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**References and Further Information**
Acknowledgements

“He waka eke noa: A vehicle for us all”

Tēnā koe me ngā āhuatanga o te wā, o tātou mate noho mai i roto i te ao wairua. Tātou o te ao ora, kia ora huihui mai tātou. He mihi maioha tēnei kia koutou mo to koutou kaha, ki te mahi tahi ki roto i tēnei kaupapa whakahirahira. Kia kaha, kia u, kia manawanui. No reira, tēna koutou, tēnā koutou, tēnā koutou katoa.

Greetings, Kia ora, Talofa lava, Malo e lelei, Kia orana, Fakalofa lahi atu, Bula vinaka, Namaste.

The purpose of this guide is to provide an introduction to the addiction sector for students, new practitioners, and allied workforces wanting to know more about the sector.

Matua Raki acknowledges the authors and reviewers of this document, Ashley Koning and Debby Sutton and special thanks to the peer reviewers who helped evaluate the usefulness of the original resource.

This introductory guide reflects practices and service provision at the time of publication. The guide is updated to reflect significant changes in the sector as resources allow.
Introduction

Welcome to A Guide to the Addiction Treatment Sector in Aotearoa New Zealand. This guide aims to enhance the reader’s understanding of the addiction treatment sector and reviews:

- substance use and gambling in Aotearoa New Zealand
- substance use and gambling disorders
- screening, assessment and treatment
- services, practitioners and workers who provide addiction treatment in Aotearoa New Zealand
- the national infrastructure that supports addiction treatment: organisations, resources, policies and relevant legislation.

This document has been written for practitioners new to the addiction sector and health and social service professionals from other sectors. Readers of this guide will gain a greater appreciation of the nature and extent of addiction-related problems, how the impact of addiction-related problems might be minimised and the rationale for different interventions and approaches.

The term ‘addiction’ is used throughout this document as a generic term to include substance (alcohol and other drugs, including tobacco) use and gambling disorders. The focus of this document is predominantly on substance use and gambling disorders rather than other behavioural addictions (eg. internet porn or gaming), because:

- they are common in Aotearoa New Zealand
- they are the main focus of public funding, study, research and treatment services
- the approaches to substance use and gambling disorders are similar, as are the workforce issues.

The term ‘addiction treatment’ is used in this guide to refer to interventions provided for a substance use or gambling-related problem.

Recovery

While in the past recovery has been equated with abstinence from substances and gambling, it is increasingly being recognised that recovery encompasses a broader range of factors. Within the addiction sector, Alcoholics Anonymous (AA) and subsequent Twelve Step fellowships have long recognised the need for emotional, psychological and spiritual wellbeing as the foundation for recovery. In 2011 the Substance Abuse and Mental Health Services Administration (SAMHSA) defined recovery as being: “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential,” recognising that there were many different pathways to recovery and that each person defines their own pathway, which may or may not include abstinence. Similarly the Peer Workforce Competency Framework (Te Pou, 2014) defines recovery as “...creating a meaningful self-directed life, regardless of challenges faced, [and] includes resilience and aspirations and the achievement of these.”
Continuum of use and addiction-related harm

Substance use occurs on a continuum of use from no use (abstinence) through to what is known as a severe substance use disorder. It is accepted that different levels or intensities of intervention are appropriate depending on the degree of use and related problems.

The continuum is also applicable to gambling.

Figure 1: Addiction-related harm continuum and intervention

Adapted from Korn and Shaffer (1999)
Substances and their effects

A psychoactive substance is any chemical that is used to create a change in mood and/or perception, often referred to as a ‘high’. The effects of substances used recreationally will vary and depend on the:

- type of substance taken
- potency (strength/concentration/purity)
- amount taken and frequency
- route of administration (eating, drinking, smoking, sniffing, or injecting)
- individual characteristics of the substance user (previous substance using experiences, genetic background and current physical, psychological and social state)
- environment.

Psychoactive substances can be described by their effects on the body and mind, although some substances may fit into more than one category. This guide uses the following four categories:

- Central Nervous System (CNS) depressants
- CNS stimulants
- hallucinogens
- cannabinoids.

Central nervous system depressants

Central nervous system (CNS) depressants are substances that slow down brain activity, particularly activity that controls core body functions. Generally people take depressants to induce feelings of relaxation, calmness and euphoria. In higher doses they have a range of effects including drowsiness, respiratory depression, reduced motor control, disinhibition and sometimes emotional depression. Overdosing on CNS depressants can result in coma and death as key body functions, such as breathing, can shut down.

The most commonly used CNS depressant is alcohol, with 80 per cent of adults in Aotearoa New Zealand having used alcohol in the past 12 months (Ministry of Health, 2013).

Other CNS depressants used recreationally include benzodiazepines (eg. diazepam/Valium), barbiturates, opioids (eg. opium, heroin, methadone, morphine, oxycodone and codeine), gamma hydroxy-butyrate (GHB) and various volatile solvents (eg. glue, paint, petrol).

These substances are used recreationally by fewer people. For example, 1.1 per cent of adults use opioids and 0.1 per cent use inhalants for recreational purposes. The most common types of opioid used for recreational purposes are prescription painkillers (Ministry of Health, 2010).

When more than one CNS depressant is used at the same time their joint effects are often heightened and unpredictable.
Central nervous system stimulants

CNS stimulants increase brain activity and the body and minds state of arousal, as if it is ready for ‘fight or flight’. Generally CNS stimulants increase alertness and energy and reduce drowsiness, fatigue and appetite. CNS stimulants often result in euphoria and disinhibition.

With high doses of stimulants the user can experience grandiosity, insomnia, irritability, impulsiveness, compulsive actions and nervousness. With some stimulants there is a small possibility of overdose causing convulsions and death through heart attack or brain haemorrhage. With chronic (ongoing) use of high dose stimulants the euphoric feeling is often replaced with emotional depression, agitation, anxiety, hyperactivity and paranoia.

One of the most commonly used CNS stimulants is nicotine with 18 per cent of New Zealanders being cigarette smokers (Ministry of Health, 2012). A 2010 survey also found 3.9 per cent of adults use other stimulants, of which the most commonly used were MDMA (ecstasy) 2.6 per cent, and amphetamines (eg. methamphetamine or ‘P’ and speed) 2.1 per cent (Ministry of Health, 2010). Other CNS stimulants include methylphenidate (Ritalin), mephedrone (bath salts) and cocaine.

Some ‘legal highs’ produce CNS stimulant effects. Prior to 2008 the main chemical ingredient in many ‘legal highs’ or ‘party pills’, was benzylpiperazine (BZP). In a survey carried out over 2007-2008 5.6 per cent of adults had tried party pills (Ministry of Health, 2010). In 2008 benzylpiperazine (BZP) was made illegal and since then levels of use of ‘party pills’ has decreased (Wilkins, Griffiths and Sweetsur, 2013).

With the introduction of the Psychoactive Substances Act in 2013, and the Psychoactive Substances Amendment Act in 2014, manufacturers and retail providers of ‘party pills’ and other ‘legal highs’ made from a range of psychoactive chemicals need to hold a license and only sell approved products. Products can be approved by the Psychoactive Substances Regulatory Authority in the Ministry of Health if use is proven to be of low risk of harm. At the time of printing the process for determining how new psychoactive substances could be proven to have a low risk of harm had not been clarified.

Hallucinogens

Hallucinogens can have similar effects to depressants and stimulants, but the main effect that hallucinogens have in common is that they produce sensory distortions. These can involve visual, auditory or tactile hallucinations, heightened emotional experiences (both positive and negative), and distortion of time and space. Harm that arises from hallucinogen use is generally through associated risky behaviours and the exacerbation of some mental health problems, such as psychosis. Some hallucinogens such as datura (Thornapple and Angels Trumpet) are particularly toxic and risky to use.

The most commonly used hallucinogen in Aotearoa New Zealand is lysergic acid diethylamide (LSD) and other synthetic hallucinogens. Other hallucinogens used include psilocybin (magic mushrooms), mescaline (cactus), and datura. Some stimulant drugs such as ecstasy also have hallucinogenic properties as well. It has been estimated that 3.2 per cent of adults in Aotearoa New Zealand use hallucinogens (Ministry of Health, 2010).

Cannabinoids

Natural cannabinoids originate from the cannabis sativa and indica plants. These plants contain more than 60 cannabinoid chemicals, such as delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD).
The psychoactive effect of many of these is still being investigated (McKim, 2003). These substances have been placed in their own category as they produce a complex combination of effects which can include CNS depressant, CNS stimulant and hallucinogenic-like properties. The desired effects usually include feelings of relaxation and calmness. Excessive use is not directly life-threatening, but can create frightening hallucinations, feelings of paranoia and can exacerbate mental health problems.

Cannabis can be used as marijuana (dried leaves and flowers); hashish (dried resin harvested from the plant); and hash oil (purified and concentrated oil extracted from both leaves and flowers). Cannabis is commonly used in Aotearoa New Zealand with approximately 14.6 per cent of adults reporting they use it on a regular basis (Ministry of Health, 2010).

Synthetic cannabinoids are psychoactive substances that attach to and stimulate the natural cannabinoid receptors in the brain and body. More than 200 synthetic cannabinoids have been identified, many of them bearing no chemical similarity to THC, and these substances can be between 3-45 times stronger than natural cannabis products. As a consequence of the increased potency, the potential harms from the use of synthetic cannabinoids are greater and there have been reports of a greater risk of exacerbating mental health problems, aggression and damage to the heart and kidneys (Ashton, 2012). Synthetic cannabinoids have been found to be one of the most common active ingredients in the smokable ‘legal highs’ and efforts to control the supply of synthetic cannabinoids by making them illegal have been confounded by the ability of suppliers to replace one active synthetic cannabinoid with another that was not illegal. The Psychoactive Substances Act (2013) is an attempt to put the onus on suppliers to provide provably low risk new psychoactive substances including synthetic cannabinoids. The Psychoactive Substances Amendment Act (2014) made all new psychoactive substances illegal to manufacture, supply and possess until such time as they are proven to be ‘safe’ to use.

Immediate harms from substance use

Some substances are used for their desired effects with very few negative consequences. Other substances that are more potent or unpredictable have risks associated with their use, regardless of whether they have been used before or not by a person. The potential for immediate harm from substance use is related to:

- effects of intoxication (through behaviour associated with intoxication or direct effects on the body)
- interactions between substances (effects can be unpredictable)
- overdose (excessive or high potency substance use can be physically dangerous)
- route of administration (some methods are more risky than others, eg. injecting substances can transfer blood borne viruses like Hepatitis C (HCV)).

Harm from long-term substance use

Most substances will cause harm if used regularly over long periods of time. These harms may be related to:

- route of administration (eg. snorting can permanently damage nasal passages)
- direct impact on the body from ongoing use (eg. long-term alcohol use can damage the heart, brain, liver and lungs)
- the development of a substance use disorder.
Substance use disorders

Many substances, including alcohol, taken frequently over a long enough period of time will lead to a substance use disorder. The development of a substance use disorder involves physical and/or psychological processes that can include tolerance, withdrawal symptoms, cravings and maladaptive behaviours. How quickly a substance use disorder develops varies and depends on the specific substance taken, frequency of use and the characteristics of the person taking it.

Tolerance

When a substance is taken regularly enough a person’s body adjusts to its presence and there is a decrease in the desired effect. In order to ‘feel normal’ the person has to continue using. To create the original desired effect, increasing amounts are needed. This is the development of tolerance. Tolerance can involve an adjustment psychologically and/or physically (through changes in brain chemistry and liver processing). After cutting down or withdrawing from a substance a person’s tolerance will decrease so, depending on their substance of choice, they have a higher risk of overdose if they use the amount they were consuming prior to their cutting down or stopping use.

Withdrawal symptoms

If use of the substance is reduced or stopped after tolerance has developed a person will experience withdrawal symptoms. These are a physical response to the reduction in substance use and the resulting chemical changes in the brain and body. These symptoms are often experienced as the opposite effect of the substance. For example, alcohol use produces relaxation and its withdrawal symptoms include anxiety.

Withdrawal symptoms can range from being simply uncomfortable through to physical and emotional pain, and can be quickly relieved by taking more of the substance or a similar substance. Alcohol, benzodiazepine and GHB withdrawal can potentially be life-threatening if not treated medically. Withdrawal symptoms will continue until the body has excreted (metabolised) all of the substance and then re-adjusted back to its ‘normal’ state. Each substance has a different withdrawal period and the most distressing, and potentially dangerous phase (in the case of alcohol, benzodiazepines and GHB), is usually over within two weeks after stopping use. Other less intense but distressing protracted withdrawal effects may be felt for months.

Cravings

A craving is a strong psychological desire for the effects of a substance (McKim, 2003). Cravings motivate people to continue with substance use even when it has become problematic. How cravings develop is not well understood but they appear to be explained by the interaction of brain chemistry and psychological learning processes.

Although cravings are experienced most frequently in the early stages of withdrawal and abstinence, some people can continue experiencing them occasionally for years afterwards. Cravings can be triggered by being around substances in use or things associated with the substance and its use (eg. certain places or people).
They’re also often triggered by physical or psychological discomfort. People who have a severe substance use disorder tend to experience excessive cravings and for longer periods of time. For them cravings are a normal part of the process of substance use and withdrawal. Cravings come and go and the urge to use alcohol or other substances will be stronger at some times than at others. Managing these strong urges can be the hardest part of withdrawal and maintaining ongoing abstinence for many people, and failure to do so can increase the likelihood of someone returning to substance use.

**Lapse and relapse**

Severe substance use disorders are described as ‘chronic relapsing disorders’. When someone who has chosen to stop using a substance, and has been abstinent for a period of time, uses substances again it can either be a slip or lapse (a brief minor return to previous substance use) or a relapse (a full return to previous patterns of substance use).

Lapses happen to most people who reduce or stop using a substance and it does not mean the end of the process or that the person has failed (though they may define this as a failure to themselves). Addiction practitioners can help people develop their coping strategies and build their networks so they can learn from the experience and do things differently next time. Long term abstinence is possible but it can be challenging to achieve and may require several attempts.

**Gambling and its effects**

Gambling is a common pastime in Aotearoa New Zealand with 52 per cent of adults having gambled in the past 12 months (Ministry of Health, 2012b). The decline in gambling over recent years has not been accompanied by a decrease in associated problems. It has been estimated that 0.3 per cent of adults in Aotearoa New Zealand have a gambling disorder and that 2.5 per cent (89,000) of the population are negatively affected by someone else’s gambling (Ministry of Health, 2012b).

Harmful effects associated with gambling can include problems with finances, work commitments, relationships, legal issues, substance use and other mental health problems. As with substance use there is also a chance that if someone gambles regularly over a period of time, they may develop a gambling disorder.

With gambling there is ‘euphoria on winning, tolerance on repetition, compulsion, withdrawal and craving’ (Academy of Medical Sciences, 2008, p. 44).

These kinds of issues have been called behavioural addictions. People have become addicted to behaviours such as gambling, shopping, eating, sex, exercise, the internet and electronic entertainment. In fact any behaviour that is reinforcing and feels good can become out of balance with other aspects of life, thus creating problems.
References and further information


Ministry of Health. (2012). The Health of New Zealand Adults 2011/12: Key findings of the New Zealand Health Survey. Wellington: Ministry of Health


Understanding the causes of addiction

In the past when people had problems controlling alcohol and other drug use or gambling this was seen as a moral issue or a weakness and that they just needed to develop stronger willpower. Religious organisations, to provide moral guidance, and the criminal justice system, to control and punish anti-social behaviours, were therefore seen as the most appropriate agencies to address the issue.

In the 20th century the concept that ‘alcoholism’ and ‘drug addiction’ were due to a physical disease was introduced to explain the loss of control of substance use on the part of some people who use substances.

There was also a suggestion that there was an ‘addictive personality’ and that people with this personality type would have a tendency for ‘addiction’.

Alcoholics Anonymous (AA) began in 1935, initiated by two men who had helped each other stop drinking. The Twelve-Step movement that evolved from AA talks about the disease of ‘alcoholism’ referring to a bio-psycho-social-spiritual dis-ease rather than a specific and known cause. Gamblers Anonymous (GA) and Narcotics Anonymous (NA) are also based on the Twelve-Step model.

More recently, studies of psychological, social and genetic factors and neurobiology has shown that there is no evidence for a single disease or an addictive personality, nor is it an issue of willpower. The causes of addiction are complex and variable.

Currently there is a wide range of theories from biological, psychological and social perspectives about what causes addiction-related problems. Although there is not yet one model that integrates all perspectives in a coherent way, it is commonly accepted by most professionals that addiction has roots in bio-psycho-social areas and therefore a holistic and comprehensive intervention is required to address it. The core theories of what causes addiction are briefly described below.

Biological theories

Within the human brain there is a common reward pathway which, when activated, releases specific chemicals (eg. dopamine) that create feelings of wellbeing and relaxation (Academy of Medical Sciences, 2008). This neural pathway is activated by behaviours necessary for survival, eg. eating in response to hunger. This process reinforces these survival behaviours and this motivates people to continue them.

Neurobiologists have identified that many psychoactive substances trigger activity in the reward pathway which reinforces their continued use (Academy of Medical Sciences, 2008).

Why different substances impact some people more strongly than others is still being explored. Some early findings are that genetics influence the number of receptors for dopamine in the brain. This may be due to a family history of substance use disorders or the impact of life events and trauma. There is certainly emerging evidence that early deprivation and trauma can have an influence on neurobiology which may increase the likelihood of later substance use problems (Berglund et al, 2013). For people with fewer receptors it appears that substance use has a greater impact, making it more likely for them to develop substance use disorders (Academy of Medical Sciences, 2008).

Research has found other behavioural addictions, such as gambling, also trigger the same reward pathway, even though they are not introducing chemicals directly into the brain (Academy of Medical Sciences, 2008). The mechanism behind this highlights the importance of the interaction between medical and psychological phenomena. Once an addiction has been established, the physical processes of tolerance and withdrawal help perpetuate it.
Psychological theories

There are a range of explanations for addiction that arise from the various psychological approaches, such as psychoanalytic and personality theories. The growing understanding of the neurobiology of addiction has highlighted how it is influenced by, and in turn influences, various psychological processes, including motivation, memory, learning, impulse control and decision-making (Academy of Medical Sciences, 2008). Learning theories have therefore become important to assist with understanding these processes.

These theories use concepts from classical conditioning, operant conditioning and social learning theory to explain the physical, psychological and social motivators to start substance use or gambling and how addiction develops and continues. For example, the concepts of reinforcement and association explain how cravings can be triggered by apparently unrelated things like particular songs or events. These theories also help to explain how gamblers learn to associate monetary reward with feelings of pleasure and how anticipation about this before or while gambling releases dopamine in their neural reward pathways (Academy of Medical Sciences, 2008).

Social theories

Sociological theories conceive of problems with substance use or gambling as being societal phenomenon, having largely cultural, social and economic origins. Such causes are often external to a person, ie. they are not due to biological, genetic or psychological traits. Instead these theories direct our attention to the immediate and wider social environments and suggest that factors outside of a person's control, such as poverty, unemployment, discrimination, colonisation and marginalisation, explain why they start and continue to use substances.

References and further information

Academy of Medical Sciences. (2008). Brain science, addiction and drugs. Great Britain: Academy of Medical Sciences


Defining substance use and gambling problems and disorders

A number of people with substance use or gambling problems seek professional assistance, and others make changes by themselves with support from friends, family, whānau or other non-specialist health and/or social services. People with more severe problems are more likely to need specialist help. The continuum of addiction-related harm (Figure 1) provides a visual representation of the range of behaviour and the type of intervention appropriate at each stage on the continuum.

Being able to identify the degree of risk for substance use and gambling disorders is important in determining the kind of intervention that could be provided.

The Ministry of Health (2013) estimated that in the previous twelve months 19 per cent of adults had consumed alcohol ‘hazardously’, defining hazardous drinking as “an established pattern that carries a risk of harming the drinker’s physical or mental health, or having harmful social effects on the drinker or others”.

In an earlier report the Ministry of Health (2010) identified that 3.5 per cent of adults had experienced ‘harmful’ effects from their use of substances other than alcohol.

Many of the people drinking alcohol or using other substances hazarding would not be considered to have substance use disorders but could benefit from a brief intervention (see the Interventions section for further explanation) to improve their awareness of the risks associated with their particular patterns of substance use. For example, the Health Promotion Agency recommends that to reduce long term health risks women should drink no more than two standard drinks of alcohol a day, up to a maximum of ten a week, and men no more than three standard drinks a day, up to a maximum of fifteen a week. Sharing this information with people can help them to put their own alcohol use into context and support healthier lifestyle choices.

For those people who may have a substance use or gambling disorder, and therefore more intensive intervention needs, there are two internationally used systems to diagnose significant mental health (including substance use and gambling) disorders: the International Classification of Disorders-10 (ICD-10) (World Health Organisation, 2010) and the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) (American Psychiatric Association, 2013). In Aotearoa New Zealand the DSM system is the main classification system used within addiction treatment settings.

The DSM should only be used by those who have received professional training and only to diagnose disorders relevant to the practitioner’s scope of practice. For addiction practitioners this may include substance use and gambling disorders and some mood and anxiety disorders. Practitioners can also make ‘provisional diagnoses’ of other mental health disorders that are identified in screening and comprehensive assessment, despite this falling outside their scope of practice, to ensure treatment for co-existing mental health problems is integrated into treatment for substance use and gambling disorders. Diagnoses are not intended to be static and they need to change as people's symptoms change in order to inform treatment planning.
Diagnosis of substance use disorders

The current DSM version, DSM-5, identifies that a person has a substance use disorder when they have met two (or more) of a set of eleven criteria within a 12-month period.

The criteria for a substance use disorder are:

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<tr>
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<th>Criteria</th>
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<tbody>
<tr>
<td>1</td>
<td>The substance is often taken in larger amounts or over a longer period than was intended</td>
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<tr>
<td>2</td>
<td>There is a persistent desire or unsuccessful efforts to cut down or control substance use</td>
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<tr>
<td>3</td>
<td>A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects</td>
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<td>4</td>
<td>Craving, or a strong desire or urge to use the substance</td>
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<td>5</td>
<td>Recurrent substance use resulting in a failure to fulfil major role obligations at work, school, or home</td>
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<tr>
<td>6</td>
<td>Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance</td>
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<td>7</td>
<td>Important social, occupational, or recreational activities are given up or reduced because of substance use</td>
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<td>8</td>
<td>Recurrent substance use in situations in which it is physically hazardous</td>
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<tr>
<td>9</td>
<td>Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance</td>
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<tr>
<td>10</td>
<td>Tolerance, as defined by either of the following:</td>
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<td></td>
<td>a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect</td>
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<tr>
<td></td>
<td>b. A markedly diminished effect with continued use of the same amount of the substance</td>
</tr>
<tr>
<td>11</td>
<td>Withdrawal, as manifested by either of the following:</td>
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<tr>
<td></td>
<td>a. The characteristic withdrawal syndrome for the substance</td>
</tr>
<tr>
<td></td>
<td>b. The substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms</td>
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</tbody>
</table>

A substance use disorder is described as:

- **Mild**: when 2-3 criteria or symptoms are met
- **Moderate**: when 4-5 criteria or symptoms are met
- **Severe**: when 6 or more criteria or symptoms are met

Diagnosis of gambling disorders

The DSM-5 includes problems with gambling as an addictive disorder. Gambling Disorder is identified when persistent and recurrent gambling behaviour meets four (or more) of a set of nine criteria within a 12-month period and the gambling behaviour is not better explained by a manic episode.

The criteria for a gambling disorder are that a person:

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<tr>
<td>1</td>
<td>Needs to gamble with increasing amounts of money in order to achieve the desired excitement</td>
</tr>
<tr>
<td>2</td>
<td>Is restless or irritable when attempting to cut down or stop gambling</td>
</tr>
<tr>
<td>3</td>
<td>Has made repeated unsuccessful efforts to control, cut back, or stop gambling</td>
</tr>
<tr>
<td>4</td>
<td>Is often preoccupied with gambling (e.g. having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble)</td>
</tr>
<tr>
<td>5</td>
<td>Often gambles when feeling distressed (e.g. helpless, guilty, anxious, depressed)</td>
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<tr>
<td>6</td>
<td>After losing money gambling, often returns another day to get even (“chasing” one’s losses)</td>
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<td>7</td>
<td>Lies to conceal the extent of involvement with gambling</td>
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<tr>
<td>8</td>
<td>Has jeopardised or lost a significant relationship, job, or educational or career opportunity because of gambling</td>
</tr>
<tr>
<td>9</td>
<td>Relies on others to provide money to relieve desperate financial situations caused by gambling</td>
</tr>
</tbody>
</table>

A gambling disorder is described as:

- **Mild**: when 4-5 criteria are met
- **Moderate**: when 6-7 criteria are met
- **Severe**: when 8-9 criteria are met

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Matua Raki. (2011). *Screening, Assessment and Evaluation: alcohol and other drug, smoking and gambling.* Wellington: Matua Raki


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Assessment and treatment planning

After a person is first welcomed at an addiction treatment service an assessment is carried out. An assessment is the process of collecting, integrating and analysing information provided by the person to develop a formulation or summary of the factors in their lives that have contributed to the development and maintenance of the issues that brought them to the service. Along with what the person wants to achieve this forms the basis for the development of an individualised treatment plan.

An assessment is much more than an information collection process. When done skilfully and empathically assessments can also be therapeutic.

Depending on the treatment setting and the severity and type of issue with which a person presents, different assessment processes can be used.

Screening for addiction problems (non-specialist settings)

Substance use or gambling can have a wide ranging impact on a person’s life. As a consequence they may initially present in primary care settings including health and social services and also criminal justice services. Workers in these settings can play a valuable role in identifying whether the person’s presenting issues could be improved by addressing their substance use or gambling.

The recommended approach is to screen people who attend these services for possible substance use and/or gambling problems. Screening tools are designed to identify people who may have a problem and positive results indicate that further assessment should be carried out to confirm severity. This can be followed up by a referral to specialist addiction treatment services and/or a brief intervention (see the Interventions section for further explanation).

The ASSIST substance use screen developed by the World Health Organisation is widely used to screen for problems with a range of substances.

The EIGHT gambling screen developed in Aotearoa New Zealand by Sullivan (2007) is also widely used to screen for problems with gambling.

The CHAT is a lifestyle and mental health screening tool developed in New Zealand by Goodyear-Smith et al (2008) for use in primary health care settings. The CHAT is an initial screening tool for physical activity, tobacco use, substance use, gambling, anxiety, stress, abuse and depression.

Brief screening and assessment (all treatment settings)

Non-specialist settings

In services for health, social and criminal justice issues, workers may follow up the use of screening tools with a brief assessment. Once a possible problem has been identified by a screening tool, further information could be gathered from a person regarding their substance use and/or gambling through an interview. The key information to be gathered would include:

- a description of current substance use and/or gambling (type, quantity and frequency)
- problems associated with this use (physical, social, legal, responsibilities)
- identification of associated harms (either current or potential) to themselves and/or others
• previous experience of substance use and/or gambling and treatment
• the person’s concerns and desire for change.

Once completed this assessment information can be used to provide a brief intervention and/or make a referral to a specialist treatment service.

**Specialist addiction treatment settings**

Brief screening and assessment can also be used by specialist treatment services. Screening tools may also be used initially as an efficient way to identify the range of substances that someone may have issues with and any co-existing mental health, physical health or social problems. Once identified, further information is gathered through an interview process similar to the content as described for the non-specialist services.

A brief assessment completed by specialist services would differ to non-specialist services in the following ways:

• a greater depth of information would be gathered
• specific information would be gathered to identify whether a provisional clinical diagnosis regarding the persons' substance use, gambling and/or co-existing problems is appropriate
• a therapeutic relationship would be developed using person-centred counselling and motivational approaches.

Whether specialist services provide brief assessment or a more comprehensive assessment will depend on the model of care they are providing, how long people engage with them and the severity or complexity of the person’s problems. For example, a telephone helpline service may only have a few minutes to work with someone and so needs to complete a brief assessment and provide some intervention during this time.

This can be compared with a residential treatment service where people live-in for eight weeks or longer or Opioid Substitution Treatment which people may participate in for some years. A longer intervention allows time for a more comprehensive and ongoing assessment process.

**Comprehensive assessment (specialist treatment settings)**

A comprehensive assessment is an in-depth holistic assessment of a person’s bio-psychosocial and spiritual background and current functioning and can include medical, psychological and biochemical testing. The aim of a comprehensive assessment is to develop a formulation of the aetiology (origins) of the substance use or gambling problem, any contributing and perpetuating factors including co-existing problems and the person’s strengths, in order to develop an appropriate individualised treatment plan.

For more detailed information about comprehensive assessment please see Screening, Assessment, and Evaluation: alcohol and other drug, smoking, gambling (Matua Rakī, 2012) and Te Ariari o te Oranga: The Assessment and Management of People with Co-existing Mental Health and Substance Use Problems (Todd, 2010).

As well as gathering information through self-report, screening and assessment tools and interview, information can also be gathered:

• from friends, family or whānau
• from referral sources (eg. general practitioners, probation officers or employers)
• through physical examination by a medical practitioner
• through breath, urine, blood or hair tests for the presence of substances and their metabolites
• through measures of physical damage from long term substance use or associated blood borne viruses (eg. through blood tests that measure liver functioning).

Assessing people with specific needs

Some groups of people have specific needs that should be included in a comprehensive assessment:

• People with co-existing problems (mental health and addiction) have received increasing recognition by addiction treatment services in Aotearoa New Zealand. Evidence suggests that around three quarters of people who go to treatment services in Aotearoa New Zealand are likely to have co-existing problems (Adamson et al, 2006 in Todd, 2010).

  The mental health issues that are most common in people with substance use and gambling disorders include depression, anxiety, bi-polar affective disorders and personality disorders. A comprehensive assessment should include screening and assessment for these common mental health issues (Todd, 2010). Other common co-existing problems include acquired brain injuries, hepatitis C, substance related physical health problems, relationship, housing and employment problems.

• People involved with the justice system are increasingly being required to undergo alcohol and other drug assessments, with the intention of addressing factors that contribute to offending and re-offending. As an example, Alcohol and Other Drug Treatment Courts are currently being piloted in the Auckland region. These courts have been developed to address the needs of people whose offending is driven by addiction and sentencing is deferred while people attend an assessment and treatment programme.

• Cultural assessment should be built into all assessments, partly to explore a person’s ethno-cultural identity but also to make sense of how this might have affected the development and maintenance of any issue. Where possible people are offered an assessment process that matches their cultural identity and assessments are carried out by workers, or with the support of workers, who are competent in the relevant language and protocols. Ideally cultural and comprehensive assessments are carried out by the same person but in some instances these will be carried out as complementary processes with the results being integrated to develop a formulation and a treatment plan.

Formulation

Assessments are most valuable when the information gathering process is followed up by formulation and treatment planning in collaboration with the person.

Formulation involves integrating the assessment information and analysing it to develop an understanding about the reasons for the current problems and what factors can support change. This summary then provides the basis for setting goals and plans for treatment. How information is analysed during formulation will depend on the model or framework that workers are trained and work in. For example, workers could use a social theory formulation or a bio-medical formulation.

Where a person has complex co-existing problems the assessment may be carried out by two or more workers from different disciplines (eg. addiction, psychology or psychiatry) over a period of time before a joint formulation is developed. A summary of the assessment and formulation (including cultural formulation) completes a comprehensive assessment process.
Treatment goals and planning

People may decide on treatment goals that relate to any associated life area as well as specifically on their substance use or gambling. When planning treatment goals regarding their substance use and gambling there are three broad options:

**Abstinence**

This is when a person wants to or chooses to abstain from using the substance or gambling completely. Sometimes this is seen as an initial goal that could be reviewed in the future. At other times it is seen as a life-long goal and may include abstinence from all psychoactive substances or addictive behaviours.

**Controlled use**

This is where a person aims to maintain a pre-arranged, low to moderate level of substance use or gambling, both in frequency and amounts. The aim of this is to prevent problems associated with excessive use or gambling.

**Harm reduction**

Harm reduction is primarily a pragmatic, evidenced-based approach to reducing addiction-related harm caused to individuals, families, whānau and communities. While harm reduction goals can include abstinence or controlled use, goals usually focus more broadly on reducing harm associated with continued substance use or gambling and its impact on wellbeing, health and behaviour. Harm reduction goals may encourage a person to:

- change the way substances are taken; for example encouraging the use of new equipment and filters when injecting or not mixing tobacco with cannabis
- change how substances are accessed; for example going into opioid substitution treatment rather than using non-prescribed opioids (eg. morphine, oxycodone, opium) and having to fund this through crime
- cut down on the amount used, the frequency of use or sustain controlled use; for example encouraging the person to plan when and how they use substances or gamble to ensure that they reduce other associated risks such as impaired driving or debt (Hamilton, King and Ritter, 2004).

**How treatment goals are selected**

The most effective approach to treatment goal selection is collaboration between a worker and a person. People have the greatest motivation for change when they have chosen their own goals. Practitioners can influence the goals that people select by ensuring they are fully informed and have discussed the options available.

When discussing the options for treatment several factors are considered:

- the model of care (eg. outpatient counselling or residential treatment) provided by the service the person is involved with
- the severity of the problem (eg. for people who have moderate to severe substance use or gambling disorders it is likely that abstinence will be recommended, at least initially, to break the physical, social and psychological patterns associated with the behaviour)
• the level of harm associated with continued substance use or gambling and whether this is due to the harmful effects of the substance (e.g. inhalants) or because the person has co-existing physical or mental health issues that would be exacerbated by further use.

Ultimately treatment goals are chosen by the person. Where they continue their substance use or gambling against professional advice workers will work with them to achieve their chosen goals, while continuing to work with their motivation to make other behavioural changes and review goals as needed.

Once initial treatment goals have been determined in partnership with the person the next stage is the development of a treatment plan, reflecting the assessment, formulation and treatment goals. A treatment plan identifies specific actions for how each goal will be achieved. It may involve the person accessing information, support, and/or interventions including medication.

References and further information

Treatment Improvement Protocols (TIPS) are available for working with people with specific needs and can be found online at Substance Abuse and Mental Health Services Administration: http://store.samhsa.gov/list/series?name=TIP-Series-Treatment-Improvement-Protocols-TIPS-


Interventions used in addiction treatment

There are a range of interventions used to treat addiction problems, some that can be applied across all addiction problems and others specific to the substance or behaviour of concern. When planning treatment the assessment formulation or summary provides an indication of which interventions are likely to be most effective. More severe problems usually require longer, more intensive, specialist treatment than less severe problems (Raistrick, Heather and Godfrey, 2006).

A stepped-care approach is recommended, that is providing people with the least intrusive, least expensive intervention which is most likely to be effective for their level of use (Sobell and Sobell, 2000, cited in Raistrick et al, 2006, p. 27). If an intervention is unsuccessful a more intensive intervention is then offered and so on until treatment is effective. A person with a severe substance use disorder will need a level of intervention that is appropriate to their needs and this is likely to be more intensive from the outset.

Pharmacological interventions

Pharmacological (medication) interventions are available to help people:

- reduce their physical dependence on substances and safely stop or reduce use of substances through withdrawal management (eg. benzodiazepines to reduce the risk of seizures in acute alcohol withdrawal)
- relieve cravings (eg. naltrexone to reduce both the desire to use and the reinforcing effects of alcohol and possibly gambling)
- reduce the attraction of substances through making their use less rewarding (eg. disulfiram, Antabuse, to make alcohol use extremely unpleasant)
- replace substances with a safer legally available alternative (eg. opioid substitution therapy)
- treat co-existing physical and mental health problems (eg. pain, depression and anxiety).

Managed withdrawal (detoxification)

Where people have developed physical dependence on certain substances they may need medical support to stop or reduce use and to manage any withdrawal symptoms. This tends to be mainly for alcohol, opioids, benzodiazepines and amphetamine-type stimulants (National Centre for Education and Training on Addiction (NCETA), 2004). There is also evidence of severe withdrawal symptoms associated with the use of some new psychoactive substances, eg. GHB and synthetic cannabinoids.

Medically assisted managed withdrawal can be provided in the community, residential or hospital settings. More intensive care is needed when withdrawal symptoms can be life-threatening, when there has been poly-drug use or when there are co-existing physical or mental health problems. Managed withdrawal services provide a range of medications and support to relieve withdrawal symptoms.

In some circumstances it is more appropriate to provide a reducing prescription of a medication with similar effects to the substance. For example, nicotine replacement therapy (NRT) is used for treating dependence on nicotine and methadone and buprenorphine are used for treating dependence on opioids.
Pharmacotherapies

For alcohol and opioids the following types of medications are available to assist people to maintain abstinence or controlled use once it is achieved.

- Anti-craving medications, eg. naltrexone.
  - Naltrexone blocks the effects of the substance in the brain and reduces the positive effects and can reduce cravings. It is only licensed in Aotearoa New Zealand for periods of up to six months in any year to use as an anti-craving medication for alcohol.

- Medications that interfere with how the body processes the substance, eg. disulfiram.
  - If alcohol is consumed while taking disulfiram it stops the body from breaking down alcohol and creates a toxic build-up. This causes the person to feel very ill and is therefore used with caution.

Where a person's goal is not abstinence, there are medications available that imitate or replace the substance of choice. Methadone and buprenorphine both produce opioid effects and are used as long-term opioid substitutes. Substitute medications are safer alternatives to ongoing substance use in that they are prescribed to be used in a safer way (eg. not injected) and are often longer acting. As prescribed medications they are also provided in a more stable and consistent manner in terms of both quantity and quality, allowing people to make other lifestyle changes including not committing crime to finance use.

Pharmacotherapies for gambling disorders are still being developed and tested, eg. naltrexone, but as yet there is no clear evidence about the biological mechanisms that contribute to gambling.

Treating co-existing mental health problems (CEP)

The majority of people with substance use or gambling disorders also have co-existing mental health problems. Addiction and other mental health issues, such as trauma, anxiety and depression, can exacerbate each other so the impact on a person's wellbeing is greater. Medications to assist with mental health issues and symptoms can therefore sometimes help people to better manage their substance use or gambling.

Psycho-social interventions

In the last few decades there has been an increase in research investigating which psycho-social treatments are most effective for substance use disorders. Unfortunately very few randomised control trials have been completed for gambling disorders (Tan and Wurtzburg, 2004).

Having a therapeutic relationship built on trust and focussed on the fundamental capacity of the practitioner to feel, show and express empathy has been shown to be vital to the ongoing effectiveness of any intervention (Lambert and Barley, 2001).

A review of treatment effectiveness for alcohol and other drug use (Gossop, 2006; Raistrick, Heather and Godfrey, 2006) concluded that a number of interventions are effective and providing people with a range of options is appropriate.

While there is a growing expectation that services will provide interventions that are supported by evidence, sufficient research has not always been completed for each specific psycho-social intervention.
Where this is the case services continue to provide a range of interventions that are either evidence-based or currently considered best practice.

Most of the evidence-based psycho-social interventions arise from the cognitive-behavioural theories of human behaviour. They are usually not solely focused on a person’s psychology but also consider social context. Many of these interventions, or talking therapies, are provided during individual counselling sessions but they can also be provided in an educational or therapeutic group format. This has the added benefit of facilitating peer support.

The key psycho-social interventions used with addiction issues are briefly described below.

**Brief intervention**

Brief intervention is a commonly used term in addiction treatment, but it is not always used consistently. Brief intervention is also described differently in the research literature, in publications and best practice guidance (Matua Raiki, 2012b). Generally the term ‘brief intervention’ is used to refer to different kinds of interventions based on the setting (Raistrick et al, 2006).

- **Non-specialist settings**: brief interventions provided by non-specialist workers in health and social service settings where people are attending for other reasons. Awareness of substance or gambling problems may have arisen or been identified through screening. The interventions can range from a few minutes of structured advice through to a 60 minute structured therapeutic intervention that may also involve a follow-up session. In a brief intervention session the intervention would be aimed at, and might include, giving people feedback, providing advice and information, assessing motivation and readiness to change, problem solving, goal setting and relapse prevention (Matua Raiki, 2012).

- **Specialist settings**: brief interventions provided by specialist staff in addiction treatment settings where people have requested assistance with their substance use or gambling. The interventions are often used as an initial step in a stepped-care approach. They involve one to four sessions and commonly involve techniques such as motivational interviewing and brief cognitive behavioural therapy.

**Motivational interviewing**

Motivational interviewing is a key component of addiction treatment (Miller and Rollnick, 2013). This intervention is based on person-centred skills but is directed by the practitioner towards behavioural change. The key is to increase a person’s motivation for change by assisting them to become aware of their own ambivalence about their substance use or gambling. Once a person’s motivation for change has increased the practitioner then supports them to put the changes into action.

**Cognitive-behavioural therapy**

Cognitive behavioural therapy (CBT) aims to adjust thoughts and behavioural patterns to create more adaptive outcomes (Te Pou, 2010). Both cognitive and behavioural techniques are used to change the patterns of thought and behaviour that contribute to the use of substances or gambling.
There are many interventions for addiction treatment that are based on cognitive behavioural principles, such as Contingency Management and Social Behaviour Network therapy. Interventions commonly used in Aotearoa New Zealand treatment services are:

- relapse prevention
- behavioural self-control training
- coping and social skills training
- community reinforcement approach.

**Case management**

Case management is also a key component of addiction treatment and, while not a psycho-social treatment as such, does involve working alongside people to plan their treatment and monitor their progress. It involves ensuring people have sufficient information to make treatment choices, linking them in with other services and advocating for their needs where necessary. Case management is a coordination role that brings together information, resources and support for people to achieve their goals.

**Dialectical behaviour therapy**

Dialectical behaviour therapy (DBT) is a relatively new form of therapy to the addiction treatment sector. It has, however, been used in the wider mental health field for some time to help people diagnosed with borderline personality disorder and where other modes of therapy have had little success. Dialectical behaviour therapy seeks to improve interpersonal, self-regulation and distress tolerance skills by integrating behavioural strategies with mindfulness practices. It focuses on validating a person’s acceptance of themselves as they are, while seeking to create motivation for change (Te Pou, 2010).

**Family inclusive practice**

Family inclusive practice (FIP) refers to a range of different interventions that involve families and whānau in treatment. These interventions have common underlying principles that are based on a collaborative, strengths-based, solution-focused and empowering approach (Kina Families and Addiction Trust, 2010).

**Therapeutic communities**

Traditionally based on ‘community as method’ approaches, therapeutic communities (TCs) are often seen as offering a type of supportive peer community. In their different adaptations they now also take a variety of psycho-social and educational approaches.

In TCs people live in a residential setting for a period of time (up to a year) that allows "a total environment in which transformation in the consumer’s conduct, attitudes and emotions are fostered, monitored and mutually reinforced by the daily regimen” (De Leon, 1995 as cited in Te Pou, 2010). Most services providing therapeutic communities also provide a phased re-introduction back into the wider community and after-care.

**Traditional cultural therapies**

These therapies are most commonly provided by specific cultural treatment services and involve a range of interventions. For example, Māori treatment services may provide karakia (prayer), rongoa (herbal remedies), mirimiri (massage) and wai karakia (blessing with water) (Matua Rakī, 2010). Specific cultural approaches to treatment tend to be more holistic and focus on culturally appropriate protocols, inclusion of family and whānau, and spiritual aspects of life.
**Twelve-Step facilitation therapy**

While the Twelve-Steps should not be seen as a treatment intervention as such, some services do incorporate the Twelve-Steps into their treatment programmes. This approach has come to be known as Twelve-Step facilitation therapy and was described in detail in Project MATCH (Nowinski, Baker and Carroll, 1992). It involves supporting people to undertake the Twelve-Steps of fellowships such as Alcoholics Anonymous and Gamblers Anonymous, attending meetings and gaining support from a sponsor chosen from the fellowship.

The key aspects of the steps are that people accept they have a chronic progressive disease and need to be abstinent, they believe a higher power can ‘restore them to sanity’ and they are actively involved with Twelve-Step meetings (Te Pou, 2010).

**Public health approach**

Although psycho-social interventions address a person’s immediate needs, they don’t initiate change in the wider community or at a societal level. The public health approach addresses substance use and gambling issues at the population level. It combines health promotion and harm minimisation activities to enhance wellness and reduce the harm caused by gambling and substance use in society (Tan and Wurtzburg, 2004).

There are two levels of public health interventions. One is at an overview level which monitors the ‘big picture’ by measuring levels of use and associated problems. This information can then inform policy development and legislative change, for example changing the legal status of a substance.

The other level is focused on local communities and tends to involve public education and community development, for example lobbying local authorities to reduce poker machine outlets (Tan and Wurtzburg, 2004). Both the alcohol and other drug and gambling sectors include public health approaches.

**References and further information**

There are several sources of guidelines for evidenced-based best practice in addiction treatment. Listed below are some key sources.

**Cochrane Reviews**

www.cochrane.org/cochrane-reviews

Cochrane collaborations provide systematic reviews of all research completed on specific topics and meet certain criteria for research methodology. They investigate what the evidence is for the effects of interventions for prevention and treatment, as well as the accuracy of diagnostic tests. The conclusions allow clinical decisions to be based on reliable and current evidence for health interventions, including for problematic substance use and gambling. Some of the relevant topics include: therapeutic communities, motivational interviewing, case management and talking therapies.
National Treatment Agency for Substance Misuse (NTA)
www.nta.nhs.uk

This website is useful for downloading NTA publications on treatments and their effectiveness.

Treatment Improvement Protocols (TIPs)
http://store.samhsa.gov/list/series?name=TIP-Series-Treatment-Improvement-Protocols-TIPS-

The Substance Abuse and Mental Health Services Administration (SAMHSA) draws together expert knowledge, clinical experience and research to produce a series of best practice guidelines called Treatment Improvement Protocols (TIPs) for working with substance use issues. Topics include: detoxification and substance abuse treatment, enhancing motivation, and brief interventions.

Turning Point Alcohol and Drug Centre
www.turningpoint.org.au

This is an Australian service that publishes a series of treatment guidelines for alcohol and drug clinicians. Topics include: controlled drug use, relapse prevention and case management.

Academy of Medical Sciences. (2008). Brain science, addiction and drugs. Great Britain: Academy of Medical Sciences


**Types of support for addiction problems**

There is a range of different services and support available for the treatment of substance use and gambling disorders. This section describes the types of service and support that are available in Aotearoa New Zealand. For information about specific services see the Addictions Treatment Directory at www.addictionshelp.org.nz/Services/Home

Information about support options is also available from the following phone lines:

- Alcohol Drug Helpline 0800 787 797
- Maori Helpline 0800 787 798
- Pasifika Helpline 0800 787 799
- Gambling Helpline 0800 654 655.

Support for addiction problems can be accessed through specialist treatment services as well as non-specialist services, peer networks and self-help groups.

**Consumer networks and peer support groups**

The most common self-help groups for addiction in Aotearoa New Zealand are ones based on the Twelve-Step programme. Other self-help groups have been established overseas, such as rational recovery (RR) in 1985, and self-management and recovery training (SMART) in 1994 (Miller, 1999), but they have not yet gained the same momentum in Aotearoa New Zealand as the Twelve-Step movement. More recently a number of peer support groups have also evolved.

**Twelve-Step groups**

Twelve-Step groups can provide ongoing support for people in the community. Twelve-Step groups have now been established for a large range of addictions and now include Narcotics Anonymous (NA), Marijuana Anonymous (MA), Gamblers Anonymous (GA), Sex Love Anonymous (SLA). There is also an equivalent movement for friends, family and whānau of ‘alcoholics’, Al-Anon, and of gamblers, Gamanon.

Twelve-Step meetings can be found all around Aotearoa New Zealand. More information can be found at the following links:

- Alcoholics Anonymous New Zealand: www.aa.org.nz
- Narcotics Anonymous: www.nzna.org
- Gambling Anonymous: www.gamblersanonymous.org

**Consumer networks**

Consumer networks, both formal and informal, have been around for a number of years. They are a platform for people to be involved in a wide range of issues and activities, from discussing topical issues within the addiction sector to participating in social and recreational activities.

Consumer networks have also been the driving force in the development of peer support groups. Consumer advisory roles, either directly or indirectly, have also played an active role in the development and support of both consumer networks and peer support groups throughout Aotearoa New Zealand.
Peer support groups

Funded peer support groups and services that have developed more recently are very much grounded in the ‘strengths’ based approach, often with a common and shared understanding that peer services ‘do not try to fix people’. Diversity is valued and respect for each other’s opinions, values and concepts of ‘recovery’ is key. There is also the recognition that some people may not have a desire to stop using substances, so people are welcomed no matter what their personal ‘recovery’ goals. There is an explicit expectation that all peer groups and peer support services are peer-led and driven.

Non-specialist addiction services

Brief intervention services

As mentioned earlier, services that work with issues in the areas of health, wellbeing and justice can play a key role in identifying and supporting people to make changes to their substance use and/or gambling.

The key services that can incorporate this into their work are:

- primary and community health services eg. general practices
- food banks
- hospital services eg. emergency departments
- mental health services eg. supported accommodation
- Department of Corrections facilities eg. probation, prison health units
- general counselling services eg. school guidance counsellors
- social work services
- budgeting services.

When these services provide support for substance use or gambling problems it usually consists of screening for issues and some form of brief intervention and, if required, a referral on to a specialist addiction treatment service.

Respite and after-care services

Other non-specialist services that provide support to people with severe substance use problems are those that provide residential respite and after-care. These services are for people who have severe substance use disorders and have very little support in the community and who want a safe place to stay post managed withdrawal or during supported community managed withdrawal.

Some respite services specialise in caring for people with dementia or other acquired brain injury which may have been caused by protracted heavy alcohol use.

Specialist addiction treatment services

There is a range of specialist treatment services for substance use disorders that cater for different needs. Most treatment services in Aotearoa New Zealand are funded by the Ministry of Health through the District Health Boards (DHBs) to meet the needs of their communities. The Department of Corrections also funds several prison based drug treatment units (DTUs) and there are a few private residential and out-patient counselling services where people fully fund their own treatment or treatment is funded through alternate sources, eg. Corrections.
DHBs fund both community alcohol and drug or addiction services (CADS) and non-government organisations (NGOs) in their own regions. Non-government organisations (NGOs) also receive contributions through fundraising. During 2011/2012 these services treated approximately 44,170 people in Aotearoa New Zealand (Ministry of Health, PRIMHD from National Committee for Addiction Treatment and Platform, 2014).

The range of addiction (substance use disorder) services

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Service Provision</th>
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</thead>
<tbody>
<tr>
<td>Phone-lines and websites</td>
<td>Information and support</td>
</tr>
<tr>
<td>Community</td>
<td>Out-patient, assessment and treatment</td>
</tr>
<tr>
<td>Day programmes</td>
<td>More intensive out-patient assessment and treatment</td>
</tr>
<tr>
<td>Residential treatment</td>
<td>Assessment, in-patient treatment, after-care</td>
</tr>
<tr>
<td>Withdrawal management services, either in community</td>
<td>Medical and/or social support depending on particular substances used, levels of use and co-existing problems</td>
</tr>
<tr>
<td>Residential treatment</td>
<td></td>
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<tr>
<td>Residential treatment</td>
<td>Assessment, in-patient treatment, after-care</td>
</tr>
<tr>
<td>Residential treatment</td>
<td>Medical and psycho-social intervention for opioid dependence</td>
</tr>
<tr>
<td>Needle exchange services</td>
<td>Provides information, support and supplies to encourage safer drug injecting practices</td>
</tr>
</tbody>
</table>

Many of these services are for the general population. However, some specialist treatment services are funded to cater for specific populations within the community.

Specialist treatment services

<table>
<thead>
<tr>
<th>Specific Population</th>
<th>Type of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth</td>
<td>Community or residential assessment and treatment</td>
</tr>
<tr>
<td>Parents</td>
<td>Community or residential based interventions</td>
</tr>
<tr>
<td>Māori</td>
<td>Community or residential assessment and treatment based on Māori Kaupapa</td>
</tr>
<tr>
<td>Pasifika</td>
<td>Community or residential assessment and treatment based on Pasifika approaches</td>
</tr>
<tr>
<td>Co-existing mental health problems</td>
<td>Community or residential assessment and treatment</td>
</tr>
<tr>
<td>People involved with the criminal justice system</td>
<td>Community or residential assessment and treatment</td>
</tr>
</tbody>
</table>

As well as services established to work with specific groups, within general addiction services there are often staff members who specialise in working with particular groups or ethnicities. For example people who are over 65 years, Māori, Pasifika and Asian, gay and lesbian. Larger services sometimes have teams that specialise in these areas of work.
Services for family and whānau members

Most specialist addiction treatment services focus on a person using substances. However family and whānau members are welcome to participate in the person’s assessment and treatment (where permission is given) and many services will provide support to family and whānau members in their own right. This can consist of:

- education about addiction and the impact of addiction on individuals, family and whānau
- information about the short and long term effects of substances and treatment options
- support and counselling for family and whānau members.

Specialist gambling treatment services

Gambling services are funded by a levy paid by gambling operators to the Crown. Gambling services funded by the government include primary (public health), secondary and tertiary prevention (intervention) services, research, evaluation and workforce development.

Most specialist gambling services in Aotearoa New Zealand are NGOs and are funded through the levy, which is sometimes supplemented through fundraising. Gambling treatment services also often provide public health services, such as policy development, awareness raising, education and strengthening communities. Over the 2011-2012 financial year these services treated approximately 11,847 people in Aotearoa New Zealand (Ministry of Health, 2014). In the 2010-2011 year the Gambling Helpline supported 3,600 people (Ministry of Health, 2014a)

There are also some private residential and out-patient counselling addiction services available where people fund their own treatment for gambling disorders.

The range of gambling services

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Service Provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone-lines and websites</td>
<td>Information and support</td>
</tr>
<tr>
<td>Community interventions</td>
<td>Out-patient, assessment and treatment. Some are for specific groups eg. Māori or Pasifika</td>
</tr>
<tr>
<td>Residential treatment</td>
<td>Assessment, in-patient treatment, after-care</td>
</tr>
</tbody>
</table>

The Gambling Helpline NZ (0800 654 655), a national free phone support service, also provides the following specialist phone lines or services:

- Māori
- Pasifika
- youth
- gambling debt
- texting.
Services for family and whānau members

Some specialist gambling treatment services provide information, support and counselling to family and whānau members of gamblers, eg. the Salvation Army Oasis Centres.

References and further information


Matua Raki. (2010). *Consumer and peer roles in the addiction sector*. Wellington: Matua Raki


National Committee for Addiction Treatment. (2010). *Alcohol and drug treatment services in New Zealand*

National Committee for Addiction Treatment and Platform. (2014). *A profile of alcohol and other drug treatment services in Aotearoa New Zealand*
The addiction treatment workforce

In 2008 there were approximately 1,370 funded positions (1,500 people) in the alcohol and other drug treatment workforce nationwide (Matua Raŋi, 2009b). With the mixed counselling and public health roles of the gambling workforce, it is difficult to estimate the number of workers specifically delivering treatment though it is estimated to be 111 people (KPMG, 2013).

This section describes this workforce and summarises the various roles found in the addiction treatment sector. Each service may have different titles or names for these roles but the tasks and responsibilities will be similar.

The culture of the addiction workforce in Aotearoa New Zealand

Due to its historical roots and the issues inherent with addiction the addiction workforce has developed its own unique culture.

A major influence on the workforce culture has been the fact that support for addiction in Aotearoa New Zealand was first developed ‘by alcoholics for alcoholics’. Much of the workforce continues to be people who have their own lived experience of substance use and/or gambling disorders, or of being a family or whānau member of someone with these issues. This background and ongoing influence tends to reduce the barriers between professionals and the people they work with and supports engagement and a collaborative person-focused approach to treatment.

Alongside this influence, as talking therapies are the mainstay of addiction treatment, the workforce has developed particular person-focused skills to engage with and retain people in treatment.

Another influence on workforce culture is the complex nature of addiction issues which requires a bio-psycho-social response. The knowledge, expertise and skills of different professions are therefore required to provide effective and appropriate addiction treatment. About 52 per cent of the alcohol and other drug workforce identify as addiction practitioners or counsellors, 16 per cent as nurses, 5 per cent as social workers and 2 per cent as medical practitioners (Matua Rāki, 2011).

As addiction is both a health and social issue, substance use and gambling disorders are often affected by socio-political decisions. Many addiction-related problems develop in the context of deprivation and marginalisation from mainstream culture. As a consequence the addiction workforce also has a strong commitment to working with social justice issues.

The last major influence on the addiction workforce culture is the focus on a harm reduction approach which grew out of the health responses to the ‘AIDS Epidemic’ in the 1980s. This requires practitioners to have a value-neutral view of substance use and gambling and the people who use substances and gamble, focusing more on supporting people to reduce the harms associated with patterns of substance use and gambling and enhancing their motivation to change attitudes and behaviours related to substance use or gambling. Marlatt (1998) describes this as a ‘bottom up approach’ that advocates for people’s needs and involves them in finding their own solutions and making treatment decisions.

Marlatt also describes harm reduction as “compassionate pragmatism [rather than] moralistic idealism” (p.56), and in many ways this also sums up the approach of the addiction workforce.
Education in addiction treatment

There are specialised alcohol and other drug qualifications at all tertiary education levels. These are provided by educators including the Auckland University of Technology, National Addiction Centre (Otago University), University of Auckland, Moana Training Institute, Anamata and the Wellington Institute of Technology (among others).

Often embedded within these qualifications are papers specific to gambling and its treatment, particularly at the University of Auckland and Auckland University of Technology. The Ministry of Health supports professional development in the addiction workforce by providing funds either directly to services or through the provision of scholarships.

Addiction workforce competencies

Although not compulsory there is a strong expectation that the people who work in mental health and addiction treatment services are competent in certain skills and attitudes. These sets of competencies are seen as complementary to the competencies developed for each professional group. These competencies include:

- *Let’s get real: Real Skills for people working in mental health and addiction* (Ministry of Health, 2008)
- *Recovery Competencies* (O’Hagan, 2001)
- *Aotearoa New Zealand Addiction Speciality Nursing Competency (Knowledge and Skills) Framework.* (Drug and Alcohol Nurses of Australasia (DANA), 2012)
- *Te Whare o Tiki: Co-existing problems knowledge and skills framework* (Matua Raki and Te Pou, 2013)
- *Peer Workforce Competencies* (Te Pou, 2014).

Addiction workforce roles

**Addiction practitioners**

This role is the most common within substance use and gambling treatment services. People in these roles can also be referred to as clinicians or counsellors. The responsibilities of this role include: assessment, treatment planning, case management, and providing relevant psycho-social interventions. Addiction practitioners employed by gambling intervention services may also provide specific public health interventions.

People employed as addiction practitioners bring with them a range of experiences, qualifications and training which may include:

- a qualification in alcohol and other drug studies, gambling, psychology, counselling, social work, nursing, psychotherapy, health science or occupational therapy
- registration with the professional body that matches their qualifications, such as New Zealand Association of Counsellors, New Zealand Nursing Council or registration as a social worker
- specific qualifications in working with alcohol and drug or gambling issues.
Over the last decade there has been a movement to enhance the qualifications and professionalism of the addiction workforce led by the Addiction Practitioners’ Association of Aotearoa-New Zealand (dapaanz). Addiction practitioners can apply to dapaanz to become Registered Practitioners.

The criteria for registration include:

- an applied bachelor degree in nursing, psychology, social work or similar
- a degree in addiction studies
- sufficient clinical experience
- ongoing clinical supervision
- verification that they demonstrate specific competencies.

There are other levels of endorsement for those who are not eligible for the practitioner level membership.

The Addiction Intervention Competency Framework describes the knowledge and skills to provide effective treatment for substance (including tobacco) use and gambling disorders (dapaanz, 2011) and provides an integrated set of competencies for those who work in addiction treatment.

The addiction competencies include a core set of competencies that the addiction workforce have in common as well as acknowledging specialist skills required in each of the three areas: i.e. substance use, tobacco use and gambling. The Ministry of Health funded the development of a separate set of public health competencies which also apply across the gambling workforce (Health Promotion Forum of New Zealand, 2012).

### Clinical supervisors

It is considered best practice for all addiction practitioners to receive regular clinical supervision to address issues that arise in relation to themselves as practitioners, in relation to the people they work with or in relation to the wider service context. Clinical supervisors may be employed within an addiction treatment service or be independent contractors. Supervisors are usually chosen based on their experience, skills and knowledge as an addiction practitioner as well as training in clinical supervision.

### Community support workers

This role was initially developed within mental health services and has a well-established education and career pathway within that setting. The tasks of community support workers focus on supporting people to implement their treatment plans, usually in a residential and/or non-government agency settings.

The role is not so well established within addiction treatment services. Support workers are often employed based on their personal experience of treatment.

### Cultural specialist roles

Workers employed in kaupapa Māori and Pasifika services are expected to operate from a cultural paradigm which does not preclude use of a range of different interventions. Māori workers can also be employed by ‘mainstream’ services in specific cultural roles.

Blended cultural and clinical competencies have been articulated to enhance work with Māori (for example the Takarangi Competency Framework, Matua Raiki, 2010b).
Cultural and clinical competencies, called Seitapu, have also been developed for the Pasifika addiction workforce, (Te Pou, 2007).

**Managers and administrators**

As with other businesses addiction treatment services require leadership and administration support. Administrators may support addiction teams in a variety of ways (for example, provide reception duties, organise meetings and take minutes). Managers and team leaders often are promoted from clinical roles and so have a good understanding of the work involved. Managers and team leaders have access to training and education options to develop their leadership skills in health service settings (eg. Blueprint for Learning).

**Medical officers, addiction medicine specialists and psychiatrists**

Many addiction treatment services employ doctors, particularly the services that provide medical interventions such as withdrawal management and opioid substitution treatment. These doctors could be medical officers, addiction medicine specialists, or psychiatrists, depending on their role and qualifications. Specialists in these services have responsibilities for assessment, diagnosis and treatment of physical and mental health issues related to substance use disorders. They provide necessary medications and some psychiatrists may also provide talking therapy interventions. Doctors may hold clinical leadership positions within services and can therefore be responsible for all the clinical services being provided.

All doctors need to be registered with the Medical Council of New Zealand and have a current annual practising certificate. There is also a professional pathway to achieve a Fellow of the Australasian Chapter of Addiction Medicine (FACHAM) through the Royal Australasian College of Physicians.

**Nurses**

Many nurses are employed by the addiction treatment sector, but not always in specific nursing roles. Specific nursing roles include tasks such as assessing and monitoring physical health, monitoring of and, under authorisation, dispensing medication, providing specialist withdrawal management and providing brief psycho-social interventions appropriate to their role.

Addiction nursing is a specialised role and the expertise is often gained from work experience. Relevant education opportunities include completing a post graduate mental health nursing specialisation which can sometimes include alcohol and drug studies.

Nurse practitioners are registered nurses with advanced education and experience who have the ability to make complex decisions on care for individual patients and populations. Nurse practitioners are expert nurses working in a specific area such as addiction. They provide a wide range of care including diagnosis, assessment and intervention and may prescribe medicines relevant to their specific area of practice (Nursing Council of New Zealand, 2007).

The Aotearoa New Zealand Addiction Speciality Nursing Competency (Knowledge and Skills) Framework has been developed for addiction specialty nurses (DANA, 2012) and builds on the Standards of Practice for Mental Health Nursing. It describes the career pathways for foundation, specialist and advanced specialist level nurses (Deering, 2010).
**Peer support workers**

Historically people with a lived experience of addiction have played a significant role in the addiction treatment sector, predominantly in clinical roles. Employing people with a lived experience of addiction and ‘recovery’ into non-clinical designated peer roles is relatively new. The roles and tasks are diverse and may be paid or voluntary. However all roles share one thing in common, that is a lived experience of a substance use and/or a gambling disorder (Matua Raki, 2010). The types of consumer and peer roles include; consumer advisor, consultant, peer support workers and consumer/peer support advocate.

**Psychologists**

Psychologists can be employed in addiction services to carry out neuropsychological assessments and provide specialist psycho-social interventions.

Psychologists need to be registered with the New Zealand Psychologists Board and hold a current annual practising certificate. Specialisation in addiction treatment develops through work experience and/or post graduate alcohol and drug studies.

**Social workers**

The addiction treatment sector often employs social workers into addiction practitioner roles. There are however some social work specific roles in the addiction sector which include tasks such as case management, linking and networking with other services to gain support for people, advocacy and outreach work.

Social workers are encouraged to be registered with the Social Workers Registration Board and to maintain annual practising certificates. Specialisation as a social worker in addiction treatment develops through work experience and post graduate alcohol and drug studies.

**Other professionals**

Larger addiction services, or those that provide specialist services, may also employ other professionals such as occupational therapists, psychotherapists and pharmacists.

**References and further information**

For more information on peer support see the Power of Peer Support Services at the Health and Disability Commission's website: http://www.hdc.org.nz/media/199050/power%20of%20peer%20support%20services.pdf

For more information about DANA see: www.danaonline.org


Matua RaKi. (2009b). *Stocktake of alcohol and other drug treatment services in New Zealand 2008*. Wellington: Matua RaKi

Matua RaKi. (2010). *Consumer and peer roles in the addiction sector*. Wellington: Matua RaKi

Matua RaKi. (2010b). *Takarangi Competency Framework*. Wellington: Matua RaKi


Matua RaKi and Te Pou o te Whakaaro Nui (Te Pou). (2013). *Te Whare o Tiki: Co-existing problems knowledge and skills framework*. Matua RaKi and Te Pou o te Whakaaro Nui


Te Pou o te Whakaaro Nui (Te Pou). (2014). *Peer Workforce Competencies for the Mental Health and Addiction Sector*. Auckland: Te Pou o te Whakaaro Nui
National organisations

This section provides a brief description of several national organisations that have an interest in substance use, gambling and treatment. They have been categorised into organisations with a focus on public health, workforce and professional development and stakeholders in the treatment sector.

Public health organisations

Health Promotion Agency (HPA)
http://www.hpa.org.nz/

In July 2012 the Health Promotion Agency (HPA) took over the functions of Alcoholic Liquor Advisory Council (ALAC), the Health Sponsorship Council (HSC) and some other health promotion functions of the Ministry of Health.

ALAC was established to promote moderate use of alcohol and strategies to reduce alcohol-related harm with a public health approach. For many years ALAC was the only national body with an interest in this area and therefore also supported the treatment sector.

The long-term focus of the HSC was on reducing the incidence and impact of gambling disorders in order to reduce associated mental, social and financial harms. The Ministry of Health funded HSC to develop and deliver a programme to raise awareness, de-stigmatise the issue and encourage help-seeking for those in need.

Alcohol Drug Association of New Zealand (ADANZ)
www.adanz.org.nz

ADANZ aims to minimise harms associated with substance use and gambling by providing expert information and policy advice, early intervention and support services. Most of these services are available through its website that also includes access to the online database of the national Addictions Treatment Directory which ADANZ compiles. ADANZ also manages the national Alcohol Drug Helpline (www.alcoholdrughelp.org.nz, phone 0800 787 797).

New Zealand Drug Foundation (NZDF)
www.nzdf.org.nz

NZDF aims to reduce and prevent harms caused by drugs by advocating for evidenced-based policies and services. It develops resources and has set up three websites to provide information and resources for those concerned about their own or someone else's substance use. These are:

- Methhelp (www.methhelp.org.nz)
- Drughelp (www.drughelp.org.nz)
- Pothelp (www.pothelp.org.nz).
Workforce development and professional organisations

Abacus Counselling, Training and Supervision Ltd
www.acts.co.nz

The Ministry of Health currently contracts Abacus as an intervention workforce development and training provider. Its role is to provide independent clinical and technical advice to the Ministry in addition to providing workforce training and support to problem gambling intervention staff working for the Ministry’s funded problem gambling intervention service providers.

Addiction Practitioners Association of Aotearoa–New Zealand (dapaanz)
(Formerly known as Drug and Alcohol Practitioners Association Aotearoa NZ)
www.dapaanz.org.nz

Anyone with a professional interest in the treatment of addiction can join dapaanz as a member to come under its code of ethics, access discounted registration for its annual conference and biennial school and to receive its newsletter. dapaanz also receives applications from people working in the treatment sector to become a registered practitioner. There is also an endorsement for those not yet ready to apply for full registration and associate practitioners. The names of current registered, provisional and associate practitioners are available on the website.

The public can make complaints about registered practitioners and if they are found to have breached the dapaanz Code of Ethics they can be censored, including being de-registered.

dapaanz also:

- provides information about dapaanz approved addiction qualifications
- ensures current registered practitioners have continuing professional development
- organises Cutting Edge (the annual national addiction treatment conference) and the School of Addiction (a series of workshops for experienced staff).

Centre for Addiction Research (CFAR)

The Centre for Addiction Research is based at the University of Auckland and is committed to providing evidence to inform policy and practice in the understanding, prevention and treatment of addictive behaviours.

Gambling and Addictions Research Centre
http://www.niphmhr.aut.ac.nz/research-centres/gambling-and-addictions-research-centre

The Gambling and Addictions Research Centre is based at Auckland University of Technology and undertakes applied research that informs policy and professional practice in public education, population health and primary and secondary health care.
Kina Families and Addictions Trust
www.kinatrust.org.nz
Kina Trust promotes family inclusive practice in addiction and mental health treatment services.

National Addiction Centre
http://www.otago.ac.nz/nationaladdictioncentre/
The National Addiction Centre is part of the University of Otago and provides post graduate education and research with the aim of promoting effective interventions for addiction issues.

Matua Raki
www.matuaraki.org.nz
Matua Raki is the National Addiction Workforce Programme established by the Ministry of Health and is currently hosted by Te Pou within the Wise Group. Matua Raki develops and promotes resources and training to build capacity and capability of the workforces working to minimise addiction-related harm. Matua Raki also funds networking events within the treatment sector, such as regular Addiction Leadership Days, and Training Providers Network meetings. Other health workforce development programmes that provide the addiction sector with support are:

- Te Pou with a focus on adult mental health workforce development (www.tepou.co.nz)
- Te Rau Matatini with a focus on Māori health workforce development (www.matatini.co.nz)
- LeVa with a focus on Pasifika health workforce development (www.leva.co.nz)
- The Werry Centre with a focus on child and adolescent mental health and alcohol and other drug workforce development (www.werrycentre.org.nz).

Treatment stakeholder organisations

National Association of Opioid Treatment Providers
The National Association of Opioid Treatment Providers represents treatment providers involved with opioid substitution treatment (OST).

National Council for Addiction Treatment
www.ncat.org.nz
The National Council for Addiction Treatment (NCAT) is the national voice of the addiction treatment sector. It plays a key role in providing expert advice, information, and advocacy on treatment for alcohol, other drugs, and gambling disorders. The aim of NCAT is to enhance the range of funded services and access to quality treatment that is based on relevant and evidenced-based approaches.
National Problem Gambling Team

The National Problem Gambling Team (NPGT) sits within the Ministry of Health and is responsible for ensuring there is an integrated problem gambling strategy focused on public health, as required by the Gambling Act. The NPGT provides policy analysis, contract management and data and information analysis.

National Coordination Service

http://www.hapai.co.nz/issues/problem-gambling

The National Coordination Service (NCS) aims to support and strengthen gambling services funded by the Ministry of Health by disseminating key messages and information to the sector.

References and further information


National Policies and Legislation for Addiction Treatment

Policies and legislation developed by the Aotearoa New Zealand government determine the approach to responding to addiction-related problems. These not only impact on the treatment sector, but also law enforcement, availability of the product and society as a whole. There are also guidelines and standards that clarify best-practice in the treatment sector. The section below outlines the key guidelines, policies and legislation.

National drug legislation and policy

The following New Zealand legislation determines which substances are illegal and controls the sale and supply of legal drugs and medicines.

- Smoke-free Environments Act 1990
- Sale and Supply of Alcohol Act 2012
- Customs and Excise Act 1996
- Misuse of Drugs Act 1975
- Medicines Act 1981
- Psychoactive Substances Act 2013
- Psychoactive Substances Amendment Act 2014

There is also legislation that influences the treatment of substance use problems.

- Alcoholism and Drug Addiction Act 1966, which regulates compulsory treatment for alcohol and drug disorders (currently under review)
- Health Practitioners Competence Assurance Act (HPCAA) 2003, which regulates particular groups of health professionals
- Health and Disability Services Standards (NZS 8134:2008), which support the safe provision of services to consumers

The National Drug Policy 2007-2012 (Ministerial Committee on Drug Policy, 2007) covers tobacco, alcohol, illegal and other drugs within a single framework. This policy aims to reduce the health, social and economic harms from substance use through supply control, demand reduction and problem limitation (National Committee for Addiction Treatment, 2010).

Strategic planning

The strategic direction for alcohol and other drug treatment services is developed by the Ministry of Health as part of the national mental health strategy which DHBs are then required to implement. The mental health strategy is described in the following documents:

- Te Tāhuhu, the second mental health and addictions plan 2005-2015 (Ministry of Health, 2005)
- Te Kökiri, the mental health and addiction action plan 2006-2015 (Ministry of Health, 2006)
- Te Puawaiwhero, the second Māori mental health and addiction national strategic framework 2008–2015 (Ministry of Health, 2008)
Health Workforce New Zealand, within the Ministry of Health, provides leadership, co-ordination and oversight of planning and development of the workforce across the country’s health and disability sector. This includes providing leadership and oversight of addiction workforce development.

Monitoring of treatment services occurs in various ways.

- The Mental Health Commissioner, within The Health and Disability Commission, reports to the government on how the national mental health strategy described in Blueprint II is being implemented.
- Specialist mental health and addiction services are required to meet service specifications as described in the Nationwide Service Framework (NSF) developed by the Ministry of Health (accessible from the NSF Library: www.nsfl.health.govt.nz).
- DHB funded addiction treatment services are required to be accredited against the Health and Disability Services Standards (2008) which support the safe provision of services to consumers and focus on the outcomes people experience when using services (Standards New Zealand, 2008a and 2008b).

National gambling legislation and policy

The Acts that regulate the gambling industry in Aotearoa New Zealand are:

- the Gambling Act 2003, which aims to develop an integrated problem gambling strategy that is focused on public health. The key purposes of the Gambling Act include controlling the growth of gambling, and preventing and minimising the harm caused by gambling
- the Racing Act 2003, which regulates the racing industry.

The Department of Internal Affairs is the main regulator of the gambling sector and ensures that gambling opportunities are provided in compliance with the Gambling Act 2003.

The Ministry of Health is responsible for funding and coordinating problem gambling services. The problem gambling strategy established by the Gambling Act 2003, including the associated treatment services, is funded by a levy paid by gambling operators to the Crown. An independent Gambling Commission decides on the levy amount.

Strategic planning

The Ministry of Health has developed a framework to guide the structure, delivery and direction of problem gambling services that they fund, which is described in the following documents:

- Preventing and Minimising Gambling Harm six-year strategic plan 2010/11 – 2015/16 (Ministry of Health, 2010)
Monitoring

The strategic plan includes a service outcome framework which underpins all service specifications. There is also a practice requirement handbook that specifies what is required from gambling intervention services (Ministry of Health, 2008b).

References and further information


National Committee for Addiction Treatment. (2010). *Alcohol and drug treatment services in New Zealand.* Wellington: National Committee for Addiction Treatment

