Addiction Treatment Research NEWS

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EDITORIAL

I write this editorial with Easter on the doorstep and Autumn well underway. I hope that by the time you read this edition of the ATRN you will have enjoyed a great break over Easter and had an opportunity to enjoy the last of the warmish weather we will see for the next few months.

This edition of ATRN begins with a very topical issue by Sean Sullivan from Abacus as he highlights the issues surrounding the classification of pathological gambling disorder as an impulse-control disorder in the DSM and ICD classification systems. Allowing ATRN readers to get an early preview of a book chapter he is writing on this issue, Sean argues for a more holistic approach to the classification of pathological gambling and substance use disorders.

After a six month sabbatical in Leeds, Simon Adamson returns as the regular writer of the National Addiction Centre (NAC) report to provide an update of the research activities at the NAC. This report highlights the increasingly wide variety of research activities that are being undertaken at the NAC and provides an overview of Simon's research activities while on sabbatical.

A few words from the ATRIG Chair, Klare Braye convey her thoughts about current issues in the addiction treatment research field both nationally and internationally. In particular, Klare highlights some of the important reviews of current alcohol and drug legislation that are underway in New Zealand and encourages us to actively partake in this process in whatever capacity we can.

The two feature articles in this edition both describe new programmes that have been developed for working with specific groups of clients in the addiction treatment field. The first article by Trish Gledhill and Megan Landon from Kina Trust provides an overview of a family inclusive practice model for working with youth that was implemented in Hawkes Bay Mental Health and Addiction Services in 2007. The second article by Bronwen Wood introduces a new programme being run in Whangarei for recidivist drink drivers. While still in the early stages of its evaluation, this article provides a good introduction to the programme and its initial evaluation. Both these articles should alert you to important spaces to watch in the future as further developments and evaluations of these programmes emerge.

Finally in this edition, "I've Been Reading" presents the musings of Marie Ditchburn (expert smoking cessation researcher at the NAC) about the diagnosis of nicotine dependence for youth. Marie's reflections on some recent literature in this area provide some interesting food for thought.

Many thanks to all contributors and all who have helped in the production of this newsletter, especially Lisa Andrews who formats every issue of ATRN. Speaking of formatting, watch out for the new and improved format being introduced in the next edition of ATRN.

Happy reading.

Ria Schroder
Editor, April 2009

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If the facts don't fit the theory, change the facts.
Albert Einstein

It won't come as news to anyone working within the addictions field that there is an intention to align treatment of addictive behaviours, namely AOD, problem gambling and tobacco use, and that each will not develop in their previously soloed approaches[1,2]. However, how well does this alignment approach fit with current diagnostic resources, such as American Psychiatric Association manual DSM-IV,[3] and the WHO manual ICD10? Granted, both of these are getting a little long in the tooth (DSM-IV 1994; ICD 10 between 1992-1994), and DSM particularly is under imminent review, which may address any inconsistencies with the NZ aligned approach. However, I wouldn't put money on it. My lack of confidence is based upon DSM's categorisation of Pathological Gambling Disorder (PGD) as an impulse disorder, despite ascribing to it criteria remarkably similar to substance dependence.

A little bit of disclosure and history

It is with some trepidation that I find myself having been asked to write a book chapter on pathological gambling and impulse disorders, so I've taken a pre-emptive opportunity with this article to air my concerns.

An initial inclusion of PGD in the 1980 DSM III was later redrafted and aligned with substance dependence for DSM IIIR in 1987, by simply replacing 'use of a substance' with 'gambling' in eight criteria and adding a purely gambling criteria of 'chasing losses'[3]. In 1994, the current DSM-IV[4] bumped the possible criteria up to ten with a few more minor changes to the criteria. Yet, despite the 'sharing' of criteria, substance abuse and dependence were categorised as 'Substance-related Disorders' within fully 98 pages of DSMIV, while the gambling disorder was relegated to a catchall category, 'Impulse-control Disorders not elsewhere categorised'. This group, as the category clearly implies, is where DSM has placed conditions it appears to struggle with, namely behavioural addictions. Obviously it may be unreasonable to expect that PGD should be entitled to its own category, although this would possibly be supported by the significant numbers identified as affected by gambling by epidemiological studies (that tend to under-estimate the prevalence) or who present for treatment. However, the refocus upon PGD as an impulse disorder, rather than a dependence-driven behaviour, suggests that the sharing of intrinsic aspects of behaviour is insufficient to align PGD with substance dependence, and smacks of changing horses in midstream.

Some mitigation and further concerns

In mitigation, DSM-IV does state that this catchall category includes 'disorders of impulse control that are not classified (*in other disorders*) e.g. Substance-related disorders…' p609. Other clinicians also point out that impulsivity (a predisposition towards rapid, unplanned reactions to either internal or external stimuli, despite negative costs), is a key element of many disorders such as substance use disorders[5]. However, at the risk of being accused of demanding undeserved entitlement, the relegation to the rear of the manual, and refocus upon control deficits, when compared with the Substance-related Disorders' focus upon dependence/abuse of a drug, suggests a distancing, despite criteria alignment. To further this perception, it is noted that at the beginning of DSM-IV, a large heading 'Cautionary Statement' expressed on its own stand alone page, explains that inclusion in the Manual doesn't mean a disorder also meets legal or other non-medical 'criteria for mental disease, mental disorder, or mental disability… (*and*) may not be wholly relevant to legal judgements, for example that take into account such issues as individual responsibility, disability determination, and competency.' (p. xxvii). Tellingly, just two examples are given, one being PGD, the other, Paedophilia. You may well ask, what does this mean for PGD? The first thought may be that there may be less backing from the DSM reviewers for PGD, such as the degree of loss of control experienced. The second might be, why is PGD such a good example for this statement, and why is a much more common example, such as an AOD disorder, not advanced?

An impulse disorder

DSMIV describes an impulse disorder as, essentially, a failure to resist an impulse, drive or temptation that is harmful to the person or others, often with an increasing arousal or tension before the act, pleasure, relief when doing the act, and possibly regret or guilt after. By comparison, compulsivity is described by DSMIV-TR[6] as repetitive behaviours with the aim of reducing or preventing anxiety and distress, rather than gratification. Aspects of impulsivity appear to have features of compulsivity, and it is possible to identify both compulsive and impulsive aspects to problem gambling. With some problem

gambling behaviour, ritualistic behaviours arise similar to Obsessive Compulsive Behaviour, which the person may describe as enjoining luck on their side. Expectation of loss does not deter the behaviour, and as stress increases, so does the urge to gamble.

ICD10's[7] description of habit and impulse control disorders is even less helpful from a PGD perspective. They are characterised by

> 'repeated acts that have no clear rational motivation, cannot be controlled, and generally harm the patient's own interests and those of other people. The patient reports that the behaviour is associated with impulses to action.' F63.

Problem gamblers would immediately describe their reasons for gambling as including a hope of winning money, a clear rationale, but that their downfall is reinvesting their winnings (together with many other costs, often less recognised by them). Within this category, PGD is described as 'frequent, repeated episodes of gambling that dominate the patient's life to the detriment of social, occupational, material, and family values and commitments'. A jaundiced eye may note that this description fits just as well alongside substance disorders as it would impulse disorders.

PGD as an impulse disorder

Problem gamblers often plan their gambling, having been influenced by access, or imminent access, to money, and to self-talk that allows dissociation from negative consequences that might otherwise deter. This raises an alternative possibility: problem gamblers may choose to ignore consequences, rather than be unable to resist an impulse. Tension prior to gambling seems commonplace for problem gamblers, but gratification while gambling may often be avoidance of stressors as they dissociate (as with compulsion). Regret is commonplace, often because gambling may continue until money is exhausted, and reality of even a worse situation becomes clear as dissociation is lost. A complicating factor is that there are a range of behaviours displayed and reported by problem gamblers, with coexisting anxiety and mood disorders commonplace, as are other disorders. For some problem gamblers, phenomenological aspects of either (or both) impulsive and compulsive behaviour will be displayed. In other findings, expected similarities between compulsive behaviours and PGD have not occurred, with the current attraction of functional MRI research identifying that neural activations differ substantially between problem gamblers and those with Obsessive-Compulsive Disorders[9,10].

Conclusion

One could ask whether or not it matters whether problem gambling is viewed by leading health professionals as essentially an impulse disorder, or as something akin to a substance use disorder. Obvious advantages arise if it can be a valid perspective that PGD and AOD have strong similarities in development, maintenance, and even perhaps neurobiological pathways. This may be further supported as those presenting are often affected by both disorders, or may even substitute disorders if this possibility is not addressed. An addiction perspective, not a DSMIV described term, it could be argued has both face validity and heuristic merit. Problem gambling, as an impulse disorder, rarely presents as a sole issue, and develops alongside such a wide range of coexisting disorders, as do AOD disorders. The DSM review may consider that a new category of addictions may have value both in categorisation and treatment, and avoid the possibility that PGD may be currently categorised as a square peg in a round hole.

Sean Sullivan
Abacus

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National Addiction Centre Report

There's certainly plenty going on at the NAC research-wise at the moment.

Doug, Ria and colleagues within the Department of Psychological Medicine are awaiting the outcome of an application to the Health Research Council for funding of the Abstinence vs. Moderation in Obesity Treatment: The 'Problem' Food Study. Even without this funding the researchers are committed to going ahead with this study in some form.

Also in the waiting category is the New Zealand Opioid Study, which was a collaboration between NAC, University of Auckland, Needle Exchange New Zealand and the Aotearoa Alcohol and Other Drug Consumers Network. A report was submitted to the Ministry of Health late last year, which contained a number of recommendations for changes in practice and we expect a response from the Ministry shortly on this. In the meantime the authors are working on a number of papers for publication looking at various aspects of treatment needs for this population.

The Moana House Evaluation Project has entered the interviewing and data collection phase and is running well thanks to the receptiveness of Moana House staff and residents to the process and to the research team. We are also very fortunate to have contracted two excellent research staff for this project: Dr Geoff Noller and Moana-o-Hinerangi.

The Treatment Evaluation of Alcohol and Mood (TEAM) study has entered the final year of recruitment. With a currently recruited sample size of 60 and a target final sample of 150 we will be recruiting hard this year. ATRN readers in the Bay of Islands, Whangarei, Auckland (the clinic is in Kingsland), Hamilton/Waikato, Nelson, Marlborough, Christchurch or Dunedin are asked to do their bit! If you know of any depressed and alcohol dependent patients who are not on antidepressant medication please let us know. You can ask them to call 0800 TEAM Research (0800 832673) or give us a call yourself – either to refer someone or to seek further information.

I have recently returned from a six month sabbatical in the UK, where I was based at the Leeds Addiction Unit. Whilst there I worked with several of the investigators on the UKATT trial and am currently making progress on several co-authored papers as a result. Some ATRN readers may recall that the United Kingdom Alcohol Treatment Trial was the second largest psychotherapy RCT for alcohol dependence (after Project MATCH of course), with 740 patients randomised to either motivational enhancement therapy (MET) or social and behavioural network therapy (SBNT). We all know about MET of course and many of you will have benefited from hearing Gillian Tober talk about SBNT on one of her visits to New Zealand. The papers I am working on relate to drinking goal and outcome, predicting outcome, predictors of therapist adherence to treatment, and a comparison between two psychotherapy rating scales used for research and clinical training/supervision.

Finally I'm very pleased to congratulate Dr Fraser Todd who has very recently passed his PhD "Cannabis Use and Mood Disorders". Fraser will be graduating soon.

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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 addiction treatment field in New Zealand.

The **executive committee** are: Klare Braye (Chairperson), Simon Adamson, Alistair Dunn, Ria Schroder (ATRN Editor), Robin Shepherd, Janie Sheridan, Lindsay Atkins (Secretary)

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SHARING THE KETE: AN EVALUATION OF TRAINING FOR THE PROMOTION OF FAMILY INCLUSIVE PRACTICE IN MENTAL HEALTH AND ADDICTION SERVICES

Sharing the Kete was a project training practitioners in the use of family inclusive practice (FIP) in mental health and addiction services that was conducted in Hawke's Bay, NZ in 2007. The outcomes demonstrate the potential for inclusive practice in MH&AS in keeping with national policy expectations. It illustrates the value of drawing on the capacities of families as agents of change in enhancing the wellbeing of youth and their whanau in Hawke's Bay.

Background

Many of the youth practice models in alcohol and other drug (AOD) treatment are based on adult models. While these approaches often validate family involvement, there is a lack of intervention frameworks that specifically recognise the capacity of family members as agents of change. There is a body of work from outside New Zealand exploring factors that include families in young people's recovery including; intensive interventions requiring high levels of expertise or resources (Cunningham and Henggeler 1999), how effective cultural practices can be linked with clinical approaches (Cargo, 2007; Huriwai et al., 2004), and the use of combined approaches, and more ecological interventions (Ozechowski & Liddle, 2000). The project outlined in this paper set out to devise, deliver and evaluate a suitable model for Family Inclusive Practice (FIP) that was accessible to the practitioners that deliver services to youth and their families, and that was appropriate to the New Zealand cultural context.

SHARING THE KETE - Engaging Whanau as Agents of Change

The project was run by the Kina Trust (Kina Families and Addictions Trust is a Hawke's Bay based, national Charitable Trust promoting FIP in the addiction sector) and the Hawke's Bay District Health Board (HBDHB) and was funded by the Ministry of Health. Kina Trust through research and consultation with national experts had created a training program for practitioners in AOD (Kina Trust, 2005). Additional feedback from the initial workshops in the programme contributed to the model applied in Hawke's Bay in 2007.

The model is primarily a social framework encompassing behavioral, ecological and resilience theories that underpin the clinical dimensions of the project. The theoretical understandings are closely linked with other intervention frameworks that are familiar to the AOD sector including; harm reduction continuum, motivational interviewing and the wheel of change, family therapy models, other FIP models, for example the Copello Stress-Coping Model and Te Whare Tapa Wha.

The key approaches in the model and included in the FIP training workshops are:

- Working explicitly with relationships to foster connections supporting change.
- Practitioners working as active agents but not central to change.
- The use of visuals, metaphors and 'hands on processes' that externalise issues.
- Non - pathologising and non-judgmental approaches.
- Ensuring transparency with the young person and their whanau.
- Reciprocal knowledge and information sharing between professionals and families.
- Planning and flexibility - Balancing responsiveness to the whanau pace alongside tangible and constructive sessions.

Measures of potential change

In order to validate the model it was important to create a good evidence base to support the use of FIP, and in particular the cultural aspects in the Hawke's Bay and New Zealand context. The project was not specifically designed as a research project, however data were collected over time to measure the impact of this short-term initiative on all participants. The project was undertaken with members of the Mental Health and Addictions Service in the HBDHB and included residential and non-residential clients.

Results

The first of the data gathering initiatives was to create a baseline level of the use of FIP in HB mental health and addiction services prior to the introductory FIP training. Twenty one practitioners from a range of mental health and addiction settings were asked their views on the relevance of FIP to their current roles. Self-reported ratings on their skill and practice levels were also collected. The relevance of FIP was rated highly by 94% (4 or 5 on a scale ranging from 1 the lowest level to 5 the highest level), while 43% rated their skill level highly, and 40% their practice level highly.

Addiction practitioners' views on the relevance of FIP to their current roles, their skill and practice levels were also analysed separately from the larger group. Addiction practitioners rated their skill and practice of FIP lower than the larger group, those

with a rating of 4 comprised 29% for both skill and practice, the remainder considered that 'some' (a rating of 3) of their practice included FIP. There was no relation between perceived skills and practice and the discussion of family and social contacts.

Detailed information about aspects of inclusive work with clients was also collected over the course of a week from a group of 10 specialist AOD staff who recorded a total of 165 contacts ranging from 6 (part time staff member) to 45 (staff member in residential services). Some of the baseline findings included; the discussion of family and social relationships in 50% of contacts, rising to 63% in addictions (non-residential). Families were present in 20% of contact sessions, and family members were seen as 'clients' in 13 % of contact sessions.

Client Outcomes

Nine young people aged between 14 and 22 years and their whanau participated in the client data collection for the project. AOD use measured by the SACS questionnaire was significantly decreased for seven clients including three who were described as abstinent from cannabis use. Other young people had significantly moderated their use to minimise harm by having less impact on school or social settings. Social outcomes significantly improved across the different domains of school, home and peers in eight clients. Interestingly, for at least three clients, the intervention impacted on the AOD use of parents who sometimes moderated their use significantly to have less impact on their children.

Change in the use of FIP over time.

Change in discussion of family with contacts

A total of 21 practitioners undertook the first survey and 16 the second survey of FIP. Data from the 11 that undertook both surveys showed an increase in FIP, particularly among the core group participants. Change in practice from the first to the second data collection showed that, five increased and two decreased their discussion of family with youth clients. The specific AOD group increased their discussion by 49% on average and the whole group by 8%, this is skewed by the results from one participant that showed a decrease in inclusive practices.

Change in practitioner reporting FIP overtime

There were eight practitioners who participated in the initial training and two data collection points, their results are shown in Table 1. They all rated family inclusive practice as being very relevant to their work as would be expected from a motivated group. The self rated skill levels increased slightly having started at good, the most change was seen in practice of FIP over the time of the study.

*Table 1: Change in practitoner reporting on FIP over time**

	First data collection	Second data collection
	Average (range)	Average (Range)
Relevance	4.4 (4-5)	4.5 (4-5)
Skills	3.5 (3-4)	3.9 (3-4)
Practise	3.4 (2-4)	3.8 (3-5)

* Rating 1 (least) – 5 (most)

One key outcome reported anecdotally was the increase in practitioners' use of FIP across all their casework. This implies that aside from the focus on the model through targeted casework, the project had a significant generalising effect on other practice and consistent change was reported.

As a result of the initial project and follow-up a number of mechanisms were suggested to increase the scope of inclusive practice in the MH&AS. These included: introductory FIP workshops for all staff, further data collection across MH&AS and a focus on specific areas of service delivery such as methadone services or residential services. For the wider sector it was recommended that this approach is implemented across a range of delivery sites to further explore how models may be applied in various cultural and regional contexts. Research projects with this focus would expand our knowledge in applying inclusive models for youth.

Conclusion

This project was developed and initiated in a short timeframe with limited budget resources. The participating practitioners started with a range of experience and interest and have undertaken this work alongside their usual caseloads meaning that the number of cases to which the model could be specifically targeted was limited. The results are therefore based on small numbers which are difficult to subject to rigorous scrutiny, it is nonetheless an important start in the acquisition of evidence for best practice for FIP in youth AOD services.

The flexibility of approaches and the nature of the strategies employed appear to be extremely important in fostering the engagement of families in ways that address the various realties of addiction and family issues. The best outcomes are indicated when these approaches are linked well with established intervention models such as motivational interviewing alongside the FIP intervention of functional analysis in a social context.

The work has had considerable influence on practitioners, especially those who participated more actively in developing and implementing the model. Practice

levels have increased in those people who only had exposure through team work and introductory training while the levels of inclusive practice significantly increased in focus group members.

One of the key risks in all projects is integrating project work well into common practice and ensuring resources are available to support the work. It is evident from this project that although significant changes were demonstrated in aspects of practitioners' work, skill development and confidence it takes time to practice skills across different case contexts with the support of supervision.

This project illustrates the potential for service development towards family inclusive practice; in particular it signals the potential for families to contribute as agents of change in improving the wellbeing of youth and their families.

Trish Gledhill and Megan Landon on behalf of Kina Trust

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What is Happening with Recidivist Drink Drivers

This article describes a recidivist drink drivers programme that is being delivered in Whangarei. The programme is currently undergoing intensive evaluation and this article will present preliminary data from this programme.

Northland Health Alcohol and Drug Service has been piloting a programme for recidivist drink drivers since June 2007. The pilot began due to an increased number of referrals from the Justice Department for recidivist drink driving offenders to engage in treatment. This in turn had an impact on the wait list for referrals to be seen by a counselor.

The programme is based on the theory of "what works" to reduce re-offending. Andrews et al. (1994)[1] found that the most beneficial programmes have a sound theoretical basis, target high risk offenders, target offence behaviour, are structured and cater for all learning styles, are cognitive behaviourally and skills focused, community based and show high treatment integrity. The Whangarei Recidivist Drink Drivers Programme is based on the above criteria to ensure treatment is effective. The aim of the programme is to reduce recidivist drink driving. The programme also addresses the level of binge drinking or dependence and provides strategies for reducing alcohol consumption levels.

Referrals are assessed for suitability to complete the programme by a trained facilitator. Suitability is based on Audit scores and readiness to change scores. The criteria for non acceptance onto the programme are current unstable mental health conditions or homicidal or suicidal thoughts. The programme is a total of 14 sessions. There are 12 group sessions and two individual sessions. Each session is two hours in duration. Participants are expected to have an active part in the sessions. There are also follow up sessions at three, six and 12 month intervals. To date the follow up sessions have been poorly attended. The group is run by working on all learning styles thereby providing visual, auditory and kinaesthetic information to provide maximum input. The programme is psycho-educational and includes elements of Motivational Interviewing, Cognitive Behavioural Therapy, Relapse Prevention, Problem Solving Theories and Victim Empathy.

Demographics of the programme

Preliminary data, gathered about the programme to date provide a brief overview of the profile of the programme participants and give some indication as to changes in alcohol consumption. The data represent participants who were accepted onto and completed the programme (n=42). They do not include participants that started the programme and did not complete (n=18). These data will be evaluated in the extensive evaluation.

Age of participants

The mean ages of participants in the five programmes that have been delivered to date are shown in Table 1.

Table 1: Mean age of participants completing the Whanagrei Recidivist Drink Drivers Programme

Group	Age (years)
Group 1	34.5
Group 2	41
Group 3	32
Group 4	27
Group 5	33

The mean age for all participants that completed the programme was 34.6 years.

Table 2 indicates the age ranges across all of the programme completers. The majority of participants were aged between 20-25 years and 31-35 years.

Table 2: Age range of programme completers

Age Group	Number of Participants
20-25	10
26-30	0
31-35	8
36-40	4
41-45	7
46-50	5
51-56	2

Ethnicity of participants that have completed the programme
Categories of ethnicity were divided into Maori, New Zealand Pakeha and Other. Results from the available data indicate that 30% of participants who completed the programme were Maori, 57% New Zealand Pakeha, 4% Other and 2.3% were unsure.

Gender of participants that have completed the programme
Eighty eight percent of participants that completed the programme were male. These figures reflect the proportion of males and females initially referred to the programme.

Alcohol Use
Evaluation questionnaires were completed by all participants at the end of each programme. Full analysis of these evaluations has not yet been completed, however, preliminary comparisons on pre and post AUDIT scores are shown in Figure 1 (below).

AUDIT scores for programme completers were found to have decreased from a mean baseline assessment AUDIT score of 17 to a mean treatment completion AUDIT score of 9.5. These findings concur with participants alcohol diaries that were completed at the end of each session. Analysis of these diaries also revealed decreased levels of alcohol consumption.

Re-offending
Ongoing research on the recidivist drink drivers programme is currently being conducted to determine the effectiveness of the programme in reducing re-offending. This research compares those that have completed the programme with those that have not been referred or who did not complete the programme. In 2008 however, data were gathered to determine the level of re-offending among those that had completed the programme. The results indicate a 100% success rate. From the first programme in June 2007 till October 2008 no recidivist drink drivers who completed the entire programme had re-offended. This is a good starting point but the conclusions that can be drawn are limited because these data do not take into account other variables. Research to address this issue is currently being undertaken and will be reported on in upcoming issues of ATRN.

Summary
Overall preliminary findings from the recidivist drink drivers programme being run in Whangarei indicate that the programme has had an impact on reducing the amount of alcohol consumed and the rates of re-offending for participants that have completed the programme. It is necessary to determine the rates of re-offending compared to those that have not completed the programme. This is currently been researched.

In conclusion the programme appears to be making changes and benefiting those that have completed the programme. This does have to compared to those that have not been referred to the programme to determine a true re-offending rate. The programme is continuing to run in the Whanagrei area, with two programmes currently running consecutively due to the volume of participants. The plan is to implement the programme into other areas in Northland.

Bronwen Wood
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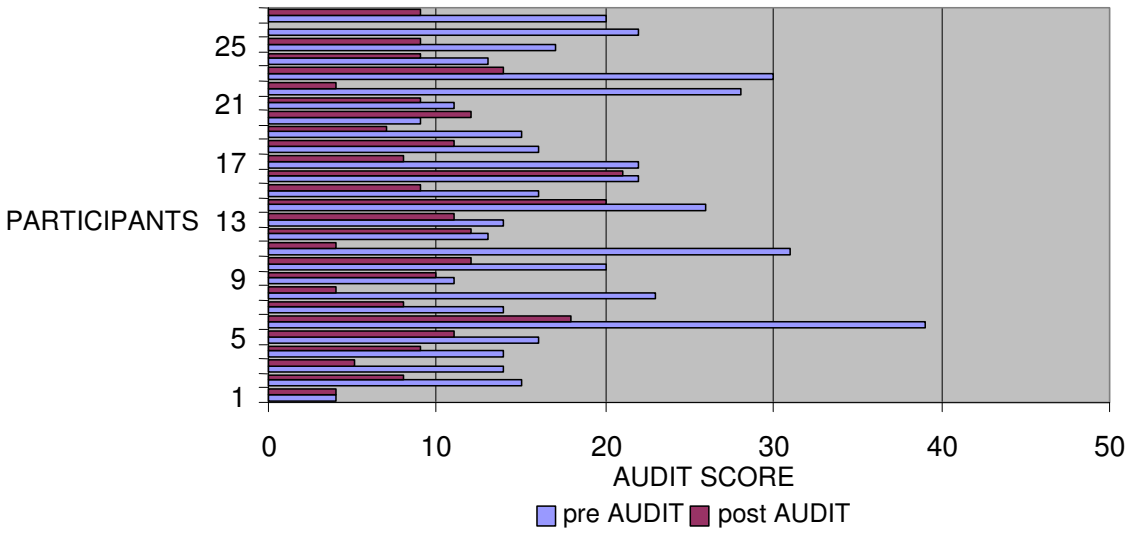
Figure 1: Pre and post AUDIT scores for programme completers



Message from the Chairperson

I cannot help but notice the increasing discourse around the changing stance on drug policy in the US. Whilst there has been some recognition of the ineffectiveness of prohibitionist policies in some states, there appears to be a much more positive mood of late to de stigmatize "addicts", to reduce consumption through campaigns of information and prevention, appropriately targeted, and implement policies and programmes of harm reduction. This is a fascinating time to be watching for a shift in emphasis of much of the literature that comes from America, and to consider if and how that will impact on the way our own, idiosyncratic, New Zealand based research is viewed.

Whilst perhaps not so internationally acclaimed but of significant value on our own turf, we have reviews of our own alcohol and drug policy and law underway. The Law Commission is looking at the Misuse of Drugs Act 1975 and the Sale of Liquor Act 1989. Whilst the Ministry of Health is reviewing the Alcohol and Drug Act 1966.These are reviews that are driven by the need to redefine the key principles and objectives of our drug legislation and their lack of coherence with policy. New Zealand's National Drug Policy is the framework developed by the government in the 1990's with the aim of reducing drug related harm and the costs of drug abuse to individuals, communities and society and to prevent or delay the uptake of drugs. This aligns closely with the focus of the UN drug control organisations and recognises that no single approach or strategy can, on its own, address drug problems. It also logically works towards a distinction between drug production and supply, as a criminal act, and drug use as a health issue, with those who use drugs having 'rights'. In February Hon Peter Dunn addressed the International Drug Policy Symposium hosted by the New Zealand Drug Foundation and the New Zealand Society on Alcohol and Drug Dependence where a multitude of drug and policy experts met to work towards the development of a health drug law. With these dramatic moves in place, it is timely to consider the impact of law reform to monitor treatment efficacy, reflect on treatment approaches and review drug trends. As members of ATRIG and thus interested parties of the addiction treatment research field, I trust that we can not only watch with interest as these developments unfold but also partake in the process that helps disseminate and promote this research and can work towards supporting the development of treatment programmes.

Klare Braye
ATRIG Chairperson

I've Been Reading …

It still never ceases to amaze me that while initiation of tobacco smoking usually begins by age 18 and early uptake predicts higher consumption, longer smoking and increased severity of dependence in adulthood, most human research on nicotine dependence has focused on adult smokers. However, I along with some others have thought that this basic premise of dependence appears similar in young people. Traditional theories of nicotine dependence suggest that dependence develops gradually as a result of heavy daily use over several years[1]. Typically adolescents smoke fewer cigarettes less regularly, and daily smoking is not as common when compared to adult smokers. For these reasons, we have been reluctant to define any but the heaviest adolescent smoker as dependent on nicotine despite young people absorbing the same amount of nicotine per cigarette as adults, smoking within an hour of waking, developing tolerance, increasing usage, reporting cravings, suffering withdrawal symptoms when abstaining, and having high relapse rates[2]. However, recently these theories have been challenged, with research from New Zealand contributing to this new way of thinking. But actually, is it a new way of thinking or just a different way of looking at nicotine dependence?

I have been reading about loss of autonomy in relation to adolescent tobacco smoking. American researchers DiFranza, Riggs and Pentz (2008)[3] suggest that loss of autonomy occurs "during infrequent smoking which is the critical event driving the subsequent trajectory of smoking" (p. 1109), with this loss of autonomy being pivotal to nicotine dependence. Simply put, individuals have lost full autonomy over their smoking when quitting becomes unpleasant or difficult[4].

In 2002, DiFranza and colleagues[5] published their findings from their Development and Assessment of Nicotine Dependence in Youth (Dandy-1) study. Using a 10-point checklist, called the Hooked on Nicotine Checklist (HONC), requiring a yes or no answer, a yes response to any of the 10 items indicates a

loss of autonomy. Based on the checklist, these authors demonstrated that novice smokers lose autonomy quickly with infrequent use, with 52% of their adolescent sample having done so by the time they had smoked on average two cigarettes per week. In 2007, the Dandy-2 study[6] replicated this result, with smoking on average two cigarettes per week at age 12 increasing the risk of proceeding to adult heavy smoking with an odds ratio of 196, meaning they were 196 times more likely to proceed to heavy smoking. Similarly, Riggs et al. (2007)[7] described a prospective study of smoking trajectories from ages 12-24 years where they identified a trajectory of "early stable users" by age 12, with these intermittent smokers having a mean cigarette consumption of two cigarettes per week. A second trajectory group of "late heavy users" identified by age 15 also reported smoking on average two cigarettes per week. Smoking as few as two cigarettes per week at age 12 increased the risk of proceeding to adult heavy smoking with an odds ratio of 174.

This brings me back to the New Zealand study conducted by Scragg and colleagues recently published in Addictive Behaviours (2008)[4], whereby the HONC was administered and data analysed on 25,000 year 10 students aged 14-15 years. Not only did the data confirm previous reports that loss of autonomy appears soon after smoking uptake, it was the first study to describe how diminished autonomy develops in relation to the total number of cigarettes smoked. Diminished autonomy was reported by 46% of smokers who smoked less often than once a month, 66% who smoked monthly, 82% weekly and 95% of daily smokers[4]. The authors concluded that smoking one cigarette in total can prompt a loss of autonomy. This evidence completely dispels the long held belief by many adults and young people that trying even just one cigarette will cause no harm.

Now to clarify the final sentence in my first paragraph whereby I mooted the idea that this may not be a new way of thinking, rather it may just be a different way of looking at nicotine dependence. Hughes and Shiffman (2008)[8] state that loss of autonomy validates earlier conceptualizations of dependence as a cumulative process beginning shortly after smoking uptake and with "loss of control" at its core. The notion of loss of control has been a central construct of most definitions of drug dependence for several decades. Furthermore, the notion that a single item can make a diagnosis has attracted its fair share of detractors for as many decades and for many reasons. Hughes and Shiffman[8] state that classifying smokers on the basis of endorsing a single marker of dependence is problematic as it classifies all users and potentially ignores the future development of the severity of dependence.

Despite these criticisms, I believe, based on my recent reading, that re-examining definitions of nicotine dependence particularly with youth can only be a positive step forward. I concur with Difranza et al (2008)[3] and Scragg and colleagues (2008)[4] that not only should early intervention require asking patients who are as young as 10 years old about smoking, it is irresponsible not to deliver clear warnings to young people about the risk of experimenting with even one cigarette. Perhaps this change of thinking is needed to identify and subsequently develop and implement effective approaches to preventing smoking initiation and reducing tobacco use among young people.

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