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B1 | Settings

Population health approach to reducing alcohol-related harm in Counties Manukau

Luisa Silailai[1], **Rosa Solomona**[2]
[1]Counties Manukau Health, Otahuhu, [2]Counties Manukau Health, Otahuhu

Alcohol causes more harm than any other drug.[1] Hazardous alcohol consumption and related harms are key drivers of inequities in health and wellbeing outcomes. In New Zealand, inequitable outcomes are apparent, with men, Maaori, young people, and those living in socially deprived areas at higher risk of alcohol-related harm. In Counties Manukau, on average, people live within a five minute drive of five alcohol off-licences, and one quarter of schools and preschools are located within a five minute walk of at least one off-licence.[2]

Counties Manukau Health's Alcohol Harm Minimisation Programme focusses on alcohol as a key determinant of population health and wellbeing outcomes, prioritising prevention and early intervention actions. This includes supporting healthcare workers to deliver the Alcohol ABC approach, and working with partners to advocate for stronger evidence-based pro-equity alcohol policies.

This presentation places hazardous drinking and alcohol-related harm in a population health context, and how it connects with alcohol and other drugs support services.

[1] Nutt, D et al. (2010). Drug harms in the UK: a multi-criteria decision analysis. *The Lancet 376* (9752), 1558-1565.
[2] GIS analysis from the Auckland Regional Public Health Service

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Alcohol and pregnancy: An online learning tool for midwives and LMCs

John Vogenthaler
[1]*Te Pou, Wellington*

The majority of women in Aoteaora are consuming alcohol when they find out that they're pregnant. Health advice regarding alcohol consumption can be inconsistent or absent for many women, a contributing factor to ongoing issues regarding FASD (Fetal Alcohol Spectrum Disorder). Midwives and LMCs are in a privileged position to provide timely and meaningful support to women throughout pregnancy and the early days of a child's life. Providing consistent messages and utilising a shared framework for this workforce is paramount to supporting more healthy pregnancies in Aotearoa.

Te Hiringa Hauora/ Health Promotion Agency, The New Zealand College of Midwives and Te Pou have collaborated to develop an e-Learning programme to support midwives and LMCs to better understand issues surrounding alcohol and pregnancy, the impact of FASD on people and communities, and the utilisation of frameworks to support women who may be experiencing mental distress or problematic alcohol use. The course combines practical knowledge regarding mental health, addiction and knowledge of FASD alongside practice examples delivered by practising midwives.

The presentation will describe the current landscape in Aotearoa and the collaborative development process in this project. We will highlight professional practice and workforce innovation, and show how effective health promotion is being utilised across the community.

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HIPs and health coaches: New roles for addressing alcohol in Primary Care

Sheryl Rush-Parkes
[1]*Gonville Health Centre, Whanganui*

Alcohol is an important but often unmanaged issue for primary care. There is a reluctance for primary care clinicians to manage alcohol problems. Awareness of alcohol as an issue for primary care patients may arise in clinical contexts or by screening but clinicians commonly cite time constraints and skills as barriers to ongoing management.

Within the new model of integrated primary mental health and addictions services (IPMHA) being implemented across New Zealand by the Ministry of Health, the roles of health coach and health improvement practitioner (HIP) offer new opportunities for alcohol management.

Patients identified with health issues including alcohol are referred to health coaches and HIPs using the ‘warm handover” personal introduction while still in the practice. Alcohol management within the IPMHA service has been reviewed after the first year in Gonville Health Centre and components required for successful management have been determined.

This presentation will inform attendees about the IPMHA roles and introduce an approach that has the potential to enhance alcohol management throughout all New Zealand primary care practices.

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From healthy living to saving lives: Are addiction services doing enough to ensure our service users are 'Equally Well'?

Debby Sutton[1], Edith Moore
[1]Aod Provider Collaborative/ Odyssey, Counties Manukau, [2]DRIVE Consumer Direction (Ember: Korowai Takitini), Counties Manukau

The national 'Equally Well' initiative has highlighted the inequity in physical health outcomes for people with addiction and mental health challenges. Diabetes, cardiovascular disease, metabolic syndrome, cancer and oral health issues are more common for this population group. These conditions can reduce people's quality, and ultimately length, of life. There are many reasons for this disparity, including barriers to accessing health services, such as stigma and discrimination. Alcohol and drug services are in a prime position to support people with their physical health needs as part of their journey to recovery and wellbeing.
From 2017 to 2020 the AOD Provider Collaborative undertook an Equally Well initiative which used a workshop and research to scope the issues and how services could enhance their support for people's physical health. The Collaborative built on the findings to develop resources which aim to enhance people's wellbeing and self-care.

This presentation will outline insights from the research for addiction services, including:

- Why supporting people with their physical health is important for recovery,
- What kind of support people want, and
- How we can enhance the support we provide to people who access services.

We will also introduce the resources developed by the AOD Collaborative which are designed to empower our workforce, and the people who access services, to discuss physical health in their work together.

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Te Ngahere - Raranga Tetahi Ki Tetahi

Sheena Maunsell[1], **Peter Sciascia**[1]
[1]*Odyssey, Auckland*

Ngati Paoa, Waikato & Raukawa
Te Ngahere is a strengths-based, intensive treatment programme delivered within custodial settings that supports participants to work on their recovery capital, rebuilding connections to whānau, tikanga and their own cultural identity. Consistent with Te Ara Poutama's Hokai Rangi strategy, Te Ngahere seeks to humanise the prison treatment experience, placing a strong emphasis on whānau connection and involvement. We will speak to the mahi of Te Ngahere, sharing insights about our approaches.

Raranga tetahi ki tetahi – the weaving of one and also to each other; delivering a unique AOD programme within the wire by engaging Kaupapa Maori frameworks, models and concepts which guide us to look into ourselves and our own ways of being. Utilising nga taonga within puna matauranga me nga puna hauora; the well springs of knowledge and well springs of health which aid us to move through phases of personal healing and growth.

- "Kore au e ngaro" He kakano ahau, an approach to recognising whakapapa, histories and the unique potentialities of every tangata.

1. "Mahea ake nga poraruraru" clearing and cleansing, exploring and connecting with wairuatanga in a pursuit to awakening mauri, enhancing mana and preserving Tapu.

2. "Rarangatia mai nga muka o tena, o tena kia maro ai te taura here tangata kei motukia" Weaving everything together to solidify the connections to sources of healing, support and wellbeing so these connections may never be severed.

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B2 | Kaupapa Māori / Pacific

Alcohol and drugs abuse is a challenge to Pacific communities and family in Porirua and the greater Wellington. The "path of Ifoga" is a qualitative case study aimed to explore conceptual considerations and practical application of Ifoga's principles, practices, and processes to how it can inform intervention for alcohol and drug misuse in the Samoan and Pacific communities in Aotearoa, New Zealand

Alapua Poasa[1]
[1]*Taeaomanino Trust, Porirua*

Background information: In the last ten years as an Alcohol and Drug counsellor, I have experienced a significantly increasing number of adults and young people with mental health and wellbeing issues as a result of drugs and alcohol misuse. Alcohol and drugs exacerbate other issues such as family violence and other addictions that have massive consequences on the lives of young people and children whom I am very concerned about. The Pacific communities and their families struggle with the challenges of bringing back their family members into well-being.

The problem/issue address: The path of *Ifoga* will address the use of cultural practices, Christian principles, and processes to inform intervention for alcohol and drugs abuse for Samoans and Pacific communities and their families.

The methodology and findings: The research identified common themes from the principles, processes, and practice of *Ifoga.* A formal and public apology is a core component of the *Ifoga*; the cultural ritual eventuates because of the aiga or family; faith or religious beliefs, as well as *Fa'a Samoa* or Samoan culture, are strong values that underpin the cultural practice of *Ifoga.* These themes were critiqued in view of the phenomenon of drugs and alcohol misuse in the Samoan community, and how these themes and concepts can apply to healing and recovery for all those involved. The key concepts drawn from the findings of this study presents the framework, "LOLE O LE OLA". The framework represents a potential approach to wellbeing pathways to deal with alcohol and drug abuse. The client is at the centre of the whole process. The framework demonstrates strengths from the collaboration of a village-based service. In addition, the presentation will also discuss the successful application of the framework to clients.

Culture 'is' clinical - A perspective on the effectiveness of using Fa'asamoa cultural protocols within addiction treatment

Sailivao Aukusitino Senio[1], **Natalie Senio**[1]
[1]*The Salvation Army, Moto'otua, Samoa*

Cultural protocols are as effective as clinical processes in terms of being a therapeutic approach. In establishing our service and treatment interventions, we have turned the traditional clinical approach upside down with the primary focus being culture not clinical based on the protocols of the three A's:

- Aganu'u (Culture)
- Atua (Spirituality)
- Aiga (Family)

Maintaining balance across these three domains is essential to recovery. When not balanced or when there is a focus on only one domain, it can be at the detriment to the other domains and open up aiga vulnerability to addiction issues.

Providing treatment interventions that are focused on the three A's provides the opportunity to reconnect to known values and beliefs which in turn, enhances engagement, openness, motivation, acceptance, accountability and behaviour change.

Language, prayer and relationships are central to every engagement provided by our service which has resulted in positive behaviour change and improved outcomes based on aiga testimony and evaluation. Often it is experienced as a 'return to basics' which were once lost to addiction; making poor choices often leading to criminal activity, negative consequences and outcomes for aiga.

It is not until the opportunity to resurrect the three A's alongside the addiction and associated behaviour's that balance is returned and positive change becomes a natural outcome. In essence, it becomes treatment that is known from within, a sense of belonging that was temporarily lost and is once again re-ignited.

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Childhood Sexual Trauma and Addiction: Understanding the importance of working with Māori and Pacific men affected by childhood sexual violence and drug use.

CEO Alexander Stevens II[1]
[1]*Standingtallnz.org, Auckland, New Zealand*

Sexual violence is prevalent across all segments of society here in New Zealand and internationally. It is complex and presents multiple challenges in identifying and addressing it. For Māori and Pacific men who have experienced childhood sexual violence and want to seek help with their trauma and addictions to cope with their past, the problem is even more complex.
Barriers such as being perceived as an offender, active sexism, racism, prejudice and not having services effectively stop our men coming forward to get the help they rightfully deserve. Given these challenges where do our men go and seek support?
This question forms part of my Kaupapa Māori doctoral research. I wanted to understand the effectiveness of creating an e-Health website and resources for Māori and Pacific men. Over a 12-month period I worked with these three key groups to design content under the brand name StandingTallNZ.org.
The people we interviewed included: Māori and Pacific men sexually violated in childhood, support people such as family and friends and finally community agencies with no experience working with sexual violence.
Results from this research has strongly indicated that addiction services do not actively work with Māori and Pacific men affected by childhood sexual trauma nor do they have online resources to support them. This contradicts the Tikanga Matatika Dapaanz Code of Ethics in being able to support equity for whānau Māori regardless of gender.
My aim is to discuss what can be done about this as a profession to ensure a proper duty of care is provided as well as preventing negligence.

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The incorporation of interventions from Te Ao Māori as a means of promoting catharsis in rangatahi Māori aged 17-24 in a prison environment

Tyrell Gemmell[1], Dene Kire[1], Kahuirangi Tauri[1]
[1]*Te Taiwhenua O Heretaunga, Hastings*

Catharsis can be defined as the process of releasing, and thereby providing relief from, strong or repressed emotions. Many rangatahi Māori in Hawkes Bay Regional Prison come from backgrounds that limit the extent to which they can freely express themselves. The hypothesis posed is whether these rangatahi will display a clinically significant improvement of behaviour when introduced to interventions from Te Ao Māori. These interventions include but are not limited to mau rākau, haka and waiata.

Through 1:1 counselling and group therapy/education, the course facilitators will be able to assess the growth and development of the rangatahi involved in the use of the interventions through an observational analysis. This will vary from each rangatahi but the idea is for a general hedonic shift towards prosocial behaviour.

The presentation will create open discussions for the introduction of interventions from Te Ao Māori but will also create a view for strength-based practice by people who are competent in the delivery of these interventions.

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Ka Po Ka Ao Ka Awatea – Transitioning from darkness to light

Melody Nepe[1]
[1]*Youth Intact Waikato, Hamilton*

He Taiohi Angitu have a vision and desire to create a safe space, to build rapport with rangatahi, to share Purakau of our ancestors before us, to provide alcohol and other drug education, and to provide awareness of the effects that could influence us today and in the future.

Ko Au te Awa, Ko te Awa ko Au
I am the river, and the river is me
'Ko Wai Au – Who Am I' is one of the many pathways that challenge our rangatahi of today and maybe our future. 'Ko Wai Au – Who Am I' can be a big, bold, and broad question for our rangatahi. In this presentation, we share how we offer pathways for rangatahi to feel Mana Motuhake and be empowered to take Rangatiratanga over their own lives.
At Youth Intact *He Taiohi Angitu Waikato,* a space has been created for rangatahi to explore the question **ko wai au? Ko wai koe? Ko taua taua?** Who am I? Who are you? Who is me, you, and us? The presentation will describe how we, as kaimahi, collectively support rangatahi to see the purpose and uniqueness of their whakapapa, their connection to people, land and the environment that surrounds them. Pūrākau, waiata, karakia and many other art forms were not only left for us to take record of events and preserve history, they were left for us as a guide to help keep us safe in the darkness so we may thrive when we come into the light….
"Ka Po Ka Ao Ka Awatea"

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B3 | Research

Many 'hazards' hinder wellbeing: The challenge of stigma for people receiving opioid substitution treatment during disasters

Denise Blake[1], **Sheridan Pooley**[2], Antonia Lyons[3]
[1]Te Herenga Waka, Victoria University of Wellington, Wellington, [2]Community Alcohol & Drug Services Auckland, Auckland, [3]Te Herenga Waka, Victoria University of Wellington, Wellington

Stigma impacts on how people experience their everyday lives and extraordinary events. Our research explored stigma experiences and perceptions for people who receive Opioid Substitution Treatment (OST) during disaster events. Although OST is a successful harm reduction strategy, people receiving treatment continue to endure stigma due to their assumed history of drug use. During a significant disaster or emergency, these forms of stigma will influence people's abilities to access utilities and services essential to disaster recovery, such as accessing shelter and food. Interviews with 21 people receiving OST from various services across four cities in Aotearoa New Zealand found four key themes were shared by participants including "experiences of stigma", "discrimination from health professionals and disasters and emergency management professionals" and the need for "support within disaster contexts". We argue that while it is essential that people are able to access life sustaining medications and other necessary medical treatments, stigmatising values and beliefs will inhibit access to these services. This in turn could have dire consequences for people who can already endure increased vulnerability during disasters. We implore those in disaster situations, both alcohol and other drug workers and emergency managers to have knowledge of and empathy for the needs of people receiving OST during these times of increased pressure and stress for all.

He Ture Kia Tika/Let the Law Be Right: Informing evidence-based policy through kaupapa Maori and co-production of lived experience

Katey Thom[1], **Stella Black**[1], **David Burnside**[1], **Jessica Hastings**[1]
[1]Centre for Non-Adversarial Justice, [2]Odyssey House

Ninety one percent of Aotearoa New Zealand prisoners have been diagnosed with either a mental health or substance use disorder within their lifetime. Challenges exists in how to meet their needs, however, there are diverse pūrākau (stories) of success to whānau ora (wellbeing) missing from academic and public discourse that should direct transformational change.

In this paper we describe the actualisation of a co-production project called He Ture Kia Tika (Let the Law be Right). We highlight how kaumātua (Māori indigenous elders), academics, and practitioners can merge their voices with people with lived experience of mental health, addiction and incarceration to create justice policy and solutions. We focus on the theory and application of co-production alongside indigenous kaupapa Māori methodology. By describing the establishment of a co-design group that actively guides the project. The development of a research kawa (protocol) or culturally clear guidelines and ethically safe practices. We then detail our collection of co-created pūrākau (storytelling) with 40 whanau (family) and 4 hapori (community) participants.

Kaupapa Māori informed co-production strengthened the way in which this research was conducted. The research kawa (protocol and guidelines) created clear direction for engagement at all levels of the project. We see this as bringing to life co-production, moving beyond theory to the practicalities of doing with each other. Tackling cultural, health, social and justice issues requires a multi-layered approach from a range of lived experience experts to inform future policy directions.

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Whānau perspectives of roll-your-own (rollies) tobacco and pictorial warning labels

Maria Ngawati[1],**Lizzie Strickett[2]**, Mei- Ling Blank[3]
Ngāti Hine, Ngāti Porou[1], Ngāpuhi ki Whangaroa, Te Aupōuri[2], Taiwanese diaspora, United States immigrant, Aotearoa immigrant[3]

Introduction and background: The New Zealand government has a contractual responsibility to ensure indigenous peoples have the same health outcomes as non-indigenous (United Nations 2007, CERD 2007). However, Māori continue to bear a disproportionate burden of harm from smoking and significantly more Māori than non- Māori report using roll-your-own tobacco (RYO). Continuing tobacco tax increases have fostered unusually high RYO use by Māori and has further highlighted the comorbidity between substance abuse, mental illness and nicotine addiction as seen within treatment facilities organizations. Plain packaging, which includes larger pictorial warning labels (PWLs) featuring new themes aims to deter smoking uptake and promote quit attempts. Given greater use of RYO by Māori, it is important to ensure PWLs are co-designed with Māori and reflect concerns salient to them. Current labels do not specifically address misperceptions and instead draw on isolated body parts to arouse fear and other negative emotions, but other appeals that might be more encouraging for Māori are yet to be explored.

Summary of methods: This project is following a culturally appropriate parallel process with Māori and non-Māori; the first phase has explored how Māori who smoke RYO tobacco and members of their whānau (who may or may not smoke) envisage effective RYO-specific PWLs. This presentation outlines preliminary analyses from this initial phase.

Participants (N= 30) across ten whānau who had at least one member who smoked RYO regularly were recruited. Participants ranged from 8 years old to 65 years. These interviews explored: how whānau Māori perceive current warning labels and efficacy messages; how current labels influence perceptions of RYO for example, addictiveness, and naturalness, and what potential images and messages might work to motivate cessation.

The preliminary findings that will be presented derived from a wananga- based, general inductive thematic analysis with a kaitiaki ropū, including whānau with lived experience of RYO use, which evolved in association with data collection.

Summary of results and conclusions:
Our presentation will report the wananga methodology, key challenges and benefits of whānau-based RYO research and some preliminary findings. Findings will be themed around

a. Whakapapa: The historical, intergenerational relationship whānau have with tobacco.
b. Disruption to whakapapa: How smoking disrupts whakapapa and connections to past and present and its impact on the lived realities of whānau including ment
c. l health, employment and relationships.
d. Restoration of whakapapa: How restoring whakapapa, enhancing whānau and community connectivity, and strengthening cultural identity could support those trying to overcome RYO addictions.

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The Social Recovery Model in practice: Early findings and examples of application within a therapeutic community

Zeddy Chaudhry[1], Darrell Wilson[2]
[1]Odyssey House / Derby University, [2]Odyssey House, Auckland

Recovery capital is an important concept in the field of recovery world-wide. Odyssey has partnered with Professor David Best and Beth Collinson at Derby University in the U.K, to research and pilot the use of three interventions that provide a practical way of engaging and supporting growth of three domains of recovery capital, namely their personal, social and community recovery capital.

This Social Recovery Model includes the REC-CAP evaluation tool, Social Identity Mapping (SIM) and Asset Based Community Engagement Tool (ABCE). The REC-CAP measures recovery capital and supports the growth of personal recovery capital (self-efficacy, self-esteem, communication, resilience and coping skills). SIM visually captures the groups someone belongs to and the strength of their connection to these groups (social recovery capital); and an ABCE Tool is a way of mapping community assets and the process for engaging people in such assets is known as 'assertive linkage' (community recovery capital).

This research project is the first time that all three interventions have been used to inform and support one another. Odyssey's Peer Navigator, Darrell has been supporting people accessing an adult residential service with these interventions and building connections in the community to support people transitioning from a therapeutic community to the wider community. This presentation will report on early findings of this pilot.

'It is the perfect platform for creating a trusting relationship that promotes a solid foundation in which to work. The innovative nature of the project supports wellbeing of our tāngata whai ora, facilitates change and inspires hope".

The one for the road group intervention for repeat drink/drug drivers: Evaluation, review, development

Alex Dawber[1], **Kilisitina Dawber**[1]
[1]*Harmony Trust, Onehunga*

Impaired (Drink/Drug) driving remains a serious problem in New Zealand (NZ). In 2019 alcohol/drugs were a factor in 37% of the 352 road deaths that year (NZTA, 2021). During 2009-2012, 47% of detected drink drivers were repeat offenders (Waters, 2013), and preventing recidivists from re-offending is likely to have the greatest impact on alcohol-related crashes (Roadsafe Auckland, 2001).

One for the Road (OFTR) is a New Zealand (NZ) based group therapy intervention targeting behaviour change in repeat drink/drugged drivers. Active since 2008 this programme has been refined and developed to achieve a best practice approach unique to a NZ context. The group utilizes primarily an emotion based/relational approach to engage with Tangata Whenua and Pacific Peoples, who comprise approximately 45% of participants. Recently an online component has been developed to assist access. Group attendees are referred by lawyers, the courts, probation, or the NZTA as a step to remove an 'indefinite' licence disqualification.

A recent independent matched control group evaluation by RIDNZ (Waters, 2019) has supported programme effectiveness, with an overall 7.5% re-offending rate, and a 20.2% reduction in reoffending over 3 years. This rigorous evaluation provided some validation for *OFTR*, but importantly an opportunity for reflective practice and informing programme development. This presentation will offer an overview of the *OFTR* group content and process, and highlight learnings regarding best practice in Drink Driver Rehabilitation.

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B4 | Prevention & Treatment

A brain-based roadmap for recovery

Keri Mcgarva[1], **Claire Crowley**[2]
[1]Bay of Plenty District Health Board, Tauranga, [2]Hanmer Clinic, Tauranga

Inspired by neuroscientific advances and the 'brain healing first aid' (BHFA) model created by Dr Hamed Ekhtiari, a pilot addiction recovery group has been created in the Bay of Plenty. Based on 'Neuroscience Informed Psychoeducation for Addiction Medicine' research (Ekhtiari et al. 2017), and delivered in collaboration between DHB and Community AOD services, BHFA provides an exciting new treatment option specifically designed for and with our Tangata whaiora who experience substance induced neurocognitive deficits.

Research indicates that global cognitive impairment is experienced by 81% of people following alcohol detox, and this is a recognised major risk factor for poor treatment outcomes. Neurocognitive deficits are both a risk factor for substance use disorders and a consequence of this, particularly with repeated episodes of withdrawal. This results in considerable negative impact on activities of daily living, ability to engage in treatment, and vulnerability to relapse. These neurocognitive changes, which greatly impact an individuals' overall functioning, are not generally targeted by traditional addiction treatments.

Key topics and resources from this group intervention will be discussed, along with the cognitive changes identified from pre and post treatment measures. We will discuss how participant and stakeholder feedback was used to modify content, activities, and facilitation of the group; resulting in an evidence based and client co-created intervention. With positive impacts on participants recovery, and improved integration between AOD services, BHFA is an evolving new treatment option that has earned its place to continue beyond the pilot period.

Piloting an electronic alcohol risk communication tool for use in primary are

Bridget Kool[1] Gayly Humphrey[2], Sarah Sharpe[3], Jessica McCormack[2], Shanthi Ameratunga[1]
[1] School of Population Health, University of Auckland, [2] National Institute of Health Innovation, University of Auckland, [3] Counties Manukau District Health Board, Auckland

Background: Clinicians often lack confidence in their ability to administer brief alcohol interventions. This project aimed to develop an Alcohol Risk Communication Tool (ARCT) to support primary care clinicians in the process of assessing and communicating alcohol harm risk and benefits of lifestyle changes.

Methods: We adapted Whittaker et al's approach for developing and evaluating Mobile Health interventions. We conceptualised the tool based on a synthesis of the current evidence and consultation with topic experts (Phase One). We built a prototype and conducted formative research to design the tool for testing (Phase Two). We conducted a national pilot of the tool in primary care settings (Phase Three).

Results: The prototype was positively received by clinicians and patients and based on their feedback refinements were made. The tool was then piloted in six practices. Six health professionals completed the baseline survey. The tool was used to screen 21 unique patients. The patients generally liked the look of the tool, found it easy to use, were comfortable with the language, and found that the results were presented in a digestible manner. The majority found the ARCT made it easy to talk to their doctor, and all indicated that tools like this are useful. Likewise, the health practitioner was positive about the look and feel of ARCT and did not find that using ARCT created a barrier between them and their patient. Time was the biggest barrier to routinely using the ARCT.

Conclusions The feedback received was generally positive; however, the low number of respondents limits the generalisability. Most health professionals recognised the need for wider alcohol use assessment. The tool has been developed with the intention of use in primary care, it has the potential to be used by other health professionals and in a range of health and community settings.

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Tackling psychiatric comorbidity in those with SUD: A transdiagnostic cognitive behaviour therapy approach

Jennifer Jordan
[1]University of Otago, Christchurch , Christchurch, [2]Community Alcohol and Drug Service & Christchurch Opioid Recovery Service, CDHB, Christchurch

In most addiction treatment settings, co-existing mental health and addictive problems are the norm. At times though, our still siloed treatment services make it difficult for our tangata whai ora with active substance use to receive specialist psychological treatment for significant mood and anxiety disorders. Mainstream services often decline referrals until the substance use is remitted. In addiction services, while anxiety comorbidity may be identified, it may be overshadowed and untreated due to the primary focus on stabilising the substance use disorder. Furthermore, substance use and mental health problems tend to exacerbate and perpetuate each other.

Cognitive behaviour therapy (CBT) is a well-established efficacious treatment for addictive disorders, and has specific treatment packages for mood and anxiety disorders. Sequential treatment is time-consuming, and arguably unnecessary, given that all CBT programmes share the core CBT model, core elements and strategies, although treatment targets will differ for specific disorders. Treatment addressing mental health and addiction problems concurrently has the potential to facilitate recovery by tacking shared underlying mechanisms across disorders.

Transdiagnostic CBT models developed over the past decade are showing promise in simultaneous treatment of comorbid mood and anxiety. To date though, little attention has been paid to trialling these approaches for those with addiction and comorbid emotional disorders.

This presentation describes the adaptation and early experiences of delivering a TCBT group to those with anxiety and depression in addition to their substance use disorders. Challenges and opportunities for TCBT in this field will be discussed.

Point-of-care rapid testing for hepatitis C antibodies at New Zealand needle exchanges

Geoff Noller[1], Jenny Bourke[2]
[1]Needle Exchange Services Trust (NEST), New Zealand Needle Exchange Programme (NZNEP), Christchurch / Dunedin, [2]Hepatitis C Community Clinic, Christchurch

AIM: The study's principal aim was to ascertain the viability of point-of-care rapid testing for hepatitis C (HCV) antibodies by non-clinician frontline peer needle exchange staff. Secondary aims included identifying HCV-exposed clients, improving their access to treatment, assessing their knowledge of HCV and strengthening client-staff relationships.

METHOD: Peer staff at three South Island needle exchange services (two urban, one mobile) were trained to administer point-of-care rapid HCV antibody tests, to clients, with finger-stick blood sampling, along with a short self-report questionnaire. Clients testing HCV antibody positive were offered on-site venepuncture by clinical staff, to confirm reactive rapid test results.

RESULTS: Two hundred and four people were tested across the three sites. Of these, 131 (64.2%) tested HCV antibody positive (reactive) and by the study's conclusion confirmatory venepuncture testing (n=55) had produced 14 new diagnoses and seven people had commenced treatment. Additionally, the study successfully assessed clients' previous HCV testing rates and their knowledge of test results. Through the interactions involved in testing participants, needle exchange staff reported strengthened relationships with clients.

CONCLUSION: This study demonstrated the viability of administering rapid point-of-care HCV antibody tests to needle exchange clients by non-clinician frontline peer staff. The efficacy of point-of-care testing and its appropriateness for use in this context to identify HCV-exposed needle exchange clients was demonstrated by the high proportion of participants receiving a reactive result, the identification of viremic clients and their support into treatment.

Co-existing problems in perinatal women with Substance Use Disorder (SUD) in the Auckland region and pathways of care

Chandni Prakash[1], Clara Dawkins
[1]*Community Alcohol and Drug Services (CADS), Auckland*

Pregnancy and Parental Service (PPS) provides care co-ordination and substance abuse treatment to pregnant and postnatal women with alcohol and substance abuse across the three Auckland DHBs.

Family violence, unemployment, poverty and childhood trauma are associated with increased risk of SUD and mental illness (MI) and act as barriers to accessing and completing treatment.

Housing problems are common for those experiencing poverty and these adversities further lead to psychological stress and poor health.

In NZ, the rate of maternal suicide is 7-fold that of UK, and 57% of these are Māori. Untreated maternal MI is associated with their children's emotional difficulties, behavioural problems and impaired physical growth and development.

Women open to PPS service were audited to review their psychosocial and mental health needs in the context of substance use disorder and their engagement with other agencies. File audit was carried out to determine the nature of substance use/abuse, family violence, housing/ transport problems, involvement of child care and protection agency, court/legal complications and physical/emotional health needs.

This presentation will provide information on the multiple psychosocial and mental health complexities experienced by women referred to PPS and pathways of care to address these needs.