Addiction Treatment Research NEWS

NEWSLETTER OF THE ADDICTION TREATMENT RESEARCH INTEREST GROUP

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EDITORIAL

Welcome to the first edition of ATRN in 2010. You will find that we have made some changes in this and upcoming editions as we endeavour to respond to reader need and feedback. Of particular note is the shorter version of this newsletter. In this increasingly time pressured world we have decreased the length of this newsletter in order to provide you with a taste of what is happening in the addiction treatment research field without taking up too much of your time. To this end, some of our regular features, including research centre reports and medical school updates, will not appear in every issue but will instead be spread out over the year. We have also reduced the number of original research articles but have retained the regular update from the gambling field via Sean Sullivan at ABACUS and our ever popular "I've Been Reading" article. You will also notice this editorial piece is much shorter and has largely been replaced by a table of contents that allows you to see at a glance the articles of relevance to you. I hope these changes enhance your opportunities to catch up with what is happening in the addiction treatment research field and allow you a couple of extra minutes each edition to think about what research you might be doing that you want the rest of the field to know about or what research you would like to do in the future. All comments on these changes, and any other comments you may have about the ATRN or any of the articles in it, are very welcome. Many thanks to all who have contributed to this edition of the ATRN.

Happy Reading

Ria Schroder
ATRN Editor

Addictions under fire?

If the only tool you have is a hammer, you tend to see every problem as a nail
Abraham Maslow

It seems almost daily that we hear of further health funding reviews which are accompanied by evidence for reducing funding for services. During a recession it may well seem appropriate that governments cautiously manage public funding, but it seems counter-intuitive if the evidence suggests that health, and particularly addiction, deteriorate during these times of privation and stress. As professionals we often believe that, especially in addictions, the behaviours can intensify during times of stress as a maladaptive stress-reduction process. It appears axiomatic that recessions result in increased stress across the community, and that increased stress may result in more, rather than less addictive behaviour. DSM-IV criteria for pathological gambling notes that

'The urge to gamble and gambling activity generally increase during periods of stress or depression'

An Australian research think-tank finding

The Australian Productivity Commission (APC) is an important federal research body that provides independent long-term advice on the community's wellbeing, albeit largely focused upon a productivity viewpoint. In 1999, it published an impressive review of Australia's gambling, reviewing costs and benefits of gambling, including problem gambling. Late last year it published a 10-year follow-up in a draft document on gambling in Australia, but surprisingly concluded that

'While some indicators point to an increase in prevalence rates of problem gambling,
the balance of evidence (and theory) suggests that prevalence rates of problem gambling have fallen' (1)

The 'balance of evidence' is able to be contested, and has been by Australian researchers reacting in a fairly robust manner (2). However, perhaps the more important focus is upon their reference to 'theory', as their theory essentially predicts that problem gambling rates will reduce over time as people adapt to the risk. Before we quickly assume that this is idiosyncratic of gambling, this theory can readily apply to substance addictions, with the possibility that strategic health planning will adjust to reduced need, especially when supported by august research bodies.

The APC posited that:

- People adjust ('adapt') to novel forms of gambling as it becomes less novel
- People overcome ('adapt') faulty cognitions about systems and cycles of winning
- Counselling and policy (harm reduction) measures may contribute to this reduction, but mainly act to adjust a floor rate (plateau)
- At risk populations will reduce to a plateau through adaptation rates exceeding new input rates (young adults and migrants not having gambled previously) but never fall to zero

As can be seen, if the second bullet point is modified to address reasons people harmfully use other agents, this theoretical model can substitute methamphetamine addiction, binge drinking by youth, RTDs, tobacco use, and even perhaps assumes that alcohol misuse has reached a plateau with the broad population having adapted. They may point to young people who binge drink on alcohol, adapting, and within a short period of years, settling down to much less problematic level of use, with or without therapy. If generalised, using this model, problematic behaviour appears in the main to be self-correcting. If so, should we therefore assume that our role is to hasten harm reduction? This would still be a laudable goal even within this narrower purpose. However, according to this theory, if we are unsuccessful, those affected will inevitably self-cure through 'adaptation', despite our failure.

There are several aspects of this theory that deserve critical analysis, especially as it appears to have logic and influence that may readily be adopted by funders and the industries, that one way or another are penalised through additional social impact taxes. Reduced tax equals reduced funding for treatment. Firstly, let me say that the evidence for reduced problem gambling prevalence is weak and the APC conclusion has been roundly criticised in Australia (2). Time and space to fully address that evidence isn't available here. However, the adaptation theory deserves consideration because of its likely attractiveness to influential (funding) stakeholders and to its likely generalisation to other addictions. Theories can have a status that influence decisions of import. They can often become accepted concepts upon which mere facts are treated as confirming or exceptions.

Testing the theory

Theories are often tested by facts that support their premises. For this theory, apart from repeated population prevalence studies showing a reduction over time (a finding that is contested), there appears to be little basis. There are many other approaches that may contribute to, but not in themselves being sufficient proof for or against its validity. Bringing these alternative explanations together in one place represents a triangulated approach that is a commonplace test for validity (3).

By formulating expectations based upon the theory, one can test if reality supports the theory, which implies:

a) Problem gamblers will choose to gamble (or not)

Treating problem gambling, and potentially other addictions, as behaviours that people enter into as participants who have control over their behaviour and make considered choices is simplistic and inaccurate. Those with control may find gambling (or substances) less alluring over time and participate less by choice, but many problem gamblers continue to gamble despite realisation that they will never win over time, or may dissociate and escape dysphoria, and so be reinforced despite loss of money over time. Addictions are complex conditions influenced not just by the behaviour, but by biological and social drivers that contribute to acceptance of skewed thoughts that can maintain the behaviour. Realistic choice is often the first casualty in addictions.

b) People recover from gambling problems over time

Commonly, 'lifetime' screens identifying problem gambling produce prevalence rates that are twice as high as current prevalence. At first blush this may be taken as evidence that people recover, often never having sought counselling or other help, possibly attributable to adaptation to the agent (gambling). Another alternative explanation is that addictions are recurrent and persistent (DSM-IV), and that at any one time, up to half will be either recovered, or between problematic gambling episodes. Clearly, many people do self-recover because of circumstances specific to the person, with support from others and their environment. But this does not mean that they have adapted to the mode of gambling, but rather, other aspects of their lives have now gained priority sufficient to overcome the addictive behaviour. Nor does it mean that the large majority will self-recover, or explain why some, perhaps many, don't.

c) Problem gamblers' losses on newer gambling modes will reduce

Pokies are clearly the most likely to cause gambling problems out of the various gambling modes. As an exemplar for the adaptation theory, one would expect to see a gradual reduction over time as less people played, and the largest assumption, that less problem gamblers played following adaptation. Recently, the amount lost on gambling machines did reduce, perhaps supporting this theory. The APC estimates that about 40% of losses on pokies are attributable to problem gambler losses. However, because of regulations the numbers of gambling machines have reduced; when a calculation is conducted of the average loss per machine, over the past five years in NZ, the annual loss has remained consistent, ranging from $44,000 to $47,000 per machine each year. Either adaptation isn't occurring, or non-problem gamblers are increasing their pokies playing. As regards the latter, the population is of course growing, but it appears gambling is decreasing as a pastime (4).

The APC also states that losses by problem gambling appear to be very high, with no apparent downward trend. This appears to be inconsistent with adaptation theory.

d) Longitudinal studies will show adaptation

Longitudinal studies may validate or disprove this theory over time, and one NZ study is referred to, where two-thirds of severe problem gamblers in 1991 remained so by 1998 (5). This study referred to thirteen problem gamblers with

severe problems, whose number had reduced to four during this period. However, by 1998 a further six lower risk problem gamblers in the study had become severe gamblers, while four of the previously severe gamblers had merely reduced their gambling to a lower problem level. In part this may suggest that problem gamblers do adapt, but there appears to be little evidence that the prevalence was reducing as also predicted by the theory. Despite longitudinal studies with gambling data becoming more numerous, this was the only study cited from throughout the world, and it was conducted twelve years ago.

e) Where is tolerance?

Adaption is a term usually associated with dependence and tolerance with drug use, yet with gambling, adaptation is given a different process: adaptation and weakening of association followed by disconnection to the behaviour (6). In addictions, of which severe problem gambling is a recognised member, tolerance develops recognised by irritability and boredom when not gambling or cutting down, which is reduced by increased gambling rather than discarding of the process (DSM-IV and DSM-V proposed).

All in all, there appears to be less support for the adaptation theory from this brief triangulated summary of different perspectives in that these appear to be inconsistent with a boredom explanation supporting gambler 'adaptation', and the consequential reduction in problem gambling over time.

A positive future?

Earlier this year the NZ government announced that it will establish its own productivity commission (NZPC) to be in place by April of next year. This has to be tentatively welcomed as an independent advisor of the impact of policy on productivity and regulatory issues, with a long-term view influenced by evidence-based economic, social and environmental impacts. Governments are often averse to advice that does not have an immediate positive payback, certainly within their tenure. An established research body that focuses upon the longer term has to be welcomed, especially if independent, of wide focus, with social costs given importance.

Problem gambling has been said to cost $4 for every $1 earned by government4 and, for AOD, $5 costs for every $1 not spent in AOD therapy (7,8). The questionable logic of the APC's conclusions is at least based upon transparent reasoning, and thereby is open to criticism, and hopefully, adjustment, as a good research process. Previous work, as well as the current review of the last decade, is impressive and helpful, notwithstanding the adaptation theory which could be treated as a 'senior moment' (I can comment on this, as belonging to that cohort). The recent review of drugs legislation by the Law Commission and immediate negative comment from government representatives, suggests that such review bodies may not automatically have the ear of government. However, a productivity perspective appears at this time to be a more acceptable 'value for money' approach than raising perceived politically charged suggestions. The imminent NZPC can be an asset for addiction treatment providers, as long as we can show effective and efficient outcomes, and that spurious theories receive a timely drubbing.

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MOBILE PHONES: A NEW ADDICTION?

Introduction

People have become increasingly reliant on technology. International reports suggest individuals can become problematically involved with or 'addicted' to technology such as the internet, video gaming, online gambling, and television (1,2). Mobile phone technology is the most recent to receive attention, both from the media and academic circles with reports of people becoming 'addicted' to their mobile phone, both locally and overseas (1,3).

Whether or not this behaviour can be deemed an addiction is debatable, however, the lack of an overarching or hermetic theory of addiction suggests it would be unwise to preclude excessive mobile phone use from the 'addiction' camp solely based on the lack of substance ingestion.

Excessive mobile phone use can have serious consequences to the user and others. Excessive texting can lead to damaged joints and arthritis in fingers and wrists (4,5); it can result in severe monetary losses (6), which may in fact lead to significant debt; the effects of cell phone radiation on the human body are still being investigated particularly, the link between cell phones and cancer (6). Mobile phones have also been linked to an increased number of vehicle crashes due to loss of driver attention (7). Mobile phone dependence has also been linked to irregular and disturbed sleeping patterns, especially in children and adolescents – this in turn has been linked to a range of health issues (8).

Given the potential seriousness of the consequences of excessive mobile phone use, an exploratory study was undertaken into the prevalence of mobile phone 'addiction' among New Zealand adolescents.

Method

The assessment tool used in this study was a survey developed and implemented by Walsh and colleagues (7). The survey was deemed a reliable and valid tool for mobile phone addiction (7). It assessed mobile phone addiction using 12 scales comprising a total of 38 items rated on a Likert scale of 1-7 (1 = strongly disagree, 7 = strongly agree). Six of the scales were based on the addiction constructs defined in Brown's theory of addiction: salience, euphoria, tolerance, withdrawal, conflict, and relapse. The other six scales were based on other facets of addiction (7). The items generally assessed to what degree participants had experienced the different constructs. An electronic version of the survey was created, using the online surveying tool www.surveymonkey.com.

Five secondary schools within New Zealand were invited to participate in the study. Of the five, two agreed to participate. One school chose to post a recruitment advertisement on their website, describing the study and inviting students above the age of 16 to participate. They also offered participants a chance to go in the draw to win an iPod Nano. The other school chose to display posters advertising the survey around the campus. Inclusion criteria were: aged 16 or above, owning a mobile phone, and attending high school in New Zealand.

Ethics approval for the study, and all the supporting documents was sought from, and granted by, the University of Auckland Ethical Committee. Potential participants were informed that they could withdraw from participation at anytime during the completion of the survey.

Results

One hundred and seventy-five participants started the survey, but only 75 completed. The age range of the responders was between 16 and 19 years of age; the sample was relatively representative in terms of gender: 53.3% males and 46.7% females; however, the sample was predominantly New Zealand European and Asian (77.4%), with Maori being under-represented. Data were analysed using SPSS programme for statistical analysis.

Scales were assessed for reliability and validity and produced high Cronbach's Alpha scores (0.701-0.902).

The mean scores of each scale were evaluated, however, when using this method it was not possible to accurately ascertain what proportion of participants scored highly on the scales. Thus, the scales were instead

assessed based on the percentage of participants scoring 5 or more out of 7 for each scale (scores of 5 or above indicated the participants had 'slightly agreed', 'agreed', or 'strongly agreed' with the statements that made up the scales).

Table 1 presents the percentage of participants scoring five or more on each of the measured constructs of addiction. The scale labelled 'Brown's Indices' was constructed using the six scales derived from Brown's theory of addiction. The final scale, labelled 'Combined Scale', was constructed using all 12 scales.

Table 1: Percentage of participants scoring 5 or above for each addiction scale

Scale	Percentage who scored 5 or above
Connectedness	38.7
Conflict	4
Salience	20
Loss of control	2.7
Euphoria	36
Withdrawal	26.7
Identity	21.3
Tolerance	4
Belonging	26.7
Cognition	12
Compulsion	10.8
Relapse	14.7
Brown's Indices	6.7
Combined Scale	8

Discussion

If one were to assess mobile phone 'addiction' by all 12 scales, the collected data suggested that eight percent of participants displayed 'addictive' tendencies towards their mobile phone. However, it is important to also analyse the scales as individual constructs as it is likely that not everyone would exhibit all signs or consequences of addictive behaviour (8).

Connectedness was the scale that had the most participants scoring five or above (38.7%). Walsh and colleagues (2009) and Orford (2001) suggested that mobile phone use could provide users with positive outcomes, such as increasing self esteem through connectedness (9,10). Consequently, some individuals may become over-involved with their mobile phone. This in turn can lead to the development of addictive patterns of behaviour, as users engage in highly frequent use of their mobile phone in order to pursue connectedness (i.e. social contact). The results suggested that this may be the case with a significant proportion of the sample (38.7%).

The second highest subscale score was 'Euphoria', with 36% of participants scoring five or above. This suggested they experienced a 'buzz' or 'high' when engaging in mobile use (11).

The subscale labelled 'Cognition' assessed to what extent participants thought they were addicted to their mobile phone. It is interesting to note that the percentage of participants scoring five or above (12%) on the Cognition scale (i.e. the proportion who thought they were addicted) is in fact higher than the percentage of participants who scored five or above on all scales (8%), and were therefore identified as exhibiting addictive tendencies.

Tolerance, conflict, and loss of control were the scales with the lowest percentage of participants scoring five or above. It is possible that these constructs are simply not applicable to mobile phone use. Charlton (2002), for example, found that not all six of Brown's criteria for addiction needed to be fulfilled in order for an individual to be considered addicted (12). Another possibility is behavioural considerations. Because these scales were more

associated with negative connotations (i.e. 'loss of control'), participants may have responded in a way that they thought to be socially desirable, rather than their actual experiences (13).

The limitations of the study merit discussion. It must be noted that these results are based on a self selected sample of 75, and are therefore not necessarily applicable to the general population.

Nonetheless, the results suggest that some New Zealand adolescents do display addictive symptomology in regards to their mobile phone use, particularly euphoria, withdrawal and salience. Incidentally, these constructs can be likened to the criteria for substance abuse outlined in the DSM-IV. Further research into which of the 'usual' criteria for addiction are applicable to mobile phone 'addiction' will aid in the development of a more refined and specific tool for assessment.

Belonging, identity and connectedness are constructs that have not been traditionally included in diagnostic criteria for 'addiction' (14), however, all three were rated highly by the participants in the current study. Walsh and colleagues (2009), and other academics (15,16) have suggested belonging, identity and connectedness as key features of problematic mobile phone use. While some preliminary research has been conducted on the role of these constructs in mobile phone use, further investigation is crucial to determine any casual links between the need to belong, the need to be connected, including a mobile phone into one's identity, and actual mobile phone usage.

Ultimately, as with any new phenomenon, more research is crucial before any concrete statements or conclusions can be made. However, the present research has identified a proportion of New Zealand youth who appear to be 'addicted' to mobile phone use. The use of longitudinal studies on mobile phone use may help to develop a greater understanding of this phenomenon, the factors causing it, and the long-term consequences associated with it.

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MESSAGE FROM THE CHAIRPERSON

I hope that this issue finds you fully recovered from Easter and stargazing at a decent hour, with the shorter evenings settling in. As well as shorter evenings April brought with it "The Building Bridges National Community Mental Health and Addictions Conference 2010" which was held in Wellington from April 14-16. This conference focused on "Transcending barriers, cultures and differences in our approach to community mental health and addictions services". Given the number of conference themes, this meeting provided a great opportunity to be challenged, provoked and to contribute to how the sector and the issues are evolving. I hope that a number of you managed to attend the conference and share your findings with your colleagues.

Another recent and very successful event was the "Alcohol Causes Violence" Conference, in Wellington, held on March 23rd. Amongst the speakers Professor Jennie Connor from the University of Otago Department of Preventative and Social Medicine presented some solid information on the impact of alcohol use and Professor John Pratt of Victoria Universities Institute of Criminology provided interesting facts and figures from his field. From here, very real solutions were proposed to reduce the impact of this relationship, in particular by the Honorable Jim Anderton and Professor Doug Sellman. If you missed this but want to catch up the conference webcast is available on http://www.alcoholaction.co.nz/

My last thoughts for this issue involve ATRIG membership. With membership renewal down from last year I would urge those of you who have left your membership to lapse to complete the renewal form and rejoin and support the dissemination and interest of research in addiction related disorders within New Zealand. I understand that Lindsay Atkins (ATRIG secretary/treasurer) has an account number that she can send to you if you would rather pay by internet banking.

In terms of membership, we are also really keen to follow up on the ideas generated at the AGM held at the Cutting Edge Conference in Wellington last year. These ideas focused on a possible collaboration with DAPAANZ, ATRN design and readership and support for budding researchers who are primarily based in clinical roles. Although we are aiming to conduct a formal survey of members to further address these issues, if you currently have any ideas or opinions you would like to share, we would love to hear from you.

Klare Braye
ATRIG Chairperson

Addiction Treatment Research News is the official newsletter of the **Addiction Treatment Research Interest Group (ATRIG).**

ATRIG was established in 1997 to promote research in the 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:
Klare Braye (Chairperson), Simon Adamson, Alistair Dunn, Ria Schroder (ATRN Editor), Robin Shepherd, Janie Sheridan, Lindsay Atkins (Secretary)

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I've Been Reading …

When I was asked to write this column, it prompted me to think about the books I keep on my bookshelf at home, and why I like them. My reading tends to go in fits and starts, and I often have a few books on the go at once. I'm a non-fiction fan but I don't stick to any particular genre. I quite like books that I can dip into at a random place in the text, and read a chapter here and there.

As a psychiatrist, the great thing is that virtually any type of literature can prompt me to think differently about things, and therefore alter my clinical practice. In fact the books that have influenced me most have come from diverse areas and generally not from within the neurosciences.

For example, Status Anxiety by philosopher Alain de Botton is a brilliant insight into the nature of life in the 21st century. De Botton argues that much of the distress currently prevalent in Western society is due to the fragile nature of individual status within it. Paradoxically the opportunity for upward social movement, which was largely absent throughout history, has created a pressure on individuals to succeed that for many is unrealistic.

In reality, attaining status depends on intelligence, luck, persistence and providence. However our society acts as if success is an inevitable consequence of being a morally sound person. Conversely those who suffer misfortune (either by inheriting the wrong genes, or via the vicissitudes of life) are stigmatised and may internalise the societal view of themselves as being somehow flawed or inferior. Even some religions have started to emphasise the role of wealth in God's plan, in contrast to the virtues of poverty and restraint in days of old! Just look at Brian Tamaki and the Destiny Church for an example of this.

The quest for wealth and material goods has become the main defence against status anxiety. Compulsive consumption has become a modern way of life- be it food, consumer goods…or alcohol on a Friday and Saturday night. Thus while addiction is by no means a new problem, there are aspects of modern society that seem to foster excess. For vulnerable individuals, that tendency to excess can spill over into binge drinking, gambling on pokies, overeating or other compulsive behaviours that resemble addictions.

At the moment I am re-reading Erik Erikson's 1950's classic Childhood and Society. My copy is a yellowing second-hand paperback of about 1980's vintage.

Erikson was a Freudian psychoanalyst who also trained as an anthropologist. Probably Erikson's most influential contribution was his approach to understanding human development throughout the life course. Many of the early psychoanalysts also had their own theories about human development, but these tended to focus on infancy, and were- surprisingly- chiefly derived through observations of adults in psychoanalysis rather than looking at children (it reminds me of the classical Greek philosophers who are said to have sat round at length debating how many teeth a horse has, rather than just counting them). Although these psychoanalytic theories were very influential in the development of psychiatry in the 20th century, I tend to find them of limited use, though there are some pearls to be found. What I find refreshing about Erikson's approach is that it makes good common sense and can easily be applied clinically.

Erikson defines eight stages of human development from birth to death, each with their own tasks and challenges. It is the post-childhood stages that I find most interesting. Erikson talks of adolescence (which these days seems to stretch well into the 20's!) as being a time for development of identity, while failure at this task leads to role confusion. Early adulthood is focussed on developing intimacy, whilst the challenges of later adulthood centre on generativity and finding meaning within work and family. With old age comes wisdom, but also a tension between acceptance of one's life ("integrity") versus the deep sense of despair that results from reflecting on a journey unfulfilled. Having a serious addiction at any stage will tend to disrupt the developmental milestones of that stage. For example alcohol dependence in mid-adult life will impair the ability to sustain family and work life, leading to what Erikson calls "stagnation". The stagnation in itself will tend to cause distress to the individual, which can have various effects including depression, anxiety and self doubt. Conversely stagnation for any reason can itself trigger addiction- for example the 50 year old who takes to sedatives or pain-killers during a mid-life crisis.

Coming back, then, to "Childhood and Society". This is an eclectic mix of Erikson's clinical and anthropological observations. The most fascinating parts of the book for me are Erikson's observations of the Sioux and Yurok Native Americans. His writings are now nearly 60 years old, but remain fresh and relevant, particularly when considering the effect of colonisation on indigenous peoples. Erikson talks about the collective identity of the Sioux as a nomadic, warrior people whose destiny was intertwined with that of the buffalo of the American Midwest. Colonisation brought about a decline of the buffalo herds, changing ways of life and along with it a deep apathetic despair. Widespread addiction, particularly to alcohol, has also resulted. This will be a familiar story to those that have examined the effects on indigenous people of losing land, culture and traditional ways of life.

When I think about what I'd like to be reading, time seems to be the biggest constraint! There are still a few books on my shelf that I either haven't managed to read, or I'd like to read again - Keri Hulme's the Bone People comes to mind. On the other hand it is pleasing that with the advance of technology the humble book hasn't, at least yet, become obsolete. And I personally doubt that electronic books will ever replace their paper forefathers. What then would we do with our bookshelves?

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Addiction Treatment Research Interest Group (ATRIG)

MEMBERSHIP/RENEWAL FORM

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

Membership in ATRIG entitles you to the following:

- three issues of the Addiction Treatment Research News via email
- membership in the ATRN email discussion group

PLEASE ENROL ME AS A MEMBER OF ATRIG (ADDICTION TREATMENT RESEARCH INTEREST GROUP). I HAVE READ AND SIGNED THE DECLARATION BELOW.

Surname _____ First Names _____

Postal Address _____

_____

Daytime Phone Number _____ Fax Number _____

E-Mail Address (please print clearly) _____

(NB - You must provide an email address if you wish to receive a copy of ATRN)

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- *To foster interest in scientific research on treatment of people with addiction related problems in Aotearoa New Zealand.*
- *To disseminate and promote research findings related to effective treatment of people with addiction related problems in Aotearoa New Zealand.*
- *To support the development of improved treatment services for people with addiction related problems in Aotearoa New Zealand.*

Declaration

I support the objectives of ATRIG and wish to be a member of ATRIG for the 2010 calendar year. I understand membership fee is $20.

Signed _____ Date _____

Please make cheques payable to: ATRIG

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

Thank you for completing this form and sending it back with payment to:
Lindsay Atkins, ATRIG, PO Box 4345, Christchurch 8140, New Zealand
(Phone 03 364-0480, Fax 03 364-1225)