Addiction Treatment Research NEWS

NEWSLETTER OF THE ADDICTION TREATMENT RESEARCH INTEREST GROUP

December 2007 ISSN 1177-8083 Vol 11 No 3

EDITORIAL

It's hard to believe that Christmas is upon us again. Where have the last 12 months disappeared to? For many of us I suspect they have disappeared into a flurry of data analysis, conference presentations, and writing of reports, peer reviewed publications and funding and ethics applications. Such is the life of a researcher! But encouragingly, emerging from the flurry and the hard grind are the visible products of our efforts, some of which are displayed in this current edition of the Addiction Treatment Research Newsletter.

To begin this issue we have a somewhat differently flavoured report from Sean Sullivan of ABACUS. Putting gambling aside, but only for a moment, Sean provides an overview of a strategy Abacus have helped to establish in order to address access issues to AOD services in South Auckland. Taking a community based approach Sean explains how this strategy is aimed at working with the particular needs of people in South Auckland communities to help them address their AOD issues.

Simon's report from the National Addiction Centre (NAC) outlines some of the current research activities at the National Addiction Centre with special mention of the great work of a number of post graduate students.

In the first of our feature articles Rachael Butler and Janie Sheridan present some research on an issue that has been hotly debated in New Zealand this year – party pills. This article provides a snapshot of some research Rachael and Janie have conducted to ascertain young people's knowledge about what party pills are and how to use them safely. Although conducted prior to the reclassification of benzylpiperazine (BZP) as a Class C substance this research raises some important points to consider regardless of the classification status of party pills.

Our second feature article written by Raine Berry provides an engaging review of New Zealand's annual AOD conference. This year, as an added bonus, our annual Cutting Edge conference was combined with the Australasian Professional Society of Alcohol and other Drugs (APSAD) annual conference to produce a bumper conference entitled "Two nations, ten cultures?". As Raine reflects this huge event really was a highlight on the Addiction Treatment calendar with the exposè of a great range of thought provoking research presentations.

Our final feature article provides a brief overview of Daryle Deering's recently completed PhD examining Methadone Maintenance Treatment (MMT) in New Zealand. This article provides an overview of the health of clients receiving MMT and discusses important implications for treatment. In particular, Daryle's research highlights the necessity of understanding the health and social needs of clients in order to be able to provide adequate services to them.

Unfortunately, due to unforeseen circumstances, our regular "I've Been Reading" section is missing from this edition of the ATRN." Rest assured though, it will be back in the next edition of ATRN.

Many thanks to all who have contributed to this edition and to all the editions of ATRN we have published this year. Your hard work is greatly appreciated especially at this extremely busy time of year.

I would like to take this opportunity to wish you all a very merry and relaxing Christmas and a happy new year.

Happy reading (and relaxing, I hope)

Ria Schroder
Editor, December 2007

A South Auckland Strategy to Address AOD Issues

"In the middle of difficulty lies opportunity"
Albert Einstein

Alcohol abuse and dependence is estimated to have affected 13% of adults sometime in their past, and other drugs are estimated to have affected 6% of adults, with considerable overlap between misuse of these substances[1]. Only a small proportion of affected people seek help from AOD services, with the vast majority largely left to their own devices, and the influence of the environment, as to whether their use of drugs reduces, stays the same, or deteriorates. Families of those affected by drugs comprise another much larger group who struggle with the consequences of drug misuse and may be in need of help, but who are even less likely to seek help. Improving the opportunity of providing help for either of these groups is a strategic goal of a new initiative of Counties Manukau District Health Board (CMDHB). An ALAC sponsored review of workplace early intervention strategies[2] found limited AOD strategies from which to determine a 'best practice' approach, and particularly limited evidence relating to early intervention strategies. The workplace is only one (albeit an important one) opportunity in which opportunistic or specifically sought-out help can be provided to those affected by alcohol and drug misuse.

A strategy to address a likely need

CMDHB is a large DHB in South Auckland covering Manukau City, Franklin and Papakura Districts. It has a diverse, fast growing population with high proportions of Maori, Pacific and Asian peoples, a greater number of young people than most other DHBs, and a disproportionately large number of people in lower socio-economic categories. It has been stated by CMDHB that low levels of the population access mental health and addiction services, despite the expected heightened need based upon the population profile. Just 1.8% of the target 3% of the population with mental health and addiction needs, access services in the district. It has been hypothesised that this low access is attributable to lower socio-economic status combining with the multi-ethnic population in some complex manner. For example, lack of transport to access a treatment service may be the final straw for someone of limited resources with not only variable motivation, but also, uncertainty about the effectiveness of accessing a service for their AOD issues. In addition, opportunities to intervene earlier, before a problem becomes established and help-seeking becomes a priority, are lost.

The CMDHB strategy to assist in addressing this under-accessing of services is to expand opportunities for people within the CMDHB district to access a wide range of trained people who can offer a range of treatment, support and other help, when AOD problems exist.

The project

Abacus Counselling Training & Supervision Ltd ('Abacus') has been contracted by CMDHB to deliver a project that seeks to address some of the challenges particular to this district's population. Abacus trainers will provide training to consultants that will include Maori, Pacific and Asian co-trainers, and in some cases, with consumers as co-trainers.

The organisations and groups that were identified as appropriate to assist with reducing harm from misuse of alcohol and other drugs through the training under the project were AOD consumer leaders, industry, social services, and health services, including AOD services. The majority of these organisations will receive a 3-hour training session which includes information, identification, brief intervention strategies, and referral for AOD issues. Consumer leaders will be offered additional training including Motivational Interviewing, relapse prevention, and an opportunity to develop skills to co-deliver the training to organisations. A target of 450 trainees from organisations will receive the one-session training and 60 consumers with receive three-session training. Specialist AOD treatment services in the CMDHB region will be offered advanced training in psychotherapeutic approaches. In addition, a 'train-the trainer' component will be provided within the project which will ensure ongoing development of this resource, with 60 trainees from organisations, consumer leaders, and AOD services being offered a four-session training programme. Overall, 70 training sessions are to be provided, with training co-presented with AOD consumer-leaders once their training has been completed.

Progress to date
A needs analysis for the AOD training was conducted in the initial months of the project with organisations within the CMDHB region identifying support for the aims of the project and interest in participation. The project anticipated that consultation, programme and resource development, enlistment and piloting would occur in the first half of the 12-month project. However, demand has resulted in the delivery and planning of at least ten training sessions prior to Christmas. Initial meetings with AOD consumers have been positive, with a number keen to complete the additional training days to become co-presenters. Within the programme there will be an evaluation component conducted by Abacus as part of the project and its obligations as an NZQA registered entity. The project is scheduled for completion and evaluation by the end of June 2008 and will offer a possible solution for the sparse evidence as to whether offering help for AOD issues through peers, non-specialist social and health services, and enhancement of specialist services, will improve access and/or provision of brief and early help for those affected by AOD issues.

Sean Sullivan
Abacus Counselling Training & Supervision Ltd

References

1. American Psychiatric Association (1994) Diagnostic and Statistical Manual of Mental Disorders. 4th Ed. Washington DC: APA.
2. Kirkwood L (2005) Review of workplace-based alcohol and other drug early intervention. Wellington: ALAC

MESSAGE FROM THE CHAIRPERSON

Last month saw the successful running of the Two Nations Ten Cultures? Conference, also know as the Combined Cutting Edge and APSAD conference. By any measure it was a great success. The 730 plus delegates comprised large contingents from Australia and New Zealand as well as a smattering of attendees from further a field. The conference had many more concurrent streams than is usually the case for a Cutting Edge conference and so this presented quite a challenge at times in deciding what to attend and what to miss. The keynote addresses were of a very high standard and covered a very diverse range of topics, from the neuropharmacological (Charles O'Brien) to the cultural (Mason Durie, Siale 'Alo Foliaki, Tracy Westerman) to the broad sweep of human civilisation and spiritual development (Lloyd Geering).

We were also treated to a superb James Rankin Oration by Dr Geoff Robinson. What is usually a plenary-style lecture (ie an oration) was this year moved to the after-dinner slot of the conference dinner, attended by 500 delegates. Most researchers would go pale at the prospect of such a task – being expected to be insightful, witty and relatively brief. It's a tall order but one that Geoff was ideally suited to. The breadth of his clinical and academic experience shone through as did his unique sense of humour.

The scale of this year's conference means that we are set to produce an excellent Addiction Treatment Research Monograph, with a significantly larger pool of New Zealand-based research presentations to receive submissions from. The editorial team are myself, Dr Ria Schroder, and Associate Professor Janie Sheridan. If you have been contacted by one of us then we look forward to your submission. The process of submissions, editing and publishing is necessarily a lengthy one given that the budget for this is largely one of goodwill rather than dollars, so New Zealand delegates from the conference will receive a copy next year, but will need to be patient.

On behalf of the ATRIG executive I would like to wish all of our members and all of our readers a very happy Christmas and New Year.

Dr Simon Adamson
ATRIG Chairperson

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 (ATRN Editor), Robin Shepherd, Janie Sheridan, Lindsay Stringer (Secretary)

Please direct **enquiries to Lindsay Stringer**,
PO Box 2924,
Christchurch Mail Centre,
Christchurch 8140
Phone (03) 364 0480,
Email:
lindsay.stringer@otago.ac.nz

The year has ended on a high note for the NAC with December seeing two PhD graduations. Dr Daryle Deering, NAC lecturer, was capped for her PhD "Methadone Maintenance in New Zealand", as was Dr Meg Harvey, former ATRN editor, whose PhD topic was "Reefer Madness: Adolescent Cannabis Use and Cognition". December also saw Geoff Noller submit his PhD, titled "Cannabis Use in New Zealand. Perceptions of Use, Users and Policy".

The year has also seen the graduation of three Masters students – Samadhi Campbell, Process of Motivational Enhancement Therapy: Relationships between Therapist and Client Behaviours, and Alcohol Use Outcome; Anna Tentori, Identifying Client Characteristics Associated with Alcohol and Other Drug Treatment Retention in Youth; and Steve Marshall, Depressed Patients' Experience of Cannabis Use.

Congratulations to these recent graduates and good luck to David Benton who has recently submitted his thesis "Concurrent Treatment for Co-Existing Post Traumatic Stress Disorder and Substance Use Disorder in an Outpatient Setting".

We have just submitted to the Ministry of Health a preliminary report titled "Opioid Dependence in New Zealand". This project, led by Professor Doug Sellman seeks to answer the following six questions:

1. How many people in New Zealand have opioid dependence (given the estimate in 1996 of 13,500 – 26,600) including consideration of opioid dependent people in prison?
2. How many people with opioid dependence want treatment, and in what form?
3. What (if any) are the barriers to people with opioid dependence gaining the treatment they want?
4. How many people are being treated using opioid substitution treatment (OST) in New Zealand, including the numbers of patients on authority to GPs and the number who have been discharged to ongoing GP care?
5. How many people are waiting for OST treatment and how long (in time) are waiting lists for OST in the various treatment programmes?
6. What has been the influence of the "methamphetamine epidemic" on the prevalence, presentation and treatment of people with opioid dependence in New Zealand?

Answers to these questions are being derived from three sources. Firstly, we aim to interview more than one hundred opioid-dependent individuals, both on and off methadone treatment, using a "snowballing" technique. Secondly, data is being collected from all methadone treatment programmes in New Zealand via a structured interview, and thirdly, we are undertaking a thorough review of the literature looking at national and international trends. This will include seeking more detailed information from two important national data-sets which have been recently published: Te Rau Hinengaro, the New Zealand Mental Health Survey, and the 2003 New Zealand Health Behaviours Survey

The project is a collaboration between the NAC, Needle Exchange Services [NEST] & Needle Exchange, NZ [NENZ] Trusts, and the Aotearoa Alcohol and Other Drug Consumer Network.

Also of recent note at the NAC is that in early December interviewing began for the National Telephone Survey of the Addiction Treatment Workforce. Repeating many of the questions of the workforce surveys in 1998 and 2004 the survey will help identify change and challenges within the field and also includes new areas of particular interest such as working with youth, nicotine dependence, current practice and beliefs in relation to working with patients with co-existing conditions and will provide a clearer picture of the nature of the "in recovery" portion of our workforce. For the first time the survey will also be extended to include the gambling treatment workforce.

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

Highs and Lows of Legal Party Pills in New Zealand: What Do Young Users Know?

This article is based on a paper given at the Youth Health Conference in Christchurch earlier this year, which presented findings from a recent study on young people's use of legal party pills containing benzylpiperazine (BZP-party pills). BZP-party pills first emerged in New Zealand around seven years ago and have since become widely used, particularly by young people. The main active ingredient in the substances is benzylpiperazine (BZP), with some products also containing trifluoromethylphenylpiperazine (TFMPP). At the time of the study in 2006 BZP was classified a 'restricted substance', thus the products were able to be sold to anyone over the age of 18.

The broad aims of the research were to explore youth use of the substances, including patterns and function of use, positive and negative effects, and knowledge of BZP-party pills. Data were collected via a series of interviews and focus groups with young people aged 17-23 years (n=58 participants in total). This short article focuses on one aspect of the findings – young people's knowledge of BZP-party pills – and incorporates awareness of what the pills contain, how to use the products safely, and sources of information for this group of users. This revealed interesting insights into the type of information young people consider important, and how they gather and assess substance-related information. (For a more detailed overview of the research findings, please see http://www.harmreductionjournal.com/content/pdf/1477-7517-4-18.pdf).

Knowledge of the products

There were varied levels of knowledge with regard to the ingredients of BZP-party pills. Some young people claimed to have *"no idea"* and no interest in what they contained. This was sometimes linked to their legal status which was felt to confer a degree of safety on the substances, resulting in less concern over what they contained. Others, however, were very well-informed (tended to be the minority) and were able to talk about the pharmacological properties of BZP-party pills. These individuals were very particular about knowing the exact components of substances that they consumed, and always checked the labelling of BZP-containing products for this information.

In exploring what young people did know, many of those interviewed were aware that *"BZP"* (far less often referred to as benzylpiperazine) was an active ingredient of the products. Most knew that the level of BZP varied across different brands and individual doses, with higher concentrations equated with a stronger high. There was also some awareness of BZP producing stimulant-like effects in users, and growing recognition that they were synthetic rather than herbal products. However, knowledge of benzylpiperazine generally did not extend beyond this. Whilst fewer people spoke about *"TFMPP"*, they linked it with hallucinogenic or *"e-like"* effects.

There was also clear evidence of some misinformation with regard to BZP-party pill ingredients. A number of young people thought that either horse tranquiliser or pepper were key components (a common historical misnomer was that the products were extracts of pepper plants). In one case, benzylpiperazine was confused with benzodiazepines and one respondent thought that because of the 'p' in 'BZP' the products contained methamphetamine. BZP's use as a *"cattle drench"* was also cited by some, which may have been linked to media stories at the time which discussed this.

Knowledge of safe use

When talking about safe use of the products, young people generally considered this in terms of not harming themselves and/or minimising the negative effects of the substances. Similar to what young people knew about what the products contained, there was evidence of varying levels of knowledge with regard to using BZP-party pills safely. In addition, much of this information was generic in that it related to general drug-taking behaviour rather than BZP-party pills specifically.

When considering safe use, most young people spoke about the level and combination of substances consumed. This included, for example, not taking too many pills in one episode, adhering to the 'recommended'

dose[1] (as identified on the packaging), and not mixing with alcohol. Some respondents highlighted that drinking water whilst taking BZP-party pills was important to avoid dehydration (particularly when use of the drugs was combined with extended periods of dancing). More experienced drug users noted that the level of liquid consumed needed to be monitored (i.e. too much could also be harmful). Other participants considered that eating before and after ingesting BZP-party pills entailed safe behaviour. In addition, some highlighted more general safety issues, such as only taking BZP-party pills with trusted friends, and ensuring that people kept an eye out for each other whilst intoxicated. Interestingly, in keeping with the fact that many of the young people were driving after taking BZP-party pills, this was not highlighted as a safety issue.

Information on the substances was gathered from a range of sources. Friends were a trusted source of information, especially those with greater drug-taking experience who were sometimes 'looked up to' by more novice users. Advice on dose and effects was often sourced from specialist BZP-party pill retailers, particularly when trialling a new product, and basic information (e.g. not mixing with alcohol and 'recommended dose') was gained from the packaging on individual products. However, this was generally only referred to on the first occasion of use of a particular brand, or in the early stages of taking BZP-party pills.

[1] It should be noted that no actual recommended dose exists as these are not medicinal products.

It is interesting to note that some of the safety data was extrapolated from ecstasy information (e.g. the importance of keeping hydrated). This was either due to an absence of party pill-specific information, or because young people assumed that given the similarities between the substances and their effects – and the situations in which they were generally consumed – the information would be applicable.

Despite knowledge of the issues, some of the safety information was ignored – particularly with regard to use with alcohol and not exceeding 'recommended dose'. Many considered this to be 'overly cautious' advice, particularly when it did not match with their experience (i.e. there had been a lack of negative consequences). In contrast, many young people interviewed assessed a safe dose in terms of their own or other people's (previous negative) experiences with the products.

Results from this study are in line with other research on youth drug use, with evidence of varying levels of knowledge amongst young people, and the fact that much information is gained through experimentation or via advice from peers. There was evidence of some misinformation with regard to young people's knowledge of BZP-party pills specifically. However, even if accurately informed, this did not necessarily influence young users' behaviour (e.g. mixing alcohol with the products). Despite the likelihood of BZP soon being reclassified as a Class C substance (and thus making it illegal), it is possible that new products of this type will emerge on the market, or that an illicit trade for BZP will develop. Thus, there is a need to ensure that accessible harm reduction information is available for young users who may continue to use these, or similar, products. This includes information that is credible and acceptable to the target audience.

Rachael Butler & Janie Sheridan
University of Auckland

There were a number of highlights for me from this large combined conference. Three weeks post conference these are some of the ones that are still making me think. It was great having such a range of presentations, posters and some excellent keynote speakers.

One of the most interesting presentations, I thought, was Martin Jackson's paper on Alcohol Related Brain Injury (ARBI). Martin believes that up to 70% of clients presenting to Addiction Services may have some degree of ARBI. He presented research indicating that although alcohol is the predominant cause of brain injury, most psychoactive substances if used regularly, especially to intoxication, for greater than 10 years can cause frontal lobe impairment resulting in problems such as poor insight and awareness, rigid and inflexible thinking, poor planning and organising skills, inability to learn from mistakes and loss of impulse control. The onset of ARBI is generally slow and gradual but progressive. He presented Australian prison research that subjected 10 randomly selected inmates from a cohort of 101 participants with histories of alcohol problems, to neuropsychological tests. Seven showed mild ARBI, two moderate and one severe. Martin proposed that these results may go some way to explain the high recidivism rate amongst inmates i.e. 50% return to prison within 2 years.

Although there is no specific treatment, recovery is usually very good following abstinence in those with mild or moderate ARBI. Martin recommended that clinicians modify their approaches to treating clients who may seem difficult or unmotivated as those with ARBI may have problems monitoring their behaviour or being able to judge whether what they have done is effective or not. He said that routine is important in treatment as ARBI affects a person's ability to cope with change. This issue becomes obvious in situations where the person is required to use higher level skills or to make multiple decisions. Martin indicated that benzodiazepines taken regularly (20mg of diazepam equivalent or greater) can also cause loss of executive function, in particular visuospatial deficits and difficulty learning and integrating new skills.

Following the conference there was a two day workshop on ARBI so hopefully we will be hearing more about the assessment and management of this very important issue from those who participated.

Professor Charles O'Brien from University of Pennsylvania gave a keynote address on 'A Genomic approach to the Treatment of Alcoholism'. I'm sure other more academically focussed people will write about this presentation but there were a few things that stuck for me. Prof O'Brien stated that in his opinion addiction is not necessarily physical but rather more characterised by daily out of control use, that it is a disorder of memory, is chronic and almost irreversible. He suggested there may be changes to the criteria for dependence in DSMV that reflect this thinking. He reported from studies showing that the risk for addiction is related to an interacting set of variables including the role of the D2 receptor. He said that addicts have a reduced D2 although it is unknown whether this caused them to become addicts or is caused by the addictive use of drugs. Those with a family history of addiction, he said, are more likely to have a lower density of D2. In addition they have been found to be more likely to like cocaine effects (assumedly this would also extend to other similar types of drugs) and to be subordinates in their social structure.

I must have missed a vital link here (likely due to being overwhelmed by the complexity of genomes) as my notes then jump to Prof O'Brien discussing why some individuals respond well to naltrexone and others don't. He presented recent evidence showing that genetic variation in the mu-opioid receptor can predict response to naltrexone in individuals with alcohol dependence. Studies using rats and rhesus monkeys (thankfully there were no animal activists in the audience as what they did to those poor creatures was rather cruel I thought), showed that if the rat or monkey had low cravings for alcohol they had a low response to naltrexone, conversely the high cravers did well on naltrexone. Transferring this to human samples, people with a family history of alcoholism also respond well to naltrexone and in particular it has been found to be very effective in blocking cue-induced relapse but not effective in blocking stress-induced relapse.

Google Prof O'Brien to see his vast range of publications. I locked onto one about the use of Quetiapine in the treatment of Type B alcoholics which was interesting. Quetiapine was found to aid in reducing craving and to be related to the subjects having fewer drinking days.

A concluding statement from Professor O'Brien's address was that we "can't treat all alcoholics or opioid addicts with the same

medications". If only we had the luxury of being able to use a range of pharmacotherapy options in New Zealand! However, Professor Robert Cloninger, in his keynote address reminded us that 'pharmacotherapies are a downward spiral, not a complete treatment'. I was very relieved to hear this from such an icon of the addiction field. I particularly liked Prof Cloninger's presentation as he emphasised the importance of spiritual and cultural aspects to recovery from addiction and the need to focus on positive goals e.g. social connectiveness, cultural and spiritual awareness, resilience and physical health.

Dr David Newcombe, from Auckland University, presented a paper 'Fluctuation in Cognitive Performance in Methadone Maintenance Patients', from research he conducted in Adelaide. Given the new legislation on driving and substance use that will be rolled out shortly in NZ his findings may be rather pertinent. He presented data from recent studies showing clear impairment in psychomotor functioning e.g. psychomotor speed and memory, and poorer performance in attention tasks, in clients receiving Methadone Treatment. David tested 16 people on Methadone on multiple occasions over a single dosing interval (including 13 blood tests over 24 hours) and measured their degree of impairment by using a computer aided tracking task then comparing results to their baseline performance. Subjects were excluded if they had had a dose change greater than 15mg in the previous 3 months; significant medical history, including elevated liver enzymes; a history of psychiatric illness; or were taking medication that might interfere with methadone pharmacokinetics. The study included a matched drug free control group of 6. The mean methadone dose was 78mg (30-150mg). His findings were that changes in psychomotor performance occurred around the time of peak plasma methadone concentration. The level of performance was found to be 94% of baseline at 2 hours post dose and did not return to baseline until 6 hours post dosing.

David summarised by recommending that we need to be advising clients (even if stabilised) that they may experience impairment at the time of peak of plasma methadone.

I've recently been reading the British Guidelines on Clinical Management of Drug Misuse and Dependence. They suggest that there are stages in treatment when a client may be at greater risk of their driving being impaired i.e. dose induction, dose adjustment and detoxification. They advise that patients should not drive for 4-5 days after beginning an opioid treatment or after a dose increase.

Catherine Spooner and Michael Lodge ran a workshop on 'Assessing net reduction in harm'. Their statement that "any intervention will have multiple outcomes", i.e. that an intervention can add or shift harm, also got me thinking. Examples put forward were e.g. school suspension for drug use can result in increased alienation, more opportunities to use, and exposure to out of school associates; and methadone programmes although having obvious benefits create opportunities for service users to mix with drug using peers etc. I started thinking about how we sometimes look for short-term approaches or interventions without thinking about the possible long-term consequences. Martin Jackson's statement about the frontal lobe damage caused by long term benzodiazepine use comes to mind here.

I went to the launches of two DVDS. One was a resource for opioid users on treatment options including methadone, buprenorphine, and detoxification. It contains information on dental care, hepatitis C, mental health issues and overdose. It also has some very useful scenarios e.g. one on an interview with the clinic doctor and a client who has been using on top of her methadone but was reluctant to increase her dose. Although its target audience is Australian users it still contains some excellent information that would be useful for NZ opioid users, family members, and allied health professionals. It can be ordered from Adam Winstock, University of New South Wales

The second DVD from the Australian National 'Can Do' Initiative was about 'Managing Mental Health and Substance Use in General Practice' This DVD has a huge amount of information and education resources useful for training a range of different professional groups. Again the very resourceful Dr Adam Winstock is involved. It can be ordered from the Australian General Practice Network. Google it.

Finally, a big highlight was having Professor Lloyd Geering, at our conference again. What a cultural icon he is. In his address titled 'The new cultural era that requires us to play God', he told us that he had developed 10 possible scenarios for the future of humankind and nine of them had tragic outcomes e.g. terrorism, nuclear war, air pollution. When asked what the tenth scenario was he said it's the one where "we muddle our way through". I think this statement summed it all up for me as we muddle our way though accepting and being able to live with the different world views reflected in our field – cultural, spiritual, scientific. No one size fits all eh.

Raine Berry, Nelson AOD Service

Health Related Findings from a Follow-up Study of Clients Receiving Methadone Maintenance Treatment: Treatment Implications and Areas for Further Research

A significant component of my PhD programme of research[1] sought the input of MMT clients in order to examine potential routine outcome and treatment satisfaction measures and client outcomes and treatment perceptions during MMT. This cross-sectional longitudinal follow-up investigation was conducted in a research setting with representative samples of Māori and non-Māori clients recruited from the Christchurch Methadone Treatment Programme. Almost 90% had received continuous treatment for one or more years. Of the 107 participants at interview one, one woman died during the course of the investigations and 93 were followed up, on average, 23 months later.

First interview

The profile of participants showed that almost a quarter were over 40 years of age, the majority were parenting dependent children and one in five (primarily women) were full time parents, less than one quarter were employed full or part-time and over half were receiving a sickness or invalid benefit. While there was a range of scores on the SF-36 Health Survey, an important finding was that compared to population norms the participants (on average) reported significantly poorer health and wellbeing[2]. This pattern was also demonstrated when the data were analysed by ethnicity and gender in relation to population norms and was consistent with the findings from a similar Auckland sample of clients established on MMT (personal communication with Dr Grant Paton-Simpson, Auckland Regional Alcohol and Drug Service). That there was no significant positive association between duration of MMT and SF-36 scores suggests the ongoing impact of health related issues for a considerable proportion of MMT clients. Other notable findings were that poorer social functioning and mental health were associated with higher frequency of benzodiazepine use, a third of participants were taking medications for a mental health problem and a similar proportion for a physical health problem. Not unexpectedly, more women than men reported taking medication for a mental health problem and women reported significantly higher frequency of benzodiazepine use than men.

As well as to reduce drug use, over 70% of participants said they had sought MMT to improve their health and for children and family reasons. For example one woman participant said "*I wanted my life and my health back*". Participants who were parenting dependent children were less likely to report injecting substance use, which is consistent with women entering treatment as a protective strategy for their children.

Follow-up interview

A significant reduction in injecting drug use and a high reported opioid abstinence rate for the four weeks prior to interview was found at follow-up as well as a significant overall reduction in benzodiazepine use. However, rates of nicotine and cannabis use were virtually unchanged. Overall, there were few changes in employment, parenting and reported health status and similar proportions continued to take medications. Of note, the majority of those with hepatitis B or C reported no specific GP health consultation in relation to their hepatitis or discussion about treatment options. Being employed, perceived better physical and mental health and social functioning were significantly associated with higher treatment satisfaction, whereas higher methadone doses and frequency of benzodiazepine use were significantly associated with lower satisfaction. For women, longer duration of treatment was associated with lower satisfaction.

Clinical implications and future research

Collectively, these findings strongly indicate the need to understand the profile of MMT client groups in order to target interventions to meet the health related treatment needs of local clients across the age span. They also have implications for models of service delivery within specialist services and primary care settings, including staff mix and professional development and scope and delivery of interventions. While monitoring of substance use and individual and public health risk remain important, once stabilisation on

methadone is achieved, individualised client goals focused on promoting wellness, client self-management and community participation within a family and whanau context should assume a high priority. Clients who have ceased injecting opioid use and do not experience other problematic substance use do not require highly restricted treatment protocols that intrude into their day to day life and potentially impact on their overall quality of life. What is important are interventions targeted to meet their health and psychosocial needs as well as associated key performance indicators and measures of client's perceptions of the interventions they receive.

As for other client groups with chronic health problems, there are variations in outcomes between individuals. Therefore, monitoring of health related outcomes with individual clients over time is required to ensure that treatment is flexible and responsive to their needs and those of their family and whanau. Routine outcomes monitoring should include social and role functioning. For parents, this would include parenting issues and the wellbeing of their dependent children as well as family and whanau support networks. Outcomes monitoring should be part of regular reviews between a staff member and a client and occur in ways that promote active participation of clients in their treatment with an expectation of significant other/family and whanau involvement. Notwithstanding that safety is a key underpinning principle for all interventions, of critical importance is a health focused and motivational approach within a treatment context that promotes honest self-reporting. Reviews of treatment progress also provide the opportunity for ongoing personalised client and family and whanau health education. In this regard, consideration should be given to the development of nationally consistent information resources which can be provided via a range of medium and are adaptable for provision by clinical staff and peer-educators.

Lastly, these findings highlight the need for further research on models of service delivery that includes a focus on staff mix and attributes, the role of consumers, peer-led initiatives, including Needle Exchange Programmes as well as for example; the health related needs of Māori clients, gender specific groups, parents and their dependent children; older clients and; interventions for clients with co-existing mental health and non-opioid substance use disorders, including nicotine dependence.

Funding support is acknowledged from the Health Research Council of New Zealand and the National Centre for Treatment Development (Alcohol, Drugs and Addiction), now National Addiction Centre, Aotearoa New Zealand). I also acknowledge the staff of the CDHB alcohol and Drug Service and the clients who so willingly participated.

Daryle Deering
National Addiction Centre

References

1. Deering D, (2007). Methadone maintenance treatment in New Zealand. Unpublished Doctor of Philosophy Thesis, University of Otago, Christchurch School of Medicine and Health Sciences New Zealand.
2. Deering, D., Frampton, C., Horn, J., Sellman, D, Adamson, S., Potiki, T. (2004). Health status of clients receiving methadone maintenance treatment using the SF-36 health survey questionnaire. *Drug and Alcohol Review, 23 (3)*, 273-80.

Contact Person for ATRN:
Ria Schroder
Ph: 03 364 0480
Email
ria.schroder@otago.ac.nz

ATRIG
PO Box 2924
Christchurch Mail Centre
Christchurch 8140

ATRIG
Is sponsored by The National Addiction Centre
Dept of Psychological Medicine
University of Otago,
Christchurch
PO Box 4345
Christchurch Mail Centre
Christchurch

Phone: 03 364 0480
Fax: 03 364 1225
www.addiction.org.nz

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 2008 calendar year. I understand membership fee is $20.

Signed _____ Date _____

Please make cheques payable to: ATRIG

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

Thank you for completing this form and sending it back to:
Lindsay Stringer, PO Box 2924, Christchurch Mail Centre, Christchurch 8140
Phone 03 364-0480, Fax 03 364-1225