Addiction Treatment Research NEWS

NEWSLETTER OF THE ADDICTION TREATMENT RESEARCH INTEREST GROUP

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EDITORIAL

As the end of another busy year approaches, it is my great pleasure and (relief!) to have completed my first issue as Editor of ATRN. As Meg has left very large 'editorial' shoes to fill I am very grateful to all those who have contributed to the publication of this issue. A very big thank you also goes to those who have written articles for this issue.

In this Christmas issue we have our regular contributors with Simon Adamson providing an update on research activities at the National Addiction Centre in his NAC report, and an update of events in the addiction field in his ATRIG Chairperson's Message. Our gambling report from Sean Sullivan at Abacus presents an interesting discussion about why there has been a drop off in clients attending problem gambling services. This issues' guest writer for 'I've Been Reading' is Ian MacEwan, Senior Project Manager of Matua Raki (National Addiction Treatment Workforce Development Programme).

Finally, in our focus on research, we take some time to remember one of the important events on the addiction workforce calendar as Alasdair Kerr reflects on Cutting Edge 2006. Mirjana Vilke's article briefly outlines a number of research projects undertaken by students completing alcohol and drug studies at Weltec. This article serves to remind us of the importance of research training to encourage practitioners to understand and utilise research in their practice and perhaps even to inspire new researchers and areas of research interest. In future issues of ATRN we hope to continue this theme as we look to profile in more depth a number of student research projects.

I hope that you and your services enjoy this final issue of ATRN in its 10th anniversary year. I look forward to any questions, comments or ideas you may have for forthcoming issues. In addition, if you, or any research students you know, are interested in writing a piece for future issues of ATRN I would love to hear from you. Please contact me at ria.schroder@chmeds.ac.nz or on 03 364 0480.

In the meantime I would like to take this opportunity to wish you and your families a very merry Christmas and a happy and safe New Year.

Happy reading.

Ria Schroder
Editor
December 15, 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, Ria Schroder (Editor), Robin Shepherd, Janie Sheridan, Lindsay Stringer (Secretary)

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ATRIG MEMBERSHIP REMINDER

Just a reminder that as it is coming up to the start of a new financial year it is time to start thinking about renewing your ATRIG membership. ATRIG membership entitles you to three issues of the Addiction Treatment Research News via email and membership in the ATRN email discussion group. Membership forms are on the last page of this newsletter. Please fill these in and post them with your membership fee to:
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WHY AREN'T CLIENT'S ATTENDING PROBLEM GAMBLING SERVICES?

In 2005, one-third fewer new clients with problem gambling issues contacted the Gambling Helpline than the year previous and 21% fewer new clients accessed face-to-face treatment services[1]. Numbers accessing these services are relatively substantial and as such these variations are not simply a consequence of statistical fluctuations on smaller numbers e.g. 65 instead of 100 contacts. Last year 2,875 new clients contacted the Helpline, down from 4,300 the year before, and 2,714 new clients accessed face-to-face services compared with 3,431 in 2004. This followed a steady rise each year in face to face clients since records began in 1997, and three years of similar numbers for the Gambling Helpline[1].

Why investigate?

There are possibly a number of reasons that one could posit to explain the drop in numbers accessing specialist services, and some may suggest that we should wait to see if it is simply a fluctuation or aberration that averages out over time. This is similar to the global warming argument that many governments use to justify inaction (but let's not go there).

However, problem gambling is far more politicised than many other addiction categories, with funding for treatment coming from the industry by way of a hypothecated tax. The recent flurry of negative publicity in the media is not unconnected with the current processes underway by the government for the first time to fix the levy for the next three years. This has been signalled as approximately $20m per annum[2] but could well be altered before recommendation goes to Cabinet for sign off, especially if a case is made for the size of the problem being now less than previously thought.

Generally speaking, the reasons for the sudden reduction could be hypothesised into two categories, or even a mix of them. They are:

1. There are fewer problem gamblers now than in the past
2. Problem gamblers are no longer willing to access help

This brief synopsis looks at the evidence to support either possibility.

The case for the problem reducing over time

In 1999 Abbott and colleagues found from their national survey that the prevalence of problem gambling had reduced substantially from their 1991 survey (down from 3.3% to 1.35% for problem or pathological gamblers)[3]. Although they acknowledged that the survey probably considerably under-estimated the true prevalence rate, this probably also occurred in 1991 and would not account for the difference. Also, in contacting and interviewing a small group who in 1991[4] had previously reported problem gambling, most had reduced or eliminated their problem gambling without professional help, and so they concluded that some may have been 'maturing out' of problematic gambling.

However, accessibility to gambling had increased substantially between 1991 and 1999, and other research indicates there is a strong connection between accessibility and prevalence rates for problem gambling (Productivity Commission 1999)[5]. In addition, up until last year, people seeking help for gambling problems had increased annually overall, albeit slowing in 2004[1]. An explanation for the reduced findings for the 1999 follow-up study may well lie in the small numbers followed up.

Changes over time were only measured for a small group of participants who were pathological gamblers in 1991 (n=13 of a total 143 participants). While these pathological gamblers reduced to just three in 1999, six of the non-pathological gamblers in 1991 presented as pathological gamblers in 1999. This resulted in a relatively smaller change from 13 to 9, within a small sample group[4].

The most likely reasons for the reduction in help-seeking in 2005 are two-fold. Firstly, late in 2003 the Gambling Act was passed, requiring reduction in numbers of machines for those sites that had become established after 2001 with more than nine machines on site. These sites were required to reduce from up to 18 machines down to nine, and between 2003 and 2005, machine numbers dropped from just over 25,000 to 21,000. However, despite a substantial drop in machine numbers, the amounts lost on gambling machines in NZ have only recently dropped, and only by a somewhat miniscule 0.8% in 2005 over the previous year[6].

It appears that although there has been a substantial reduction in the number of gambling machines available, the amount gambled overall on machines has stayed remarkably constant. This is in line with general findings that newer machines have higher takings than earlier machines, as they become more attractive and players play longer. If over three-quarters of problem gamblers are attributable to gambling machine problems[1], and losses remain constant despite fewer machines[6], the only conclusion to be drawn, if there are indeed fewer problem gamblers, is that non-problem gamblers are increasing their playing while losses attributable to the fewer problem gamblers, are reducing.

A further possible effect on the prevalence of problem gambling may be the advent of the Smoking Environment Amendment Act 2003. Problem gamblers appear to be considerably more likely to smoke than non-problem gamblers[7,8], and

to smoke heavily during gambling. It may well be that competing addictions have won out in favour of smoking, with problem gamblers choosing to smoke and not gamble, rather than gamble without smoking. Certainly, reductions have been noted in Australia following such legislation, but this has gradually recovered over time. In NZ, casinos increased their earnings between 2003 and 2004 by 6%, then dropped back by 2% during 2004 and 2005[6]. It would appear that the effects of smoking may not reduce problem gambling to any extent, unless one were to accept the hypothesis above that non-problem gamblers have increased their spending as overall, the fewer problem gamblers have reduced their contribution.

However, as estimated by the Australian Productivity Commission ('APC') approximately one-third of gambling losses are attributable to problem gamblers, therefore requiring a substantial change in who is contributing to losses, if in fact the 21%-30% reduction in help-seeking in NZ reflects a reduction in problem gambling prevalence by this amount.

The case for reduced help-seeking rather than reduced problems

If the correct cause for the reduction in help-seeking is that help-seeking has become less attractive, what evidence is there for this hypothesis? It appears that only a small proportion of people with gambling problems seek help from counselling services (including problem gambling helplines). Volberg[9] estimates this as about 3% while the APC[5] estimates these at 11%, based upon those who are willing to disclose their gambling problems (and therefore being an over-estimation). The APC also identifies reasons for not accessing services, including poor awareness of services, inconvenient hours, poor location, preference for informal assistance, cultural or gender factors, not considering their problems serious, and stigma associated with problem gambling. Whereas these are all valid reasons, it is unlikely that any of these will have changed substantially between 2004 and 2005 when the NZ help-seeking decreased so substantially.

Conclusions

Pathological Gambling Disorder is described in DSM-IV as a 'persistent and recurrent' problem[10]. It is not too long a bow to draw that the impact of the smoking legislation coupled in the same year with gambling legislation that reduces the number of machines has resulted in 'time-out' for many problem gamblers, and at the same time a reduction in new problem gamblers. It is likely that many problem gamblers do change their behaviour without assistance from professional counsellors. Separating smoking addiction and gambling addiction may enhance such self-recovery, and further research in this area is warranted. However, with gambling losses remaining high despite a small drop in revenue, the variation in the small proportion of problem gamblers who seek help may not be a valid basis upon which to base a reduced estimate of funding needs for the next three years.

A most likely explanation for the help-seeking reduction appears to be the impact of legislation, which may be somewhat temporary. Improvements in gambling machines as well as 'acclimatising' to smoking restrictions is likely to result in recovery from the previous decline in gambling spending. This was the Australian experience of new smoking regulations. What may be a self-fulfilling outcome is that if it is concluded that problem gambling has in fact reduced and resources can be reduced accordingly, if the need increases, the unavailability of resources for increased demand may result in continued reduced levels of help-seeking. If those accessing specialist help only comprise 3% or so of those in need, then basing needs on the fluctuations of this minority will be taking a gamble indeed.

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NAC REPORT

The NAC is a hive of PhD-related activity at the moment, with one dissertation currently being examined and a further four on the brink of submission.

Karen deZwart, Research Fellow, will be defending her PhD dissertation in January as the final stage of her degree looking at nicotine use in a clinical adolescent sample. Karen's research has focussed on identifying factors associated with nicotine use, the natural course of nicotine use and dependence into early adulthood, and predictors of change in smoking status.

Meg Harvey, Assistant Research Fellow will be submitting her PhD dissertation before Christmas. Meg has investigated cognitive functioning in an adolescent population in relation to their cannabis use. This has required the highly challenging task of recruiting an adolescent sample, with a good representation of cannabis users ranging from occasional to heavy users, as well as non-users, all of whom were required to undertake a battery of cognitive tests. By controlling for IQ, education level, psychiatric functioning and age Meg was able to demonstrate that cannabis use exerts a subtle but significant influence on cognitive functioning, with impaired executive functioning, particularly working memory.

Three further PhD dissertations will be submitted in the early part of 2007. Daryle Deering, Lecturer, has built on her Masters work to further develop the Methadone Treatment Index (MTI) and examine methadone treatment, and client's perceptions of that treatment, in New Zealand. Daryle's work has been able to demonstrate adequate psychometric properties of the MTI for routine outcome measurement as well as produce a detailed profile of the health status, substance use, and perceptions of a representative sample of patients being treated on the Christchurch Methadone Treatment Programme.

Fraser Todd, Senior Lecturer, has extended his expertise in treatment of patients with co-existing mental health and addiction problems by examining the relationship between cannabis use and mood disorders in two samples – one a community sample of depressed patients undergoing treatment, and the second a sample of patients recruited when undergoing a first hospitalisation for bipolar disorder with psychotic features. In these samples Fraser investigates the relationship between cannabis use and psychosis in both bipolar and unipolar depression and the impact of cannabis use on engagement and outcome of treatment for depression, as well as the course of cannabis use for the inpatient sample.

Geoff Noller, a full-time PhD candidate, is examining perceptions of cannabis use by cannabis users and policy makers and the development of social policy. Geoff originally developed this dissertation whilst in the Anthropology Department and is now nearing completion having transferred to Psychological Medicine in early 2005. Geoff is using a mixed qualitative-quantitative methodology. His primary data source is close to 80 interviews with cannabis users from the Dunedin area who responded to newspaper advertisements, while Geoff was also able to interview a selection of officials in the health and drug policy arena.

A PhD is the highest formal qualification bestowed by New Zealand universities (with the exception of the rare Doctor of Science and Doctor of Letters) and for a candidate to be passed their dissertation must represent a significant contribution to knowledge in the chosen field. As a norm it is expected that a PhD will take three years of full-time study, or the part-time equivalent, to complete. In addition to considering whether a dissertation makes an original contribution examiners must agree that the work meets internationally recognised standards for the conduct and presentation of research in its field, displays a mastery of appropriate methodological and theoretical material, demonstrates a thorough knowledge of the literature relevant to its subject and the candidate's ability to exercise critical and analytical judgement of that literature.

These PhD dissertations will add to the five PhDs already completed within the NAC, with a further three PhD candidates at various stages of their course of study.

Dr Simon Adamson
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CUTTING EDGE 2006

Cutting Edge continues to be a worthwhile national conference with a successful inclusive format. It is the mix of research, experience, practice and innovation that attracts a diverse group of colleagues within the field. This diversity was successfully represented in the range of presentations given. This article provides a brief overview of my reflections on Cutting Edge 2006 which took place at the Duxton Hotel in Wellington 7th – 9th September.

Rae Lamb's keynote address highlighting the process of complaint through the Health and Disability Commission reassured me that there is a robust process in place for all health and disability consumers. Some may remember Rae from her role as Radio New Zealand's health correspondent.

Associate professor Papaarangi Reid provided an interesting keynote speech on health disparity for Māori from a public health perspective. Her presentation challenged health providers to bridge the gaps.

Dr Judith Martin related experiences of working with opioid dependent clients in East Oakland at the 14th Street Clinic. Although some may consider our opioid substitution programs to be restrictive in comparison to East Oakland our approach is very liberal. This is a reflection of the communities that are served and the consumers that access services. Dr Martin outlined the introduction and use of Buprenorphine with Naloxone added. This medication assisted opioid dependent clients gain treatment in other settings such as primary health.

There were also a number of Maori and Pacific presenters. Presentations included cultural safety, marae based services, youth, workforce development and research. It was noted that other countries look to New Zealand for leadership, knowledge and innovation in working with the health needs of indigenous peoples.

The poster displays were impressive and covered a wide range of topics. This forum provided an opportunity for discussion, in an informal setting, of the wide range of initiatives and research on addictive behaviors that are being undertaken in New Zealand.

Workforce development was also a strong theme, alcohol and drug competencies and scopes of practice were discussed for alcohol and drug practitioners. Issues in relation to legislation such as the Health Practitioner's Competency Act were also raised. The notion that the workforce needs to be regulated and the role of professional bodies made for interesting debate.

My personal highlight of the conference however, reminds me of the infamous Forrest Gump. He was a man with outstanding abilities that were predicated on random genetic variables. The supposition that genetics not only account for appearance, health but also addictive behaviour has resulted in robust debate and research. We were very fortunate to have Dr Marc Schuckit as a keynote speaker at this year's conference. He is an eminent researcher into the genetics of alcoholism. He has conducted adoption studies, identified genetic characteristics that lead to increased risk of alcoholism and continues to research related genes. Dr Schuckit impressed with his humanity, sense of humor, passion and ebullient presentation.

The evidence is substantial[1] that genetic factors lead to vulnerability in alcoholism. Of note is the etiologic complexity and variation in vulnerability across generations and across cultures. Studies have utilised psycho-physiological and neurochemical markers of alcoholism for analysis of genetic association, transmission, and linkage. The markers have included the low P300 event related potential, sensitivity to ethanol's intoxicating and euphoric effects, platelet Adenylate Cyclase and neurotransmitter metabolite concentrations.

Over the past twenty years there has been considerable study[2] of P300 in alcoholism. Systematically reduced amplitude was detected in alcoholics and their children. Studies on twins indicated that the waves of the evoked potential are under genetic control.

The role of the D2 dopamine receptor (DRD2) gene (not R2D2 a well known droid) in alcoholism and other substance use disorders has come under intense investigation since the minor Taql A (A1) allele of the DRD2 gene was first reported to be associated with alcoholism. In a Meta-analysis[3] of 15 US and international studies of European Caucasians (1015 alcoholics and 898 controls), alcoholics had a higher prevalence and frequency of the A1 allele than controls.

The often posed question, if a parent is alcoholic are their children at risk of substance dependence, takes on new meaning in the ever emerging knowledge of genetics. Dr Schuckit clearly demonstrated that a low response to alcohol in early life is predictive of the development of alcoholism[4]. Interestingly the initial research did not show significant risk of the development of other substance dependence. Dr Schuckit is focused on understanding the causes and development of Alcohol Dependence in order to help

people prevent and treat the disorder. Through the consideration of the factors that influence the disorder unique treatment approaches and public health initiatives can be envisaged.

So what would Forrest make of this? Well he was a pragmatist when it came to research and should have the last word. "Momma always says there is an awful lot you can tell about a person by their shoes Where they're going. Where they've been."

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THINKING ABOUT OUR STUDENTS' RESEARCH

Within our degree, there are some courses that almost all students invariably look forward to – courses like Motivational Interviewing, Assessment and Treatment planning, Treaty of Waitangi, and Cognitive Behavioural Interventions. Then there are two research courses that more often than not evoke sighs of apprehension and doubtful thoughts. Many students find these courses somewhat daunting given that the majority of them are faced, for the first time in their lives, with the challenge of learning the basic theoretical constructs of research and implementing a small scale research project.

Accordingly, we as lecturers need to strike the right balance between the beginners' knowledge and skills and quality of the final products. Everyone involved understands the importance of research. In order to be a holistic and well rounded alcohol and drug practitioner in New Zealand, one needs to be able to demonstrate a high level of foundation, generic and vocational competencies[1], all of which are, to a certain degree, needed to successfully meet the criteria for passing the above mentioned research papers.

While the introductory research course approaches the subject matter from a theoretical perspective, in the second course students need to undertake a small scale research project, analyse findings and write a short report on the results.

The aim of the Introduction to Research course is for the students to gain a working knowledge of basic research methodology and basic skills in critical analysis. By the end of that module, students should be able to analyse research methodology and identify research processes, critically appraise scientific papers and give a clear and rational interpretation of the material in a literature review. They should be able to explain and assess the importance of research to the professional field of practice, demonstrate the ability to critically read research articles, design a small research project and describe issues related to gaining ethical approval.

In the Research Project course, applying theory into practice, students must choose a research topic, develop research question(s), design their study, collect, analyse and interpret data, write a report, and disseminate the results via presentations in class.

When selecting topics, students are encouraged to research an aspect of the alcohol and drug field in New Zealand. Their literature search starts at this point, and often clarifies a number of issues related to the choice of topic. Students are encouraged to consult either the agencies where they are placed or their own workplace, and tie the research into an area of the agency's interest. This process often produces positive outcomes for students and agencies and reinforces the fact that applied research is beneficial when initiated by the needs of the field. For students, there is also an opportunity to link the outcomes of their research project with another comprehensive task - to design an alcohol and drug intervention, which is targeted at a specific group of alcohol and drug consumers (and is an assessment for another level seven paper – Integrated Theories and Interventions for Alcohol and Drug Problems).

It has been interesting to browse through the topics that our Wellington students have chosen for their research projects in the last three years.

A number of them have focused on the area of young people and drug

use – researching drinking habits and knowledge of alcohol effects on 18-year olds, opinions on under age drinking, nicotine use and attitudes towards smoking cessation, youth development recreation and perceptions of drug testing as a tool in drug rehabilitation.

Another popular topic focuses on cultural issues. To mention only a few – Pacific perspectives of community awareness of alcohol use, Māori women and benzodiazepine use, leisure activities of clients from a Kaupapa Māori alcohol and drug service, importance of cultural assessment for Māori clients and comparison of Pasifika and Palagi attitudes to drinking.

Other students have focused on various aspects of alcohol and drug treatment provision, i.e. the support provided to clients while on a methadone reduction program, the role of higher power and power of prayer in overcoming addiction to psychoactive substances, the importance of consideration of client's sexual orientation while in treatment and the use of family therapy in addressing addiction in New Zealand.

The fourth group of topics focuses on the provision of treatment services for women – i.e. evaluation of after-care support services for women in recovery and attitudes of women towards alcohol and drug use.

A number of students have chosen to focus on various advertising and educational factors: i.e. people's purchasing patterns of alcohol, effectiveness of alcohol advertising and drug and alcohol workplace education in New Zealand.

After making a final decision about their research topic, and refining the research questions, students start focusing on the choice of methodology. Having in mind the level and scope of the project, students are encouraged to limit the numbers of participants and choose the realistic qualitative or quantitative methods, which they will be able to implement.

The next step is an application for ethical approval. All projects have to involve participants who are over 18 years of age, and need to meet the requirements of the Category B Ethical Approval at School Level of a Proposal Involving Human Participants[2].

After ethical approval has been granted, students collect the data, conduct analysis and interpretation, and write the final report.

This whole process is very involved and lasts for seven months. A lot of positive thinking and challenging of students' negative automatic thoughts needs to happen before they are convinced that they too can become beginning researchers. Every student is encouraged to have frequent individual contacts with their research supervisor (allocated Weltec lecturer). The final reports often present small scale, but valuable and creative insights into respective topics. More and more of our students go to Cutting Edge conferences, and start being a part of the alcohol and drug practitioners' network during the final year of their study at Weltec. We are certain that their learning about research, its theory and practice, although at times hard, contributes to students becoming critical thinkers, creative problem solvers, holistic practitioners, and – maybe – future applied researchers.

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ATRIG CHAIRPERSON REPORT

Since the last edition of ATRN we have enjoyed a successful Cutting Edge Conference, which I know many of you attended. Two awards were given out for presentations of original research. These were the John Dobson Memorial Foundation Prize for an opioid-related presentation, which went to Charles Henderson, and the John O'Hagan award for a young researcher which was shared by Maria King and ATRN's own Ria Schroder. Warm congratulations to these presenters.

Last month I was fortunate to be able to travel to Cairns for the Australasian Professional Society on Alcohol and other Drugs (APSAD) annual conference. This was an excellent conference with a high calibre and wide variety of content. As many of you will know, next year a joint APSAD-Cutting Edge conference will be held in Auckland (4-7 November). This provides an excellent opportunity for closer links to be forged between the New Zealand and Australian research and clinical communities as well as a chance to attend what is essentially an international conference here in New Zealand.

The Ministry of Health has recently released Te Kōkiri: The Mental Health and Addiction Plan 2006-2015. The action points relating to the addiction sector contain a number of areas where local research has been or will be important. These include "improving the availability of and access to quality addiction services" which raises the question of what is quality and how is it measured. Improved access to opioid treatment is likely to include the implementation of recently developed interim prescribing guidelines. These were formulated in the light of several trials for which indicative outcome data was collected and presented at more than one Cutting Edge conference. The identification of the need to develop addiction-related outcome measures for addiction treatment services

refers to work undertaken over the past four years funded by the Ministry of Health, examining the shortcomings of a generic mental health outcome measure, such as HoNOS, for addiction services. This has been looked at from a generic clinical and consumer perspective as well as for Maori and Pacific populations. Research in this area is ongoing. Finally, the plan calls for the implementation of a problem gambling research plan. Elsewhere in the plan reference is made to the challenges of adequately addressing the complexities of working with clients experiencing addiction and co-existing mental health problems. Research highlighting the true extent of this overlap is likely to have played a part in ensuring that mental health and addiction services and treatment populations are considered in a single document such as Te Kōkiri.

Dr Simon Adamson
ATRIG Chairperson

I'VE BEEN READING

It was Claire Aitken's suggestion. So, I knew it would not leave me feeling comfortable. Contrary to the current fashion of pharmacology, neural pathways, and genetic trails it was a book that addressed the inner journey. Odd for the ATRIG news I know, and I risk the reader's just hidden sneer, well, I sneered out loud and settled for the three minute skim usually reserved for workforce policy documents.

But, it was a good read, a page turner, not quite a thriller or whodunit, but a reminder of the essential skills of the talking therapy. Easily underdone, allowed to rust, but without which we don't have the ability to communicate. The author writes about the struggles and anxieties of being face-to-face with people in distress.

Many of us can paint the picture, often one of disillusion, on both sides of the counselling table. A profound shift has occurred in recent years among the professionals working with alcohol and drug related problems. There is a new morality. That has come from the respect we've been able to give our clients since we stopped patronising their illnesses. It has allowed us instead to collaborate with them and not stand in judgement. They have choices now and so do we. They now carry with their new status, new responsibility which allows them to share the work with us. There's a recognition now that, though we may know a lot about what liquor does to the liver and what the sudden absence of drugs might do to the brain, the client knows more about what he or she wants, what they are trying to be, how they are trying to do it and whether they are satisfied with their endeavours.

The author is a professor of psychology, a clinical psychologist and the author of *The Neuroscience of Psychotherapy* and *Building and Rebuilding the Human Brain*. I haven't read either of those and I haven't met any who have. But in this book, he sets out practical survival strategies for reasoning with the paradox of client resistance, understanding and managing transference and its counter, pathological care-taking, shame-based experience and behaviour, clients who are brighter than you are (these pages are pasted on my wall).

Sure in your confidence to be effective in helping people? Calm in the face of those who look expectantly at you for wise words that will change everything? Ever experienced therapeutic panic? I live with it. So, I found much of value, not just in what I had forgotten, but in new learning. Not least the timely reminder that unless we can communicate with our clients, we are trying to cross Antarctica with frostbite.

The Making of a Therapist. Louis Cozolino. 2004. Norton. New York/London.

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Addiction Treatment Research Interest Group (ATRIG)

MEMBERSHIP/RENEWAL FORM

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

Membership in ATRIG entitles you to the following

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

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

Surname _____ First Names _____

Postal Address _____

_____

Daytime Phone Number _____ Fax Number _____

E-Mail Address _____

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

The objectives of ATRIG are:

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

Declaration

I support the objectives of ATRIG and wish to be a member of ATRIG for the 2007 calendar year. I understand membership fee is $20.

Signed _____ Date _____

Please make cheques payable to: ATRIG

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

Thank you for completing this form and sending it back to:
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