

# Addiction Treatment Research NEWS

NEWSLETTER OF THE ADDICTION TREATMENT RESEARCH INTEREST GROUP



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## EDITORIAL

Welcome to the first edition of ATRN for 2008. Already we are at the end of April but with a fabulous summer behind us and a winter ahead that does not look like its going to be too cold, I hope you are all energised and ready for this latest edition of the Addiction Treatment Research News.

This edition illustrates some of the diversity of topics addressed and issues faced by those working in the addiction treatment field. Sean Sullivan from Abacus leads this discussion with his article about the position of addiction workers, particularly those working in the problem gambling workforce, in relation to the Health Practitioners Competence Assurance Act 2003 (HPCAA). Simon Adamson's update of research activities at the NAC provides the latest progress of two longstanding research projects at the NAC and introduces one of many new projects being started. The political landscape features again in the message from the ATRIG chair where Simon reflects on the revision of two major pieces of drug legislation in New Zealand - the Alcoholism and Drug Addiction Act (1966) and the Misuse of Drugs Act (1975).

Our two feature articles are both written by familiar names in the Addiction Treatment Research Field, both of whom should be congratulated for recently completing their doctoral degrees. The first article by Meg Harvey provides a summary of the final results of her PhD research examining the effects of cannabis use on adolescent cognitive functioning. This is a project which I am sure many of you have been following for a long time, so it is wonderful indeed to see the interesting results this study has produced.

The second feature article by Justin Pulford addresses the issue of clinical assessments for those clients with short term treatment attendance. This study conducted with expert AOD clinicians makes some useful suggestions for priority assessment areas to help produce the most gain for clients when treatment time is limited to one session.

Finally, in this edition of ATRN our regular 'I've Been Reading' section returns. For something a little different Jane Elmslie (Dietitian and Research Fellow) share with us her thoughts on the concept of addictive overeating and how this might relate to the obesity epidemic. This very interesting article, about a topic which sits

somewhat outside of the square for many in the addiction treatment field, provides interesting food for thought to contemplate both in terms of treatment provision and addiction treatment research.

As always, my greatest thanks to all who have contributed to this edition and to all who continue to support the ATRN.

Happy Reading

**Ria Schroder**  
Editor  
April 2008



"Obstacles are those frightful things you see when you take your eyes off your goal"  
Henry Ford

### Introduction

Laws and regulations are often dry and confusing texts of arcane words that result in the glazing over of eyes following the first paragraph. At about this stage we find any other task to do in order to avoid further stultification of our mind. On a few occasions, however, they impact upon us in a direct and immediate way, and unfortunately, the Health Practitioners Competence Assurance Act 2003 (HPCAA) is one such act.

A potted explanation of the impact of this act on the addiction workforce to date is now attempted, particularly incorporating the added difficulty that the problem gambling workforce finds itself in.

The HPCAA came into full force in September 2004, with the purpose of protecting the public by ensuring that health professionals were 'competent and fit to practise their professions'. Those intending to register are required to satisfy the Minister of Health that:

- the health practice poses a risk of harm to the public if not registered, or it's in the public interest to register it
- it is an identifiable group
- there is a general agreement on the qualifications, standards and competencies for the scopes of practice in the health service

Currently sixteen professions are regulated under the Act and a further five are pending, awaiting

the Minister of Health's decision. The addiction workforce is not currently one of them.

### A heart-stopping moment

Following the passing of the Act, a number of restricted activities followed, including the contentious requirement (for addiction workers) that a registered health practitioner must approve the treatment plan when 'performing a psychosocial intervention with an expectation of treating a serious mental illness'. This immediately posed a problem as probably only nurses, psychologists, and medical doctors who worked in the addictions field would meet this Order in Council as having their professions registered at the time. These made up only a minority of the addiction workforce and they appeared destined to spend their future employment reviewing and approving treatment plans.

Fortunately, a clarification followed shortly thereafter that this was not intended to interfere with those in unregistered 'established professions' who currently carry out these activities without harm. This is confusing, but is clearly aimed at defusing an unforeseen consequence of the Act where a relatively major sector of the health workforce has insufficient registered members belonging to registered professions, due to its specialist focus and a wide range of staff qualifications and training. However, the addiction workforce at this stage breathed a collective sigh of relief and reduced its level of anxiety, despite remaining somewhat unclear about the non-compliance status that can result in a fine of \$30,000, and the implication that

addictions may not be viewed as a 'serious mental illness'.

### Can 'addictions' meet the registration requirements?

#### Risk warrants registration?

One could imagine that most working in the field of addictions would acknowledge that a misguided therapeutic intervention poses risk, possibly serious risk, to the public. The Minister of Health can always initiate the registration her/himself on her/his own volition if the risk warrants this. This acknowledgement of risk may meet the first requirement, although doesn't necessarily ask whether there is a consensus among those in the field to apply for registration under the Act.

#### Meeting the 'group' criteria

Is 'addictions' an identifiable group? In the past a discussion lingered as to whether behaviour, such as problem gambling, could rightly be described within an addiction paradigm, especially as it was categorised as an impulse disorder in DSM-IV. Chemical addictions provide an identifiable, separate substance that entered the body, had physical, often life-threatening, consequences. By contrast, gambling was a behaviour that appeared to have a less invasive pathway, had less physical withdrawal effects, and less apparent loss of control ('don't they just choose to gamble?'). Also, where does one draw the line on such a nebulous term as 'addiction'. The question may then arise as to whether to include those working with other behaviours such as internet addiction, pornography addiction, and sexual addiction, in a seemingly boundless, growing category.

Without going into too many details, gambling can have very long-lasting and serious consequences, with suicidal ideation perhaps being even higher than other addictions. Similarities of problem gambling to AOD addictions probably exceed differences, whereas processes including CNS pathways are similar. This topic is too large to include here and perhaps deserves its own paper.

From an altogether different perspective but just as compelling, AOD and problem gambling commonly coexist, while other mental health problems are often common to both. The trend is for strategic health plans to address mental health and addictions issues together, or at least contemporaneously, with the client's preference often being in-house to some extent. This is not always possible, of course, but where issues impact upon each other (as arguably do AOD and gambling issues) opportunities should be grasped. Essentially, it appears that the writing is on the wall that the addressing of mental health issues are coalescing rather than separating [1].

#### Qualifications, standards and competences

Although tertiary problem gambling programmes, and therefore specific qualifications, are relatively few in NZ (and indeed elsewhere), AOD qualifications are readily available. However, availability often follows demand, and so it is likely that these opportunities will increase, should addictions that include problem gambling be approved for registration under the HPCAA. Neither should this be a barrier to registration for AOD. The Act clearly allows for a range of similar subgroups to be registered, as is demonstrated by the registration of the single group of differing sub-skills of

dentistry, dental hygiene, clinical dental technology, dental technology and dental therapy. In addition, the Act provides for other allied health groups to be added to an existing registered group and creating a 'blended' authority, albeit controlled by a single responsible authority.

#### **Can problem gambling treatment be included?**

DAPAANZ is currently reviewing AOD competencies, one of the prerequisites of registration under the HPCAA. Although from an addiction perspective, many of the competencies will be the same (especially if addressing common co-occurring issues/disorders are included), there are a few specific competencies that are critical for effective interventions. However, this possible barrier to inclusion of problem gambling treatment practitioners in an AOD based 'addiction' profession, when the fact that probably close to half of problem gamblers are misusing alcohol and over one-fifth of AOD clients are problem gambling, argues for a joint approach [2].

Currently one in four problem gambling practitioners have an AOD background, while many of this smaller field are now working within AOD. In a recent survey conducted with about two-thirds of problem gambling practitioners, the majority (67%; a further 17% undecided or 'maybe') agreed that this body was an appropriate responsible authority under the HPCAA for their field. Already much of the information exists as to the profile of these practitioners, including their qualifications, skills perceptions and needs, while 30% are current members of DAPAANZ. Whereas problem gambling practitioners could elect to go it on their own, or be a later partner once AOD had been registered in a blended

arrangement, the former is financially a no-go for a total complement of less than 150, while the latter appears to be professional disaster when the fear of a fragile field is that AOD will absorb problem gambling into its much larger service. Registration of AOD practitioners without the problem gambling field is likely to reflect badly upon this newer and smaller specialist cousin that has had a history of funding uncertainty, implying less quality and professionalism, and could increase the flow of its practitioners to AOD.

In short, the chance is now upon us to show a concerted approach to an opportunity to integrate, not absorb, the problem gambling treatment practitioner into a mainstream HPCAA addiction body, and produce a stronger representative group that furthers the goals identified in *Tauawhitia te Wero: National Mental Health and Addiction Workforce Development Plan 2006-2009* [3].

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**Sean Sullivan  
Abacus**



2008 has been very active so far for NAC research staff. In December we started interviews for the national telephone survey of the addiction workforce and have several other projects in their early stages, of which I'll mention an evaluation of Moana House and ADOPT.

The 2008 addiction workforce survey (yes we cheated by starting in December!) is near completion with a large representative sample of both alcohol and drug and gambling workers being interviewed. This is the first time we have extended the survey to include the gambling workforce, which we are doing in conjunction with Dr Phil Townsend, Problem Gambling Foundation. Two related studies are follow-up interviews of nurses working in the addiction sector, and youth addiction treatment workers. All respondents to the main survey who are either nurses or work substantially with youth are asked to take part in these follow-up interviews. Dr Daryle Deering is undertaking a repeat of the 2004 alcohol and drug nurses survey to investigate developments in nurses roles, advanced practice, and professional development needs.

Dr Ria Schroder, a name familiar to all ATRN readers, is leading the survey of addiction youth workers. This is the first time we have focussed attention on this group of workers. Our interest in doing so arose out of an awareness of the fact that youth workers are a minority voice in the sector and are often overlooked, with discussion on addiction treatment issues usually framed with respect to adult clients. Furthermore it is

our suspicion that many youth workers are isolated from others doing similar work as many will be the sole youth worker in an all-ages service. The survey will tell us whether this belief is correct and provides an opportunity to identify other issues and experiences of youth-focussed addiction workers.

Both the nursing and the youth surveys have only just started, so if you took part in the main survey and agreed to one of these follow-ups you can expect a call in the next month or two.

Daryle Deering is also keeping busy with ongoing involvement in Adopt phase II. The focus of this Te Pou project is the development of a brief outcome measure for routine use with AOD clients to monitor their outcomes during treatment. Daryle is undertaking this in collaboration with the Clinical Research and Resource Centre, Auckland. Phase II involves the psychometric evaluation of a proposed ADOPT questionnaire which will be trialled in clinical settings against other instruments with a range of CADS clients in Auckland and Christchurch. The testing will involve three interviews with clients conducted by CADS clinicians. It is expected that it will take three months to complete this phase with 50 clients before analysing the information and completing the report.

Earlier this year ALAC put out a call for tenders to undertake an evaluation of Moana House which is a residential AOD programme in Dunedin. The NAC were successful in being selected as the investigative team. This

evaluation grew out of the increasing interest in providing effective interventions for offender populations, so-called "early interventions". Moana House was recognised as a programme with a long history of providing such treatment for offenders with substance use issues and appears to be doing this well. The contract, which is about to be signed, calls for an evaluation to demonstrate positive outcomes, to identify factors within the programme that contribute to these positive outcomes and also those that might have a negative effect. We are also asked to determine whether or not this treatment model could be adopted elsewhere, and if so under what conditions. We are excited about this project as it provides the opportunity to work closely with a strongly bicultural programme and to consider its connections with, and impact on, the wider community. The evaluation will use a mixed quantitative and qualitative methodology. We are fortunate to have Geoff Noller as one of the team members, Geoff will draw on his experience to undertake an ethnographic evaluation of the experience of programme residents, their whanau and the wider community, including staff, referrers and funders. The project will also benefit from the skills of another team member, Moana-O-Hinerangi whose strong connection with the rununga of Otago and service development experience will greatly contribute to the project.

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

Though designer drugs, such as P, are a growing concern in New Zealand, cannabis remains a popular drug to use, increasingly so for younger members of society. Cannabis is the most popular, illegal, recreationally-used drug in New Zealand with estimates that 52% of the general population have tried cannabis and 20% have used it in past 12 months (Wilkins, et al., 2002). The Christchurch Health and Development study (CHDS) found that by the age of 21 years, around 70% of adolescents had tried cannabis (Fergusson & Horwood, 2000). Furthermore, 30% of people presenting to Alcohol and Other Drug (AOD) services are having problems with cannabis (Adamson et al., 2000).

There is some evidence of non-acute cannabis effects on cognition such as memory and attention. For example, Solowij et al. (1998) has concluded that long-term cannabis use does not have a severe debilitating impairment on cognitive function, but does lead to subtle selective impairment. This subtle impairment may have more significance for adolescents who are in an accelerated phase of life in terms of developing cognitive abilities and expanding their knowledge through education. Further concern arises from the finding that cognitive deficits from cannabis in adults may not be entirely reversible or reversible for all individuals. Added to the issue is that other additional variables may affect the outcome of the relationship between cannabis use and cognition in adolescents. Whilst the literature is complex, there is evidence that cognitive function may be affected by mood (Porter et al., 2003; Stordal et al., 2004),

Attention Deficit Hyperactivity Disorder (ADHD), conduct disorder (Barnett et al., 2001; Oosterlaan et al., 2005; Speltz et al., 1999), gender (Lowe et al., 2003; Kaufmann et al., 1988), alcohol (Townshend & Duka, 2005; Brown et al., 2000), use of other drugs, particularly MDMA or amphetamines (McKetin & Mattick, 1998; Fox et al., 2001) and menstruation (O'Reilly et al., 2004; Rosenberg and Park, 2002).

PACC (Project on Cannabis use and adolescent Cognition) investigated the non-acute relationship between cannabis and cognitive function in a sample of adolescents with a continuum of cannabis use. Since the 1970s there have been a number of studies allowing for the non-acute effects of cannabis on cognition. Non-acute refers to the effects of the drug after acute intoxication, that is, residual effects from cannabis use (usually accepted as 12 or more hours after use). There are few consistent and replicated results in this area, particularly with adolescents.

Our study recruited 70 adolescents from clinical and community sources, and through newspaper advertisements for baseline and three-month follow-up interviews. Inclusion criteria were that the adolescents were aged 13-18 years and not currently suffering from a psychotic condition (as reported by referring clinician). Informed written consent was obtained from both participants and their parents or caregiver.

Each time, adolescents were interviewed (after a minimum of 12 hours self-reported cannabis abstinence: self-report occurred

in a safe and confidential setting) at the location of their choosing, most typically (70%) the study offices. Adolescents completed a two-hour interview covering: demographics; drug use; cognitive performance; and psychiatric and general functioning.

Specifically, demographics included age, ethnicity, school enrolment status, and self-rated ability in Primary School in reading, spelling and arithmetic. The alcohol and drug measures were a drug and alcohol use history and the Timeline Follow-back (TLFB) questionnaire (Sobell & Sobell, 1992) for drug use in the past 28 days. In addition, adolescents gave a urine sample at the time of the interview, for testing of the presence of cannabis.

Psychiatric functioning measures included: Visual Analogue Scale for Mood (present mood); Beck Depression Inventory II (Beck et al., 1996) ; Hamilton Depression Rating Scale (Hamilton, 1960); Conduct Disorder and Attention Deficit Hyperactivity Disorder based on DSM-IV (APA, 1994); Structured Clinical Interview for the DSM-IV (First et al., 1997); and the Global Assessment of Functioning Scale (APA, 1994).

The cognitive test battery measured intelligence, memory, attention and executive functioning using a combination of computerised tasks and pen and paper tests. Intelligence was measured using the Wechsler Abbreviated Scale of Intelligence (The Psychological Corporation, 1999). The computerised testing was done on the Cambridge Neuropsychological Test Automated Battery (Sahakian & Owen, 1992) a computerised test

battery that utilises touch screen technology. The tests used were: Motor Screening; Rapid Visual Information Processing; Spatial Working Memory; Intradimensional Extradimensional shift; Paired Associates Learning; and Spatial Span. Pen and paper cognitive tests applied were: the Rey Auditory-Verbal Learning Test (Rey, 1964); Digit Span (Wechsler, 1997) and Symbol Digit Modalities Test (Smith, 1982).

The study found there was a significant non-acute relationship between cannabis and cognitive function in adolescents even with controlling for psychiatric functioning, general functioning, demographics and other drug use. There was a significant relationship between the frequency of cannabis use and three cognitive measures after allowing for additional variables. It appears that aspects of cognitive function (particularly executive function and working memory) are independently related to the frequency of cannabis use beyond acute intoxication and despite additional variables. The significant findings in this study were despite what could be seen as relatively low cannabis use in the regular users.

The mean age of the sample was 16.2 years (range 13.5 to 18.4 years). Sixty percent were female and twenty-seven percent were Māori. Nearly 60% were currently attending secondary school and the median number of secondary school years completed was two. Timeline Follow-back showed that 68.5% of the sample had used cannabis in the past 28 days. The sample was split on the median days of use (median = 4), which produced groups of adolescents who used either once a week or less (non-regular users, n=36) and

those who used more than once a week (regular users, n=34). Days of cannabis use in the past 28 days was strongly correlated with all other cannabis measures and was consequently used as the standard cannabis measure in all analyses.

At baseline adolescents who used cannabis more than once a week had a significantly poorer performance on measures of spatial working memory and verbal recall after additional variables were included in a multivariate regression analysis. That is, cannabis use independently predicted performance on three out of four significant cognitive measure results - Spatial Working Memory strategy and total errors, and Rey Auditory-Verbal Learning Test. At follow-up 47 (67%) adolescents were re-interviewed. Only spatial working memory was significantly related to cannabis use after additional variables were accounted for in regression.

The results suggest that aspects of adolescent cognitive function, particularly working memory, are independently related to the frequency of cannabis use beyond acute intoxication. These results have implications for adolescent regular cannabis users and their functioning in school, as well as the information retained long-term from therapy. Executive functioning and working memory are important in processing and efficiently storing information, and consequently important during the adolescent phase of cognitive development.

#### **Megan Harvey**

A full list of references for this article is available from the editor [ria.schroder@otago.ac.nz](mailto:ria.schroder@otago.ac.nz)

If you are interested in reading further about this study full details of the baseline data can be found in:

Harvey, M.A., Sellman, J.D., Porter, R.J., & Frampton, C.M. (2007). The relationship between non-acute adolescent cannabis use and cognition. *Drug and Alcohol Review*, 26(3), 309-319.

#### **Acknowledgements**

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#### **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 (ATRIG Editor), Robin Shepherd, Janie Sheridan, Lindsay Atkins (Secretary)

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This paper presents findings from a Delphi survey that sought to identify an appropriate level of clinical assessment in a short-term treatment context; specifically, a single 60-minute intervention opportunity at a specialist outpatient alcohol and other drug treatment service. This information was sought as research suggests that, irrespective of problem type and severity, many outpatient AOD treatment clients will only attend a single treatment appointment [1]. Identifying an appropriate level of assessment for single session clients is important as, if assessment is too extensive then there may be little time to provide an informed treatment recommendation, yet if it is too minimal then the subsequent treatment recommendation may be poorly suited to the client's presenting problem. Participants in this study were all 'expert' AOD treatment clinicians recruited from six AOD treatment services located across the country.

### Method

The Delphi technique is a structured research process that utilizes a series of questionnaire rounds to obtain the opinions of experts, with the aim of achieving consensus of opinion, judgment or choice [2]. The Delphi process begins with an initial idea-generating questionnaire in which a novel problem/question is presented to participants with recognized expertise in the subject area. The aim of this first questionnaire is to generate as many responses as possible, from across the expert panel of participants, to the presented problem/question. Responses are collated and presented to all participants in the form of a second questionnaire. Participants are then asked to identify the most important of the listed

response items, typically by a rating or ranking methodology and always in the context of the original question. Opportunity is also provided to seek clarification and/or provide comment on any or all of the listed items. Participant response, feedback and requested clarifications are presented in a third questionnaire. Armed with this additional information, participants are once again asked to select the most important of the individual response items. The process of ranking/rating and seeking feedback continues until consensus has been gained or sufficient information exchange has occurred [3].

The Delphi process employed in this study consisted of four questionnaire rounds. Questionnaire One presented the study problem to participants in the form of an AOD treatment scenario. The aim of this scenario was to identify the minimum level of clinical assessment information that participants would be willing to collect during a single intervention opportunity of 60 minutes in duration. It was specifically stated that the clinical aim of this appointment was to facilitate as much client gain as potentially realizable, independent of further treatment contact. Having read the scenario, participants were asked to specify the assessment information that they would consider essential in order to inform the most appropriate course of action. "Assessment" was defined as: "the collection of client information for the purposes of clinical decision-making". "Essential" was described as: "an effort should always be made to obtain the specified assessment information". Participants were instructed to assume the scenario context was their current place of

employment, that the client presented in a stable state (i.e. was not intoxicated, hysterical or overtly mentally unwell) and that client responses to any assessment question were in a clinically normal range (i.e. typical of psychosocial treatment clients at their respective services).

Upon receipt, participant responses to the treatment scenario were collected and grouped according to common themes. Questionnaire Two presented participants with the collated list of assessment items, instructed them to re-read the AOD treatment scenario and then to rate the extent to which they agreed that each item would be essential to collect in the scenario context. The five-point rating scale consisted of the options: strongly disagree (1), disagree (2), unsure (3), agree (4), and strongly agree (5). Participants were provided the opportunity to seek clarification on any of the assessment items or to provide comment in response to any of the listed items. Questionnaire Three re-presented participants with the list of assessment items, the initial participant ratings of each item and any feedback or clarification requests. Participants were then asked to rate each item again based on this additional information. It was made clear to participants that the resulting assessment guidelines would be based on their responses to this questionnaire. An item was subsequently included in the proposed guidelines if 80% or more of participants 'agreed' or 'strongly agreed' that the listed assessment item was essential. Questionnaire Four presented the resulting assessment guidelines to participants for comment.

## Results

Eighteen participants were recruited from across the six treatment settings. Collectively, these 18 participants identified 27 assessment items in response to the treatment scenario presented in Questionnaire One. However, only seven out of the 27 listed assessment items subsequently met the consensus criteria. These are listed in Table 1.

### Please see below for Table 1

The content of Table 1 may be considered the assessment items considered essential to inform clinical decision-making during the course of a single 60-minute intervention opportunity at a specialist outpatient AOD treatment service. Delphi participants were asked to estimate how long it would take them to collect the stated assessment information under normal clinical circumstances (Table 1 items). Estimates ranged from 20-60 minutes, with a median estimated time of 40 minutes and a mean estimated time of 41 minutes (SD 13 minutes). Thus, on average, participants would dedicate 40 minutes of a 60 minute initial treatment appointment to collecting the specified

assessment information. All participants 'agreed' (12) or 'strongly agreed' (6) that the stated assessment content was appropriate for an initial 60-minute treatment appointment conducted under normal clinical circumstances. However, four participants 'strongly disagreed' (1) or 'disagreed' (3) with the statement that "Additional assessment information should not be sought at an initial appointment under normal clinical circumstances". Five participants provided an 'unsure' response and the remaining nine 'agreed' (8) or 'strongly agreed' (1).

## Discussion

This study was successful in producing an assessment model *potentially* suited to short-term attendance, but participant reluctance to strictly adhere to the model suggests it may be difficult to implement in practice. Nevertheless, the assessment model presented in this paper retains some value as a 'measure' of short-term appropriate assessment. If AOD treatment clinicians routinely seek to obtain a greater range of assessment information during an initial treatment appointment, in a treatment context that deals with a high proportion of short-term attendees, then the model

presents a challenge to the wisdom of this approach. Interested readers are encouraged to contact Justin Pulford for further information regarding this study. [justin.pulford@waitematadhb.govt.nz](mailto:justin.pulford@waitematadhb.govt.nz)

**Justin Pulford**  
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No.	Assessment Item
1	Explain confidentiality, client rights & complaints process
2	Assess client risk to self and others when straight and intoxicated
3	Assess use of current medications
4	Assess current alcohol and other drug (AOD) use <ul style="list-style-type: none"><li>• Type, quantity, frequency, method, source, context</li></ul>
5	Explore any problems associated with current AOD use <ul style="list-style-type: none"><li>• Including: health, work &amp; recreation, family &amp; friends</li></ul>
6	Determine the client's treatment goals
7	Assess presence of positive support systems <ul style="list-style-type: none"><li>• Inclusive of family, social and professional supports</li></ul>

Currently two important pieces of legislation important to the addiction sector are under review. These are the Alcoholism and Drug Addiction Act (1966) and the Misuse of Drugs Act (1975). Both acts are showing their age, with dramatic changes in drug availability, research knowledge, clinical practice and public expectations since their initial enactment.

The ADAA is widely recognised as not working well in practice, with few facilities available for those placed under the Act and a failure of the provisions of the Act to keep pace with raised consumer rights expectations and good clinical practice. The Act is being reviewed by the Ministry of Health.

The MDA is an amalgam of the original Act and over 20 subsequent amendments. It has been widely criticised as being inconsistent and irrational and is out of step with a modern harm-minimisation philosophy, as is formally encapsulated within the National Drug Policy. The Act is being reviewed by the Law Commission which has described the review as "first principles". This intention is laudable, as the consideration of the wider context of drugs in New Zealand is needed. Such a review ought to produce a rational process by which existing drugs are classified according to harm and which provides a mechanism for new drugs to be evaluated and appropriate responses formulated in a timely fashion. Prohibition should not be the only response where some level of harm may occur, with other

mechanisms such as outlet and advertising restrictions also employed.

The MDA review explicitly excludes the two most misused drugs in New Zealand - alcohol and tobacco. While the Law Commission no doubt truthfully states that their inclusion would hugely complicate the task and lead to significant delays in its completion, ultimately this is not an adequate response. The review most certainly will not be "first principles" if these two elephants need to be stepped around whilst putting the rest of the room in order. The exclusion of alcohol and tobacco represents a major missed opportunity for the advancement of drug policy in New Zealand.

The review of these two Acts will be of interest to readers of ATRN for several reasons, one of which is the importance of evidence as a contributor to good public policy. Secondly, major law change ought to be accompanied by a monitoring of the consequences of those changes. If the new Acts prove to be problematic, let's hope we won't have to wait another 30 to 40 years for them to be fixed.

**Dr Simon Adamson**  
**ATRIG Chairperson**



The theme of this years conference is 'Life and Death'. The dates are 4 - 6 September, and the venue is the Christchurch Convention Centre.

Watch out for the call for papers coming out soon.



### ANY RESEARCH IN THE ADDICTION TREATMENT FIELD TO SHARE?

To keep our readers up to date with research in the field, we are always looking for new areas of research to report on in the ATRN. If you know of any research being conducted in New Zealand that is applicable to the addiction treatment field and you think it would be good to share with others please contact Ria Schroder (ATRIN Editor) at [ria.schroder@otago.ac.nz](mailto:ria.schroder@otago.ac.nz) or phone (03) 364 0480. I look forward to hearing your ideas.

### Is Obesity the Result of Addictive Overeating?

In 2005 the World Health Organisation estimated that at least 400 million adults were obese. In the same year the age standardised estimate for obesity prevalence in New Zealand was 23% for men and 31.5% for women [1] an increase of 8% and 11.5% respectively since 1989 [2].

So why are more of us becoming obese? Quite simply we are eating more energy than we need. Many people regularly overeat, sometimes without realising, sometimes without wanting to and sometimes because they feel driven to eat by forces beyond their control. In the past we ate to avoid starvation and now the pursuit of pleasure and distraction from stress and painful emotions have become equally important motivations for eating.

'I've been reading...' a review article which considers how our current 'food environment' may be "creating an appetitive counterpart to other hedonically driven activities such as drug use and compulsive gambling." [3]. Lowe and Butryn argue that to fully understand eating behaviour and its relation to weight gain we need to distinguish between "homeostatic hunger" and "hedonic hunger" [3]. "The development of homeostatic hunger is based on the prolonged absence of energy intake" and the motivation to eat that arises from this form of hunger is related to our energy requirements. According to this concept of hunger, palatability is largely irrelevant, while the opposite is true for hedonic

hunger. Hedonic hunger motivates us to eat for pleasure and does not necessarily correspond to a physiological need for food. The authors emphasise the importance of the distinction between wanting and liking a substance. They point out that "although these motivational drives normally go hand in hand ... they are subserved by neurophysiological mechanisms that can be experimentally differentiated", thus it is possible for them to occur separately and together. These observations may explain why when our food supply is higher in calories than ever before and we have less reason to be physically active, we continue to eat in excess of our physiological requirements.

This distinction may have lessons to teach us about how to design more effective obesity treatments. Lifestyle change (eating fewer calories and increasing physical activity) is the cornerstone of treatment for obesity. This works well for those who can manage it but many people find that reducing their energy (calorie) intake and increasing their physical activity is a lot more difficult than it sounds [4]. Humans are designed to withstand famine. For this reason, we are better at knowing we are hungry than recognising we are full, and our bodies are exquisitely sensitive to weight loss. If we attempt to lose weight at any more than a snail's pace our metabolic rate drops, further reducing our total energy requirement. However if we are prepared to tolerate a slower rate of weight loss we can lose significant weight in the long term. The downside of this is that in order to maintain our

weight loss we need to change our eating behaviour permanently and for most of us this will result in some degree of "hedonic" hunger.

The most commonly used descriptor for any type of intentional change to an individual's habitual eating pattern is "dieting" or "going on a diet". Recently "dieting" and its closely related cousin "dietary restraint" have been the target of considerable debate [5] and a backlash against concerns over the obesity epidemic [6]. "Dieting", has been variously blamed for binge eating, eating disorders, exaggerated reductions in metabolic rate, cumulative adverse effects on physiological and psychological functioning [7] and depressive relapse [8]. Also because most people eventually regain their lost weight "dieting" is widely believed to be ineffective [7]. However there is very little doubt that obesity is associated with negative health outcomes and that weight loss can prevent, delay or reverse many of these [9]. But how do we lose weight if we can't change what we eat and if "dieting" is harmful how can losing weight improve health outcomes?

Is it possible that dietary and lifestyle change might really be good for you and that the reason some of us find even the idea of dietary change difficult is that we are addicted to food? It can hardly be argued that people who are obese need more food but they continue to eat more despite this. Until recently the idea that foods might be addictive was largely rejected but recent evidence suggests that rats, and under some circumstances humans, become

addicted to sugar [10,11]. It is therefore interesting that palatability the defining feature of hedonic hunger is also influenced by stress [3]. Corticotrophin releasing factor is reduced in rats after the addition of highly palatable foods to an all chow diet. When these are withdrawn, rats exhibit behavioural and physiological signs of stress [12]. Lowe and Butryn (2007) point out the obvious parallel between this cycle and that involved in drug addiction [3]. In humans the relationship between stress and eating behaviour is less clear-cut but there is no doubt that stress increases the desire for highly palatable energy dense foods and that it may be causally linked to weight gain [13-15].

To date there have been no studies to test the suitability of an addiction treatment model for treating obesity and very little is known about the prevalence of addictive overeating in obese people. However motivational interviewing has shown promise in conjunction with behavioural treatment and further research in this area is clearly warranted.

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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.

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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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