Addiction Treatment Research NEWS

NEWSLETTER OF THE ADDICTION TREATMENT RESEARCH INTEREST GROUP

April 2006 Vol 10 No 1

EDITORIAL

Another year has begun and another ATRN has made its way to your desk. It is not just another year for ATRN, however, with 2006 being the 10 year anniversary of the first issue of the then TRN under the editorship of Raine Berry. A lot of names have been changed since that first issue. In that TRN there were stories about the NCTD (now the NAC), research at CIT (now Weltec) and mention of the CCCAD (which has evolved into ADA).

At the first issue the mailing list (then free of charge) numbered 134. The Addiction Treatment Research Interest Group now has 74 official paying members and is always looking for more. It is due to these paying members that the ATRN is able to continue to be brought to you. It is an interesting time to be in and considering the addiction field with not only our workforce and how it is trained evolving, but also the kind of drugs and their related issues we encounter in our day-to-day practice changing.

You will notice that we also have a new look for the ATRN. This is in keeping with the updated image of ATRIG overall since our name change last year. I hope you enjoy the more modern feel.

This issue we have our regular contributions from Simon Adamson as Deputy Director (Research) for the NAC and as the Chairperson of ATRIG. We also have our gambling report from Abacus on the development of the gambling treatment workforce. Our guest writer for "I've been reading" this issue is Geoff Noller, a PhD student studying cannabis with the University of Otago. We have interesting articles from Keriata Stuart on fetal alcohol spectrum disorder (FASD) as well as a challenging piece on spirituality in the treatment of alcohol and drug clients from Michael Baker.

It would be very beneficial to make this the 10th year of the ATRN a special one with the discussion and reporting of the abundant research in AOD going on around the country. Please feel free to send contributions to myself at PO Box 4345, Christchurch.

In the meantime, stay warm in the coming winter months and happy reading.

Meg Harvey
Editor
April 21, 2006

LETTER TO THE EDITOR

Dear Editor

I would like to acknowledge the article by Dr Nick Chamberlain on skin infections due to intravenous drug abuse, December 2005 edition.

I found this article very relevant and consistent with what I had observed while I was working at a needle exchange (NEP). Clients who presented with infections due to injecting drug use (IDU) would be referred to a local primary health organisation PHO for free medical assistance. This arrangement reduces barriers to accessing the necessary medical treatment as clients often do not have a current GP or are unwilling to seek help from their own GP due to disclosing their current status as an injecting drug user (IDUs). Disclosure is also an issue for clients of methadone maintenance treatment (MMT) where seeking medical advice could potentially threaten takeaway privileges. Thus, this particular population of IDUs are unlikely to seek education or advice around skin infections from MMT providers. NEPs have the potential to not only educate IDUs, but to refer clients to PHOs or GPs who understand the needs of this often discriminated against population.

Rhonda Robertson
Consumer Advisory Board member
of the National Community Training Programme for Addictions

ATRIG 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.

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)

Please direct **enquiries to Lindsay Stringer**, PO Box 2924, Christchurch, Phone (03) 364 0480, email: lindsay.stringer@chmeds.ac.nz

THE PROBLEM GAMBLING TREATMENT WORKFORCE: DEVELOPING A BEST PRACTICE MODEL

In 2003 the Gambling Act came into law, and alongside it the Ministry of Health adopted the responsibility to manage the minimisation of harm that arose from gambling. Previously, the funding of services, research, and management of treatment and its goals resided in a committee comprising the gambling industry and the treatment providers. With the inherent power imbalance in this arrangement, in retrospect it seems more than surprising that it not only survived, but did so with relative effectiveness for more or less eight years.

However, largely since the passing of the legislation, the numbers of treatment providers has increased from the 'big three' of Oasis, the Problem Gambling Foundation and the Gambling Helpline, to currently some 28 providers and approximately 110 problem gambling treatment practitioners within those services. With the rapid growth of both generic and specialist treatment services in this field, the Ministry of Health has funded research to identify the current resources of the workforce and a model for the future that will ensure that consumer and workforce needs are met through a best practice approach. This research is developing alongside similar projects, including the Matua Raki National Addiction Treatment Workforce Development Programme of the National Addiction Centre.

Overseas experience

A somewhat disquieting conclusion reached by a recent publication (Dept Families & Communities 2005) is that there are no internationally-established best practice models for problem gambling treatment, largely due to limited evaluation and outcome studies of existing models. However, it notes support for broad bio-psychosocial approaches with multimodal therapeutic approaches, rather than adherence to a single therapy, with the importance of the therapeutic relationship between the practitioner and the client being a major factor in a successful outcome. Effective intervention must include approaches being based upon clear theoretical models, a thorough assessment, clear goal setting established with client input, and processes of review. In New Zealand, it is unlikely that there would be any great disagreement with these findings. However, one clear finding from the literature identifies:

> "Problem gamblers need more than simply 'treatment' and necessary services include financial counselling, advocacy and negotiation (e.g. around housing), and relationship counselling"

p50 Dept Families & Communities 2005

Although the Australian physical and social environment differs from that in New Zealand, in the gambling realm it has more similarities than differences. Like New Zealanders, they participate more in legal gambling than virtually every other country in the world, with problem gamblers seeking help late in the progression of their gambling problems. Unlike drugs, there is no satiation and gambling can seem to be both the cause of and solution to the gamblers' predicament. The Australian treatment approach, however, has differed in problem gambling in that they have generally required in-house financial counselling as an integral element of treatment. In addition, treatment is usually delivered through services contracted by the various State relationship and family services, rather than health, as it is in New Zealand, and this may influence approaches to treatment.

The NZ approach to identify what is best practice

Abacus has taken a wide approach to this question. As with other workforce development approaches, the individual is but one of the factors to be examined. The system that the treatment is provided within, and organisational capacity building are also important factors alongside the development of a skilled workforce (Skinner et al 2003).

In 2003, practitioners attending a national clinical symposium were presented with feedback from clients and were invited to provide their own feedback as to a best approach for providing help for those affected by gambling (Sullivan 2003). These findings provided evidence of both clients and practitioners supporting extending interventions beyond therapy to meet identified client needs. The workforce project has incorporated these findings into other evidence of needs in positing the need for a wider, more multi-faceted approach to treatment for those affected by problem gambling.

Abacus took the usual approach in conducting a literature review to identify the models of treatment used overseas, evidence of effectiveness, and an enquiry into New Zealand models. A 'wider model' that posited the need for psychotherapy, social support, and the ability to provide additional assistance in specific areas such as financial counselling, housing and work.

The Process

The project comprises a series of steps that inform the next steps as they progress. They are:

1. Feedback was sought from organisations on a variety of topics around their support for such a wider model, and their ability to deliver it, or what resources would be needed to deliver it.
2. Practitioners were then surveyed for their support, and whether the findings of the 2003 symposium still applied, and their support for a wider model of intervention. Motivation to participate in training and intention to stay in the field was identified. This stage has just been completed.
3. The next step is to approach consumers, both those affected by their own gambling and their families, and seek their feedback, again to identify current needs, and compare these with the earlier consumer findings provided to the symposium.

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4. Concurrently, each of the estimated 110 problem gambling treatment practitioners will be asked, either by survey questionnaire, telephone or face-to-face if possible, for information about their qualifications and experience, approaches to treatment, and confidence and skills to deliver a wider intervention model.
5. Identification of screens, assessment processes, algorithms and outcome measures will be identified.
6. Training needs to deliver the wider model will be ascertained and reported upon, and will be provided through Abacus. This will include assessment and screen feedback, designing a treatment plan, reviewing processes and outcome assessment.

A brief summary of findings to date

At the 2003 Symposium the consumer findings were reported upon, essentially that clients preferred interventions that also assisted with social problems that included financial counselling and legal advocacy, work assistance and relationship issues. This appears to align with the overseas findings (GRP 2003; Dept Families & Communities 2005). Practitioners strongly supported providing this wider model, identifying outcomes and participating in upskilling as necessary.

In 2005, 94% of the then problem gambling treatment provider organizations were contacted and interviewed. There was very strong support (over 90%) for the wider approach and that it suited all cultures. This support continued in the use of formal treatment plans, ongoing training to meet such a model, development and integration of treatment outcomes, intention of the organisation to remain in the problem gambling treatment field, and for more comprehensive screening and assessment, providing support/training was available. There were, however, mixed responses as to whether they had sufficient staff to deliver the model at the time of survey. This information was then presented to the field at problem gambling conferences (Sullivan 2005a and 2005b).

At a problem gambling workshop in November 2005 practitioners were surveyed and again early this year. Those who had not attended the workshop were also surveyed. Responses were anonymous to enhance candour and approximately two-thirds of the total practitioner workforce responded. All of those surveyed agreed that screening for commonly co-existing conditions (e.g. depression, anxiety, suicidal ideation, alcohol misuse, financial problems) were important assessment issues, while over 80% supported their involving themselves in clients' social support issues. Strong majorities (over 90%) were willing to participate in more training and identify outcomes of their interventions. Approximately 80% supported a practitioner selected psychotherapeutic model rather than a mandated approach.

Conclusion

There is clear support for delivery of a wider model of intervention whereby psychotherapy is just part, albeit an important part, of the treatment plan. There is confidence to deliver the model, providing training and support is available, and an awareness of the importance of outcome measures. The next process will identify whether this is a realistic perception for the field, and whether consumers continue to buy into the model in the rapidly changing gambling environment.

Thus far the motivation to deliver the model identified by New Zealand consumers and practitioners, and overseas researchers, appears to be convergent in the delivery of a model of intervention that addresses the complex mix of issues that problem gamblers and their families commonly present with.

Abacus Counselling Training & Supervision Ltd

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Contact Person for Addiction Treatment Research News:
Meg Harvey
Phone: 364-0480
Email:meg.harvey@chmeds.ac.nz

Addiction Treatment Research Interest Group (ATRIG)
PO Box 2924
Christchurch

ATRIG is sponsored by the National Addiction Centre
Dept of Psychological Medicine
Chch School of Medicine & Health Sciences
4 Oxford Terrace
PO Box 4345, Christchurch
Phone 364-0480, Fax 364-1225
www.addiction.org.nz

Last time I outlined all recently and more distantly completed studies still being written up within the NAC. For this edition of ATRN I thought I'd give people a run down of the ongoing (i.e., data collection still underway) and planned studies at the NAC.

Ongoing Research:

- Naturalistic Treatment Outcome Study – Five Year Follow-up. We're about a quarter of the way through interviews for this sample of 102 former patients from CADS Hamilton and CADS Christchurch, all of whom were interviewed at the time of a treatment episode in 2000-2001 and again nine months later. Data generated from this study will provide the best information to date on longer term treatment outcome for New Zealand AOD treatment clients, as well as service utilisation patterns. Funded by ALAC, Dr Simon Adamson is principal investigator.
- Youth Retention Study. This study, lead by Dr Ria Schorder, aims to identify factors associated with retention or early dropout from AOD treatment for youth (i.e., those aged 14-18 for this study). This is being investigated by interviewing 140 youth who have attended AOD treatment services during 2003-2004 in seven centres around New Zealand, covering residential, day programme, and outpatient services. This study will also gather valuable information on the current functioning of these former clients. To supplement the interviews with youth the study also includes questioning programme staff in relation to identified youth and for their general views on factors affecting retention. Clinical files are also accessed, once permission has been gained.
- Odyssey Youth Outcome Study is currently part way through interviewing 80 consecutive admissions to the Christchurch Odyssey Youth Day or Residential programme. Interviews are conducted at treatment entry, six weeks, 12 weeks, six months, and 12 months. The study will be examining multi-dimensional treatment outcome, including substance use, mental health, general health, social functioning, criminal activity, and personality development, as well as gaining the youth's impressions of the treatment they are receiving. Significant others are interviewed at baseline, six months and 12 months to gain their views on the appropriateness of treatment provided, quality of family relationships and their impression of the youth's current functioning. This study will also examine factors related to retention, as well as predictors of outcome. The co-principal investigators are Prof Doug Sellman and Dr Ria Schroder.
- CUDIT Revision Study. The Cannabis Use Disorders Identification Test (Adamson & Sellman, Drug & Alcohol Review, 2003;22(3):309-15) was developed as a screening tool for cannabis abuse or dependence. A range of alternate items are currently being explored to improve the precision of this measure, lead by Dr Simon Adamson and in collaboration with colleagues from the University of Newcastle, New South Wales. This study will also measure the test-retest reliability of the CUDIT and investigate the CUDIT's sensitivity to change and therefore its potential as a brief measure of treatment outcome. The CUDIT is also being employed in the Odyssey Youth Outcome Study and Youth Retention Study (see above) where its appropriateness for an adolescent population will be examined.
- The Effectiveness of Naltrexone in Reducing the Craving of People with Pathological Gambling. This randomised controlled trial, which forms part of Dr Dominic Lim's PhD work, is testing the effect of Naltrexone on gambling-related craving and gambling behaviour. It is nearing the end of the patient recruitment phase and the preliminary data analysis supports a positive role for naltrexone in reducing gambling craving and gambling behaviour.
- Experiences and Needs of Maori Methadone Maintenance Treatment (MMT) Patients. Under the supervision of Dr Paul Robertson and Christchurch Methadone Programme staff Ra Bates and Wiki Crofts, a Maori medical student (Courtney Hore) has interviewed nine Maori MMT patients, asking about their wants, needs and experiences of MMT. Dr Robertson is currently overseeing a thematic analysis of interview material.
- Resilience in Indigenous Health Networks. This project is being undertaken in collaboration with a Canadian indigenous research group, with Dr Paul Robertson as the principal investigator of the New Zealand arm. This study aims to develop a framework for resilient indigenous health worker networks. Although the study is broadly focused on the range of health workers, Dr Robertson has a particular interest in the development and maintenance of Maori addiction worker networks.
- Development of Maori AOD Services and Workforce in Aotearoa New Zealand. Tami Cave is the principal investigator for this history project, which is funded as part of Matua Raki, the National Addiction Treatment Workforce Development Programme. Tami has recently finished interviewing 14 key informants, people who have played critical roles in the development of Maori AOD services over the years. She is currently undertaking a thematic analysis and will be producing a monograph in time for Cutting Edge 2006 in September.
- Nicotine Maintenance Feasibility Trial. This trial, lead by Dr Mark Wallace-Bell and funded by the Canterbury Medical Research Foundation, has involved establishing a smoking cessation research clinic, venued within Respiratory Outpatients at Christchurch public hospital. The feasibility trial, which is currently underway, will recruit 20 chronic relapsing smokers to determine the tolerability of long-term nicotine replacement therapy to reduce smoking and maintain cessation, with a view to undertaking a larger randomised outcome trial.
- Pre-quit Nicotine Replacement Therapy (NRT) Trial. This HRC funded study is lead by the Clinical trials research Unit, Auckland University (www.smokingiq.co.nz) in collaboration with Dr Mark Wallace-Bell at the NAC.

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SPIRITUALITY: DOES IT MAKE A DIFFERENCE IN THE TREATMENT OF DRUG AND ALCOHOL CLIENTS?

This article attempts to summarise the published research about spirituality and its relationship to the treatment of drug and alcohol addictions. A distinction has been made between three different, but related constructs: 'spirituality,' 'religion,' and 'Twelve-Step (or AA) involvement.' Spirituality has come to refer to the subjective side of religious experience, an aspect of a person's character, personality or disposition that is associated with the sacred, transcendent and immaterial features of life. Religion, on the other hand, is viewed as a social phenomenon, defined by its institutions, leadership, beliefs and rituals. It should be noted, however, that for many people spirituality is influenced by their culture and/or formal religion, and tends to be expressed within a social context (often cultural or religious).

Twelve-step groups, of which Alcoholics Anonymous (AA) is the largest, are the most popular form of mutual-help groups in New Zealand if not the western-world. Twelve-step philosophy teaches that addiction (to alcohol, drugs and other problem behaviours) is a 'disease' beyond the control of the individual, and recommends that the addict accept the help of a Higher Power, gets involved in twelve-step groups and actively practices the Twelve Steps in their lives. The therapeutic mechanism of change is thought to be a '*spiritual awakening'* experienced as a result of following the Twelve Steps. Supporting the relatedness of these three constructs, studies have found high levels of covariance between religion and spirituality, and spirituality and AA involvement.

Due to the spiritual nature of the Twelve Steps, some clinicians have thought that non-religious individuals should not be referred to AA and other twelve-step groups. While one US study found evidence that some clinicians chose not to refer their less religious individuals to twelve-step groups, it also found that religious involvement was not associated with twelve-step meeting attendance. An inpatient study, though, found that attendance to religious services was associated with fewer dropouts from twelve-step groups at one-year follow-up. A New Zealand study of 90 alcoholic men treated at Queen Mary Hospital noted a relationship between reported religious observance and AA involvement at follow-up, and proposed that active religious beliefs may serve as a predisposing variable for the acceptance of AA's regimen and ideology.

Project MATCH, which at the time was the largest randomized controlled study involving three psychotherapies - Twelve Step Facilitation (TSF), Cognitive-Behavioral Therapy (CBT) and Motivational Enhancement Therapy (MET), tested the hypothesis: that more religious participants would fare better in TSF than less religious ones. Initial results did not support this, as participants low in religiosity fared just as well in the TSF arm of the study as in the other therapies. (A closer inspection revealed a positive association between TSF and shifts in God beliefs; and that self identified Atheists and Agnostics attended fewer AA meetings than Spiritual or Religious participants.) However, by 3-year follow-up religiosity was associated with less drinking intensity, but not days abstinent. While TSF did show slight-to-moderate increased rates of twelve-step involvement, across the whole study AA involvement was generally predictive of better outcomes (especially with regards to sustained abstinence), and appeared to have a protective effect for individuals who lived in an environment supportive of drinking.

Community studies involving AA members have found associations between AA involvement and aspects of spirituality. In one survey 82% of the sample reported a *'spiritual experience'* as a result of AA. Those claiming such an experience were older and more involved in the twelve-step programme. Another survey found that length of time in AA was predictive of affiliates' preferred spiritual coping style, in that it fostered an attitude that considered God to be involved in their coping. Correlations, also, have been found between spirituality and psychological adjustment (i.e., contentment and purpose in life), and spirituality and length of sobriety.

A number of naturalistic studies involving treatment populations have found spirituality to be moderately predictive of twelve-step attendance, but failed to find relationships between aspects of spirituality and treatment outcomes. Although, in one cross-sectional study, greater internal spiritual well-being and sense of spiritual surrender were related to length of abstinence; and in another study, at 3-year follow-up, claims of a *'spiritual awakening'* were associated with continuous sobriety in the past year. In an investigation of factors involved in relapse, the spiritual elements of twelve-step involvement did not predict less relapse, but belief in a Higher Power and prayer were negatively associated with the severity of relapse, in those who relapsed. Also, aspects of spirituality (self-transcendence, forgiveness and spiritual coping) were found to be negatively associated with psychiatric severity.

Finally, in a mixed community and treatment sample, while there was no relationship between psychiatric severity and AA attendance, there were negative relationships between psychiatric severity and (i) aspects of spirituality (i.e., self-transcendence, forgiveness and spiritual coping) and (ii) 12-step involvement (i.e., completing the Twelve Steps and being a sponsor). The authors suggest that severe psychiatric symptoms may impact on the social skills needed to become involved in AA, and hinder the development of a sense of spirituality.

In conclusion then:

1. Prior religious involvement does not predict outcome of treatment;
2. Spirituality and religious involvement may moderate engagement with AA and other twelve-step groups;
3. AA involvement is associated with aspects of spirituality;
4. Twelve-step involvement and spirituality are negatively associated with psychiatric severity, and positively associated with psychological adjustment;
5. Twelve-step involvement is generally associated with better outcomes – especially related to abstinence, and less severity of relapses.

Michael Baker
(For references please e-mail Michael at: pmbaker@xtra.co.nz).

FETAL ALCOHOL SPECTRUM DISORDER: WHY IT MATTERS TO AOD SECTOR WORKERS AND HOW YOU CAN MAKE A DIFFERENCE

"To some extent I can understand the reluctance of doctors to advance the subject of FAS to a mother". "Was this reluctance a misunderstanding of the condition and its ramifications or was it indeed sensitivity and compassion toward the person who had caused the condition? Either way it was harmful…" (Russell, 2005, p.234).

The problem

Alcohol drunk by a pregnant woman can have damaging effects on her child. Not only does whatever alcohol the mother drinks pass to the fetus, but the alcohol has major teratogenic (cell mutating) effects.

"Fetal Alcohol Spectrum Disorder" or FASD is the term for the *range of effects* from prenatal alcohol exposure. This ranges from the most severe and best-known condition, Fetal Alcohol Syndrome (FAS), to low-level disabilities and behavioural problems (for instance, some attention deficit disorders) whose links to the mother's alcohol intake are often unrecognised. There are high personal, social, and financial costs - about $NZ20,000 a year to care for each person with FASD.

FAS is the single most preventable cause of non-genetic intellectual impairment. People with FAS have physical problems, major learning and behavioural problems and often have mild to severe intellectual disability. They very often have poor social outcomes, especially if their condition is undiagnosed, and this can lead to a higher risk of imprisonment, and of alcohol and drug problems.

How common is Fetal Alcohol Spectrum Disorder? Estimates vary, but in Canada each year about four babies with FASD are born for every 1,000 live births. Based on these rates, as many as 220 New Zealand children every year may be born with FASD.

Women who drink at risk levels when pregnant

Women do not deliberately choose to harm their unborn child. They may self-medicate, some may not be aware of their pregnancy, they may not be aware of the damage their drinking is causing; or they may have received advice that alcohol was not as big a problem as everyone makes out.

The main cause of FASD is binge drinking (five or more standard drinks at a single session). The mother's age, genetic factors, and interaction with other drugs (particularly smoking) also affect the probability and level of damage. A 2001 study estimated that around 10% of New Zealand women were drinking at "high-risk" levels when pregnant.

There is no 'typical' profile of a woman who drinks during pregnancy, and children with FASD come from across the socio-economic spectrum. While many mothers of children with FASD would not meet alcohol dependence criteria, women with alcohol dependence problems are at most risk - one study estimates that 4.3% of heavy-drinking women give birth to a child with Fetal Alcohol Syndrome. Mothers of children with severe FASD are more likely to have been drinking from before age 15; be living at poverty level; have low support; be victims of serious abuse themselves and have post-traumatic stress disorder or other mental health problems; and/or be living with a partner who does not want them to quit abusing substances. Women with alcohol dependence also are more likely to have fetal alcohol-related conditions themselves than women in the general population. Women who have already had a child with FASD are also at very high risk of having another. All this makes women of childbearing age with alcohol dependence a key target group for identification and appropriate treatment and support.

Preventing FASD

The prevention and intervention of FASD is a complex, sensitive and contentious area. At one extreme, some US states have jailed pregnant mothers for endangering their unborn children; while at the other end is the 'do nothing' approach. Canada, the United States, and more recently Australia have introduced population-based prevention programmes, such as awareness-raising and primary care interventions. These are having some effects on the general population; but as AOD treatment workers will recognise, women with problematic drinking are often the least responsive group to such methods. New Zealand has yet to develop sustained population-based prevention programmes.

Interventions for women with alcohol dependence

Pregnancy is a risk point for women with alcohol dependence. It is also one point where woman are often motivated to change.

Interventions for which there is evidence of effectiveness include:

- Screening using the T-ACE or TWEAK questionnaires, designed especially for use with pregnant women, are effective at identifying women at risk.
- Services specifically targeted at pregnant women and at-risk mothers, both in-patient and community-based, have a good reach, especially when tailored to the woman's ethnic or socio-economic group.
- Brief intervention programmes are effective at reducing women's alcohol intake. They may be more effective when the woman's partner participates in the intervention.
- Where women at risk receive pre-natal and post-natal advocacy, mental health treatment and have some satisfactory social support, they can significantly reduce drinking. The Seattle "Birth to 3" project targeted women who already had a child with FASD, and women who received support had abstinence rates 96% higher than before the intervention.

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How people in the treatment sector can help prevent FASD

"Pregnant women identified as consuming risky levels of alcohol (as defined in the Australian Alcohol Guidelines) should have priority access to alcohol treatment services, including comprehensive assessment and detoxification, but also including therapeutic options such as brief intervention, cognitive behavioural therapy and group sessions."(Australian National Clinical Guidelines, 2006:27)

For treatment workers:

- When treating people with alcohol and drug dependence who also have a history of behavioural problems, consider FASD as a possible contributing factor.
- Assume any woman of childbearing age presenting with AOD problems is at risk of having child with FASD, and ensure she receives targeted advice.
- Screen clients who are pregnant using appropriate tools, and work to get them immediate access to treatment.
- Ensure those women are linked not only to ante-natal, but to post-natal support.

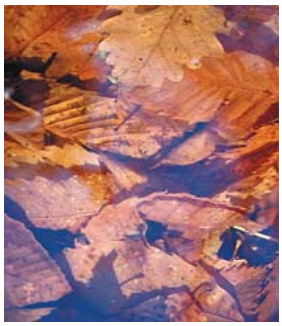
For everyone in the sector:

- Advocate for treatment and appropriate post-natal support services for pregnant women - New Zealand has relatively few dedicated AOD services for women.
- Advocate for better training and resources on FASD for AOD treatment workers, and support service workers.
- Advocate for New Zealand-specific research to support effective, appropriate and culturally safe FASD prevention strategies.

Treating a woman's alcohol problem is a key part of preventing future cases of FASD - you can be part of the solution.

Keriata Stuart
Senior Policy Analyst
New Zealand Drug Foundation – Te Tuapapa Tarukino o Aotearoa

(Please contact the Editor for article references)



NATIONAL ADDICTION CENTRE CONTINUED

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The pre-quit Nicotine Replacement Therapy (NRT) Trial aims to recruit 1100 participants through the national Quitline, who will be randomised to either two weeks of NRT with concurrent smoking (i.e., pre-quit) plus standard treatment (i.e., eight weeks of NRT post-quit) or standard treatment alone, with both groups receiving pro-active telephone counselling. All participants will be followed up at six months.

- The Alcohol and Drug Outcomes Project (ADOPT) – Part II. This development project, lead by Dr Gail Robinson (Waitemata DHB) and Daryle Deering (NAC) and funded by the Mental Health Research & Development Strategy, is looking at the feasibility of routine outcome measurement in AOD services. Currently the investigators are undertaking a preliminary feasibility trial of a set of draft substance use items with a small number of clinicians in adult outpatient services in Auckland and Christchurch, which will also include focus groups with consumers and AOD workers. The study will also comprise a review of the companion items intended to measure broader functioning, to ensure that duplication with other MH-SMART items (i.e., HoNOS etc) is avoided.

Planned Research:

- Treatment Evaluation of Alcohol and Mood (TEAM) Study. This is a multi-site study funded by the National Drug Policy Discretionary Fund and headed by Prof Doug Sellman. It is a randomised controlled trial of combined pharmacotherapy for patients with coexisting alcohol dependence and a major depressive illness. All participants will receive 12 weeks of naltrexone, an anti-craving drug, and supportive clinical case management over the 24 week course of the study. Half of the group will be randomised to receive 12 weeks of Citalopram, an SSRI antidepressant, and half a placebo. Participants will be followed up 12 weeks after the end of the pharmacotherapy phase of the trial. We will also be seeking funding to conduct a further follow-up at twelve months as well as to investigate genetic and pharmacokinetic factors in relation to treatment response. Recruitment will commence soon in Whangarei, Auckland, Hamilton, Christchurch, and Dunedin.
- National Telephone Survey – 2007. In 2007 we will be repeating the successful telephone surveys of the AOD workforce previously conducted in 1998 and 2004, allowing us to continue to monitor changes in the qualifications, practice, knowledge and attitudes of our workforce, as well as obtain a nationally representative snapshot of clients.
- Piloting a Māori Addiction Practitioner Competency Framework. This development project is overseen by Pam Armstrong, who is the interim Maori Project manager for Matua Raki. Its intention is to provide initial validation of a framework for Maori Addiction Practitioner competencies. The goal is to develop competencies that complement and are compatible with those promoted by DAPAANZ, the Drug and Alcohol Practitioners Association of Aotearoa New Zealand. This project originated from a contract undertaken by Nga Mangu Puriri for ALAC, but has now been incorporated into the Matua Raki programme.

So, as you can see, we're keeping ourselves pretty busy. Please don't hesitate to contact the identified researchers if you have a specific interest in any of the projects outlined above.

Dr Simon Adamson
Senior Lecturer
and Deputy Director (Research)
National Addiction Centre

Although now a PhD student in the Christchurch School of Medicine's Department of Psychological Medicine, I began my research into New Zealand cannabis use under the auspices of Otago University's Division of Humanities. There, as an anthropology postgraduate, I commenced an ethnography of cannabis use as a means to examining how perceptions of use and user are constructed. Despite at this initial stage being more concerned with user culture, a principal thrust of the research involved a critique of what social theorists working in this area characterize as the dominating discourse of pathology. Here the emphasis on negative health consequences associated with cannabis use eclipses a broader purview possible with more holistic sociological analyses locating psychotropic use in a web of social meaning (Moore, 2005). Thus my reading explored general discussions of drug use occurring in books and edited volumes adopting a broad perspective, as well as engaging with specific phenomena examined in discretely focused journal articles.

Regarding drug use and the tendency to privilege health, Goodman et al (1995) note the topic's framing in the context of addiction and abuse, with medical, legal and media perspectives dominating. Cultural critic David Lenson (1995) agrees, remarking that "writing about drugs [pharmacography] without proper credentials is still hardly more defensible than taking them". Though totally, and perhaps foolishly, unencumbered by any clinical, medical or scientific learning, I soon appreciated that a critique of the dominant portrayal of cannabis use requires not only engaging with the discourse of health harms, but also familiarizing oneself with specific health issues. As these relate to cannabis, two of the more significant concern mental health and lung function. It is the latter I would like to discuss for several reasons, not the least being that in mediating these harms, certain conundrums potentially arise for treatment professionals concerned with addiction and dependency.

As most cannabis is consumed by smoking a generally accepted health concern relates to respiratory dysfunction. A variety of carcinogens are generated by burning cannabis including vinyl chloride, dimethylnitrosamine, methylethylnitrosoamine, benz(a)anthracene and benzo(a)pyrene, the latter two being of particular significance due to their greater concentrations in cannabis smoke than tobacco (BMA, 1997). Compared with tobacco, cannabis smoke produces a five-fold increase in carboxyhaemoglobin, thereby preventing haemoglobin from carrying oxygen to the tissues (Benson and Bentley, 1995); and, due to style of smoking, deeper inhalation and greater puff volume mean more damaging particles are inhaled and more tar retained than with tobacco (Wu et al., 1988). Other potential negative physical health effects include exposure to contaminants such as fungi (BMA, 1997), and concerns over immunosuppressant effects (Cabral and Petitt, 1998, Adams and Martin, 1996) and neurotoxicity (see Smith, 2002:129-131 for a review and critique).

However, opinions regarding pulmonary harms are inconsistent. While Barsky et al (1998) report a tendency to pathological abnormalities on bronchial epithelium suggesting the early stages of lung cancer, and Taylor et al (2000) argue for a direct casual link between smoking and respiratory dysfunction in cannabis dependent smokers, others (Hall and Solowij, 1998, Zimmer and Morgan, 1997) acknowledge these but question the extent of cannabis' negative impact on respiratory function. Hall observes that there is scant evidence for any *causative* link between cancer and cannabis smoking and that there is no evidence that oral administration is linked to physical pathologies. A review of evidence by Melamede (2005) supports this. He notes that while both tobacco and cannabis smoke have similar chemical properties, pharmacologically their activities differ significantly, with components of cannabis smoke minimizing some carcinogenic pathways and tobacco smoke enhancing some.

While both types of smoke potentially enhance the carcinogenic effects of their constituents, cannabis typically down-regulates immunologically-generated free radical production, as well as its psychoactive component (THC) inhibiting the enzyme necessary to activate some of the carcinogens found in smoke. Further, while the presence of respiratory epithelial cell nicotine receptors increases the likelihood of lung cancer for tobacco smokers, cannabinoid receptors have not been reported in respiratory epithelial cells. Finally, while nicotine promotes tumor growth cannabis inhibits it. Though Melamede acknowledges that an aging cannabis-consuming population might in the long-term exhibit profiles similar to what is now observed with tobacco smokers, current knowledge suggests this is unlikely.

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As with so much of the debate surrounding cannabis, the science engaging with its health implications presents a far from unified perspective; and neither is this complexity reflected in the media, the major conduit for information reaching that most significant group – cannabis users themselves.

Further complicating matters, particularly for treatment professionals, is New Zealand's confused policy situation, which sees harm minimization simultaneously promoted yet starved of resources in the treatment and education sectors, compared with enforcement. With the National Drug Policy (NDP) currently up for consultation (Health, 2006) it is instructive to note how a central tenet of harm minimization - reduction of harm rather than use *per se* - (Lenton and Single, 1998, Single, 1995, Wodak and Saunders, 1995), is being eroded and that harm minimisation as a strategy is under attack (Brown, 2005). In fact, comparing a drug policy paper prepared in the mid nineties (Howden-Chapman et al., 1994) with the current NDP shows just how far this erosion has gone.

The status of harm minimization is especially relevant for cannabis users as the pulmonary harm they are exposed to by smoking may be ameliorated through certain techniques and technologies. For example, using a vaporizer allows the user to experience the psychotropic effects of THC while also almost eliminating exposure to harmful effects due to inhaling particles from loosely-rolled joints (Chemic Laboratories Inc., 2003). Similarly, and perhaps more controversially, the use of stronger cannabis (i.e. cannabis with a higher percentage of THC) has been shown to result in lesser deposits of harmful substances in the lung as many users tend to titrate their dose to achieve a preferred 'high' (Matthias et al., 1997).

Of course this returns us to the conundrums alluded to earlier. To what extent is it appropriate to advise cannabis users on the safest means to imbibe cannabis? What, therefore, is the place of harm minimisation in the context of treatment? If one provides such information is one not opening the gate for continued use, and potentially, further problems? Contrarily, if such information is not provided, is it not the case that users are being exposed to greater range of harms? Given the level of cannabis use in Aotearoa, and the current NDP consultation process, I believe these are issues worth discussion.

Geoff Noller

References available from the Editor

MESSAGE FROM THE CHAIRPERSON

This edition marks the start of a new look for ATRIG. As part of the process of changing our name, from TRIG, the executive undertook to commission a logo, which will be used for the newsletter masthead, as a letterhead, as a banner at the top of our webpage, and also for a trade banner, which will be on display at future Cutting Edge conferences and other meetings should ATRIG have a significant role, or be invited to promote our activities.

The new logo, which can be seen at the top of the cover page, was developed by ImageLab in Christchurch. Given the very limited budget with which they were asked to work we are delighted with the result. Do look out for the trade banner at this year's Cutting Edge, where the new look has the maximum visual impact.

The image shown as part of the new logo might be taken to mean a variety of things. What I would like to suggest is that it represents the belief that small organisations, such as ATRIG, can have a positive influence that is widely felt. This has been a defining belief of ATRIG since its inception nearly ten years ago. Reflect on the mission statement of ATRIG: "to promote interest in and disseminate addiction treatment related research in New Zealand" and it is apparent that the activities of ATRIG – promotion and dissemination – are modest, at least on the scale we are able to undertake.

It is our firm belief, however, that through the work of ATRIG we are contributing to a substantial shift in the addiction treatment culture in New Zealand, a shift that increasingly sees treatment work being undertaken by qualified staff with an awareness of, and respect for, research findings in this area, supported by likeminded managers, and backed up by a dedicated group of researchers (many of whom are also clinicians) generating locally-relevant and clinically meaningful research findings. As the professionalism of our field increases in this way we increasingly gain the respect of our colleagues in mental health, and more importantly, we are in a position to better influence funders and policy makers. All of these things will contribute to improved provision of services to people struggling with addiction, and their families.

Dr Simon Adamson
ATRIG Chairperson

Addiction Treatment Research Interest Group (ATRIG)

MEMBERSHIP/RENEWAL FORM

Please note all individuals wishing to be a member of ATRIG must join by completing this form regardless of current membership status.

Membership in ATRIG entitles you to the following

- three issues of the Addiction Treatment Research News via email
- membership in the ATRN email discussion group

PLEASE ENROL ME AS A MEMBER OF ATRIG (ADDICTION TREATMENT RESEARCH INTEREST GROUP). I HAVE READ AND SIGNED THE DECLARATION BELOW.

Surname _____ First Names _____

Postal Address _____

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Daytime Phone Number _____ Fax Number _____

E-Mail Address _____

(NB - You Must Provide An Email Address If You Wish To Receive A Copy Of ATRN)

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.*

Declaration

I support the objectives of ATRIG and wish to be a member of ATRIG for the 2006 calendar year. I understand membership fee is $20.

Signed _____ Date _____

Please make cheques payable to: ATRIG

I am interested in participating in an email discussion group around ATRN ☐

Thank you for completing this form and sending it back to:
Lindsay Stringer, PO Box 2924, Christchurch (Phone 03 364-0480, Fax 03 364-1225)