Addiction Treatment Research NEWS

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EDITORIAL

As the end of 2009 quickly approaches it is a good time to reflect on what has been a relatively big year for the addiction treatment field. Most memorable in my mind has been the initiation of the Alcohol Action campaign cemented by Prof Doug Sellman's nationwide "Ten Things The Alcohol Industry Won't Tell You About Alcohol" tour. This campaign has served not only to raise awareness of the serious side of excess alcohol sales and consumption among the general public but has also helped to promote the voice of the addiction treatment field to ensure that it will be represented in the release of the Law Commission's final report due out next year. As Doug points out in his latest newsletter, however, this is just the beginning and the initial momentum must be continued and built upon to ensure the ongoing impact of this campaign.

Such pioneering work has also been reflected elsewhere in our sector this year, some of which culminated in a new look Cutting Edge Conference at Te Papa in September. Many contributors to this edition of ATRN make mention of this conference and its resounding success in, once again, bringing together consumers, clinicians, researchers and many other people interested in the addiction treatment field.

In particular, Daryle Deering's report about Cutting Edge 2009 notes the smooth transition of this conference into the very capable hands of DAPAANZ and features the main highlights of the conference for her. Klare Braye in the ATRIG Chairperson's Report also tells us about her standout moments of the conference and discusses future directions for ATRIG in terms of broadening its scope and profile through collaboration with other organisations.

Our regular contributors keep us well informed about current issues in their centres. Simon Adamson keeps us up to date with the latest activities at the National Addiction Centre, while Sean Sullivan reports how the funding of gambling treatment again raises its head as submissions are sought by the Gambling Commission about levies on the gambling industry over the next three years. Sean's discussion of this issue, in relation to the implications derived from the recently released Australian Productivity Commission report of gambling in Australia, suggests that strong voices from the sector will be required to ensure that the signalled recommendations that look sure to reduce accessibility to gambling treatment and research are not realised.

Alistair Dunn has written a special report for this issue reviewing current ideas on benzodiazepine prescribing. Of note in his report is the transatlantic divide of opinion regarding the long term usefulness of benzodiazepines. Also included are the Royal Australian and New Zealand College of Psychiatrists' guidelines for prescribing of benzodiazepines.

Finally, to round off this last issue of ATRN for 2009, "I've Been Reading" provides a review of New Zealand's very own Dr Peter Adams' book "Fragmented Intimacy: Addiction in a Social World". This excellent review by Andrew Raven illustrates not only the usefulness of this book for theoretical ideas that underpin practice but also for clinical practice itself.

Many thanks to all the contributors to this edition and to those who have contributed over the year. A very special thanks to Lisa Andrews for her ongoing creative input into this newsletter.

Wishing you all the very best for the holiday season.

Happy Reading

Ria Schroder
ATRN Editor

Real knowledge is to know the extent of one's ignorance. ~Confucius

Is Problem Gambling fixed?

A recent invitation was sent by the Gambling Commission to stake-holders to provide submissions and, if desired, to present oral submissions to it in a brief (5 minute) presentation covering what levy should be made on the gambling industry for the coming three-year period. This is a critical decision, especially as problem gambling treatment aligns with AOD and Smoking Cessation workforces. Funding problem gambling treatment for prevention, interventions and support will totally depend upon this set resource, as it is not funded through Vote: Health, which funds AOD and Tobacco Cessation (TC).

Why the concern?

Many may ask what the problem is. Surely being funded from an alternative resource to other health issues is a real positive, as the need for AOD and TC to compete for funding with other more 'acceptable' health issues is a real disadvantage compared with problem gambling. Yes it is, provided it is adequately funded, based upon the usual principles of identified need, best practice and outcome effectiveness. The concern is, problem gambling has considerable difficulty in defining levels of gambling as a harmful behaviour, compared with chemical addictions, where the chemicals themselves are harmful in relatively precise quantities. There is no gold standard measure that is relatively accepted as quantifying harm, consumption risk, or biological effects. There may be, therefore, a tendency to perceive it as a lesser 'addiction', one that even the DSM-IV describes in terms of impulse, rather than dependence. It is likely that if problem gambling was funded through Vote: Health, its share of the pie would be even lower than its current funding. The problem is, with the fluidity of its definition, comes many interpretations of its effect, with little ability to deter claims of over-estimate of prevalence in the absence of persuasive research.

Very recent influential research

The Australian Productivity Commission (APC) (1), which in 1999 released a comprehensive study in several volumes, of gambling in Australia, has again released in the last month, a draft follow-up of its findings a decade ago. This prestigious federal research commission has considered several Australian prevalence studies, and has concluded that 'on balance, the evidence suggests that the prevalence rates *have* fallen' (p4.39).

Such a conclusion is both good and bad. If it is correct, perhaps the same can be assumed for New Zealand, and the harm minimisation strategies put in place by the Gambling Act and other focussed approaches are having a positive impact. However, if incorrect, or if not able to be generalised to New Zealand, then there is (unsustainable) evidence for reduced interventions being required in the future, reduced concern for introduction of new forms of gambling (e.g. Bullseye), and of course, less funding required. It is at this point that we should critically assess, as impartially as we can, the evidence for this conclusion.

A hopefully unbiased critique

At this stage I should confess my general suspicion towards politicians, judges, health professionals like myself, and others, who state that they remain impartial and are not influenced by beliefs that would bias an otherwise rational and independent conclusion. We are often unconsciously biased, and by denying such effects, can lead to assumptions that are never challenged. I may be therefore hoisted by my own petard whatever conclusion I reach. Nevertheless, sufficient funding to address harm reduction for problem gambling throughout New Zealand is a very important topic, especially when setting funding for three years into the somewhat uncertain future.

The APC looked at a prodigious 33 Australian estimates of prevalence between 1994 and 2008, before reaching a tentative conclusion that the prevalence of problem gambling was reducing. They refer to Professor Abbott's research of a sample of NZ problem gamblers between 1991 and 1998 (2), whereby only one third of serious problem gamblers identified in 1991 remained so in 1998. The APC further concludes, 'It is unclear how much this reflects natural adaptation or the impact of government policy, though both are likely to have contributed' (p4.45).

A first glance at the prevalence studies offers a far from clear picture, and not one necessarily supporting the conclusion drawn. As the APC acknowledges, the instrument measuring problem gambling changed as studies moved into the new millennium, and although reductions in prevalence appear regular in recent surveys, the numbers are very small, with the likelihood that any false negatives could completely change the conclusion. This is a constant problem where the condition measured only comprises a small proportion of the population. The APC readily notes that the reductions are not statistically significant, but that with successive reductions, the likelihood of error reduces.

Why problem gambling would reduce

The APC identify a number of reasons for expecting that problem gambling would reduce in Australia (and these could apply to NZ), one being adaptation:

- Australians were suddenly exposed to gambling (other than NSW, with gambling machines having a long history) and some would develop problems
- Novelty wanes and people adapt, with less gambling, with the help of government and gambling industry strategies
- As people resolve their gambling problems, they are less likely to relapse through 'inoculation'

My first response would be that outcome evidence for the adaptation theory appears thin, as does evidence for effectiveness of government and gambling industry strategies. Certainly, it's headed in the right direction, but to assume at this stage it has been effective, is somewhat premature. Also, it is a very large leap to assume that people with addictions inoculate themselves against relapse, so this is another long draw of the bow. Certainly, many affected by addictions recover both with and without professional assistance, but numbers do live with a roller coaster of recovery, as would be expected with a persistent and recurrent behaviour, common to many addictions. Add these to new cases, and there would have to be substantial reductions of new cases over time, to reduce prevalence.

Some contrary thoughts

There are many reasons why the prevalence numbers may be an under-estimate of the problem, quite apart from the difficulty in measuring a low prevalence condition. The APC acknowledges this, stating that measures taken at some point in time and compared with a later point, can have a number of sampling errors, systematic errors that can affect estimates. Quite apart from these, I often wonder whether people's willingness to respond to surveys, or respond truthfully, remains constant. I suspect that nowadays, people are more circumspect when talking to strangers about problems that are stigmatised throughout society, and may not participate if they are defensive about their behaviour. Consider this: if only 75% of those surveyed agree to participate (a percentage considered very good), and the 25% non-participants have a higher proportion of problem gamblers, a prevalence of 1% could easily double if the non-participants had agreed, and responded truthfully. If so, the APC would have concluded on its findings, that prevalence of problem gambling had in fact increased, possibly even to a statistically significant level. In the 1999 APC survey (3), they reported a finding that only 29% of problem gamblers would be fully truthful about their gambling (Table 6.9). Perhaps a solution would be to survey those affected by another's gambling; these people may be more willing to disclose their situation, and at an estimated seven or so of these for every problem gambler, many of the problems of low prevalence may be avoided. Over time, we could see if these numbers reduced, as an indicator of problem gambling prevalence.

Conclusion

Having possibly been destroyed by my own petard (it's a bomb, not a rope), and having come the full circle, what concerns do I have for the forthcoming Gambling Commission hearing? Firstly, this new evidence of the APC will certainly support reduced funding recommendations, and coming out of the blue at this time, it couldn't have been more influential if it tried. In fact, it has been signalled by papers before the Gambling Commission that there will be a gradual reduction in funding over the next three years. For a relatively new field, without the support of robust research that exists in other long-accepted fields, we will increasingly rely upon conclusions reached in overseas environments. I suspect that New Zealanders may be differentially affected by gambling problems when compared to Australians, but where are the research initiatives to build upon the APC's important findings and conclusions? Within the recommendations that have been signalled, will be assumptions that intervention service needs will remain constant in the next three years, and research will reduce annually from $2.5m to $1.4m in the third year. No

contingency funds are set aside for unexpected impacts or opportunistic strategies that arise. We are in a recession of undetermined length, have an acknowledged lower average per capita income than Australians, and have a steadily growing investment in gambling losses. Whether or not the APC's findings are accepted as a positive direction for Australia, there are a number of differences that apply here that should suggest caution.

It appears we may consider we already know all we need to know about problem gamblers in New Zealand.

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NATIONAL ADDICTION CENTRE REPORT

There are plenty of good things happening at the NAC at the moment. Our dear Editor Ria has been successful in gaining seeding funding from the Heart Foundation for the Problem Food Study, various aspects of which have been described in earlier ATRNs.

Michael Baker has submitted his PhD, titled "Spirituality and Treatment of People with Alcohol and Drug Dependence". You can read about some of Michael's doctoral work in: Baker PB, Sellman JD, Horn J. The spiritual characteristics of New Zealanders entering treatment for alcohol/other drug dependence. Alcoholism Treatment Quarterly 2007;24(4):137-155.

Doug Sellman has a paper "The 10 most important things known about addiction" ready for publication in the January 2010 edition of *Addiction*. This paper started life as a discussion piece at the Addiction Summit meeting held in Melbourne last year. The paper has generated a number of commentaries from lead researchers in the international field and is well worth a read.

The review of alcohol policy being undertaken by the Law Commission has captured the public imagination. With the widespread nature of alcohol-related harm this is no great surprise. At the NAC we take some pride in the contribution we are making to this debate, in particularly through the lecture tour undertaken by Doug Sellman – "Ten things the alcohol industry won't tell you about alcohol (Doug obviously relies on his fingers when it comes to counting). Two recent editorials, published in the November 20 edition of the New Zealand Medical Journal were part of that effort. The first, by Doug Sellman and Jennie Connor (Department of Preventive and Social Medicine, University of Otago, Dunedin) highlighted the preventable tragedy of *in utero* alcohol exposure and the resultant brain damage, affecting something like six hundred newborns per year in New Zealand. The second editorial, authored by myself and Elisabeth Wells (Department of Public Health and General Practice, University of Otago, Christchurch) revealed that hazardous drinking is a problem experienced by the majority of drinkers in New Zealand at some point in their lives. Both editorials show that the research highlights more of a problem with alcohol than is often conveyed by others, and argue that the widespread nature of the problem means that policy change needs to be broad-based to be effective.

As the year ends we continue to think ahead to prospects for future research at the NAC. One area of developing interest is pharmacological "addiction interrupting" treatment research, with preliminary talks underway between the NAC and the Department of Psychological Medicine in Dunedin. The aim is to scientifically evaluate the potential of psychoactive drugs, such as LSD, psilocybin and ibogaine, as therapeutic agents in addiction treatment. With the

present resurgence of interest in ibogaine and varying perspectives this focus is highly topical. A second area for future development relates to opioid dependence and treatment. Following on from the Ministry of Health funded report *Opioid Dependence in New Zealand* (now available on our website www.addiction.org.nz), Daryle Deering is looking to undertake further research in the effective treatment of opioid dependence.

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

MESSAGE FROM THE CHAIRPERSON

I hope that many of you took the opportunity to attend this years Cutting Edge Conference held at Te Papa in September. It was a wonderful event hosted by DAPAANZ and sponsored by ALAC and the Ministry of Health. I understand that nearly 400 practitioners, consumers, researchers, workforce developers, policy makers and interested parties attended what proved to be an excellent line-up of keynote speakers, presenters and posters. I note in the DAPAANZ Bulletin (September 2009) that they have already summarised the evaluations with positive ratings being very high. The events reported as being the most enjoyed were the networking and the keynote speakers. In particular, Steve Onken, from the University of Hawaii who passionately discussed 'wellbeing' in relation to mental health recovery and Moana Jackson of Ngati Kahungunu and Ngati Porou, on orator of exceptional standards.

Whilst the focus of the presentations was not necessarily directly on research, my interest in what I took from the presentations was. Moana highlighted how data about Māori is so often comparative to pakeha, rather than being within the context of the culture. Steve Onken noted how 'hope' has become a national outcome measure in the US, in relation to concepts of wellbeing. Sir Geoffrey Palmer stressed the need for submissions and anecdotal evidence to support the future of the Law Commission proposals. Professor George De Leon portrayed his passion for therapeutic communities through both practical work and paper publications and Dr Simon Adamson focused on the outcome data of clients with coexisting disorders. That is just a snapshot of the keynote speakers. In addition to this Denise Nassenstein, also the much deserved recipient of the practitioner presentation award, provided a detailed overview of the use of Dialectic Behaviour Therapy in a client with a coexisting disorder. Hayley Theyers and Paul Burns presented some wonderful consumer insights into perceived future direction of services and Dr Tom Flewett collated information on the successes and mistakes of the development of a coexisting disorders service...and so it went on. What this conference highlighted to me is how with collated evidence, outcome measures and what may at times feel like basic number crunching, we can shape the way that our services are delivered and our tangata whaiora are supported.

The other event of note at Cutting Edge was, of course, the ATRIG AGM. This in practice is a time of official reports from executive members, financial statement approval and executive election processes. Whilst this process did occur, I must confess that without the formal guidance of our esteemed secretary, Lindsay Atkins, the discussion jumped fairly rapidly to the general business topic of the direction that members would like ATRIG to take in the future. There was certainly an enthusiasm for working to broaden our membership and raise the profile of ATRIG, with many members very supportive of the intent, but in reality struggling to make research a priority in their more practitioner focused roles. General interest in broadening ATRIG membership through a collaboration with DAPAANZ was indicated. There was also discussion about targeting training institutes and capturing the up and coming practitioners and researchers in the field, linking membership and ATRN contributions to DAPAANZ CEP credits and to work to increase the frequency, (but perhaps reduce the content) of ATRN, making it a more regular feature to cross the coffee tables. In conclusion there was great discussion and passion to develop the addiction research profile in New Zealand and it was agreed that ATRIG as a small yet established set up, working in collaboration with other established organisations in the field, was the way to do it.

Klare Braye
ATRIG Chair

IMPRESSIONS FROM CUTTING EDGE 2009

The theme of the 14th Cutting Edge addiction treatment conference held at Te Papa in Wellington from 10th to 12th of September was *Our Place, Our Future*. Principle support was provided by ALAC, the Ministry of Health and the Mental Health Commission. This year marked the very successful transition in my view of the hosting of Cutting Edge from the National Addiction Centre to DAPAANZ (Drug and Alcohol Practitioners Association). Longer sessions were scheduled to promote greater exploration of topics by keynote speakers and presenters in a smaller number of streams. It was not possible to attend every session and as with each Cutting Edge conference I was aware of missing many high quality presentations. However, the availability of USB sticks for delegates enabled access to power-point displays and, for those not able to attend, access via the Matua Raki website.

My personal impressions were of an inclusive and culturally rich conference comprising a broad range of verbal and poster presentations. These ranged from prevention and legislative change (e.g. liquor law reform and drug driving) to brief interventions and the nature of primary health consultations to therapeutic interventions that included on-line interventions, expressive writing and musical conversations. In addition there were a number of presentations that addressed the common issues and differences between AOD and gambling, cultural and clinical models, peer support, competencies, aspects of education and training (e.g. consumer advisor, reflective practice, supervision) and quality processes (e.g. in relation to Pacific AOD services). I noted multiple references to the concepts of trauma, recovery, wellness and wellbeing, healing, integration and re-integration and outcomes as well as a focus on social, multi-systemic and individual therapeutic approaches. Music was a feature; Pacific music and waiata. The nature of the conference where delegates remained in close proximity and the dinner, made it very easy to catch up with colleagues and friends.

The challenges issued by Moana Jackson in relation to research objectivity and comparative research designs, particularly in relation to Māori, and cultural misperceptions arising from media reports have stayed with me. Moana's example of asking us to signal if we were aware of the names of Māori and Pakeha children who died as result of abuse from their care-givers brought the media's role in promoting public perceptions home to everyone in the room. A key reminder from George de Leon in respect to the social role of healing within the therapeutic community programme which may be embedded in a range of settings (residential, day programmes, opioid substitution treatment outpatient programmes) and the importance of separating the programme from the "residence" has also stayed with me. This is particularly important in an environment of constrained resources in which the need to reduce costs leads to a risk of *trimming* the effective components of the therapeutic community to below a threshold of effectiveness. Peter Adams emphasised the social nature of addiction and the time required to bring about the building and/or rebuilding of a social network that moves away from the central addictive relationship. The importance of relationships and support as both a positive and a negative influence to change were also identified in the outcomes research provided by Simon Adamson. Steve Onken touched many at an emotional level in his person centred address that focused on recovery journeys within a broader community framework. More broadly, the keynote speakers all made links in someway to the themes of community, recovery and well-being, social inclusion and exclusion, citizenship, culture and relationships. Finally, it was of historic importance that Sir Geoffrey Palmer came and sought the views of the delegates on treatment issues in respect to the *Discussion Paper Alcohol in Our Lives* and Doug Sellman launched the alcohol action campaign with his address titled *"10 things the alcohol industry won't tell you about alcohol*." I left the conference being reminded of the importance of both prevention and treatment in respect to the conference theme of *Our Place, Our Future*.

Daryle Deering
National Addiction Centre

LITERATURE REVIEW: PRESCRIBING BENZODIAZEPINES

Background

Benzodiazepines are commonly used anxiolytics and hypnotics which act via GABA receptors. They were introduced in the early 1960s and rapidly replaced barbiturates because of fewer side effects, drug interactions and greater safety in overdose (1).

However after their initial popularity, benzodiazepine prescribing decreased after the late 1970s following reports of both physiological and physical dependence (2). Other complications became apparent including impaired cognitive function and memory, disinhibition and aggression, falls or accidents (especially in the elderly) and overdose (3).

In response to these concerns, guidelines[1] were developed to assist doctors prescribe benzodiazepines safely. These commonly advise short term prescriptions, using the lowest possible dose, and caution in patients with a history of substance use disorders (3,4).

This literature review sought to summarise recent evidence and current opinion regarding the prescribing of benzodiazepines.

Method

Whangarei Hospital library staff kindly undertook a literature search for articles about benzodiazepine prescribing published within the last ten years .

Results

Interestingly there appeared to be a "trans – Atlantic" divide in opinion regarding the usefulness of benzodiazepines in the longer term. Several American authors were more positive and supportive of long-term use, whereas British authors sounded a more cautionary note.

U.S.A

Pomerantz, in his review paper, concluded that the long term use of benzodiazepines was still an effective option, i.e. the medication maintained their effectiveness over time (5). However he also noted that cognitive impairment remains a concern, and, while the risk/benefit balance currently seems acceptable, this could change if evidence accumulates of significant cognitive disturbances and associated, possibly irreversible, brain changes. His choice of references appeared somewhat selective however, citing Romach's study (6) of patients who were described as neither abusing nor addicted to benzodiazepines, taking either a constant or reducing dose. What Pomerantz failed to mention was that this study involved a population of patients actively seeking help because they felt they no longer required their medication but were having difficulty discontinuing its use on their own, or because they had simply become concerned about the length of time they had used the medication and wanted support in discontinuing it.

Soumerai (7) examined 2440 patients prescribed benzodiazepines over a two year period. He found little relationship between long term benzodizepine use and escalation to higher doses. The vast majority did *not* increase their dose to "high" doses (>40 mg diazepam), with only 1.6 % doing so. Soumerai identified those subjects more likely to increase their dose as "pharmacy hoppers", those on narcotic analgesics and those obtaining duplicate scripts.

Stevens and Pollack (8) made the interesting observation that despite American Psychiatric Association guidelines recommending SSRIs as first choice medication in treating panic disorder, benzodiazepines remain the most frequently prescribed anxiolytic. They found evidence for the efficacy of benzodiazepines in treating anxiety but also cited a study showing benzodiazepines may actually have an *adverse* effect on recovery from acute trauma, increasing the risk of developing PTSD, despite the fact that they successfully reduced sleep disturbance, anxiety and agitation. They concluded that benzodiazepines "have remained a mainstay of anxiolytic pharmacotherapy because of their robust

[1] It is important to note that there are other approaches to the treatment of anxiety, such as the use of CBT and SSRIs, that are considered to be potentially more effective and safer treatment options. However, when benzodiazepines are indicated, these guidelines are recommended.

efficacy, rapid onset, and generally favourable side effect profile. *With the exception of patients with a substance abuse diathesis*, the data are reassuring regarding tolerance, and dose escalation with long term use" (8).

One psychiatrist reviewing his own benzodiazepine prescribing practice after 22 years concluded that problems occurred only in a small minority with co-existing substance abuse disorders (9).

United Kingdom

Lader's admittedly older (1999) paper begins with the assertion that "benzodiazepines are now recognized as major drugs of abuse and addiction. Other drug and non-drug therapies are available and have a superior risk benefit ratio in long term use" (10). He considers that the risk/benefit ratio of these drugs becomes less favourable or even adverse as treatment becomes prolonged and efficacy wanes and risks accumulate. Lader concluded that benzodiazepines should be reserved for short term use – up to 4 weeks – and in a conservative dose. He also delved further into the role of benzodiazepines in polydrug abuse, where it is used to intensify euphoria with opioids, ease the 'crash ' down from stimulants and provide enough disinhibition to engage in the criminal activities needed to sustain the polydrug habit. He also highlights the adverse sequelae of injecting, and the contribution of benzodiazepines to polydrug overdose.

More recently, Ashton's (2005) review paper states that *"Long term prescribing has resulted in large numbers of long term users who have become dependent on benzodiazepines and has also led to leakage of benzodiazepines into the illicit drug market"* (11). She advises that benzodiazepine dependence could be prevented by adherence to recommendations for short term prescribing (2-4 weeks only when possible). Evidence is given demonstrating tolerance and dose escalation when benzodiazepines are used for insomnia and numerous papers are cited regarding withdrawal problems, which can lead patients to continue taking benzodiazepines after the initial indication for the drug has passed. Ashton also advises *"particular care should be taken in prescribing benzodiazepines for patients with alcohol or drug dependence, and doctors should be aware that prescriptions may enter the illicit market."*

Elsewhere

Two Canadian authors outlined the challenges involved in attempting to modify doctors' prescribing of benzodiazepines. Neutel (2005) found that education programmes failed to modify behaviour and referred to the lack of adherence to the APA guidelines mentioned earlier (12). Rosser described a project set in General Practice in Ottawa, where guidelines failed to alter prescribing at one year review, but an educational programme involving feedback about the results of the study did produce a reduction in benzodiazepine dose and duration , especially in the elderly (13).

Conclusion

In summary, while there is conflicting evidence and opinion regarding the efficacy of long-term use of benzodiazepines, it seems reasonable in the majority of cases. However, the prescriber needs to be aware of the potential adverse effects and in particular the abuse potential of benzodiazepines. Alternative treatments (Buspirone, counselling, CBT) should also be considered. Guidelines have been developed to assist clinicians to prescribe benzodiazepines safely and these are outlined below.

New Zealand Guidelines

The Ministry of Health "Guidelines for Prescribing Psychoactive Drugs" (1996) note that prescribing benzodiazepines "*requires special care and precautions because of the risk of dependency".* It notes that a history of AOD abuse or dependence is a "*relative contraindication*" and urges the prescriber to consider other non- pharmacological options (counselling, CBT) (3). It recommends a dose range of 2-25 mg/day diazepam for the treatment of anxiety and 5-10 mg diazepam nocte as an appropriate hypnosedative dose.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) Guidelines for Use of Benzodiazepines in Psychiatric Practice (2008) provide a useful framework and are attached as a separate document (14).

The key points are:

1. Have a clear diagnosis (comprehensive assessment)
2. Prescribe short term except for 'particular individuals'

3. Prescribe the lowest effective dose necessary
4. Beware sedation especially in the elderly with risk of falls
5. Caution in persons with history/current substance use
6. Concurrent prescription of more than one benzodiazepine requires justification
7. Advise re dangers of tolerance, dependence and withdrawals, and document advice that dosage and period of prescription are not to be exceeded
8. Repeat prescription should not generally be provided without a clinical review

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I'VE BEEN READING …

Fragmented Intimacy: Addiction in a Social World
Dr Peter J. Adams,
Springer, 2008.

Although I did not attend the Cutting Edge Conference 2009, those returning reported an excellent conference: an interesting range of presentations, thought provoking material and with sessions long enough to allow the full development of ideas.

One was from Dr Peter Adams, University of Auckland, titled "Fragmented Intimacy: Recovery/Reintegration in a Social Framework" based on work done when on sabbatical in 2006. Dr Adams wrote a number of books over that

year, including “Fragmented Intimacy: Addiction in a Social World”, in which he laid out the ideas presented in part at Cutting Edge and which I have been re-reading recently, and review here.

The primary aim of this book is to challenge the predominating biological and psychological approaches in the addiction field, arguing for a perspective that locates both understanding and treatment of addiction in a social and relational context. The author calls on his experience as a Clinical Psychologist, his study of philosophy and social theory and his understanding of post modernism to propose a paradigm shift in our consideration of addiction: away from what are labelled particle paradigms (Medical Model, Biopsychosocial Model) to a social paradigm. The social paradigm focuses on understanding people in terms of their relationships and the social constructions in which they live. Addiction can then be viewed as a social event, with the individual developing an increasingly intense relationship with a substance or process, a relationship that increasingly excludes relationships with partner, family, friends, and work. The argument is made that any positive change, and interventions to support people with such change, must focus on their re-socialisation and re-integration into a sustaining social network of intimate relationships.

The impression gained might be that this is a book for academics, not those working in treatment services and certainly of no value to clients. This is not the case, with the book devoting a significant proportion of space to the practical and applied aspects of a social theory. This is aided by four case studies tracked through each chapter and illustrating both the impacts of addiction and changes made. There are also numerous diagrams that assist understanding and these, along with chapter summaries and a logical development of ideas, ensure the reader remains well connected with the ideas the author is developing.

“Fragmented Intimacy” is divided into four parts. The first outlines the theory of a social perspective on addiction and how addiction can develop in a social system, the second describes in more detail intimacy and the impacts of addiction. The third section introduces how change might occur at a number of levels with detailed suggestions about how to work towards re-integration. The final part focuses on specific areas of change application, including specific suggestions for practice (in both assessment and intervention stages) and some cultural perspectives.

The book is well supported with a glossary, author notes for each chapter, a bibliography and index by both author and subject.

To date I have found this book useful in a number of ways.

Firstly, the conceptual framework has been useful in guiding my work as a member of Kina Trust. Kina is increasingly well known for its advocacy of family inclusive practice within the addiction treatment work place (1) and this is a valued focus for change. However the Trust is also about a more contextualised, systemic view of treatment and attitudes to addiction - encouraging practitioners to view their clients as part of a social environment that contributes to both the creation of addictive patterns and contains the resources and supports for change. Dr Adams book brings clarity and detail to this perspective, provoking and supporting more useful dialogue amongst Trustees and between the Trust and wider community.

Secondly, I have found this work useful in the classroom. Student addiction counsellors find the ideas appealing, connecting easily with the conceptual framework and appreciating the practice based approach. As an example, students are aware of the value of intimacy but struggle to develop a deeper understanding of how this links to psychological health and addiction interventions. This book not only offers an explanation, but also operationalises the concepts involved and how practitioners might make a difference.

Finally, I utilise this book clinically. This is definitely not a “self help book”, but I have shared some of the content with clients whose backgrounds allow them to access the material. They find the ideas relevant, and connect with both the central concept and the suggested areas of change. Most clients appreciate that they have developed a relationship with an addictive substance or process to the exclusion of intimacy: loneliness and “burnt bridges” are key features in their lives. Abstinence is a process of letting go an old friend, sometimes of grieving: there is fear and uncertainty about steps towards integration. Being able to talk at this level and plan that reintegration is a significant part of their change. I recall a recent conversation with a client, a man with a history of alcohol abuse and depression. We were reviewing his reaction to a recent stressor when he became quiet and thoughtful, then turned

to me and said quietly "You know Andrew, having alcohol in your life is like living with someone, you know. You owe it allegiance". In responding to this man, and his world view, Dr Adam's work was prominent in my thinking and informed the intervention subsequently conducted.

As noted at the beginning of this review, Dr Adams has written this book as a challenge to predominant thinking and practice in the addiction field, and indeed the wider community, as it faces an increasing availability of potentially addictive substances and processes. His ideas will find resonance amongst many, particularly those keen on developing practices based on social network therapy (2), bicultural approaches (3) or family inclusive practice (1) as examples. It remains to be seen how the wider addiction community responds to this challenge.

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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.

ATRIG's objectives are:
- To foster interest in scientific research on treatment of people with addiction related problems within Aotearoa NZ.
- To disseminate and promote research findings related to effective treatment of people with addiction related problems in Aotearoa NZ.
- To support the development of improved treatment services for people with addiction related problems within Aotearoa NZ.

The **executive committee** are:
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Addiction Treatment Research Interest Group (ATRIG)

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

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