Addiction Treatment Research NEWS

September 2005 *Newsletter of the Addiction Treatment Research Interest Group* **Vol 9 No 2**

EDITORIAL

Welcome to the first issue of the ATRN. The Treatment Research Interest Group had its last AGM at Cutting Edge earlier in the month, as it was voted that the group is now the ADDICTION Treatment Research Group. Consequently, to keep in line with this development the TRN has now become the Addiction Treatment Research News.

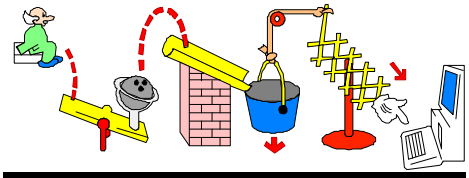
With the passing of the 10th Cutting Edge conference we are all now on the downhill slope to the end of the year. Frighteningly time just moves faster and faster. A good time seemed to be had by all in Dunedin with extra flavour from Moana House and some Scottish clans. Dunedin provided us with lovely weather – much in keeping with the "winter" we had this year. Even the late September snow seemed magical given how Spring has been shaping up (though I'm sure the farmers don't agree).

After a long period of quiet it is good to see the A&D link up and firing with discussion again. We are fortunate as a sector to have a discussion group that is so open, widely disseminated and used across the whole country. The AOD problems in New Zealand and elsewhere seem to be, deservedly, getting a lot of press of late. There have been documentaries on the history of drugs in New Zealand and on adolescents and cannabis to name just a couple.

This issue we have a pertinent article from Paul Robinson about Māori men and AOD treatment. We also have an article from Heather Muir and Sarah Redfearn in Dunedin on smoking cessation. Mike Goulding tells us about screening and brief intervention resources for AOD and gambling. This issue also contains a summary of the 10th Cutting Edge conference from Tami Gibson. Simon Adamson once more fills us in on news in the field from the perspectives of ATRIG Chairperson and the NAC update. Continuing with our guest writers for "I've been reading", we are pleased to hear what Tom Flewett from Wellington CADS has been perusing.

Enjoy the newly christened Addiction Treatment Research News. I hope it has a lot to offer you and your service. As always we would be very excited to receive letters to the editor. Happy reading.

Meg Harvey
Editor
September 30, 2005



ATRIG! BLESS YOU!

The Treatment Research Interest Group (Alcohol, drugs and addiction) voted at their AGM in September to officially change its name to the Addiction Treatment Research Interest Group. The TRN has followed suit. We are now the Addiction Treatment Research News. We hope that our name change will provide little confusion for people and are looking forward to a fresh new look with the new ATRIG logo in December.

TRIG MEMBERSHIP

The executive committee of the Addiction Treatment Research Interest Group (ATRIG) would once again like to take this opportunity to remind current members that membership of ATRIG is annual. Currently we have 67 members, only a handful of whom have renewed their membership for 2005.

New members wishing to join ATRIG are warmly invited to fill in the membership form on the last page of this newsletter. Current members are also able to use this form to renew their membership.

Membership of ATRIG entitles members to an email copy of each edition of the Addiction Treatment Research News (ATRN) and participation in the ATRN discussion group.

Addiction Treatment Research News is the official newsletter of the **Addiction Treatment Research Interest Group (ATRIG).**

ATRIG was established in 1997 to promote research in the alcohol and other drugs field in New Zealand.

The **executive committee** are: Simon Adamson (Chairperson), Klare Braye, Alistair Dunn, Meg Harvey (Editor), Robin Shepherd, Janie Sheridan, Lindsay Stringer (Secretary)

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In the Alcohol and Other Drug field and more recently, the Problem Gambling field we have long recognised the value and efficacy of early identification and brief intervention, but it has remained an ideal goal, not a frequent reality. There are a number of obstacles to providing widespread early intervention opportunities, not the least of which is the huge task of educating, upskilling and providing relevant resources to the primary care workforce throughout New Zealand, in the specialist area of addictions. Towards the end of 2004, the Ministry of Health took a positive step towards this goal by commissioning a project with Abacus Counselling and Training Services to develop both a resource manual and a secondary prevention training manual aimed at primary care practitioners, for alcohol and other drugs and problem gambling.

In the Ministry of Health's Mental Health and Addiction Plan, 2005-2015 (MOH 2004), one of the goals was to provide more and better services working together with other health and social services so that peoples' (including family members) needs are met and "every door is the right door". There is recognition that only 5-10% of those with serious addiction-related problems are referred to specialist services and therefore, intervention and referral from primary care services plays an extremely important role. Potential opportunities to intervene arise frequently in a wide variety of services like budgeting, housing, ethnic specific social services, community advice bureaux, stopping violence services, youth services, justice, refuges, food banks and PHOs, and these should not be lost.

Rationale

There are a number of rationales to support staff training in these types of agencies. The Royal College of General Practitioners (2005) highlight that "AOD misuse may add to the difficulty of managing on a limited budget and increases tension in relationships". Further, AOD use disproportionately affects Mäori in Aotearoa, for example, Mäori males are 2.7 times more likely than non-Mäori to die of alcohol-related consequences (ALAC, 2003). The Department of Corrections strategy for 2005-2008 is to reduce offending by reducing drug and alcohol use by offenders not only in prison but also post-release. The goals are to reduce drug supply, reduce offender demand and to increase attention on reducing harm from drugs. There is therefore a real need for identification, assessment and treatment for offenders with alcohol and other drug problems, which would then lead to an increase in offenders starting and completing programmes.

There is little research regarding the prevalence of clients with gambling problems attending budget services, but Pentland (1997) highlights the role of financial advisors and budget services for those with gambling problems. In terms of gambling problems in prison, Abbott and Volberg (2000) surveyed 357 inmates in four NZ prisons and found that 31% had experienced significant gambling problems sometime in their lives and 23% had current problems. Although 46% said that they wanted help, no-one had been directed to treatment. A screening project by four Mäori health and social service providers found that 22-29% of the participants were gambling problematically, 53% were affected by another's gambling at some time, and 13% were currently affected (Abacus/Toiora Healthy Lifestyles, 2004). In addition, an Auckland social service food bank screening project identified that one in eight clients were affected by their own gambling problems and 22.5% were affected by another's gambling. Three quarters of the participants had children in the household and 78% of the clients were Mäori or Pacific peoples (Abacus Counselling and Training Services, 2004c).

The Pilot Programme

The first step was to design a resource manual which would describe the most prevalent drugs (including alcohol) and also gambling, in terms of facts and effects and signs and symptoms, together with the most appropriate screening tools, scoring information and referral resources, throughout Aotearoa New Zealand. Included also, were sections on "raising the issue", brief interventions (including Motivational Interviewing), co-existing disorders, The Privacy Act, and Family/Whanau issues. A training manual with powerpoint presentation was also designed to complement the resource manual, which included specific relevance for each service/setting. Interactive exercises and case studies for each class of substance were included, as well as suggested model answers for intervening. Training in screening and brief interventions including role-plays with a Motivational Interviewing focus were provided, as well as a session on referrals.

Feedback on both manuals was sought from significant stakeholders in the field, for example ALAC, DAPAANZ, NAC, TADS and Ministry of Health. Four types of organisations were selected to participate in the pilot training programme: A Justice service in Rotorua, an Iwi service network in Whangarei, a Work and Income service in the South Island and a Budget service in Auckland. The training was completed in all sites and sessions were evaluated both pre and post delivery. A follow-up visit was made to each service approximately 3 months afterwards to evaluate the integration and impact of the training both from participant's and manager's point of view. In all cases, the feedback was extremely positive and a number of participants indicated interest in undertaking further training to train others within their organisations.

The Next Step

The anticipated extension of this project is to use the experience of doing the pilot and the feedback to further refine the material, and then to produce sufficient manuals to provide a resource to a significant number of services in different settings throughout the country. Then, a "train the trainers" programme can be implemented, **Continued on Page 3**

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utilising the refined training manuals, to enable a number of key personnel to train appropriate staff in primary care organisations. This will provide a unique opportunity to "widen the net" in terms of opportunistic identification of those who have developing AOD and/or gambling problems, and lead to better integrated and more responsive services for clients and their families, throughout Aotearoa New Zealand.

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National Addiction Centre

Cutting Edge 2005 again saw a range of research work undertaken at the NAC being presented. This included Masters research (Cate Kearney: Treatment outcome for women), PhD research (Paul Robertson: Māori men's experience of addiction treatment, Karen de Zwart: Nicotine dependence in a clinical adolescent sample, Meg Harvey: Cannabis and cognition in adolescents, Dominic Lim: Naltrexone, craving, and pathological gambling, Michael Baker: Spirituality and treatment outcome), and a range of other research projects (Daryle Deering: Nursing role in AOD, Simon Adamson: National profile of AOD clients, Paul Robertson: Māori AOD workers, Hatarei Peka/Ria Schroder: Profile of Odyssey House residents). This gives a fair idea of the breadth of ongoing and recently completed research within the NAC, and the significant contribution made by research students to the overall level of research activity.

Three of the presentations above related to research undertaken as part of a series of telephone surveys of the alcohol and other drug treatment workforce in 2004. The National Telephone Survey comprised interviews with 288 alcohol and other drug treatment workers. All workers interviewed who were nurses were asked to take part in a follow-up interview looking specifically at issues for nurses in the AOD field. This study was lead by Daryle Deering. All Māori AOD workers interviewed were asked to take part in a follow-up interview looking specifically at issues for Māori in the AOD field. This study was lead by Paul Robertson. All three studies benefited from a very high rate of agreement to participate from those contacted, with response rates of around 90% for each. Cutting Edge provides an excellent opportunity to disseminate findings from these studies to those who took part and to the workforce as a whole. Some of these findings may also been found in the Matua Raki discussion document on our website (www.addiction.org.nz), and will be summarised as part of the Addiction Treatment Research Monograph to be distributed to all Cutting Edge registrants in December, as well as being made available on our website.

We are currently in the planning stage of a telephone survey of the gambling treatment workforce, with similar aims as for the national survey of the alcohol and other drug treatment workforce. Such surveys provide the opportunity to answer a range of questions about the current and optimal practice of our workforce, their attitudes and knowledge, qualification level and professional affiliation, as well as providing a representative snapshot of the clients being seen by respondents. The first workforce survey was undertaken in 1998. With the advent of the National Addiction Sector Workforce Development Programme (Matua Raki), this exercise has gained increased significance, and as a result we now hope to survey the addiction workforce on a three-yearly basis.

A further example of an ongoing programme of research is the recently commenced five year follow-up interviews of participants who took part in the Naturalistic Treatment Outcome Project. One hundred and five clients from CADS Christchurch and CADS Hamilton were interviewed in 2000/2001, with 102 of these re-interviewed nine months later. All participants re-interviewed agreed to being contacted for a third interview at some point in the future. The first five year interviews have just been completed, with the full series of interviews expected to take about 18 months. This study provided valuable information on the profile of clients initiating treatment, particularly in respect to levels of comorbidity, and demonstrated that significant improvements in substance use, mental health, and social functioning occurred between treatment entry and the nine-month assessment. The five year follow-up interviews will greatly extend our knowledge of the longer-term outcomes of treatment for clients attending our services.

Dr Simon Adamson
Senior Lecturer
National Addiction Centre

TALKING THE WALK:
CONSTRUCTING THE SELF AS MÄORI IN THE CONTEXT OF ADDICTION TREATMENT

In addiction treatment and research the emphasis has tended to be on "walking the talk" of recovery. This study took a different perspective by investigating how a group of men in treatment talked about themselves, primarily in relation to being Mäori and addiction. The aim was to increase understanding of how participants used talk to create positive positions of self as addicts in recovery and as Mäori. The focus was on both the content and how different types of talk were used for particular purposes, for example, mitigating addiction related behaviour or locating oneself as belonging within Te Ao Mäori.

The focus on the talk of, and about, being Mäori and addiction necessitated development of an innovative mixed methodology. This was founded on the principles of kaupapa Mäori research (KMR), which has arisen from a desire to undertake research unequivocally privileging and located within the values, practices and aspirations of Mäori. While based firmly within the 'realities' and preferences of Te Ao Mäori, KMR allows for the integration of elements of compatible western methodologies. The current study drew on complementary elements from discursive psychology and critical discourse analysis, as well as the deconstructive work of Derrida. This platform provided the basis for collecting, analysing and re-presenting the interview data gathered from 11 men in a Mäori focused treatment programme.

An integral part of the study was identifying the common ways in which being Mäori and addiction are talked about in influential texts. Such texts include not only scientific literature, but also discourse routinely accessed or used by 'ordinary people'. A review of such texts suggested that much talk used for constructing being Mäori is drawn from narratives of tradition, for example, those related to collectivism, spirituality and connection to the land. For some, however, 'being Mäori' has been more readily constituted through talk of loss and alienation. The so called 'Mäori renaissance' and related re-assertion of Mäori values, beliefs and practices has provided some antidote to such narratives of loss and provided potential for constructing oneself as Mäori in a relatively more positive vein. In spite of this, dominant culture constructs have remained influential in locating Mäori in less than positive positions. Historically these have been predicated on discourses of the inferior 'savage', which have more recently been constituted as self inflicted disparity. Identifying Mäori as receiving special rights and containing Mäori culture within historical freeze frames of authentic tradition have also been significant limiting elements of mainstream narratives.

'Addicts' have also characteristically been constituted as 'deviant', particularly in the context of morality based discourses, which along with narratives of disease and disorder, maintain those with addiction related problems on the margins of normal society. Within the narratives AA and the 12 Steps, which predominated in the current study, these margins potentially provide a basis for relatively positive positioning as an 'addict in recovery'. In this context addicts are constituted as being afflicted by an inherited disease and lacking capacity to sustain abstinence, without recourse to a transcendent higher power. The spiritual focus of AA has contrasted the more secular scientific nature of the other dominant discourses. Within these, addiction has been constructed as being the result of genetic inheritance and chemical action, with some consideration potentially being given to psychological facets. Socio-cultural based talk related to broader environmental contingencies, has tended to have an even more distal role in discussion of individual's addiction and treatment.

The relationship between being Mäori and addiction, which was a primary focus of the study, is based in an historical context in which Mäori have been located within a tradition of abstinence, while also being constituted as drunken savages. Discourses of colonialisation and ongoing marginalisation have been salient in Mäori narratives of addiction causality, while those of the mainstream have characteristically focused on attributions related to cultural deficit. In this context, Mäori models of health have provided a practical resource for addressing addiction related problems, as well as material for constructing more positive talk about being Mäori.

The results of the current study indicated that while the talk of cultural tradition was central to narratives of 'being Mäori', discourses of alienation and loss were equally salient. In terms of 'addiction', discourses of genetic inheritance were most prominent, although psychosocially constituted negative underlying 'issues' were also clearly located as being important. Such 'issues' were linked to both general life experiences and those associated with being Mäori. Treatment talk revolved around transformative narratives of 'self'. These involved disconnection from addiction and underlying 'issues' and reconnection with a positive 'essential self', previously compromised by 'addiction'.

It's a relief because it explains. I'm not a bad person. There are reasons for the way I am… (Mikaere)

Two main discourses were utilised in terms of the relationship between 'being Mäori' and 'addiction'. The first, primarily used in causal narratives, constituted an inevitable link between being Mäori and problematic substance use, frequently drawing on stereotypes, for example, as evident in the film *Once Were Warriors*. The second type of talk was more commonly used in the context of treatment and located substance use as being incompatible with 'traditional Mäori culture'. The latter is arguably more useful than that which locates being Mäori as inevitably associated with substance use problems, but may limit options for constructing the self as Mäori. The risk is that it will not allow for emergence of the range of positions available to and taken up by Mäori in contemporary Aotearoa/New Zealand.

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Such potential limitations notwithstanding, tradition based narratives can provide an important beachhead, as tangata whaiora seek to change their personal narratives of being Mäori in the context of addiction.

When they powhiri us forward, they're giving us dignity…you come forward feeling proud…I'm a Mäori person and no matter what I have done I am accepted here. (Bill)

While the talk of both Mäori and 12 Step traditions were highlighted in participants' narratives, the latter tended be dominant. This was not surprising given the broader mainstream context in which the programme was run. Being Mäori was identified as important by all participants, however, the opportunity to engage with integrated indigenised narratives of 'addiction' and treatment was limited by several factors. Historical freeze frame notions of authentic Mäori 'tradition' tended to dominate, such the range of experiences of contemporary Mäori were not readily accounted for. This arguably impeded individuals developing positive positions for being Mäori that could be sustained within the less supportive broader social context. Additionally, the domination of '12 Step' discourses of 'addiction' and 'treatment' limited the degree to which individuals could make use of, and develop broader, more Mäori centred talk of recovery.

Pakeha side of it, can't get into how a Mäori thinks, acts and why he acts that way. Why he is so lost. They can't rejuvenate that lostness of where they come from, their tikanga, their reo, their whakapapa… (Bill)

Overall, the results provided support for Mäori focused addiction treatment programmes. There is, however, a clear need to provide these in a way that moves beyond essentialist notions of tradition and addiction, and responds to the varied needs, capacity and experiences of individuals and whanau. Sustaining positive talk related to being Mäori within dominant culture contexts is likely to continue to be a challenge, such that more than just the promoting Mäori culture within addiction treatments is required.

Its not just about learning kapa haka and karakia … its about switching onto one's Mäoriness. In one form or another all of that have been through that programme have been brutalised, so connection with one's self is distant. It's a form of colonisation, cultures destroyed from within. (Zac)

Attending to the development of tangata whaiora capacity for some level of critical analysis (decolonisation) is important given the culturally laden, but characteristically implicit nature of taken for granted dominant talk of addiction and normality. Thus, while elements of Mäori and mainstream treatments may have some compatibility, power imbalance remains in the broader contexts within which they are constituted.

In summary, Mäori focused programmes clearly provide a space for recovery from the impact of negative narratives of being Mäori, including those associated with addiction, and provide a venue for developing positive narratives of ones self. However, more explicit attention needs to be given to the talk of the walk to enable tangata whaiora to maintain robust positive narratives, which can be sustained in the less supportive contexts beyond treatment

…outside world does become a bit of a harsh reality. … Back in the real world you don't get hugs every day and not everyone's talking about the real stuff. (Mikaere)

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CUTTING EDGE 2005

Delegates converged on the city of Dunedin for the 10th Cutting Edge conference for alcohol and other drug treatment and research workers, held at the Dunedin Centre from September 8-10. A first time host to the Cutting Edge conference, Dunedin's proud Scottish heritage combined with the strong cultural flavour of the conference itself, provided a unique and stimulating conference experience.

This year the theme of the conference was 'Looking Back to Move Forward: Celebrating 10 years of Cutting Edge'. This was echoed through the many presentations which sought to explore, review and reflect on changes and developments that have occurred within the addiction treatment sector in the last 10 years. Future directions for the sector were also the focus of many of the papers and presentations. Again, a wide array of treatment and research topics were covered, including presentations on women's addiction issues, gambling, methadone maintenance and issues for Mäori and Pacific Peoples in the alcohol and drug field.

This year the John Dobson Memorial prize for the best presentation on an opioid topic was awarded to David Mellor for his presentation on 'Interim Methadone Prescribing Programme (IMPP) - Preliminary Results from Dunedin'. Meg Harvey was the recipient of the John O'Hagan prize for the best presentation by someone under the age of 35-years for the culmination of her work presented in 'The End of the Road: Final Results from the Project on Adolescent Cannabis Use and Cognition'. The DAPAANZ prize was awarded to Claire Aitken and the Moana House Whanau for their outstanding workshop titled 'Ideal to Real'.

The NAC are producing proceedings from the conference and ATRIG has once again been charged with the task of compiling a Monograph from the research stream.

Tami Gibson NAC/MIHI
Christchurch School of Medicine & Health Sciences

Research-based guidelines for health services in the UK conclude that, "the more time is spent with smokers the greater the effect in aiding cessation." They further note the potential effectiveness of "a programme of support involving multiple contacts for a period of four weeks or more given by specialists employed and trained for the purpose" (West et al., 2000).

The experience of clinicians in a local hospital setting supports these findings. Outcome research on a New Zealand brief intervention programme with parents, where the parent or their child had been in hospital, shows a relatively low quit rate at 12 months, despite 74% of clients agreeing that being in hospital had "definitely" or "probably" been a good time to consider stopping smoking (BRC Marketing and Social Research Report, 2003).

This may simply demonstrate the limitations of a brief intervention approach in the face of severe nicotine dependence. However, clinical experience suggests that there are some situational factors for hospital patients that work against long-term success in quitting.

Serious smoking–related illness gives a person an excellent reason to quit, but it may also provide a stressful and disempowering experience featuring pain, confusion, fear, guilt, resentment, reactive depression, and tiredness i.e., a sense of powerlessness to change. Powerlessness also works against uptake of assertive strategies such as "set a quit date and stick to it" (National Health Committee, 2002).

Dysphoria enhances the desire for familiar and effective comforts such as a cigarette. This creates dissonance around desiring the very thing that is seen to be killing you. This dissonance can be reduced by resolving to quit – but it can be also reduced by denying that smoking is really to blame.

Resolutions to quit made under the duress of being unwell in an alien environment can fade quickly when sickness is alleviated by medical treatment and the person has returned to their own home. This contrasts with the considered decision to quit made by a relatively well-functioning individual after due preparation, where the resolve is likely to be strengthened by the heightened well-being experienced post-withdrawal.

Case Study 1

Mrs P is a 51-year-old woman who had been referred from the Eye Specialist. She arrived on time, but looked very worried about what to expect, especially combined with the fear of quitting. Her mood appeared down and she talked about needing to quit now due to her deteriorating eye condition. However, when we talked about her past quitting experiences she said that it had been very difficult and she didn't know how she was going to do it again. She also looked sad and almost tearful at times and talked about a recent death in the family.

Mrs P was depressed due to a recent death in the family and coping with her ongoing health problems. She was very motivated to quit, but was ambivalent due to past experiences of quitting and relapsing. When discussing a plan she had initially said she wanted to quit tomorrow using patches. When asked if she would like to look at other options, which may be easier and more gradual, she looked relieved.

Plan to increase mood and confidence in quitting

1. See GP re Nortriptyline to help with her low mood and poor sleep
2. Smoking Diary to track current smoking thus give her more control and increase her understanding of her smoking pattern
3. Trial of NRT patches to gain confidence and become familiar with them
4. Practice delaying techniques after meals to increase confidence in dealing with cravings
5. Regular ME sessions with smoking cessation counsellor to increase engagement and client sense of control.

After 2 weeks Mrs P's mood improved, she had more energy and was more hopeful regarding the future and her smoking had decreased by 50%. At 4 weeks, she had been smoke-free for the last 3 days.

Case Study 2

Mary had rung several times asking to use the service alongside popping in when she came to see the psychiatrist. She talked about coming, but didn't turn up for her follow-up appointments. Mary had a chronic psychotic disorder and said she spent most days sitting by the heater smoking all day. She was really worried about her health and especially her deteriorating breathing, and had noticed she was having increased difficulty with her walking. On the other hand she said she needed to smoke to help her deal with her mental illness and stress. We arranged an appointment over the phone. The preliminary plan was to take small steps, use NRT Patches to help reduce smoking and go walking without cigarettes. She cancelled the initial appointment.

A week later she rang again saying: "I can't stop smoking". She said her GP told her she must stop smoking. She sounded quite distressed. This had been the pattern over the last 18 months. I requested permission to discuss the situation with her psychiatric district nurse. We decided to home visit together - Mary agreed. The PDN said she had been having difficulty getting to see Mary at home as she had not been opening the door when she arrived. Mary was waiting for us. She welcomed us inside and spoke positively about our plan. She also talked freely with the PDN about her medication and how she was managing her mental health.

Plan

1. Reduction using NRT patches
2. Smoking outside during the day
3. Go for short walks without cigarettes

Over 4 visits Mary reduced from 40 - 50 cigarettes a day to 10. She would smoke them outside during the day and at night smoke in the kitchen with the window open. She said long-term she wanted to quit, but reduction at this stage was her goal. Some days she was going for two walks a day depending on the weather. After two weeks her breathing had improved, she was more positive and was getting on better with her non smoking son. Six months later, she was still maintaining her changes and smoking 10 a day, without NRT. Mary was still keen to look at quitting in the future. Things that contributed to her success included: time, NRT to reduce more comfortably, small steps to give her success and increased confidence.

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Another important factor was visiting her 'on her own turf' where she felt secure, and collaboration with the PDN.

Clients with long-standing co-existing mental health problems are another sizeable group of smokers who may benefit from a more extended intervention. It is well-recognised that this is an area of high need that is still very poorly serviced (e.g. Ziedonis and Williams, 2003). Obstacles to providing an adequate response include widespread beliefs by staff, such as: smoking is a good strategy to cope with stress and especially important when the person is mentally unwell; Smoking is the lesser of all addictions; Patients can only deal with one thing – so smoking needs to be looked at later; It's too difficult for people with mental illness to quit; It's their right to be able to smoke where they live; It's their only pleasure in life; It's not my place to go on about their smoking; The stress of quitting will provoke a relapse of mental illness.

Common client beliefs also present a barrier: I feel trapped; I smoke to fill in the day; It's the only pleasure in my life; I know I would never be able to quit; It helps to pass the time; I can't stop thinking about smoking; Smoking helps me keep well; When I run out I can smoke my butts and other peoples'.

While initial engagement with existing smoking cessation services may be tentative, good outcomes can be achieved with a client-centred treatment response.

General principles that are helpful in working with this group:

- Time and accessibility
- Moving slowly
- Getting support from clinicians and close contacts/family
- Working on small, progressive changes around smoking behaviours and around replacement activities
- Using NRT to reduce, not just quit
- Affirmation of achievements
- Giving the positive message that clients can make changes and reach their long term goal of being smoke free.

Conclusion

Although current national guidelines and service plans include specialist cessation services as part of the total range of interventions and programmes, the focus remains on providing minimal to brief interventions for a particularly challenging form of substance dependence. Clinical experience demonstrates the gains that can be made by providing counselling and follow-up that extends beyond simple withdrawal management to encompass working with relapse over an extended time period. The objective of assisting conflicted or poorly-empowered patients to quit smoking is no less feasible for taking longer to achieve.

Heather Muir & Sarah Redfearn
Smoking Cessation, Otago DHB

Message from the Chairperson

The 2005 AGM for ATRIG was held in September at the Cutting Edge conference, hosted this year in Dunedin, and was attended by a small, but enthusiastic group. The new executive voted for at this meeting are:

Simon Adamson (Chch - Chairperson)
Klare Braye (Wellington)
Alistair Dunn (Whangarei)
Meg Harvey (Chch - Editor, ATRN)
Robin Shepherd (Auckland)
Janie Sheridan (Auckland)
Lindsay Stringer (Chch - Secretary/Treasurer)

An especially warm welcome is extended to Robyn Shepherd who is newly elected to the executive.

ATRIG has had a relatively quiet year, but has continued to do what it does well, to publish the Treatment Research News three times a year, and to publish the Treatment Research Monograph. The 2005 Treatment Research Monograph is currently in preparation and should be distributed by Christmas. The ATRN has continued to receive strong support through its varied contributors and its many readers. As ever we owe a substantial debt of gratitude to Meg Harvey, who as editor of the ATRN is the person most responsible for the ongoing success of this publication.

The Treatment Research Monograph from last year's Cutting Edge Conference was the largest yet. In addition to being sent to over three hundred registrants from Cutting Edge '04 the Monograph is available to be downloaded from the NAC website, www.addiction.org.nz, for anyone who would like to locate research presentations from that year. Although this publication represents a substantial amount of work for all involved I believe this is well justified, producing as it does a permanent record of addiction-related research undertaken in this country, where in most cases this work may not have gone on to be published elsewhere. Thus the Monograph represents precisely the sort of outcome that ATRIG was formed to support. I would like to ask all ATRIG members to support this publication, as contributors, readers, and promoters. Also, I would like to again express my gratitude to the Alcohol Advisory Council for its ongoing financial support of the Monograph.

The finances and membership of ATRIG, although both modest, remain healthy. It is hoped that the coming 12 months will see an increase in membership and I look forward to the opportunity of working as a member of the Executive to achieve this.

The renaming of TRIG as ATRIG – the Addiction Treatment Research Group – was discussed and carried in a unanimous vote at this year's AGM. The full name of TRIG was the Treatment Research Interest Group (Alcohol, Drugs, and Addiction). Not surprisingly this has traditionally been shortened to the Treatment Research Interest Group, but has left us with a day-to-day name that does not convey the focus of ATRIG. The new name will better express the focus of the organisation and will align it with the newly created National Committee for Addiction Treatment (NCAT).

In addition to Meg Harvey, whom I have already thanked, I would like to thank all contributors to the ATRN, and the Addiction Treatment Research Monograph, and especially to all members of ATRIG who have completed their membership forms and paid a modest $20 for the annual subscription, as well as those about to do so of course. Finally, I'd like express my appreciation for the contributions of members of the TRIG executive committee, and in particular thanks goes out to Lindsay Stringer, Secretary and Treasurer.

Dr Simon Adamson
TRIG Chairperson

"SPIRITUS CONTRA SPIRITUM"

This quote, written in a letter from Dr Carl Jung to Mr Bill Wilson, a cofounder of AA, January 30, 1961 has been frequently cited within the Big Book with reference to the Higher Power to be sought as alcoholics work through the 12 steps. To reread the letter sent to Dr Jung by Bill Wilson and Dr Jung's reply is fascinating and humbling as the insights developed over 40 years ago retain their validity today. (***http://www.barefootsworld.net/wilsonletter.html and http://www.barefootsworld.net/jungletter.html***). Using this as the starting point for my current reading list gives me the possibility of integrating an AA approach with my interest in analytical psychology.

There are few references to addiction within the field of analytical psychology. Here's an amazing quote from ***Edward Edinger's book, "Anatomy of the Psyche"*** which summarises the essence of addiction for me and helps makes sense of the AA 12 step philosophy within the wider field of addiction treatment:

"In general, the Dionysian (*archetype*) is daemonic and ecstatic, promoting intensity of experience rather than clear, structured meaning. It is a dissolver of limits and boundaries, bringing life without measure. In its extreme form it is wild, irrational, mad, ecstatic, and boundless. It is the enemy of all conventional laws, rules and established forms. It is in the service, not of safety, but of life and rejuvenation. The weak and immature may be destroyed by its onslaughts; the healthy will be fertilised and enlivened like the land by the flooding of the Nile. Many classical syndromes are due to a concretistic identification with the Dionysian principle. Alcoholism and drug addiction are obvious."

Knowing that Dionysus was the Greek god of wine and debauchery may help to understand this quote. When I replace the word Dionysian with "the use of drugs", everything slots into place. My favourite reading about Dionysus in the Greek myths is Robert Graves' works.

General teaching is that alcoholism is a chronic relapsing condition. This has always struck me as being therapeutic nihilism and a defence so that we do not have to acknowledge our own therapeutic failures and lack of understanding of the addictive process. The recent article by George Vaillant (***Australian and New Zealand Journal of Psychiatry 2005; 39: 431-436***) entitled "Alcoholics Anonymous: culture or cure?" gives several references which help me understand the addictive process. It also reports on the 4 therapeutic components to AA:

1. Deepened spirituality
2. Ritual dependency on a competing behaviour
3. External supervision
4. New love relationships.

If these really are the most useful aspects of AA, I need to ask myself whether I can incorporate these themes into my own work or whether in my role as an addiction specialist and psychiatrist I should leave these themes to AA and concentrate on other areas of work.

Deepened Spirituality

My psychotherapy training was predominantly in analytical (Jungian) psychology. Although left of centre in today's world, I find myself returning again and again to this rich field where a holistic view of the human psyche is central for the understanding of psychopathology. My favourite book that describes the structure and workings of the human psyche is ***"Ego and Archetype" by Edward Edinger***. The first three chapters of this book give me a structure for understanding psychopathological processes and help guide me in the development of treatments that can be meaningful. Another of his books, ***"The Meaning of Consciousness"*** further supports me as I try to disentangle the defensive structures that are invariably hidden further away in patients with substance dependence than is usually the case in most mental health patients. These two books rarely spend more than a few months on my bookshelves before I pull them out again and try and make sense of a patient's presentation, which is confusing me.

If I am going to use a 12 step approach in my treatment, making sense of how the "Higher Power" may be experienced by a wide variety of patients will be a challenge to me. The fear that patients have of attending AA/NA type programs is widespread and introducing the concept can often be a challenge in itself. Understanding the types of projections that both my patients and myself use to first touch the concept of a "Higher Power" becomes important. My reading around this tends to lead me to ***Edward Whitmont's "The Symbolic Quest"***. Whitmont and Edinger give me some hope that I can bring a sense of spirituality into my work whilst at the same time offering my psychiatric and medical skills.

Ritual dependency on a competing behaviour

Should I be considering offering the ritual dependency on a competing behaviour? Could I incorporate this important facet of successful treatment within AA/NA into my work? The ritual dependency strikes me as being symptom displacement in a sublimated form and perhaps no bad thing in itself, but not for me to promote within a one-to-one therapeutic relationship. I struggle with this intervention, but as yet have found no reading to help me make sense of it.

External supervision

Joel Porter's article on what he was reading in the last issue is perhaps of relevance here. How we use the concept of attachment theory in our everyday work is not sufficiently recognised yet.

New love relationships

New love relationships - now there's a conundrum. What does this mean? This concept has always struck me as being at the centre of the addictive process and the reason that our interventions are so ineffective.

Here, I think, is the spiritus that Jung was referring to: A subtle, volatile, active and vivifying essence such as alcohol was understood to be. (***Collected Works, volume nine, paragraph 387***). The word "spirit" is one which psychologists and psychiatrists prefer to leave well alone. It is too difficult to quantify, measure and apply logical interventions to. If we can't have or don't know how to have "love relationships", where else but addiction can we go to find the vivifying essence which gives life meaning. Here we have Dionysus, the god of wine, in an unregulated, dangerous form.

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Addiction Treatment Research INTEREST GROUP (ATRIG)

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The objectives of ATRIG are:-

- *To foster interest in scientific research on treatment of people with alcohol and other drugs related problems in New Zealand.*
- *To disseminate and promote research findings related to effective treatment of people with alcohol and other drugs related problems within New Zealand.*
- *To support the development of improved treatment services for people with alcohol and other drugs related problems in New Zealand.*

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