Addiction Treatment Research NEWS

NEWSLETTER OF THE ADDICTION TREATMENT RESEARCH INTEREST GROUP

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EDITORIAL

We are all, I'm sure, looking forward to Spring as we have endured a long, cold and wet winter right around the country. The AOD sector has over winter been busy preparing for our annual conference Cutting Edge, to be held in Wellington at the Duxton Hotel this year from September 7 to 9. Also keeping us busy has been the release of the draft National Drug Policy 2006-2011 and the ensuing consultation. The policy has sparked a number of debates and raised a number of concerns within the sector. Letters to the editor regarding these issues are most welcome.

We are proud with this issue of the Addiction Treatment Research News to be celebrating our 10th year. The first issue of ATRN (then the TRN) was produced by Raine Berry in January 1997. Since that long ago day the ATRN has changed names, editors, and appearance. Yet we still endure and work hard to bring you the latest in research and evidence-based practice in our sector.

Consequently, this issue is full of special retrospectives of the past 10 years as well as our faithful regulars. Doug Sellman gives us a brief history of ATRIG, while Simon Adamson, in his Chairperson message, talks about the next ten years for the group. Simon also looks at the last ten years at the NAC in his report from the National Addiction Centre. We have a special 10 year "We've been reading", with Fraser Todd returning for this issue. Peter Adams also makes a return to ATRN telling us why he likes dangerous consumptions. Tami Cave, Paul Robertson and Terry Huriwai offer up a look at Maori addiction research in the last decade. Sean Sullivan and the team at Abacus provide with a view of the gambling sector and research in the past ten years and into the future. We also have a look at developments in psychopharmacology in the last ten years from Lee Nixon. Last, but not least in terms of our retrospectives Helen Moriatry gives us a decade long perspective on AOD research in the Wellington School of Medicine. Additionally, we have two interesting articles. Janie Sheriden writes about general healthcare for methadone clients. Robin Shepard provides us with a look at host responsibility in gambling venues.

Finally, I write this as my last editorial for the Addiction Treatment Research News. I will be resigning as Editor of the ATRN as of the ATRIG Annual General Meeting at Cutting Edge. I have very much enjoyed my years as Editor. My departure comes as I am about to leave the National Addiction Centre and embark on a new vocation. As of February 2007 I will be studying for ordination as a priest in the Anglican Church at St John's College in Auckland.

In my work with the ATRN and the National Addiction Centre I have learnt a great deal about the realities of drug use, abuse and dependence. Too often our preconceived ideas and prejudices, regularly reinforced by the media, stop us from seeing the people and the issues behind drug use. My time here has helped to educate me to look past the stereotypes and stigma and reach out to the person. This skill, be it with drug users or others, will be invaluable as a Christian and a Vicar. More specifically, my time with ATRIG, the ATRN and as a researcher in this field has reinforced for me the value of truth and evidence in this world. I have always been a strong believer in the value of research and my stretch with the ATRN and the NAC has reinforced that knowledge is power.

The clinicians and administrators in the AOD sector that I work with every day have shown me what it is to be truly dedicated and earnest. I am constantly impressed by the hours and warmth I see being put into improving the treatment of alcohol and drug addiction in New Zealand. I am humbled by the commitment of this sector.

I wish the Addiction Treatment Research Interest Group and the Addiction Treatment Research News all the best for the years to come. I sincerely hope you are both around for many, many years.

And a final – happy reading.

Meg Harvey
Editor
August 18, 2006

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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Letter to the Editor

Dear Editor

I note and endorse the letter from Rhonda Robertson about the importance of access to treatment for intravenous drug users who have injection-related skin infections.

She points out that "Disclosure is also an issue for clients of methadone maintenance treatment" pointing out that seeking medical advice could potentially threaten takeaway privileges. No doubt she is right. While she focuses solely on this issue, it actually should form part of a much larger debate concerning the application of contingency management in addiction treatment in general and opioid substitution treatment in particular. Like so much of what we do, linking "takeaways" to the provision of "clean urines" entered the culture of treatment services prior to the development of emphasis on evidence-based treatment. While there is some evidence that contingency management improves outcomes in methadone maintenance (for example, Peirce et al, Arch of Gen Psych 2006, **63:** 201-208) this refers to the availability of positive contingencies, which are generally considered more effective than negative ones. While obtaining takeaway "privileges" are indeed a positive contingency, I am concerned that our patients all too often see their removal as a negative contingency. This should lead to a debate about whether takeaway privileges constitute the best, or even an appropriate, contingency to employ, or whether other contingencies would be more effective.

Yours sincerely,
Lee Nixon
Addiction Medicine Specialist
A and D Service, Nelson Hospital

ATRIG AGM

The Addiction Treatment Research Interest Group (ATRIG) will have its Annual General Meeting at the Cutting Edge conference being held in Wellington at the Duxton Hotel. The meeting will be at lunchtime, 12:15pm, on Friday September 8th. All past, present and future members are warmly invited to attend.

Amendment

We would like to make an amendment to the article "Fetal alcohol spectrum disorder: Why it matters to the AOD sector workers and how you can make a difference", which appeared in the last issue of the ATRN. The article was co-authored by Christine Rogan, Health Promotion Advisor for Alcohol Healthwatch.

Cutting Edge 2006

This year's annual conference of New Zealand Alcohol and Drug workers is being held in Wellington at the Duxton Hotel. It will run from Thursday September 7th to Saturday the 9th. There are still places available. Registration forms are downloadable from the NAC website at www.addiction.org.nz, under National Conference.

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Development of Addiction Research at the Wellington School of Medicine and Health Sciences in the last 10 years

The National Addiction Centre deserves a medal for taking the lead and championing drug and alcohol teaching and research both at the University of Otago and across New Zealand, and also for maintaining the momentum for so long. In contrast to the success of the research scene in Christchurch stimulated by NAC, the AOD discipline has struggled to maintain visibility over the years at Wellington School of Medicine and Health Sciences. This problem has been compounded by absence of any dedicated department or academic unit (such as NAC) to provide a focal point for research activity, and also paucity of dedicated academic and support staff to keep up momentum of both AOD teaching and research interest.

The establishment of a CADEMs coordinator role in the mid 1990s was the first step toward dedicating some academic leadership time to drug and alcohol. Dr John Durham was first appointed to the part-time post, which was initially funded by ALAC at two tenths (one day) a week. Dr Durham left New Zealand in 1999 to take on an academic GP leadership position in Western Australia, but after a two year void the University took over funding of the CADEMS role in 2001, which enabled Helen Moriarty to continue his work. This part-time position has maintained the capacity within WSMHS to respond to pressing demands of AOD undergraduate teaching, but AOD leadership has been and remains (less than) a one-man band, at the expense of sustained research effort. Despite this there have been several research success stories.

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Wellington School of Medicine & Health Sciences

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Chrissy Severensen recently completed her Masters thesis. Her research project was focussed on role of whanau in aiding their rangitane through drug and alcohol recovery. Based in the Wairarapa community, this qualitative project researched experiences of Maori AOD clients and their family members and reaffirmed the therapeutic importance of a caring extended family.

In 2004 a John Dobson Award was received to foster a junior researcher interest in the AOD field. This assisted Monique MacKenzie to do some research during a year of maternity leave from her medical studies. Her interest in drug use in gangs was very topical. Monique's project during 2005 tested a qualitative method of asking sensitive questions acceptable in high-risk group settings. Working with extended family of a local gang, she held focus groups using a brainstorming technique with the exchange of comments written on cards. This methodology will assist further research work on drug use phenomenology to be undertaken, within communities where illicit activities are common but not freely spoken about. A paper for publication is planned.

Summer student research projects notable for their innovative topics, and dissemination in peer reviewed publication and international conferences.

In 2002, Nimeshan Geevasinge audited outcomes for the community opioid detoxifixation service. The main findings were that Wellington outpatient detox results were very similar to those overseas and identical to Australian results, despite the wider range of pharmacological agents (then only methadone detox was available in NZ) and greater service sophistication and funding for client support that is available elsewhere. A discussion paper on community detoxification, based on his research, was published in the New Zealand Family Physician journal, which enjoys wide readership with community-based doctors and nurses.

During summer 2003/4, Liz Stockman conducted a project called "What about Pot?" The NZ Asthma and Respiratory Foundation funded her project. Liz audited records of acute medical admissions at Hutt Hospital to find out how complete the record of smoking history was. Liz then did a medical staff educational intervention explaining the health effects of cannabis smoking and sent to staff reminders for them to ask their inpatients about cannabis as well as nicotine smoking. At Hutt Hospital smoking is a compulsory field on the discharge summery, but many summaries had scant or no smoking information (e.g. records said "smoker" but no details of how much of what). After the intervention the smoking documentation improved overall, and documentation of cannabis use increased, but not significantly. Of concern were the inconsistencies: where medical notes on a patient said "non-smoker" but the nursing notes said "off ward times 2 for a smoke, this shift". The hospital-based medical staff does still not take smoking history seriously. Liz had a poster accepted for Cutting Edge in 2004 and she also presented as an original scientific paper at the prestigious RACP Annual Scientific Conference in Wellington in 2005.

The work of championing of summer projects continues. In summer of 2006/7, one research student will undertake a study of care of pregnant women on the methadone maintenance programme, and another will study the relationship between methadone dose and the risk of cardiac arrhythmia (long-QT syndrome) at the Wellington methadone clinic.

In addition to continuing to provide supervision for small projects such as these, WSMHS has provided expertise for AOD thesis examination and in giving external advice to AOD research projects in other centres. One such project is research into the phenomenology of Legal Party Pill use, conducted by the Pharmacy Department at University of Auckland, one of several research sites to be funded by the Ministry of Health's National Drug Policy discretionary fund.

We are still hopeful that a substantial academic position in Wellington will one day be funded to secure good AOD research leadership.

Helen Moriarty
Senior Lecturer
Wellington School of Medicine & Health Sciences

Although ostensibly behavioural in nature, problem gambling's acceptance as an 'addiction' has made substantial progress over the past decade. Problem gambling has had a difficult time in placement within both past and, to a lesser extent, current medical categorisation (nosology, from a disease perspective). It was first included in DSM in 1980, reviewed in DSM-III-R in 1987, and again in DSM-IV (1994). It sits within Impulse Control Disorders Not Elsewhere Categorised, and suffers from some ignominy of being specifically mentioned in the cautionary statement (p.xxxvii) that,

'It is to be understood that inclusion here (DSM-IV) for clinical and research purposes, of a diagnostic category such as Pathological Gambling or Pedophilia does not imply that the condition meets legal or other nonmedical criteria for what constitutes mental disease, mental disorder, or mental disability.'

This emphasises the general perception a decade ago, that problem gambling (and many other behavioural addictions) had less acceptance outside of those specifically dealing with mental health, while within mental health it barely had a toehold.

Within New Zealand, some recognition of the impact of problem gambling was arising. In 1992 the Compulsive Gambling Society was established with a foundation grant from the Minister of Internal Affairs, and six experienced health and educationalist professionals led by a prominent psychiatrist Dr Fraser McDonald formed the board and executive of a helpline, face-to-face treatment facility, and active voice for those affected by gambling. In many ways New Zealand became a leader in service provision in these early days, with a further two years elapsing before similar services were established in Australia. In North America such services were either insurance funded residential services for those already meeting Pathological Gambling Disorder, or receiving small grants from individual States for new helplines. Community-based services were relatively new, and not funded to the extent of the New Zealand experiment.

However, funding moved from government in 1995/6 to direct industry funding through an unusual quango recognised by legislation, in which equal numbers of treatment providers and gambling industry met in committee and made decisions around funding needs and direction. This was further complicated in that some of the industry had either strong government recognition (the racing industry in the persona of the Minister of Racing) or was wholly government owned (the Lottery Commission), while continued funding was provided solely by one side - the gambling industry. From the industry's perspective, the spectre of imposed regulation and funding was always a possibility, and may have encouraged consensus. Remarkably, the Problem Gambling Committee functioned well and mutual respect was engendered between what to outsiders may have seen as implacable adversaries.

The present

In late 2003, after a decade of drafting, the Gambling Act was passed in which the Problem Gambling Committee passed its responsibility for problem gambling prevention and harm reduction to the Ministry of Health (MoH), with regulation remaining the responsibility of the Department of Internal Affairs. This compares with Australia, where Relationships Australia has assumed responsibility for problem gambling.

With the MoH assuming responsibility for problem gambling has come a drive to identify how it develops, which influences can prevent or reduce harm, best practice in treatment, and ensuring a workforce can meet these standards for the foreseeable future. Unlike other addictions, a specific funding source other than the health vote has been incorporated in the legislation, with each sector of the gambling industry contributing in proportion to the identified harm caused by their gambling mode.

Research into problem gambling has until recently been relatively low priority, with much of the (limited) research occurring in other countries, and generalised back to New Zealand. The MoH has now allocated specific funding to research and is seeking feedback for the coming three years.

As regards acceptance within the health and addiction field, the latest 10 year plan (Te Kokiri: the mental health and addiction action plan 2006-2015) specifically addresses problem gambling as an accepted addiction.

The future

The problem gambling workforce is now stated to include, in addition to specialist services, PHOs, DHBs, as well as other mental health and addiction services. In current projects, primary screening opportunities in both health and social settings may increase in the future the numbers accessing specialist problem gambling treatment services, and may also result in help-seeking at an earlier stage in their problematic behaviour.

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Currently, help-seeking is late-stage, possibly influenced by both the absence of satiation found in substance addictions (which may accelerate the process to the severe stage) and the perception that gambling may also provide the solution to the ostensible financial symptom resulting in reluctance to stop while hope exists. Awareness-raising before substantial debts arise and motivation depleting depression, relationship breakdown, and offending become established, can result in less resources being required to minimise harm.

The previous lack of a biological marker in the central nervous system found in substance addictions has been both a difficulty in ensuring that problem gambling exists, and that, despite being behavioural, it can have an impact that is sufficiently serious to register in the CNS. Recent research has shown similar decreased activation for problem gamblers in the ventral striatum (reward and motivation) as found in substance use disorders.

It appears likely that in the future, a broader perception of addiction will encompass both substance use and behaviours, and that a 'syndrome' model for addiction as proposed by Shaffer and his colleagues (2004) will hold sway. They propose addiction as 'a cluster of symptoms and signs related to a underlying condition' with a similar developmental pattern, and depends upon personal vulnerabilities, exposure to the object/activity, and personal experiences with them.

Acceptance of behaviours within an addiction syndrome is likely to focus upon a generic service provision for addictions together with add-on specifics. In addition, the very low accessing of services by family members affected by gambling may be remedied through additional resource focusing of support for these forgotten consequences of addictions. The Gambling Act signals this wider focus through its definition of harm from gambling to 'the person's spouse, partner, family, whanau, or wider community'.

This may well be reflected in the future DSM-V's description of Pathological Gambling Disorder, while additional problem gambling disorders that incorporate the high coexistence of alcohol and depression may be added as biological similarities to substance dependence are discovered.

Thus, in the future, one could expect to see a workforce with enhanced skills to address behavioural and substance addictions, a wider focus on affected others, acceptance of behaviours as an addictive process equalling substance addictions in seriousness, and research that may indicate that behavioural addictions may have always been a similar syndrome to any substance addiction.

Sean Sullivan
Abacus

Message from the Chairperson

Dear Members and those contemplating becoming members

Ten years is a substantial milestone for an incorporated society, run on a shoestring and largely relying on the goodwill and enthusiasm of its membership. The membership has certainly fluctuated over that time, as is well described by Doug Sellman in his contribution to this decennial edition of ATRN. When I look forward over the next ten years I do so with the belief that we can pencil in the 20 year anniversary in 2016 with great confidence.

Over the coming years ATRIG will continue to produce the ATRN, which has established itself as a platform for the dissemination, promotion, and discussion of addiction-related research activity in New Zealand. ATRIG will continue to produce the Addiction Treatment Research Monograph, providing the opportunity for publication of original research findings. The form that these two documents take may change over time in response to demands and opportunities.

The monograph has long been thought of as a potential vehicle for the establishment of a formal peer-reviewed academic journal devoted to the topic of addiction. Over the five years that this has been produced the Sydney-based journal Drug and Alcohol Review has grown in stature, with increased circulation, impact factor, and frequency of publication, while the Australian and New Zealand Journal of Psychiatry and the New Zealand Medical Journal continue to publish addiction-related research findings. As an addiction-focussed journal Drug and Alcohol Review does not publish a large number of studies in the area of co-existing disorders, perhaps reflecting the stronger divide between addiction and mental health service deliver on the other side of the Tasman. Thus, it is unclear whether there is a clear and sufficient niche for our monograph to evolve into a peer reviewed journal. In the meantime, however, what is clear is that it continues to provide a valuable opportunity for emerging researchers to develop publication skills and for more experienced researchers to increase the dissemination of findings to a New Zealand audience.

In the past ten years a number of new organisations have emerged and these are likely to influence the role ATRIG may serve in the coming ten years. These include the Drug and Alcohol Practitioners Association of Aotearoa New Zealand (DAPAANZ), the National Committee on Addiction Treatment (NCAT) and the National Addiction Treatment Sector Workforce Development Programme (Matua Raki). The establishment of these organisations is part of the increasing credibility and professionalism of the addiction treatment sector. ATRIG welcomes these developments and I believe that they will lead to a field more receptive to and demanding of the availability of clinically relevant addiction research.

A more immediate development is planned for 2007. In December of that year Auckland will host the first combined Cutting Edge and APSAD conference. APSAD is the Australasian Professional Society on Alcohol and Other Drugs. This conference will provide the opportunity for both countries to take a better look at the work the other is doing and for discussion between researchers, clinicians, consumer, managers and others.

Finally, another milestone I would like to mark is that this is the 18th and last ATRN for Meg Harvey as editor.

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In keeping with the theme of this edition of the ATRN I'd like to briefly review the activities of the NAC over the past ten years. This is a particularly apt exercise as this year also marks ten years of operation of the NAC, which was established as the National Centre for Treatment Development (Alcohol, Drugs and Addiction), or the NCTD in 1996. The contract with ALAC was signed in June of that year, with the first staff appointed in September.

The Centre was established following a competitive process in which four bids were received by ALAC for the establishment for a centre of excellence aimed at improving treatment delivery. As part of the Christchurch School of Medicine's successful bid Doug Sellman argued that active participation in high quality research would be an essential element of an effective centre. This argument was accepted by ALAC and is reflected in the founding mission statement of the NCTD: "Developing, evaluating and promoting effective treatments for people with alcohol and drug-related problems in New Zealand."

In 2003 the contract with ALAC expired and we then entered into an agreement, starting in 2004, with the Ministry of Health, also taking the opportunity to change to a simpler and clearer name: the National Addiction Centre (NAC). The Ministry of Health contract saw the establishment of Matua Raki: the National Addiction Treatment Workforce Development Programme. Matua Raki does not constitute the sole funding for the NAC, with teaching and research activities continuing to be support as part of the Department of Psychological Medicine, Christchurch School of Medicine and Health Sciences (Otago University). Matua Raki has brought with it the opportunity to continue research examining the nature of the addiction treatment workforce in New Zealand, while multi-centred clinical research is also recognised as an important contributor to development of clinical skills and an evidence based practice culture.

Over that ten years NAC staff and graduate research students have undertaken approximately forty research projects and have generated close to 80 peer reviewed publications. NAC staff have also supervised 18 graduate degrees including five PhDs, with a sixth currently under examination. This represents a substantial increase in the addiction research capacity in New Zealand. During that time the NAC has also had the opportunity to collaborate with other researchers in Auckland, Wellington, Dunedin, Australia, and Canada, as well as conducting clinical research in collaboration with addiction treatment staff in Whangarei, Auckland, Hamilton, Hawkes Bay, Christchurch, and Dunedin.

As well as having had several staff move on during that time we have also marked the passing of John Dobson (1998), Alison Pickering (2000), and Takarangi Metekingi (2004). Each has made a uniquely important contribution to the NAC. Specifically in relation to research, John was an inspiration behind the establishment of both the NCTD and TRIG, Alison was one of the founding employees of the NCTD and as a research assistant set a standard that would be difficult to exceed. Takarangi challenged us to strive for and expect excellence in our work in general and engaging with Te Ao Maori in particular.

Since 1996 there have been a number of significant changes in New Zealand relevant to addiction treatment research. While nicotine and alcohol continue to dominate the landscape, methamphetamine has come from obscurity to be a substance of major public and clinical concern. In 1996 BZP was all but unknown as a recreational substance. Naltrexone was yet to be identified in the published literature as an effective treatment for alcohol dependence let alone be available as a subsidised medicine here. There has been an explosion of electronic gambling machines nationally with a more recent curtailing of their spread. Nicotine replacement treatment has become widely available as a subsidised treatment with support available from Quitline. All of these changes pose new questions, which can be systematically addressed via original research and by being aware of the extant research literature. Rational policy and clinical responses to these challenges and opportunities has been aided by such research, with the NAC playing a lead role in this respect in New Zealand.

Finally, I'm delighted to report that we recently formally welcomed Terry Huriwai in a mihi whakatau on his return to the NAC. Terry was appointed to the NCTD in January 1997 as a lecturer. He moved on to the Ministry of Health in July 2001. Terry's new role is as project manager for Matua Raki, with primary responsibility for Maori treatment workforce initiatives. We look forward to Terry's continued contribution to addiction research, with Terry recognised internationally for his published research on the addiction treatment needs of Maori.

Bring on the next ten years I say! We're certainly looking forward to them here at the NAC.

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

A BRIEF HISTORY OF ATRIG

Kia ora to the current ATRIG Executive for inviting me to briefly reminisce on ATRIG's history.

The inaugural meeting of ATRIG was at a rather unique conference called "The Long and the Short of Treatment for Mental Disorders" in Christchurch, July 1996. This mental health conference was unique in having a strong addiction stream (called AOD in those days). Amanda Baker, Wayne Hall and Robert Cloninger were the keynote speakers for the stream and there was a very good turn out from our field at the conference.

Developing a research interest group in the field was an idea of mine in the lead up to our Christchurch bid for the ALAC's national tender for a clinically focused "centre of excellence"; and thankfully the idea was strongly supported by an enthusiastic group of colleagues – there were 30 at the inaugural meeting at the Long and the Short conference. The initial Executive group voted in included: Raine Berry, Terry Huriwai, Lee-Ann Ryan-Verry, Goldie May, Henck van Bilsen and myself as Chair. Terry was a central figure in establishing the Treatment Research Interest Group (Alcohol, Drugs and Addiction) (TRIG, as it was known as then) as an Incorporated Society, following another meeting at ALAC's "Perspectives for Change" conference in September 1996.

The initial membership fee was zero, and this sparked a quickly growing membership, which after one year reached 209. We were successful in gaining $4000 from the wound up New Zealand Society on Alcohol and other Drugs, which not only helped TRIG become formally established but allowed us to begin publishing editions of the Treatment Research News. Raine Berry was the first editor of the newsletter and got the wheels turning before Meg Harvey took over in 2000 and subsequently maintained a top rate newsletter relevant to the treatment field in New Zealand through to the current time. Raine was also the first Treasurer and formalized the TRIG accounts as well as set up the TRIG PO Box number (PO Box 2924, Christchurch).
From the outset TRIG was supported secretarially by the National Centre for Treatment Development (NCTD), as it was called then. This essentially meant that Lisa Andrews, as Secretary of the NCTD, provided (free and very high quality) secretarial input to TRIG. Without her input at the beginning and then similar excellent service from Lindsay Stringer who took over in 1999, the group would not have flourished as it has.

We lost John Dobson in May 1998, just as TRIG was really starting to gain momentum. One of John's great contributions to the field was his avid reading of the research literature and then pestering anyone in the vicinity who he thought would be good to influence with new information. The newsletter unfortunately never received a contribution from John, but his energy lives on in those whose lives he touched.

By the end of the second year, in 1997, TRIG had 271 members and the membership fee remained at zero. Very gratefully received donations from ALAC and Odyssey House and a further $1500 raised in relation to TRIG members' forgoing their $20 reduced fee at Cutting Edge '98, kept the finances buoyant.

Two significant potential initiatives at that stage emerged. The first consisted of Greg Ariell beginning to argue for the development of a formal New Zealand connection with the Australian Professional Society on Alcohol and Other Drugs (APSAD). The second related to the conspicuous lack of a publicly visible constituency in AOD, such as the Heart Foundation. It was suggested that if TRIG became a stable viable group then further development of the organization into something like an Addiction Society (like the Cancer Society) was a possible future direction. It is noteworthy that neither has occurred to date, although APSAD has now changed its name to the Australasian Professional Society on Alcohol and other Drugs and we are having a combined conference with them in November 2007; and of course, we have seen the development and consolidation of the Drug and Alcohol Practitioners Association, Aotearoa New Zealand (DAPAANZ) in place of a broader-based Society or Association.

I stepped down as Chair of TRIG after three years and Sandy MacLean thankfully became Chair in 1999 and 2000, followed by the ubiquitous Raine Berry who held the position in 2001. I then returned in 2002 at which point TRIG had been in existence for six years. Over 20 editions of the Treatment Research News had been produced, with Fraser Todd's iconic "I've been reading…" having become a must read section. With the help of the NCTD, TRIG had produced its first treatment research monograph, following the globally shocked, Cutting Edge conference in Napier, September 2001, two days after 9/11. These research monographs have become a yearly feature, providing the field with an ongoing documentation of New Zealand developments in clinical research as well as the documentation of important international findings and their applicability in the New Zealand context, based on the best research papers presented at the annual Cutting Edge conference.

By 2002 the TRIG membership numbered 367, although the membership fee was still zero. However, the financial position of TRIG was beginning to reach a crisis point with a budget for the year sufficient for only one newsletter. A call for an annual voluntary membership fee to be paid yielded only 21 replies from the membership. The future of TRIG was in jeopardy. However, the AGM at the Nelson Cutting Edge conference found renewed energy and enthusiasm. Peter Adams was one of a number of voices urging TRIG to battle on. So TRIG survived with the decision to charge a membership fee of $20 per year even though it was anticipated the membership numbers could fall.

And fall they did, from a high of 367 in 2002 to a low of 36 (paying members) by the end of 2003. We can still hear the 1999 disapproval of our greatly missed John O'Hagan!

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Best practice is a process or a methodology that represents the most effective way of achieving a specific objective. A best practice is one that has been proven to work well and deliver good outcomes, and is therefore recommended as a model. Best practice is 'best' when it is seen as an exercise in community development, aimed at the well-being of the whole community and developed consensually by the key 'players' in that context, through a process that is inclusive and involving of any stakeholders (for example, those affected by, or having an interest in gambling and/or harms caused by gambling). With regard to New Zealand communities, the Treaty of Waitangi must be acknowledged to ensure that Maori, who are disproportionately affected by gambling related harms, are duly consulted and involved.

This research was guided by government legislation, particularly the Gambling Act 2003, and entailed the first systematic attempt to reproduce a comprehensive framework for best practice in New Zealand. Therefore, this study started with an extensive review of the international and local best practice research literature, followed by consultation with key organisations within the gambling industry, the problem gambling intervention service sectors, and with key officials in relevant government sectors. The consultation phase also included site visits to a variety of different gambling venues where managers were interviewed regarding their venue's best practice. Researchers interviewed managers from a TAB, RSA, and casino in the Auckland area. In addition, a community development framework was utilised to conduct group interviews amongst Korean, Chinese, Maori, and Pacific Peoples to assess specific cultural needs related to gambling harm. The results are beyond the scope of this newsletter, but the following is an example of the findings on best practice in gambling venues.

Findings regarding the effectiveness of 'pop ups' on electronic gaming machines (EGMs) varied widely (pop ups are messages that come up on gaming machines to alert players how much money they have spent or how much time they have spent on the machine). For example, one casino manager suggested that such measures may actually elicit perverse outcomes. He felt that making patrons explicitly aware of their actual losses through 'pop ups' may result in the chasing of losses due to an expectation of an imminent win. One problem gambling service commented that pop ups would reduce problem gambling, but that they would only be truly effective where the machine is capable of identifying players. Population groups suggested that there are so many different languages that it is not practical to display the message in all possible languages, but that meaningful symbols or cartoons (e.g., displays relating to family harm or inability to pay rent) would be beneficial. Feedback from site visits indicated that some session information is displayed by EGMs already – in the sense that current credits show on the main EGM screen.

Overall, the findings led the project team to view best practice guidelines as a community development approach to encourage all stakeholders with a connection to gambling practices in venues to work together to reduce harms from gambling. The practices currently mandated by explicit legislative provisions provide a base-line to further develop best practice guidelines.

This conceptual analysis has resulted in the development of a guidelines framework for New Zealand gambling venues. These guidelines formed a three dimensional model (content, process and relationship) of shared understandings of the key areas of host responsibility. The content dimension is a synthesis of key concerns within the literature on gambling harms with eight identified areas of 'host responsibility' and these are: safe product, responsible marketing, safe access, informing patrons responsibly, responsible venue design, responsible delivery, assisting with responsible community problem solving, and assisting with responsible community planning. These elements of host responsibility will involve ongoing negotiations (particularly as the definition of host may shift with environmental changes over time).

The second dimension is the 'process' framework, which links intervention and action to protect the consumer and reduce gambling harms. Three key 'process' elements include: a typology of harm from gambling matched to a corresponding typology of harm prevention or minimisation measures; a typology of medium of intervention (e.g. technological, human and environmental); and finally, a range of evidential sources.

These are to be used to assess the likelihood of a link between the intervention and the harm it purports to address, and for determining the form(s) of intervention currently indicated as best practice by those sources. This dimension creates a space for different 'players' in the gambling environment to test and assess what is 'best practice'.

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PROVIDING GENERAL HEALTHCARE TO METHADONE CLIENTS: WHOSE ROLE?

Just like the general population, methadone clients will suffer from health problems. Some of these may be directly related to their drug use; others will be health problems and minor ailments suffered by the general population. Research worldwide suggests that health status of methadone clients is poorer than that of the general population. In Australia, research on clients entering methadone treatment using the SF36 found that psychological health was similar to "psychiatrically depressed" patients, whilst physical health was poorer (Ryan and White 1996). In New Zealand, a study exploring the general health status of methadone clients, also using the SF36, found that the mean SF36 score was significantly poorer than that of the general population. In addition, 75% had been seeking treatment to improve general health, and in the previous 4 weeks 34% had been prescribed treatment for medical conditions and a similar proportion for emotional problems (Deering, Frampton et al. 2004).

Some health problems are likely to be more prevalent among this client group; for instance, constipation – a side effect of opiates – is commonly reported as an issue (Gray and Spence 2005), and dental problems are common among drug users (Scheutz 1984; Molendijk, Ter Horst et al. 1996; Sheridan, Aggleton et al. 2001). A study in London, which explored patients and customers at community pharmacies, found that drug users were significantly more likely to have suffered dental problems in the last 12 months than non-drug users, and those suffering dental problems were also significantly less likely to seek treatment for this (Sheridan, Aggleton et al. 2001; Stein, Herman et al. 2004). Sleep disturbance is also commonly reported (Stein, Herman et al. 2004) and is believed to be a major factor in relapse from detoxification. In addition to this, our methadone clients are likely to be suffering from a similar range of health problems to the general population, but bearing in mind their poorer overall health status, the frequency of occurrence of these problems may be higher.

A recent study of the incidence of general health problems in the previous 3 months among a group of Auckland methadone clients found rates of 24% for a cold, 56% for headaches, 23% for indigestion, 24% for cough, and 12% for hay fever, among a list of issues researched. Furthermore, the incidence of more chronic medical problems included: 52% for hepatitis C, 23% for chronic pain, 21% for migraine, 16% for allergies, 9% for skin problems, 8% for hypertension and 5% for arthritis. The study explored help-seeking from health professional during the previous 3 months, the results indicating very poor levels of contact being made by methadone clients and GPs, for example. Furthermore, this group reported that only 53% had a GP with whom they felt comfortable discussing their health problems. This potentially leaves a whole raft of untreated general health issues (Sheridan, Wheeler et al. 2005).

Whilst the GP is the health professional clients most commonly report as the person to whom they would go for treatment, the study also explored the community pharmacist as a potential health professional for providing support and treatment for some of these health problems. Two thirds indicated they might seek help from a pharmacist, but a number of barriers to this included financial, lack of privacy, a belief that pharmacists might not understand their problems and concerns about confidentiality (Sheridan, Wheeler et al. 2005).

It is probable that we are also gaining an aging methadone treatment population, with the proportion of older clients rising each year. With age comes a raft of other health issues, for example cardiovascular, diabetes and pulmonary, with liver and renal function also on the decline.

So where should our clients be going to seek treatment? For more minor ailments, it is probable that community pharmacists could play an important role, providing advice and (subsidised?) treatments for condition such as constipation, dental pain (with referral), and advice on appropriate short term relief from general coughs and colds. Financial constraints might be relieved through the introduction for subsidised over-the-counter treatments, as in the UK's 'minor ailments scheme'.

Another model might be that methadone services consider setting up a one-stop shop for all of a client's health needs, with primary healthcare clinics including GPs, primary care nurses and pharmacists, complete with a system of referrals for specialist treatment or should we continue to rely on client seeking treatment from GPs AND funded by the government. Whilst there would be costs associated with this type of model, long term cost savings might be made for issues such as prevention of hepatitis B through vaccination schemes, better management of chronic conditions, and even an increased sense of wellbeing and general health amongst clients.

Assoc. Professor Janie Sheridan
School of Pharmacy
University of Auckland

MĀORI ADDICTION TREATMENT RELATED RESEARCH OVER THE LAST 10 YEARS

Over the last two decades, there has been a growing responsiveness to the needs of Māori in terms of alcohol and other drug (AOD) treatment alongside the development of the broader addiction treatment sector in Aotearoa. This has contributed to the emergence of an increasingly visible Māori AOD treatment workforce and the development of a range of Māori focused AOD treatment services and interventions. More recently Māori focused problem gambling intervention services have also been established.

Numerous developments by Māori in areas such as training, education, service, treatment and workforce development have assisted the growth of the Māori addiction treatment sector over the last 10 years. Despite the importance of research to the ongoing development and advancement of the sector, however, only a limited amount of Māori addiction treatment research has been undertaken. Nevertheless, since "Alcohol and the Māori People" (Awatere et al., 1984), there has been an increasing number of working papers and surveys looking at substance use amongst Māori. This article will provide a general summary of Māori addiction related research conducted over the last decade in Aotearoa and also look at current developments and endeavours within Māori addiction treatment research in particular.

The Whariki Māori Health Research Group worked in partnership with the Alcohol & Public Health Research Unit (APHRU) at the University of Auckland. The unit has been heavily involved in community action research, evaluation of programmes implemented by Māori providers, and in the last 10 years, involved in the analysis of the data collected as part of the National Drug Surveys. Their work has resulted in such reports as Te Ao Waipiro: Māori and Alcohol in 1995 and Te Ao Taru Kino: Drug Use Among Māori, 1998. Since 2002, Whariki has been venued within Massey University and the unit continues to produce Māori related health research, in partnership with the Centre for Social Health Outcomes Research and Evaluation (SHORE).

Another organisation that has been responsible for commissioning a number of Māori focused AOD research projects has been the Alcohol Advisory Council of New Zealand (ALAC). These projects have included periodic reviews of Māori AOD treatment services and ALAC's Māori activities. These reviews have often collated opinions from the Māori community on issues of importance to Māori in the AOD sector at the time, such as Te Tiriti O Waitangi, the structure of ALAC, treatment, health promotion, research and training.

ALAC has also been involved in community action AOD research at a global level, with Margaret Manuka-Sullivan and Kayleen Katene (both ALAC workers) instrumental in the selection of two Māori communities (Moerewa and Gisborne) as sites to test the effectiveness of action plans developed by the World Health Organisation (WHO) for Phase III of the WHO Programme on Substance Abuse Project. This project was conducted with a number of indigenous communities worldwide.

Finally, ALAC has continued to be very pro-active in supporting Māori alcohol-related research through scholarship programmes, with a wide range of valuable research projects and literature reviews completed by Māori as part of the ALAC Māori Student Summer Scholarship programme e.g., Warbrick (2000).

In 1996 ALAC supported the establishment of a clinically focused alcohol and other drug treatment centre in Aotearoa. The National Centre for Treatment Development (NCTD) was established within the Christchurch School of Medicine and officially opened in July 1997. Now known as the National Addiction Centre (NAC), the organisation's primary role is to develop and promote effective interventions for people with alcohol, drug and addiction related problems in Aotearoa, including Māori. One of the ways in which this has been achieved over the last 10 years is through the production of clinically relevant research. A great deal of this research has investigated how cultural variables might relate to treatment outcome for Māori, for example, Sellman, Huriwai, Sant Ram & Deering's (1997) paper, which reported on the positive effects of culture in treatment; Huriwai, Sellman, Sullivan & Potiki's (2000) paper, which found a high endorsement of cultural factors in treatment among a clinical sample of Māori; and Huriwai, Robertson, Armstrong, Kingi & Huata's article (2001), which investigated levels of engagement with and knowledge of processes around whanaungatanga, as well as the possible implementation of these in treatment. Participants in the study cited belonging to an iwi, having pride and identifying as Māori as being important in the treatment/recovery process.

This work has helped to provide a platform for the validation of Māori ways of working with tangata whaiora, as well as support Māori addiction treatment workers to further develop their practice. Additionally, this research has emphasised the clinical application of cultural input into the treatment/recovery process and encouraged a bridging of the gap between cultural and clinical practices. This has supported the development of an environment more conducive to the fusion of these practices in addiction treatment for Māori with alcohol and other drug related problems.

More recent NAC Māori focused AOD research includes a qualitative evaluation of Māori men's experience of the addiction treatment and recovery process. Findings from this study supported the need for Māori focused treatment programmes, which are based on Māori values, beliefs and experiences. The results indicated that such programmes need to avoid restrictive notions of what it is to be Māori that fail to "reflect the varied needs, capacity and experiences of individuals and whānau" (Robertson, 2005).

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MĀORI AOD RESEARCH

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Further, such programmes need to locate addiction and its treatment within the broader contexts of an individual's life in order to ensure a comprehensive response to an individual's problems.

Input by Māori staff and Māori advisors into other NAC projects has ensured consideration of Māori issues across a range of NAC projects. This in turn has helped to increase uptake of information by Māori addiction treatment workers and non-Māori providers who have Māori clients. An example of this is demonstrated by the National Telephone Surveys (NTS) of the addiction workforce conducted by the NAC in 1998, and again in 2004.

While not solely Māori focused, they have provided a profile of Māori AOD clients seen at AOD treatment services throughout Aotearoa (Adamson et al., 2000), as well as information about the degree of support among clinicians for adapting their treatment to be more responsive to the needs of Māori clients (Robertson et al., 2001).

One significant change between results of the 1998 and 2004 NTS, which raises concern, is the substantial decrease in the treatment follow-up rates of Māori clients (Adamson, Sellman, Deering, Robertson & de Zwart, 2006). The ratio between assessment and engaging in the treatment process for 'Kaupapa Māori' services is, in contrast, encouraging, suggesting that non-Māori AOD services are failing to retain Māori clients in treatment. This apparent decrease in the engagement of Māori at non-Māori services may be indicative of limited impact of Māori research on non-Māori services and practitioners.

In the last few years, Māori AOD related research projects have focused on a number of different areas. Workforce development projects have been brought to the fore of late under the auspices of Matua Raki- the National Addiction Treatment Workforce Development Programme. Presently, there are a number of Māori addiction workforce development projects, which are located within this programme. Recently completed projects include a telephone survey of Māori addiction treatment workers, which focused on training issues specific to Māori, integration of Māori elements of practice and working with whānau (Robertson Cave & Adamson, 2005). Results of the Māori Telephone Survey, in combination with the National Telephone Surveys, indicated that Māori addiction treatment workers were strongly committed to their work and many are engaged in ongoing education. Respondents identified wanting both Māori and western focused training, illustrating the need for training, which integrates Māori and western knowledge, skills and processes of learning. While the results indicated workers are engaging in western science based training, the results of the current surveys and other research indicate a clear desire for any training to be cognisant of, if not located within, the frameworks of Te Ao Māori.

The second research project being undertaken within Matua Raki is a write up of the history of the development of Māori AOD treatment services and the Māori addiction treatment workforce in Aotearoa. Key informants identified as being centrally involved in the early development of Māori AOD treatment services/workforce have been interviewed and analysis of key themes is currently underway, with presentation and dissemination of the findings due before the end of 2006.

Other Māori focused research undertaken in the last few years includes a review of the models of practice used by Māori AOD practitioners in New Zealand and consideration of the extent to which practitioners were willing to incorporate problem gambling into their practice (Abacus Counselling and Training Services Ltd, 2004). This project was initiated through the Mental Health Research and Development Strategy.

A second project committed to contributing to the development of problem gambling services for Māori was also conducted in te rohe o Ngai Tahu. The aim of the study was to identify the current capacity and willingness of local Māori health and social service providers to engage in the provision of problem gambling services. A framework was developed to guide the advancement of Māori responsive services and interventions in the region (Robertson, Pitama, Huriwai, Ahuriri-Driscoll, Haitana, Larsen & Uta'I, 2005).

Other research looking at problem gambling and Māori mainly centre on the relationship and impacts of gambling on Māori individuals, whānau and community (e.g., Dyall, Te Runanga o Kirikiriroa), however, Ministry of Health sponsored research will explore other aspects of problem gambling for Māori as their research strategy unfolds.

Another emerging area of research has been related to treatment of Māori with opioid problems. Although reported at a low rate in the general population and clinical samples, a relatively significant number of Māori are engaged in methadone programmes in some parts of the country. Research in 2004 exploring costs, benefits and cost-effectiveness of alcohol and drug services used by Māori compared with non-Māori has involved interviewing clients on the Christchurch Methadone Programme. Results indicated that although monetary costs of drug use and benefits of MMT were similar for Māori and non-Māori, MMT was associated with greater savings in life for Māori clients (Sheerin, 2004). A recent small qualitative study, undertaken with Māori clients involved with the Whānau Clinic of the Christchurch Methadone Programme, found that clients were supportive of culturally integrated treatment, which they felt had aided their rehabilitation (Hore, 2006).

In summary, there has been a steadily increasing body of literature in Aotearoa with specific relevance to Māori and addiction and this research has played a role in the development of the Māori addiction treatment sector.

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Why I like Dangerous Consumptions

It is interesting for me to reflect back on the last ten years since the origins of what was then TRIG. Hasn't time moved fast? In those early periods its regular newsletter provided an excellent way for researchers to connect and share progress on their work. In the first three years I contributed regularly to the newsletter updating on what was happening at the University of Auckland. Since then I've drifted into other areas, but on this special anniversary I'd like to take the opportunity to share one current passion.

Four years ago Charles Livingstone in Melbourne, disillusioned by the lack of representation of modern social science at alcohol and drug and gambling conferences, initiated a two-day "Dangerous Consumptions" colloquium in Melbourne. Since then we, along with social academics from the University of Melbourne, and Australian National University, have hosted two further events, one in Auckland and another last year in Melbourne. The colloquium this year (DC4) will be hosted at ANU in Canberra on the 4th and 5th of December – for more information check out:
http://arts.anu.edu.au/humanities/gend_conf/

Each year we have invited key social theorists publishing on dangerous consumptions to provide a focal point for discussion. In 2003 Gerda Reith from Scotland presented work from her book providing a cultural analysis of addiction and gambling. In 2004 John Booth Davies provided a base for lively debate on theories and models of addiction. In 2005 Robin Room stimulated discussion on public/private boundaries in media depictions of celebrities with addictions and John Scanlon widened the concept of dangerous consumption in his analysis of garbage. Indeed, the contributions have become increasingly diverse with papers on other dangerous consumptions such as body enhancers, plastic surgery, IV needles, and even public health messages and treatment services. For me the main enjoyment has come from hearing about innovative applications of social theory and to participate in associated debates and discussions.
To provide a flavour of presentations from the last colloquium (DC3): Helen Keane from ANU presented on progress with her analysis of intimacy and addictions; David Wain from the Burnet Institute presented on the cultures of use amongst male anabolic androgenic steroid users; a group from Whariki at Massey University – Tim McCreanor, Suaree Borell, Mandi Gregory and Hector Kaiwai – presented a series of papers on forms of liquor promotion targeting young people, particularly young Maori, and how they might be resisted, and Linda Hancock from Deakin University reported on her experiences chairing state panel purchasing gambling research and the processes that led to it being disbanded.

The two days are not streamed, so everyone who attends has a chance to listen to all that is going on. This also creates a strong sense of common connection and involvement. Most people attending the colloquiums also present a paper, which means attendees are exposed to a broad range of orientations and disciplines ranging from history to geography, from sociology to ethnography and psychology to medicine. Another feature of the events is avoidance of any sources of funds that might influence what and how content is presented. Consequently, unlike other forums in the field, conscious effort is made to ensure funding is not received from the gambling industry, pharmaceutical companies, breweries or government or quasi-government agencies with their own policy agendas.

What is becoming increasingly clear from these meetings is that shifting from an orientation of "alcohol and other drug misuse" to a focus on "dangerous consumptions" introduces a whole new range of relationships. These relationships are embedded in the meanings of the two words themselves. Talking of "consumptions" instead of "use" or "abuse" emphasizes the nature of these activities as behaviours of choice and signals that these choices are being made in relation to industrial complexes that involve systems of product manufacturing, packaging and marketing. A bottle of beer does not occur naturally in the environment; it is a manufactured product that brings with it a long history of development and layers of marketing and cultural associations. The first word "dangerous" reinforces the importance of choice; it locates those involved both in the manufacture and consumption in a zone of responsibility. "Dangerous" is better thought of as a coded term; it signals that certain ways of behaving within the designated zone have a high probability of causing harm and that one can expect that zone to be managed in a manner that is intended to reduce the probability of such harm. In this way, both the terms "dangerous" and "consumptions" emphasize the critical importance of understanding their use as occurring within a socio-cultural context.

In this way I see the focus on dangerous consumptions as an intersection point that breaks down many of the boundaries that fragment studies in this field. It brings people working in communities and public health interventions closer together with those working in treatment services. It creates a valid space for cultural and gender perspectives. Furthermore, the emphasis on consumptions and commodities brings together people working with tobacco, alcohol, other drugs and gambling over common concerns regarding modes of production and the role of governments. It provides a platform for linking interests in the body, the psyche, relationships, culture and spirituality.

So that's why I like dangerous consumptions and why I see indulging in them will be good for you too. I wish ATRIG and its newsletter another successful decade in supporting research and promoting open dialogue.

Peter Adams,
Social and Community Health,
University of Auckland.

The increasing availability of effective medications for the management of substance related problems has led to an increased emphasis on medical intervention in treatment. This should not allow attention to be diverted from the provision of non-pharmacological management; in general medications are but an adjunct to effective treatment and even when they form the mainstay, as in opioid substitution, there is clear evidence that they provide better outcomes for most individuals when used in the context of appropriate psychotherapy.

Alcohol

Disulfiram was first used in treatment for alcohol dependence in 1946. Following a study in 1986 (Fuller et al.), which was interpreted as showing poor efficacy, but actually showed the importance of compliance, use of disulfiram declined. The reduced support for its use may also reflect the swing away from abstinence towards harm reduction and controlled use that has occurred in recent years.

There have been a number of more recent studies of its effectiveness, these being summarised in a several reviews (Highes and Cook, 1997; Anton, 2001; Fuller and Gordis, 2004). These have in general supported its use with supervision. Observational studies support its use for severely dependent recidivist alcoholics where supervision of consumption is provided in the context of well resourced assertive outpatient care (Khari et al., 2004). Disulfiram remains an under-utilised tool, but one requiring care in selection of patients and avoidance of complications. In a recent head-to-head comparison with naltrexone it was shown to be markedly more effective (de Sousa and de Sousa, 2004). Although it must be used with care for those with significant liver disease and other consequences of alcohol dependence, this can be managed (Chick, 1999).

A medication with similar mode of action to disulfiram in the treatment of alcohol dependence was calcium carbimide ("Dipsan"). This, however, had a much shorter period of action, and was withdrawn in the late 1990s.

Nalrexone and acamprosate have become well-known in the last ten years, although both were shown to be effective well before this. They have both been the subject of a huge amount of research during this decade. Many of these studies have been limited by small numbers of subjects, or exclusion criteria severely limiting the generalisability of the results. The recent American COMBINE study (Anton et al., 2006) focused on subjects with mild-moderate uncomplicated alcohol dependence and showed for this group of subjects that naltrexone significantly improved drinking outcomes while the effect of acamprosate was indistinguishable from placebo. This is in agreement with the findings of a recent multicentre Australian study (Morely et al., 2006), which found that in general neither acamprosate nor naltrexone were effective, although post hoc analysis showed that naltrexone was effective for those with mild-moderate dependence. The bizarre limitation on duration of use of naltrexone imposed by Pharmac is a classical example of lack of understanding that absence of evidence does not equate to evidence of absence.

There remain a large number of other medications that are under study. Ondansetron (Johnson et al., 2000) and topirimate (Johnson et al., 2003) have been shown to be effective in preliminary trials. Selective serotonin reuptake inhibitors reduce drinking in those with comorbid alcohol dependence and depression, but generally not in others. The combination of benzodiazepines with thiamine was established before our decade of interest and remains the established approach.

Tobacco

Nicotine replacement therapy (NRT), bupropion and nortriptyline remain the best supported medications to assist tobacco cessation. The initial use of NRT well predates the last decade, but it is only since the mid-1990s that both bupropion and nortriptyline have been shown to have specific action in the treatment of nicotine dependence. While the efficacy for bupropion and nortriptyline is similar, only the use of the former has been widely supported, presumably due to lack of interest by pharmaceutical manufacturers in nortriptyline as it is well out of patent.

Stimulants

Most research in this area has occurred in the United States and has been focused on cocaine, as this is the major concern in that country. Many medications have been investigated for effectiveness, this being well summarised by Gorelick et al., (2004). Disulfiram has been shown to have utility (presumably by increasing dopamine levels via inhibition of dopamine-β-hydroxylase) and a cocaine-vaccine has been found to be well tolerated and able to produce anti-cocaine antibodies for some months. None of these approaches have yet reached clinical utility.

There has been less emphasis on pharmacological treatment of methamphetamine dependence. In a Cochrane review in 2001, Srisurapanont et al., concluded that fluoxetine may reduce craving in short-term use, and imipramine may improve treatment adherence in the medium term. In a companion review the same authors (2001) reported that amineptine was the only medication shown to have "limited benefits" in amphetamine withdrawal, but it had been withdrawn from the market.

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Gorelick et al., also comment that methylphenidate and amphetamine have "shown promise in a stimulant substitution approach". In a retrospective review of dexamphetamine prescribing involving over 200 cases of amphetamine abuse, White (2000) reported substantial benefit. In more controlled trials Shearer et al., have shown benefit both in amphetamine dependence (2001) and cocaine dependence (2003). More recently, modafinil, a stimulant used in the treatment of narcolepsy, has been shown to have some effectiveness (Dackis et al., 2005). Given these encouraging pilot studies and the lack of success in finding other effective pharmacotherapies, the failure to further investigate substitution treatments may be a result of politically driven reluctance to engage in substitution therapy, given the experience with opioid substitution where clinicians still experience opposition despite forty years of evidence-based utility.

Cannabis

Despite the widespread use of this drug, with documented harm for the substantial numbers dependent on cannabis, there remains no effective agent for treatment either of cannabis withdrawal or dependence. Animal studies have demonstrated that opioids will ameliorate the cannabinoid withdrawal syndrome, suggesting that this may be treated in a similar manner to the well established management of opioid withdrawal, but there are no good trials to substantiate this. Sodium valproate and lithium have anecdotal support for use in withdrawal, but the only formal trials fail to show efficacy.

Opioids

The treatment of opioid dependence with methadone substitution predates our decade of interest by thirty years. During the last ten years, however, there have been ongoing trials of its effectiveness and that of other agents. Notable has been the Australian NEPOD (National Evaluation of Pharmacotherapy for Opioid Dependence), a series of multicentre trials comparing methadone, buprenorphine and levo-alpha-acetylmethadol (LAAM) as substitution agents, both in comparison with each other, and against managed withdrawal regimes with subsequent abstinence supported by naltrexone. LAAM has subsequently been withdrawn from the market in response to concerns about toxicity (although this was mediated by potential for cardiac complications shared by methadone). In brief, the NEPOD trials showed that substitution therapy utilising any of the three agents was in general much more effective than detoxification with or without naltrexone as supporting agent (although the small proportion of those who continued to take naltrexone did remain abstinent). Methadone was consistently slightly more effective than buprenorphine. Diguisto et al., (2004) reporting the small incidence of adverse events in these trials, provide a convenient list of references to trial outcomes.

Buprenorphine was used extensively in Europe, especially France, beginning in the mid-1990s. Guichard et al., (2003) describe the initial introduction of unsupervised buprenorphine in France, with rapid uptake and fall in heroin related mortality. More recently, buprenorphine was "discovered" by the United States, where a combination buprenorphine/naloxone tablet has made "office based" treatment available (that is, substitution treatment of opioid dependence carried out in the context of medical consultation rather than the restrictive environs of the clinics). This preparation has recently been licensed for use in New Zealand and will provide a valuable alternative to methadone for those intolerant of this. In particular, it avoids the hypogonadal effects of methadone (Bliesener et al., 2005). All comparative studies have, however, shown methadone to provide superior outcomes on measures of retention in treatment and ongoing heroin use. The main benefit of buprenorphine is as "not-methadone" that is, to avoid the stigma that has come to be associated with methadone maintenance.

During this time, buprenorphine was also shown to be clearly superior to non-opioid regimes for managed withdrawal from opioids, and to provide less "rebound" withdrawal at the end of the detoxification process. There was a brief flurry of excitement in the lay press extolling the use of rapid opioid detoxification as a "cure" for heroin dependence ("I woke up cured!"; Women's Weekly), but this failed to live up to its promise, although it retains a place for selected individuals, as do depot preparations of naltrexone. The commercialisation of these approaches is not without hazard.

Summary

At the beginning of the decade the only readily available medications for the treatment of dependence were benzodiazepines and thiamine for alcohol withdrawal, disulfiram as an anti-alcohol aversive agent, nicotine replacement therapy for tobacco cessation, and methadone for opioid substitution treatment. In the intervening ten years they have been jointed by naltrexone for alcohol dependence, buproprion and nortriptyline for nicotine, and buprenorphine for opioid dependence. In addition, more progress has been made on the appropriate use of the medications we have.

Lee Nixon
Nelson Alcohol & Other Drugs Service

Message from the Chairperson cont.

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Meg has worked extremely hard over this time to ensure that the ATRN is published regularly with a full, varied and interesting content and has done this while also meeting substantial other commitments. Meg will be leaving the NAC to undergo training within the Anglican Church. She takes with her an impressive set of skills that I'm sure will serve her and the community well. On behalf of the ATRIG membership and ATRN readership I would like to extend most sincere thanks and best wishes to Meg.

I look forward to seeing many of you at this year's Cutting Edge conference in Wellington.

Dr Simon Adamson
ATRIG Chairperson

A brief history of ATRIG cont.

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The 2003 Waitangi Cutting Edge conference was one of our greatest. Lloyd Geering spoke like a 21st Century prophet and offered hope and wisdom for the field and the world in general. Geoff Robinson, David Benton, Fraser Todd, Claire Aitken and Takarangi Metekingi all gave plenary talks of great substance. Ian MacEwan's huge contribution to the field through his ALAC position, at that time coming to an end, was celebrated. It was a good time for me to hand over to a new Chair of TRIG for them to begin the process of rebuilding. "Always good to buy shares at the bottom", I think I said to Simon Adamson, as he took over the reins in 2004 and who has done a really sterling job to the present day ensuring the continuance of the regular newsletters, maintaining the annual research monograph, steering TRIG through to its new name ATRIG and more than doubling its paid up membership, now standing at 81. Well done Simon, but also Meg, Lindsay and other members of the various annual executive teams!

Without research, the field will not continue to develop. ATRIG remains a key mechanism for fostering and disseminating research in the field and I am rapt to have had the opportunity to contribute to this ongoing cutting edge organization over the past 10 years.

Na
Doug Sellman
Professor of Psychiatry and Addiction Medicine
Director, National Addiction Centre

Host responsibility in gambling venues cont.

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The third dimension states that best practice must exist within a context of a particular 'relationship'. Relationships between governmental sectors, helping agencies, community sector, research sector, and the gambling industry would benefit from the formation of an independent best practice development group (IBPDG). It is proposed that this group would operate separately, but in strong communication with the relevant sectors and proposed that this group would be responsible for ongoing management of a host responsibility intervention database; communication and development of information channels; facilitation of an ongoing five sector consultation; co-ordination of input into development of research and evaluation; and act as an advocate for best practice. Overall, the IBPDG would require substantial Maori input in the ongoing dialogue of developing best practice.

In conclusion, this research has formed the basis for a best practice model of evolving standards for host responsibility. Best practice (including evolving standards) for host responsibility requires acceptance of open and willing dialogue (including the process of making exemplars public) between all parties involved in, and affected by harms from gambling, forms the basis for a best practice model of evolving standards for host responsibility. In the face of rapidly changing gambling technologies and a plethora of gambling research, a database is required to support and enable open and willing dialogue for the development of best practice within our gambling venues.

Robin-Marie Shepherd, Lecturer & Samson Tse, Rachel Stevenson, Peter Adams, Robert Brown, Fiona Rossen.
University of Auckland, Centre for Gambling Studies

I thought this would be a simple task. Write something around "I've been reading…" for the 10th anniversary issue of the ATN. A "best of the last 10 years" article. My memory is pretty good, I thought; shouldn't be too hard to come up with something interesting that does justice to the honour. I remember, for example, the inaugural meeting of ATN, way back at the Auckland Cutting Edge Conference in Wellington, Otago. I have this vision of Julius Caesar chairing the meeting. There was a spot of bother from Queen Elizabeth. The first. Hmmm. Can you see the problem? My mind seems full of stuff, mostly irrelevant, and I can't for the life of me remember how it got in there. What I'll do, I decided, is see who I can get to do it for me. I asked a number of people to nominate the single piece of writing that has most influenced their views or practice in the area of addiction. There responses were both interesting and telling:

"Upon resolution, for me, it is the writing of Bill Miller and Stephen Rollnick on Motivation and Negotiating Behaviour Change. I thought long about the writing of Jim Orford ("Excessive Appetites") and hard about Alan Marlatt ("The Dynamics of Relapse"), but as well-thumbed are the pages of my copies of their work, it is Miller and Rollnick that have influenced my thinking the most. And if I must select one piece of writing, then I shall choose a summary paper by Bill Miller: Why do people change addictive behaviour? (Addiction, 1998: 93(2); 163-172).

Although our work lives are focused on addiction treatment, and there have been sixty years of scientific research endeavour, the reasons why people change addictive behaviours are still not well understood. We no longer accept that people change because they receive treatment. Many people who recover do so without formal treatment. The recent COMBINE research trial showed that client compliance with many different approaches, including placebo medication, has been linked to better outcomes. It seems that the most consistent feature in sustained recovery is some kind of spiritually transformative change within the client. This article considers various models that help in understanding the intriguing puzzle of change. Motivational interventions are well placed to provide a framework within which to understand the shifting meaning of an addiction when it collides with higher-level values and conceptions of the self. Miller wants to be able to present a fully-developed model of behaviour change. Instead he can offer only a vision of an understanding of recovery. It needs to be focussed on higher cognitive processes and the hierarchical organisation of goals and values. Change may not behave by the rules we imagine. I can think of no more fascinating or satisfying topic to which to devote one's clinical life than to work with my clients on this enduring puzzle."

Ian MacEwan

"I'll cheat and go slightly outside of the time frame. For me the most influential piece of writing that has influenced my thinking about the addictions over the last 14 years has been Miller and Rollnick's book, Motivational Interviewing - preparing people to change addictive behaviour.

This book has heavily influenced the way we have taught primary care providers about how to detect and appropriately intervene for those of their patients with problem use of alcohol and drugs and how to motivate people to seek treatment for their dependency. Although I would strongly deny we teach motivational interviewing, the principles outlined in this book are very much present in our teaching curriculate and our research."

Ross McCormick

"I have read many works that have strongly influenced my thinking about addictions. I would not say it is a weekly or even monthly event, but each year I stumble over a few books or articles that help me to describe/understand, what I intuitively feel. Lately that has been mainly in the field of health management, rather than addiction. But if I was to pick a book that did influence me (to the point where I went as far as meeting the author) it was The Myth of Addiction by John Booth Davies (John Booth Davies. The Myth of Addiction; second edition. Harwood academic publishers 1997). Davies builds his work on the writings about attribution theory. This theory helps to understand the ways in which people explain what happens to them. It helped me to understand the importance of context when we interact with our clients. I had made the observation that our clients modify their interactions depending on who they talk to. Lately I stumbled over that phenomena again when I was studying the psychology of the internet and was reading the work of Asher. Are people more or less "real" when they are interacting anonymously on the internet? That would have implications for treating them on line. Anyway, Davies showed me the importance of choice of words when we interact with our clients and importance of context (amongst other things). Since I make a real effort to avoid concepts that lock our clients into thinking that addiction is forever and make it clear that change is the norm (no matter how bad things are). The link is important; if our clients think they can change, they will.

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This is more complex then it seems at first sight. Davies makes it clear that our clients pick up our thinking through verbal as well as non-verbal clues. And wider societal concepts of "addiction" may always permeate the conversation, no matter how careful we are. Since reading Davies I have observed that clients do adjust their thinking and talking to what they think the Alcohol and Drug professional thinks or what seems appropriate to the counselling/clinical situation to them. I have also become a bit more tolerant for the so-called "justice clients" in our services. Rather than classifying it as a deviant wilful manipulative behaviour, I see it more a natural behaviour. The challenge is to get past it, rather than classify it as denial."

Robert Steenhuisen

"I can think of a number of books from the last decade, which describe the neuro-pharmacological findings relevant to our field well and make them accessible to us non-bio-chemists. Writers like McKim (Drugs and Behaviour, 1997), Avis (Drugs and Life, 1996) and Snyder have produced some very exciting literature in this area. However purely personally, I would have picked Davies (1997), Drugspeak: The analysis of drug discourse (Amsterdam: Harwood Academic Publishers). Its influence was not so much in that I would agree with all the views expressed in this book, but it has like no other publication, stimulated me to reflect about the nature of addiction. Davies has raised my awareness for the fact that like any phenomenon, addiction can be viewed and described in a number of ways (biology, neuro-chemistry, behaviour, interaction, experience, spirituality etc.), and has helped to clarify my thinking about the fundamental differences in applying various paradigms to this subject, and that these paradigms are not always compatible."

Wolfgang Theuerkauf

"Goodness. That's hard. Many papers I suppose. An early paper that affected me was by Gregory Bateson on AA in his book Ecology of Mind. It looked at the concepts of pride and humility and their importance. (Bateson, G. (1972). Steps in an Ecology of Mind. London: Granada). More recently I read something by Eve Sedgewick (Sedgewick, E. K. Epidemics of the will. In Tendencies (pp.130-142). Durham: Duke University Press, 1993). It is a lively criticism highlighting governance tension regarding control and unruly desires."

Peter Adams

"Stanton Peele and Jim Orford have perhaps influenced my thinking around addiction in terms of journal articles and books. "Mauri Ora; the Dynamics of Maori Health" perhaps has been the more interesting of Mason Duries' recent books to me although it is more his speeches that I find compelling (the notes not the delivery because it is here he often puts the practice to the dream or framework). In terms of the gambling I'd say the first Problem Gambling Geography (Problem Gambling Geography of New Zealand, Ministry of Health 2003) and probably David Korn's writings around public health approaches."

Pam Armstrong

Just one?! To understand addiction we must understand what a human being is in relation to the environment. Richard Dawkins' "The Selfish Gene" provides a compelling explanation of how come, through evolution, genes congregated and formed bodies. Matt Ridley's "Nature via Nurture" describes the fascinating interaction between genes (within bodies) and the environment – neither "work" without the other. Ronald Hammer's chapter on addiction in "Brain Circuitry and Signaling in Psychiatry" gets down to the nitty gritty of the engine room where we begin to glimpse the pathology of addiction. Sorry that's three, but there are half a dozen papers I'd want to mention if there was more room. Another time.

Doug Sellman

Finally, **Cate Kearney** nominates Covington (2002). Helping Women Recover: creating gender-responsive treatment (Chapter 3 in S.L.A. Straussner & S. Brown (Eds.). The Handbook of Addiction Treatment for Women. pp. 127-54. San-Francisco: Jossey-Bass) and writes, "This book chapter succinctly summarised the underpinning issues that form the context for many women who seek treatment for alcohol and drug addiction. Covington went further than many writers and, having thoroughly researched and summarized the issues, she presented a comprehensive treatment model that addressed alcohol and drug treatment, including mental and physical health, women's developmental psychology and trauma theory. This model offers an integrated approach to the delivery of women's treatment, whether individual or in a group setting."

It is interesting to note that for many, the most influential writing is less an original piece of quantitative scientific research and more the elaboration of an idea that makes intuitive sense of things and changes our frames of reference to allow us to see what we know differently. It's the same for me; there are a couple of original research papers I find myself continually returning to.

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We've been reading

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In general what has influenced my thinking most have been books or articles in which important thinkers synthesize the current state of research on a topic and insert their own interpretation in a way, which ties together a range of ideas and provide a new framework from which to think about the people we work with, or challenge our traditional way of seeing things.

I struggle to limit myself to a particular piece of writing, but rather draw on a number of sources, which elaborate an idea. And I must state at this point that the most influential learning experiences I have had come from discussions with people who have big brains filled with wisdom. But this article is limited to writing, because I get the last word, I'm going to allow myself a top 10 and let myself go off on a bit of a non-clinical tangent.

The single piece of quantitative research that most influenced my thinking on a topic was probably the study by Linszen and colleagues (Linszen, D.H. Dingemans, P.M. Lenior, M.E. Cannabis abuse and the course of recent onset schizophrenic disorder. Archives of General Psychiatry 1994; 51: 273-279) in which a dose response relationship between levels of cannabis use and outcome in schizophrenia was demonstrated, but equally influential from the mental health and addiction journals was Degenhardt's thorough and balanced review of the relationship between cannabis and depression (Degenhardt, L. Hall, W. Lynskey, M. Exploring the association between cannabis use and depression. Addiction 2003; 98: 1493–1504) and Osher and Kofoed's paper on their Engagement-Persuasion model of organizing and staging treatment of people with co-existing substance use and mental health disorders, which allows the effective incorporation of motivational and relapse prevention approaches into treatment (Osher, F. C. & Kofoed,L. L. Treatment of patients with psychiatric and psychoactive substance abuse disorders. Hospital and Community Psychiatry 1989; 40: 1025-1030).

However, again it is the general writing of scientific journalists and scientists in books where they are able to extract the implications of research and articulate the vision that underpins their research that have most influenced me and make up my "top of the pops". Going back almost twenty years, the single most influential book I have read must be James Gleick's drawing together of the strands of non-linear systems theory into an understandable outline of the implications of this way of thinking about the world (James Gleick (1988). Chaos; Making a New Science), closely followed by Lewin's popular explanation of the related field of emergence or complexity (Complexity; Life at the Edge of Chaos). This paradigm was elaborated in the area of consciousness (Dennett, 1992: Humphrey, 1999), social and evolutionary sciences (Barkov, Cosmides, Tooby, 1995), religion and spirituality (D'Aquili, Newberg, 1999), and the development of brain and mind (McCrone, 1999: Marcus, 2004). Chaos and complexity talks of the science and philosophy of the interconnectedness of the components of our world, and resonates with other world views as expressed by Ken Wilbur (2000) and Rev. Maori Marsden (2003).

It is hard to separate these books. While distinct and individual in their content, they share a coherent thread, which draws together different perspectives on the world and for me has changed the way I understand people. The single most influential, for sparking the process albeit almost twenty years old now (and yet still widely unread), is Gleick's Chaos. Of the last decade for taking the thinking a leap further, Lewin's Complexity.

Fraser Todd
National Addiction Centre

Māori AOD research

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The value of Māori addiction-related research has been apparent over the last decade as a means by which to: explore Māori addiction issues, validate the practices of Māori addiction treatment workers, demonstrate the clinical relevance of cultural input into treatment for Māori and therefore move closer to bridging the gap between cultural and clinical practices. Māori addiction related research has also been useful in informing new developments and initiatives in the Māori addiction treatment sector, however, there is still a dearth of Māori specific treatment data.

Māori addiction related research has also increasingly played a part in providing non-Māori addiction treatment workers with relevant, practical and culturally responsive information. The challenge here lies with the ability of non-Māori services and addiction treatment workers to take up and utilise the research being produced to improve the care and treatment being provided to Māori with alcohol and other drug-related problems, and in the process, encourage better engagement of Māori clients with non-Māori services. Nevertheless, challenges do also remain for further development of research within the Māori addiction treatment sector. If the sector is to be sustained, continued building of the body of research on Māori and addiction is crucial, as is specific attention to increasing workforce capacity in this area.

Tami Cave, Paul Robertson
NAC/MIHI, & Terry Huriwai
Matua Raki

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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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.

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