problems. The way forward is to strengthen and resource the mental health and addiction workforces and to plan for integrated services and contracts which include requirements to treat co-existing problems.

New Zealand research indicates that the rate of co-existing psychiatric disorders in a representative sample from Community Alcohol and Drug Services was 74% for a current diagnosis and 90% for a lifetime diagnosis.[15]

People accessing treatment primarily for mental illness or alcohol and other drug addiction, share negative outcomes that include hospitalisation, overdose, violence, legal problems, homelessness, victimisation, HIV infection and hepatitis.

A recent report from Matua Raki highlights the following requirements:

- An increase in co-existing disorder-capable services.
- Improved workforce alignment between mental health services and alcohol and drug services.
- An integrated response to the needs of people with co-existing disorders.
- Improved assessment and specialisation skills of the two workforces.

Treatment for people who have been convicted of crime

Increasing capacity to provide addiction treatment to people who have been convicted of crime is undoubtedly one of the key challenges for the addiction treatment sector in the immediate and medium-term future.

In New Zealand a significant number of the 200,000 people arrested each year are under the influence of alcohol and other drugs at the time of arrest. It is estimated that up to 80% of offenders who appear in court have an alcohol or other drug problem, and that 83% of prisoners in New Zealand have had a substance misuse disorder at some time in their lives (against 32% in the general population).[16] Offenders are part of the community and many already access treatment services.

The Ministry of Health and Ministry of Justice have developed the Effective Interventions Programme to address the needs of the offender population. A number of addiction treatment programmes and services aimed at treating the offender population are being piloted and a number of workforce development initiatives are underway.

Most people entering addiction treatment are forced to do so by pressures from the courts, an employer, or family members. Research indicates that coerced treatment is as effective as "voluntary" treatment.

- There is a strong link between alcohol and violent crime.
- Alcohol use can be a significant factor in family violence.
- In the 2001 New Zealand National Survey of Crime Victims, 30-40% of those who had experienced violence at the hands of a partner or someone known to them, said the person was affected by alcohol or drugs.[17]
- Effectively addressing the co-existing problems of alcohol use/abuse and violence requires an integrated, coordinated response by a range of agencies.

Alcohol Healthwatch: Alcohol Related Violence in Families and Communities, 2006

15. Adamson et al., 2006
16. Ministry of Justice, 2008
17. Ministry of Justice, 2003 cited in Alcohol Healthwatch, 2006

Alcohol

Alcohol is the most widely used psychoactive (or mood-changing) recreational drug in New Zealand. It remains the primary drug of misuse for those attending addiction treatment services. Many people enjoy alcohol, however research consistently demonstrates that the personal, social and economic costs to society of alcohol misuse are significant.

In New Zealand we estimate that alcohol harm costs somewhere between $1 billion and $4 billion a year.

- It costs the public health sector $655 million.
- It costs in crime and related costs $240 million.
- It costs in social welfare $200 million and in other government spending $330 million.
- In lost productivity, it costs about $1.17 billion a year.
- Alcohol is responsible for 70 percent of accident and emergency hospital admissions.
- 75 to 90 percent of weekend crime is attributable to alcohol.

Alcohol Advisory Council of New Zealand, retrieved 2008

Illicit Drugs

Cannabis is New Zealand's most widely used illicit drug[18] and cannabis use is the second most commonly used drug among addiction treatment consumers. Opioid users constitute the third largest group of consumers of alcohol and other drug treatment. National household survey data suggests that the population prevalence of opiate use has remained the same in 2006 compared to 2003.[19] With changes in drug-taking trends, opioid substitution treatment specialist services are managing significant numbers of older people with general age-related issues as well as issues related to long-term methadone and other drug use.

Increasingly, problems related to methamphetamine use are of concern to the New Zealand public. Chronic heavy methamphetamine use is associated with aggression and serious psychological problems. The population prevalence of amphetamine use, as measured in the national household drug survey, has remained stable since 2003.[20] One study noted that the percentage of addiction treatment consumers citing use of amphetamine-type stimulants as their "main drug used" rose from near zero in 1998 to 10% of the study sample in 2004.[21] Frequent methamphetamine users utilised more health services in 2007 than in 2006 including more ambulance services, Accident and Emergency Department services, alcohol and other drug workers, counsellors and general practitioners. Greater utilisation of medical and emergency services suggests heavier use of methamphetamine and other drugs by some methamphetamine users.[22]

Gambling

There are various estimates of pathological and problem gambling levels in New Zealand. The most recent data from the New Zealand Health Survey 06/07 states that 0.6% of gamblers met the criteria for problem gambling and a further 2.0% were at moderate risk of their gambling being a problem.[23] Prevalence of problem gambling is not evenly spread over populations or gambling products. For example 18-25% of people who regularly gamble on "pokies" are considered to be problem gamblers. Electronic gaming machines, track betting and casino games are more addictive and cause more problems than other types of gambling such as lotteries. At New Zealand face-to-face problem gambling counselling services in 2003, almost all new clients cited non-casino gaming machines (76.7%) as their primary mode of problematic gambling.[24]

Electronic gaming machines have been described as the 'crack cocaine of gambling'.

Marshall and Wynne, 2003

New technologies are well suited to offering the more problematic types of continuous access gambling. Internet and mobile phone access to gambling are not widely used in NZ yet but these gambling access mediums are available, and are expected to become increasingly prevalent. These developments require consideration in service planning. Gambling services are currently confined to addressing the needs of people where gambling for money is the problem.

Many people with gambling-related problems also have a mental health problems and/or alcohol and other drug-related problems. Often the mental health and alcohol and other drug-related problems are unrecognised until the gambling behaviour is being addressed.

18,19,20. Wilkins et al., 2006
21. Adamson et al., 200
23. Ministry of Health, 2008
24. Paton-Simpson et al., 2004 cited in Ministry of Health 2008b

LOOKING FORWARD

Discrimination & Stigma

Addiction treatment consumers consistently raise issues related to the discrimination and stigma that they face. While some excellent work has been undertaken in de-stigmatising mental health conditions, this has yet to be achieved for addiction. There is an urgent need for development in this area.

Workforce

Over the last decade the addiction treatment sector has faced multiple challenges, as have other parts of the health workforce. These include a substantially expanded knowledge base and emphasis on research and evidence based practice; increased commercial and contractual demands on services, particularly non-government services; increased professionalism and greater accountability.

Adding to these in the future are challenges for:

- Greater connectedness between disciplines and between addiction services and the mental health and general health sectors.
- Further expansion of the knowledge base to respond to co-morbidities.
- More consumer leadership and more consumer-run services.
- Further development of, and evaluation of, service models, particularly for Māori and for Pacific peoples.

Lack of workforce capacity is increasingly a barrier to expanding treatment capacity. The challenge for funders, purchasers and providers is to determine the most effective areas for further investment to enhance outcomes.

Addressing the barriers to accessing addiction treatment

There is more to learn about what keeps people from seeking or accessing addiction treatment. Findings from recent New Zealand research on illicit drug use[25] suggest that barriers to treatment are different for different groups of drug users. Factors like social pressure to keep using, fear of what might happen once contact is made with a service, perceptions that services are not suitable and/or not readily available continue to provide a challenge that policy makers, planners, funders and treatment providers must work together to address.

It is not enough to provide high quality treatment services; services must be readily available in sufficient quantity, they must be suited to a range of diverse needs and those who need the services must be well-informed about what is available.

Review of Nationwide Service Framework

The current Ministry of Health review of the Nationwide Service Framework is likely to have significant implications for service planning and funding. NCAT anticipates that changes to the Nationwide Service Framework will bring opportunities and challenges for all addiction treatment stakeholders and looks forward to ongoing discussion with planners, funders and policy makers to realise opportunities to enhance treatment options. NCAT anticipates considerable scope for enhancing the range of addiction-related interventions in areas such as peer-support, brief intervention and continuing care and for exploring a more integrated clinical public health approach.

NCAT looks forward to working with planners, funders, purchasers and policy makers to:

- Expand capacity and broaden the range of treatment services.
- Develop an addiction and mental health workforce that is "co-existing capable."
- Destigmatise addiction and the people that experience addiction-related harm.
- Continue the investment in high-quality addiction treatment to meet the needs of the people of New Zealand.

FOR FURTHER INFORMATION

NCAT welcomes your enquires. Please contact in the first instance: Co-ordinator for NCAT, Level 1, Latimer House; 215 Gloucester St, Christchurch. Phone: 03 379 8626 ext 840 Email: info@ncat.org.nz

25. Wilkins et al., 2006

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