Addiction Treatment Research NEWS

NEWSLETTER OF THE ADDICTION TREATMENT RESEARCH INTEREST GROUP

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EDITORIAL

Greetings to you all and welcome to another edition of the Addiction Treatment Research News.

This edition appears to have a distinct medical flavour with updates from the Dunedin and Wellington Schools of Medicine and an interesting discussion article from Dr Tanya Quin. Dr Quin's article is aimed at fostering interest among AOD medical specialists regarding thiamine deficiency in people with severe alcohol dependence and the need for affordable parenteral thiamine formulations to be made available in New Zealand.

Gavin Cape's update from the Dunedin School of Medicine presents interesting results from a longitudinal study that followed a cohort of medical students from their second through to their sixth year of training. Gavin reports on the students' perceived competence for dealing with patients with AOD related problems and raises some important issues about the need for more extensive training for future generations of medics.

From Helen Moriarty's update on the research happenings at the Wellington School of Medicine, it is evident that there are a number of people, both students and collaborative groups of researchers and clinicians who are working together to examine a range of topics relevant to the addiction treatment field.

Sean Sullivan's regular update from Abacus discusses the challenges, at both a personal and structural level, that practitioners potentially face in providing treatment for clients with co-existing disorders. With so many clients presenting to treatment with a range of complex issues, this article provides an opportunity to identify these barriers and to reflect on how they might be overcome.

Simon Adamson presents his final reflections as ATRIG Chairperson. Simon who has been the Chairperson of ATRIG for the last five years has recently resigned this position. A very big thanks must go to Simon for the superb work he did in this role especially with regard to the growth in membership and increased visibility that ATRIG has experienced under his leadership. Elections for Simon's successor will take place at the ATRIG AGM to be held at the Cutting Edge Conference in Christchurch (4th-6th September 2008). All current ATRIG members and interested members are encouraged to attend this meeting (whether you are attending Cutting Edge or not), so I look forward to seeing you there as the future leadership of ATRIG is decided.

In Simon's absence from the NAC (as he spends his sabbatical at the Leeds Addiction Unit) Mark Wallace-Bell provides an update of the latest nicotine addiction research being conducted at the NAC.

Finally in this issue Ann Flintoff in "I've Been Reading" shares with us her ideas about how New Zealand's Alcohol and Drug policy measures up internationally after her reading of the literature that has evaluated our policy against a number of other countries. As Ann points out, while there are some areas of our policy that measure up well internationally, there are other areas that require significant review.

Thanks to all who have contributed to this edition of the ATRN. Hope you are now all gearing up for Cutting Edge 2008. Look forward to seeing you all there.

Happy Reading

Ria Schroder
Editor, August 2008

ATRIG AGM

The Addiction Treatment Research Group (ATRIG) will have its Annual General Meeting at the Cutting Edge conference held at the Christchurch Convention Centre, 4-6th September, 2008. The meeting will start sharply at 12.45pm on Thursday 4th September. Elections will be held for all Officers and members of the Executive. All past, present and future members are warmly invited to attend this meeting, regardless of whether or not you are a delegate at the conference. If you have any further queries about this meeting please contact the ATRIG secretary Lindsay Atkins on (03) 3640480 or lindsay.atkins@otago.ac.nz.

Strong reasons make
for strong actions
William Shakespeare

Introduction

As health practitioners are aware, those in need of treatment for addictions are often affected by more than one health issue and rarely present only affected by the addiction. The focus of health delivery, however, often depends upon where the client presents and the field that the specialist health provider practices within. This prioritisation of resources may not be overtly stated, but does occur. It is natural to expect that a client affected by drug misuse or problem gambling will receive treatment largely based upon minimising the harm arising from the drug use or gambling through strategies that address decisions to use drugs/gamble, consumption of the drug or gambling behaviour, coping behaviours and relapse prevention, and many others. Common co-existing issues such as depression, anxiety, gambling (if assessed in an AOD setting), drug misuse (if assessed in a gambling treatment setting), and others may not receive the same attention as that which the addiction specialist and setting operate from. Why this prioritisation occurs may be due to a number of factors including:

- The perspective of the addiction specialist who may place heavier weighting on their trained specialty due to greater awareness of symptoms, costs and progression of the condition if untreated. The addiction may be perceived as the primary health problem.
- Practitioner concerns as to their competency to diagnose, treat, and to answer questions/discuss relevant details with the client of co-existing health conditions.
- The possibility, or even perceived likelihood, that the coexisting condition is a consequence of the identified addiction, and will abate once the addiction has been addressed.
- Funding allocated to specific addiction issues, with the expectation that clients will be referred to those funded to address the co-existing issues. With time being at a premium, addressing the condition they are primarily funded for may be a priority.

However, these factors may be flawed in perception, assumptions, and process and arguably may result in a client not receiving the best practice intervention that he or she may expect will result from their presentation.

Weighting in favour of specialty

Most problem gambling practitioners would probably declare that problem gambling issues are at least as serious as drug addictions, with wide consequences that substantially impact upon a large number of family/whanau in addition to the gambler. Similarly, those practising in the AOD field may consider the serious physical effects of drug abuse may outweigh a purely 'behavioural' addiction such as problem gambling. When training enables identification of many of the symptoms of the disorder, it is natural that the presenting disorder that corresponds with the service's work will appear more profound than another disorder that is less understood.

In addition, as addiction practitioners will readily agree, clients are differentially motivated to address their issues, and are often unaware of, or minimise, one issue over another. It is one thing to be client-centred as a practitioner, but as a health professional, awareness of serious health conditions should be raised and information offered where clients may have a distorted or absent understanding of their co-existing condition. This of course requires the practitioner to identify the co-existing condition, have an understanding of its impact and progression, as well as what relevance it may have to the recovery in the addiction they specialise in.

Competency to address co-existing issues

A very important factor, made clear by the Health Practitioners Competency Assurance Act 2003, is that health practitioners should be competent to practice in their field. This is a given, in that we should do no harm. However, to turn this around, do we do enough sometimes to meet what competency should be in the field we work within. A brief intervention in a coexisting issue may be highly effective, while referral is known to be a difficulty for many affected by addictions and barriers can easily discourage those clients with low motivation or anxiety issues. In problem gambling, the Ministry has recently funded a 'Facilitation' process, that ensures that those with other co-existing issues (or screened and even found are not affected by gambling) can engage with other specialist services.

Where conditions are commonly associated with those presenting to addiction services, it is posited that these should be incorporated within treatment plans, and become an essential competency for the addiction intervention, even if ultimately referral is the outcome.

Is the co-existing condition likely to abate?

Certainly drug misuse such as alcohol can cause depression through its ultimate impact upon

neurotransmitters and central nervous system structures. Similarly, substantial losses of non-disposable income, loss of trust, deceit and offending can also contribute to the high levels of depression. Therefore, if consumption is reduced, depression might be expected to lift, and in many cases it does. Indeed, one study indicated that those recovering from alcohol misuse were 16.7 times more likely to recover from a mood or anxiety disorder than those who continued to use [1]. However, this is not always the case. Many people may self-medicate with addictive behaviours to avoid mood and anxiety conditions [2,3] and these clients may remain depressed even in the absence of the addictive behaviour, or even deteriorate. Identification and monitoring of coexisting conditions may be an important first step in best practice.

Funding and future directions

For most services, funding is attached to addressing specific issues, with the expectations that clients with non-core issues are referred to services that specialise in that condition. The concern might be that to fund services to treat conditions that other services specialise in effectively increases costs, with the condition costing more to address than it should. Certainly in the gambling sector, with hypothecated compulsory funding from the gambling industry, there would be concern if other health issues were addressed with the funding. The industry's rationale appears to be that they pay tax from which Vote: Health is allocated funds to address health issues. Problem gambling is a health issue and should be met out of general taxation. Instead they pay additional tax for problem gambling treatment (and other relevant purposes) and are effectively double taxed. To extend the hypothecated funding to cover health issues other than problem gambling is rubbing salt into a wound (or similar metaphor). This argument is easily countered but is best left to another time.

The issue may be more subtle with other addictions but double funding a health condition may be considered a waste of precious resources. Alternatively, a perception might be that providing assistance to a client in need, and perhaps at an earlier stage, is good practice, humane and warranted. Fortunately, this latter approach is being adopted. There is clearly a trend in strategic plans to align and integrate mental health and addictions, including problem gambling (Te Kokiri: The Mental Health and Addiction Action Plan 2006-2015). This is clearly a policy of 'every door is the right door', and an indication that cross-skills and integration of services will be the norm for the future. As the AOD and problem gambling fields work towards this goal, the need for additional training for both fields to work in the other's is signalled, and reinforced by the numbers of clients who are affected by both AOD and problem gambling contemporaneously.

Summary

Where certain co-existing issues are common for an addiction, there is a good reason for concluding that they may have a direct or mediating negative effect on recovery from the addiction. It follows that identification of these, and addressing them within a treatment plan, is probably good, or even best practice, until research provides evidence this isn't warranted. Fortunately the factors that may act as a barrier to this approach can be removed, and this process is underway.

The factors discussed above as to why addiction practitioners may want to 'stick to their knitting' are not independent of each other. Any strategy to ensure that a client receives the best practice and ensures that any door is the right door when help-seeking requires all of these issues to be addressed. Networking will enable more effective referral, however for many clients the only intervention for their co-existing issues will be the addiction service they present to. When cognisance of the fact that high rates of AOD issues are found in those with clinical depression (27.2%) and bipolar disorder (60.7%) [1] there is good reason for addictions to also be addressed within mental health settings. The challenge may also be for mental health services to effectively identify addictions, provide brief or full interventions for them, or ensure clients are facilitated to access addiction services.

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Nicotine Addiction Research

The National Addiction Centre has been conducting nicotine-related research for a number of years. A PhD project by Karen de Zwart has investigated the prevalence of nicotine addiction in a mental health sample of adolescents and Mark Wallace-Bell has investigated the impact of using nicotine replacement therapy in heavy smokers. This report highlights a new project that is investigating the extent of nicotine addiction in the mental health and addiction workforce.

Nicotine addiction is one of the most prevalent addictions in NZ society but the most neglected in Mental Health and Addictions. The research is unequivocal that mental health (MH) and addiction service (AS) users and their associated workforce have the highest smoking prevalence rates in the health sector [1,2]. The ASH-KAN [2] report found that smoking rates in mental health nurses (29%) are higher than the New Zealand general population (21%) [3]. This is of concern because the smoking status of nurses has been shown to affect their attitudes towards smoking and smoking cessation, and also has an impact on provision of smoking cessation advice [4].

In Te Kōkiri [5] a key objective is to build the expertise of addiction and mental health providers to conduct complementary assessments and treatment planning with a specific action point being to implement Matua Raki, the addiction treatment sector work force development programme. Nicotine dependence may be the most important and neglected addiction in this context [5].

More data is required to determine not only the extent of nicotine addiction in the MH and AS workforce but also what attitudes and behaviours the smoking workforce hold and how these might influence clinical practice.

Research Fellows Mark Wallace-Bell and Karen de Zwart along with Professor Doug Sellman are currently conducting a Ministry of Health funded postal survey of 250 MH and AS workers in the Canterbury DHB. The survey aims to gather data on smoking prevalence in the workforce and assess clinical practice in relation to nicotine addiction. This research will provide an important insight into what attitudes clinicians hold regarding nicotine addiction and how these attitudes may effect treatments for nicotine addiction. The results from this survey will have implications for workforce development and the training needs of the sector.

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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 (Outcoing Chairperson), Klare Braye, Alistair Dunn, Ria Schroder (ATRN Editor), Robin Shepherd, Janie Sheridan, Lindsay Atkins (Secretary)

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Following a review of Northland Health Ltd hospital alcohol detoxification protocols it was noted that oral thiamine only, was recommended during alcohol detoxification. This is inadequate in view of current literature findings and recommendations. New local hospital guidelines have therefore been drafted based on available evidence supporting the use of parenteral thiamine, both in alcoholics with acute Wernicke's encephalopathy (WE), and as prophylaxis for high risk alcoholics. Ideally these parenteral recommendations should also apply in the community outpatient setting. Underdiagnosis of WE, lack of optimal dose and the unavailability of a "registered" parenteral thiamine formulation in New Zealand are the issues that have arisen from this process, prompting us to take the opportunity at the 2007 Combined APSAD and Cutting Edge Addiction Conference to discuss these issues with our New Zealand and Australian colleagues.

Background

Clinically, various studies over a long period of time confirm oral thiamine is inadequate, ineffective and unreliable in those with malnutrition and alcohol misuse. While these studies lack randomised controlled data they have been performed or reviewed by well known authors on this subject. Oral thiamine fails to improve the function of thiamine dependent enzymes, elevate thiamine levels or improve the clinical picture of patients with WE. Alcoholics with WE appear to require more thiamine to treat the condition successfully compared to subjects with a nutritional thiamine deficiency only. Furthermore, malnourished alcoholics have impaired absorption of thiamine, compounded by the increased demand for thiamine that occurs during alcohol withdrawal.

Points for Discussion

1. *Wernicke's encephalopathy in alcoholics is poorly diagnosed and thus effective treatment with parenteral thiamine, for potentially reversible brain damage, is often not given leading to serious consequences that may have been preventable.*

In our area most of the alcoholics are managed by counsellors or other non medical alcohol service workers. They are more likely to see a GP or A&E officer than AOD medical officers. Alcohol related Wernicke's encephalopathy may be missed due to the non specific presentation which overlaps with signs of intoxication and withdrawal.

The diagnosis needs to be thought of in the confused, malnourished, severely dependent alcoholic and considered as a risk in those entering alcohol detoxification. I see it as our responsibility to raise the awareness of hospital and community clinicians about the difficult diagnosis of Wernicke's encephalopathy in alcoholics.

2. *There is still a need for further studies to define the optimal dose of parenteral thiamine that is effective for the treatment and prevention of Wernicke's encephalopathy in alcoholics.*

From the available evidence, I have taken into consideration parenteral doses shown to be too low and the highest documented dose requirement to create our guidelines which are dependent on the formulation of thiamine available. (Thiamine HCl 200mg/2ml vials are currently available for Northland DHB).

Please see Table on page 7.

3. *There is no registered parenteral formulation of thiamine for use in thiamine deficiency in New Zealand.*

Northland Health Ltd imports Thiamine Hydrochloride from Abraxis Pharmaceuticals in the United States. Its use in the hospital requires a process known as 'Section 29'. Feedback from our local hospital physicians is that this process would be a deterrent for the use of Thiamine HCl as prophylaxis or for those alcoholics where the diagnosis of Wernicke's encephalopathy is not clear. This will likely undermine the attempts of this guideline to improve the treatment of alcoholics who have or are at risk of Wernicke's encephalopathy. Abraxis is not interested in going through the process of registering their product in New Zealand.

Raising awareness within general practice and amongst community non medical clinicians has therefore been put on 'hold' until

there is an available 'affordable' parenteral thiamine formulation for alcoholics in the community.

It is my suggestion that medical specialists in the alcohol service foster an interest in this subject and make recommendations to Medsafe and Pharmac, who are currently uninformed about the issues around thiamine deficiency in alcoholics. This article is part of my attempts to foster that interest.

Further Issues to Note

- Other countries face difficulties with parenteral thiamine formulations and availability (Agabio, 2005).

- Lipid soluble oral thiamine (Thiasure) is as effective in raising serum levels as IV due to diffusion mechanism across the GI wall. This is used in Japan and Germany. Issues around this formulation of thiamine should be reviewed.

- One study showed an increase in the appropriate use of parenteral thiamine with inpatients when a regime similar to above was inserted on the alcohol withdrawal chart. This also included, on the back, a summary of how WE in alcoholics may present and who may be high risk patients. (McIntosh et al., 2005).

- A thiamine deficiency questionnaire has been developed by Sgouros (2004) and is predictive of thiamine pyrophosphate deficiency in severely dependent alcoholics. This may be a useful tool to identify at risk patients. Two of the questions were highly predictive and could be used as a minimal question screening tool in the A&E setting.

- Identifying 'at risk' patients needs to take into regard predisposition. Not all alcoholics with thiamine deficiency will develop WE. The genetic predisposition relates to the enzyme and transport function of thiamine metabolism. Previous damage from WE is also a factor. How long the person had WE rather than how often is more important. Alcohol withdrawal 'primes' the brain to further damage from thiamine deficiency via the NMDA receptor. This is unrelated to the increase in demand for thiamine the alcohol withdrawal creates metabolically. Also, alcohol damages the brain to a greater extent if it is thiamine depleted.

- Leading authors in this subject warn that missing or failing to adequately treat WE in an alcoholic could be the subject of litigation as it is seen as a potentially reversible acute brain damage with serious consequences. However, they also make the statement that 'it remains to be demonstrated that our early intervention will be effective in preventing permanent brain damage' without careful long term follow up studies (Thomson, 2007). It is also unclear how reversible the direct neurotoxic effect of alcohol is in this condition.

- WE is considered a clinical diagnosis as the various tests take time and may indicate thiamine deficiency and thus 'at risk' patients, but not confirm the clinical 'syndrome' of WE. The availability of markers for thiamine is limited in NZ and HPLC for thiamine pyrophosphate levels is only available in Australia as far as I am aware, after discussion with Allen Stowell ESR. It must be noted that 'normal thiamine levels' may not be reassuring as alcoholics can have impaired utilisation of available thiamine.

- MRI and PET studies correlate to pathology findings but availability limits the usefulness of these investigations.

- There is no evidence for the apparent change in the practice from using parenteral thiamine to oral thiamine for at risk alcoholics and those with WE. This occurred in the UK following what may be a disproportionate reaction to a warning of adverse events with parentrovite in 1989 and then the subsequent lack of parenteral thiamine for nearly 2 years in the early 90's in the UK.

- The risk of reaction of parenteral thiamine is considered rare. Serious allergic reactions occurred more commonly in multiple IV dosing of parentrovite compared to im. Reactions to the US formulation of thiamine hydrochloride were studied by Wrenn and Slovis (1992). 12 adverse reactions, 1.1%, (one major reaction of generalised pruritis) were reported in 989 patients (1070 IV bolus doses). This is compared to 1-10% chance of allergic reaction to penicillin.

- IV infusion may cause fewer reactions as the adverse events with parenteral thiamine may relate to a dose dependent 'anaphylactoid' mechanism.

Outcome from Discussions at Cutting Edge 2007
There was general consensus on the need to ensure the return to parenteral thiamine

Dosage regimes are unclear, consistent with the lack of data on this internationally, and reflected in the differing dose regimes from centres in and between both countries. There is an opportunity and need to further follow up the use and effectiveness of dosage regimes in our local centres and share this information.

The extent of identifying 'high risk' patients vary. E.g. St Vincent's have created protocols for parenteral thiamine for use pre operatively. This contrasts with the resistance I experienced from our local medical physicians in regard to prophylactic use of parenteral thiamine.

Formulation availability was an agreed rate limiting step in appropriate treatment and prescribing patterns had changed in response to this, consistent with the literature on this issue.

There is a need to bring this subject to discussion with FAChAM and make a recommendation to Pharmac and Medsafe. Until that occurs patients may not be treated appropriately and there will be continued resistance to using parenteral thiamine in the inpatient setting.

Dr Tanya Quin
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References available on request from the Editor.

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Invitation to the John Dobson Memorial Foundation Cocktail Party & Auction

A warm invitation is extended to all ATRIG members and readers of ATRN to attend the upcoming Cocktail Party and Auction to be held at the Christchurch Convention Centre, **Friday 5 September 6.30pm to 8.30pm**. This is an opportunity to support a great Canterbury initiative – the ongoing work of the John Dobson Memorial Foundation (JDMF) as an independent voice and strong advocate for the addiction and mental health treatment field in New Zealand. An enjoyable evening is guaranteed with the Master of Ceremonies being the irrepressible Jim Hopkins. For more information and to purchase tickets please visit our website http://www.uoc.otago.ac.nz/departments/psychmed/treatment/jdmfcocktail.htm or contact Lindsay Atkins, Event Administrator, Phone 03 364 0480 or email lindsay.atkins@otago.ac.nz

Prophylaxis for WE– 200mg Thiamine HCl IV infusion/IM od for 3 – 5 days

Treatment for WE– 400mg Thiamine HCl IV infusion/IM bd to tds for 3 days

- If response then 200mg IV infusion/IM od for 3 – 5 days
- If no response or deteriorating review diagnosis and consider referral

Ongoing supplement– 50mg po tds with food

Check Magnesium levels – treat if low
Prescribe folic acid and multi B complex orally
Appropriate resuscitation facilities must be available for parenteral thiamine use
(IV infusion over 30min in 100ml normal saline)

Message from the Chairperson

I write this on my return from the Addiction Summit held in Melbourne 9-12 July. It was a highly successful meeting with many stimulating presentations and discussions. Future research directions for the field came up a number of times during the conference. In particular there was a call for greater collaboration between various disciplines and to move beyond simply looking at which treatments are better. Instead of this "horserace" approach several speakers talked about the need to better understand the mechanisms of behaviour change: internal to the client, within the client-therapist interaction, and as influenced by interpersonal and societal factors.

As is not uncommon at such conferences, the challenges of maximising the impact of research on clinical practice and policy development – technology transfer and policy influence – was also mentioned a number of times. It is an underlying belief of ATRIG that the fostering of interest in research activities and findings contributes to a stronger more informed addiction treatment community across the areas of practice, management and policy as well as for those directly involved in research.

This is my last Chairperson's Message as I am standing down following five years in the role. I will be putting my name forward to remain a member of the ATRIG executive and look forward to supporting the new chair who will be elected following the 2008 AGM in September. I would like to encourage others to attend the AGM, to be held at Cutting Edge, and to consider becoming involved in the ATRIG executive. It is not an onerous commitment and is an opportunity to discuss ATRIG business and support its overall activities. It is not necessary to be actively involved in research activities of your own: as with ATRIG membership, all that is required is an interest in addiction treatment (and related) research.

Dr Simon Adamson
Outgoing ATRIG Chairperson

Medical School Update: What's New in AOD Research in Wellington

The level of research activity at the University of Otago, Wellington was reflected in success at the 2007 Combined Cutting Edge/APSAD conference where several AOD research groups presented papers.

In an oral presentation, the lower North Island Addiction Group presented their completed work surveying injecting behaviours of patients on methadone programmes. This group is a collaboration of clinician/ researchers located at treatment services geographically spread from Napier across to Taranaki and down to Cook Straight. The project, which took two years to complete, was also a collaboration with the Medical Research Institute of New Zealand who assisted with anonymous data collation and analysis. The findings have set the scene for better understanding the injecting behaviours of clients on methadone programmes in New Zealand, and a paper based on this work has been submitted for publication.

In addition a poster on relationship of QT intervals to methadone dose from the team of Brent Hyslop, Tom Flewett and Helen Moriarty won for Brent Hyslop the John Dobson Prize for best junior research poster. At the same conference, Calvin Chan and Helen Moriarty presented a poster on issues for women on the methadone programme, and Sue Blyth, Moira Gilmour, Klare Brae and Helen Moriarty presented a poster on AOD skills for workforce development.
The ARCH research group (applied research on communication in health) have recently been successful in obtaining grant funding to carry out a project investigating how GPs and their patients engage in discussion about drug and alcohol issues and how GPs manage AOD issues in primary care. More information about this will be available as the project progresses.

There is also a new and growing interest in family-based research at UOW. One project soon to get off the ground is to look at issues for families affected by the AOD use of an extended family member.

Watch this space!

Helen Moriarty
University of Otago, Wellington

Health issues are the most common reason for individuals to address alcohol and drug problems in New Zealand and doctors are seen as credible and as having expertise in this area [1] but are under utilised [2]. This research looks at the training of medical students to determine their therapeutic commitment to the addictions. According to previous research on alcohol and drug teaching, medical students have poor undergraduate education [3], increasingly negative attitudes as training progresses [4] and there appears to be a widespread misperception that alcohol use disorders are uncommon and untreatable [5].

The following report is based on a longitudinal cohort study carried out between 1999 and 2003 involving the medical student population of New Zealand [6]. This research was funded by ALAC and attempted to determine the knowledge, skills and attitudes of medical students to alcohol and other drug problems and how this changes over the undergraduate course.

Methodology and results

A questionnaire was distributed to all 2nd year New Zealand medical students (Schools of Medicine in Dunedin, Christchurch, Wellington and Auckland) in 1999, then again to this cohort in their 4th year (2001) and 6th year (2003) of training. The survey consisted of a number of multi-choice or true/false questions, scenarios, attitudinal questions and demographic details including their own alcohol and tobacco consumption. A good response rate was received when the cohort were in their 2nd (98%) and 4th years (75%) of training but dropped when they were in their 6th (34%) with an overall equal gender distribution and a total of 637 completed questionnaires.

Tobacco use remained low at 5% throughout the training years. The proportion of non-drinkers decreased from 2nd to 6th year (from 27% to 13%) with no difference in the frequency of alcohol consumption but students drank less per session as training progressed. There was a stepwise increase in knowledge as training progressed and by the 6th year of training there was little difference between the schools. The students displayed many strengths including correctly identifying drug classification, safe levels of alcohol consumption and withdrawal effects. There were however, a number of areas of weakness including estimating the number of units of alcohol, physical sequelae, safe prescribing, drug interactions and metabolism.

Students felt more effective in treating smoking and alcohol problems by their 6th year of training, but the opposite pattern was shown for illicit drug use. Acceptability of self-prescribing generally decreased, but even by the 6th year a substantial minority still regarded this as appropriate. Unfortunately, interest in specialising in the addictions field decreased from 18% (2nd year) to just 7% (6th year) and confidence in managing drug users diminished as training progressed.

Therapeutic commitment

The identification of barriers to adequate care of patients has led to the suggestion that a number of factors influence a doctor's intellectual and emotional preparedness or 'therapeutic commitment' to work with substance users. The three main factors identified are: role adequacy or the belief that the doctor has sufficient knowledge, role legitimacy or the belief that substance use issues are a legitimate health area for the doctor to examine and lastly, role support or the belief that appropriate advice and assistance is available when needed [2]. The evidence suggests that doctors with greater therapeutic commitment are more willing to become involved in the management of drinkers and drug users with problems [7].

Discussion and summary

The medical students' perception of their ability to confidently manage patients engaged in illicit drug use declined as training progressed as did their perceived ability to detect problem drinkers. Overall as training progressed their perception of knowledge and skills (role adequacy) diminished despite their knowledge/skill scores increasing.

These results appear to indicate that the senior medical students regard themselves as inadequately prepared to

confidently assess and manage drinkers and drug users with problems or dependence. This may be a function of increased knowledge, increasing their awareness of the complex nature of these problems, or it may simply reflect a negative personal attitude towards illicit drug users. This may involve the students' perception that illicit drug users are 'difficult, drug seeking patients which are best avoided'. One way of addressing these problems might be to provide greater clinical exposure and curriculum time specific to these areas.

Medical school is a critical and essential stage in the development of physicians who are confident and competent in the assessment and treatment of substance use problems. The stepwise increase in clinical competency as training progresses indicated that the students were responding to teaching input and to some extent signified that the alcohol and drug teaching programmes have been successful. It is also evident that there were specific deficits which require greater educational emphasis and curriculum attention. The perception by medical students that treatment of alcohol and other drug problems has a low efficacy also warrants addressing which as suggested by Roche [3] may take the form of skills training (e.g. motivational interviewing) and training/education in the newer pharmacotherapies.

Addiction Medicine is an emerging subspecialty and becoming increasingly recognised as an essential component both at an undergraduate and postgraduate level. Addiction Medicine encompasses a range of health services including pain clinics, general medicine, mental health, public health, palliative care, professional development, alcohol and drug clinics and indigenous health. The development of a separate Addiction Medicine curriculum during undergraduate years would help to considerably raise its importance in students' minds and more fully prepare students to practise as medical practitioners in the real world. Continuing input from interested physicians, lecturers, teaching coordinators and academic departments will be necessary to ensure a strong foundation for teaching and curriculum time needed to improve the therapeutic commitment of doctors to the health care of people with alcohol and other drug problems.

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CUTTING EDGE 2008

The theme of this years conference is 'Life and Death'. The dates are 4 – 6 September, and the venue is the Christchurch Convention Centre. For further information about the conference (including registration and programme) please visit the conference website:

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How Good is New Zealand's Alcohol and Drug Policy?

While on research leave in Paris last year I had the opportunity to reflect upon New Zealand's Alcohol and Drug policy. What are its strengths and weaknesses? And indeed what criteria should be applied in an evaluation of national alcohol and drug policies?

The last decade has been 'a coming of age' for alcohol and drug policy in New Zealand. The first National Drug Policy was fully released in 1998. Several other important national alcohol and drug polices, strategies and plans have also been released over the last decade including: the National Alcohol Strategy in 2001, National Strategic Framework for Alcohol and Drug Services in 2001, Action Plan on Methamphetamines in 2003, Action Plan on Alcohol and Illicit Drugs in 2004, Te Tahuhu (Mental Health and Addiction Plan) in 2005, Te Kokiri (Mental Health and Addiction Action Plan) in 2006 and the second National Drug Policy in 2007. The inter-relationships between these different policies are summarised by Fig 1.

Please see next page for Fig 1

In spite of the relative infancy of these policy, strategy and planning documents they have already attracted some attention from commentators and reviewers both within and outside New Zealand.

First of all, in 2007 a team led by Iain Crombie [1] evaluated the 'alcohol policy documents' of 12 developed countries. Included in these 12 countries were New Zealand, Australia, Canada, Denmark, England, Ireland, Japan, Northern Ireland Scotland, Sweden, USA and Wales. One disappointing aspect of Crombie's review is that it only focussed on the *National Alcohol Strategy* which was jointly released by the Ministry of Health and ALAC in 2001. They seemed to be unaware of the other policy documents depicted in Fig1. Nevertheless, Iain Crombie's paper provides an interesting comparative analysis of national policy documents.

Each policy document was evaluated in terms of their treatment of:

- *'the nature of the problem'* (how well the policy document addressed: consumption and patterns of consumption; individual health risk factors; social and economic harm; and the benefits of alcohol consumption);
- *interventions* (taxation and pricing, legalisation and enforcement, drink driving, marketing of alcohol, drinking environment, high risks groups, problem drinkers and education)

They found that New Zealand's National Alcohol Strategy scored well in assessing 'the nature of the problem' and stood out (along with Australia) as 'having the most well developed and integrated interventions'. The New Zealand *National Alcohol Strategy (NAS)* was assessed to be a 'substantial and comprehensive' policy compared with most other countries which were assessed to be more narrowly focussed policies e.g. Northern Ireland and Japan. New Zealand's *NAS* got the highest possible rating (along with Australia, England, Ireland and Scotland) for addressing each of the categories: 'consumption patterns', 'harm to individual health' and 'social and economic harm'. But the *NAS* didn't score as well as these countries in dealing with the health benefits of moderate consumption and the economic benefits (employment, export earnings).

In terms of policy intervention tools, a few countries (including New Zealand, Australia and Ireland) 'featured strongly across all of the categories of intervention tools', whereas the United Kingdom countries did not use all of the available tools. Crombie's team found that almost every national alcohol strategy/plan failed to 'describe actions to implement the strategies at the regional and municipal level', and indeed failed in general to outline how to implement the policies.

In New Zealand, there have been surprisingly few attempts to *specifically evaluate* our Alcohol and Drug Policy *documents*, in spite of methodologies beginning to emerge on how to do this. 'Allen & Clarke' a New Zealand based consultancy firm specialising in public policy evaluation have however undertaken two very useful reviews [2,3] of the 2001 *National Alcohol Strategy* and the 1998 *first National Drug Policy.* Both these are comprehensive reviews covering many aspects of alcohol policy and its implementation in New Zealand. Both reviews are well worth reading – the *NAS* review can be downloaded from the MoH website.

I will focus on 'Allen & Clarke's findings with respect to the *NAS* [3] as it is the same document

evaluated by Crombie. 'Allen & Clarke's key findings were:

- 'Leadership (in the *NAS*) needed to be stronger, and specific responsibilities need to be given with agencies accountable for the delivery of specified outcomes.
- The *NAS* lacked a robust monitoring framework with requirements for reporting. Allen and Clarke commented that this 'needs to be specifically resourced'.
- The profile of the *NAS* and the messages contained within it needed to be more visible, particularly for non-government sectors.
- An evidence-based approach needs to be the basis for a new Strategy
- A new Strategy will need to ensure 'buy-in' from those organisations to be involved in its development and implementation.

These concerns about the lack of policy implementation details, and 'follow-up monitoring' of the effectiveness of the policy, were similar to those concerns voiced by Crombie [1] in his 12 country review. Interestingly 'Allen & Clarke' also arrived at a similar conclusion in their review [2] of NZ's *first* National Drug Policy.

Similarly Allen & Clarke's recommendation for an evidence-based approach is also echoed in the international literature, including those articles appearing in the most recent edition of the *International Journal of Drug Policy* [4,5]. These studies found that the gap between 'research evidence' and 'policy' seems to be even more problematic in the United States and Canada, than in New Zealand.

I hope these thoughts are heeded in the monitoring of current documents such as Te Kokiri, and the resulting action plans that are to follow. While I can certainly see some improvement I found these articles consideration of the basis of NZ policy documents to objectify my previous vague feeling of frustration with them.

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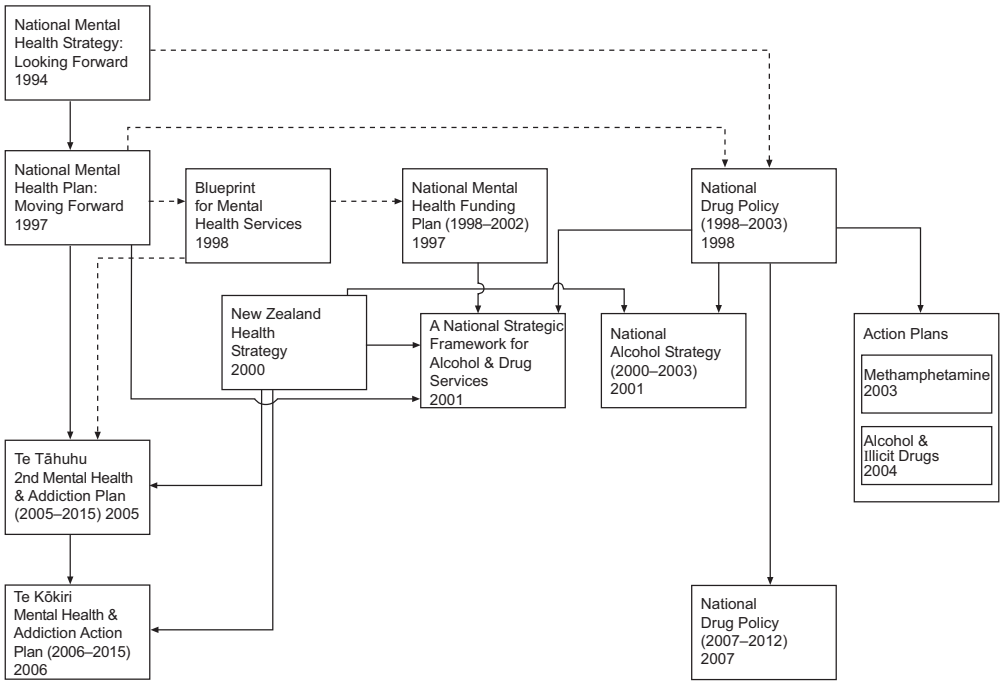
Fig 1



Addiction Treatment Research Interest Group (ATRIG)

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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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I support the objectives of ATRIG and wish to be a member of ATRIG for the 2009 calendar year. I understand the membership fee is $20.

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