Addiction Treatment Research NEWS

NEWSLETTER OF THE ADDICTION TREATMENT RESEARCH INTEREST GROUP

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EDITORIAL

Hello, hello is anybody out there? This is the question I ask myself each time as I sit down to write my editorial for the ATRN and ponder whether this newsletter is meeting the needs of those interested in the NZ addiction treatment research field. My hope, of course, is that it is, but alas with little reader feedback I continue to be left questioning. My reason for pointing this out is not to try and guilt you all into writing detailed letters to the editor expressing your views about the pertinent issues raised in the various articles (although I would gladly welcome these letters), but to encourage you to see this newsletter as an opportunity to learn more about what others are doing in the addiction treatment research field and, of course, for you to share with others what research you are doing in the field.

You will see from the articles in the current newsletter that addiction treatment research is producing some incredibly interesting and relevant information that can be directly used to enhance treatment practices and thereby the care of people with addiction related issues. You will also note, however, that ongoing research is integral to further enhancing our ideas, as is collaboration and communication between researchers and those utilising research, in order to identify gaps in the research and to work out ways of addressing them. It is my hope that ATRN, as the official newsletter of the Addiction Treatment Research Interest Group (ATRIG), provides one step toward facilitating this communication. To further strengthen this, I would like to encourage those of you who are active researchers in the addiction treatment research field to make contact to let me know what you are doing, so that we can explore the possibilities of highlighting your work to others through the ATRN. For those of you who are not active researchers but have an interest in the addiction treatment research field (a number of clinicians I would hope), I would like to encourage you to make contact to let me know how research impacts on your work and how ATRN could be useful to you to better facilitate that.

In the meantime, I hope you enjoy reading this latest edition of the ATRN. My thanks go to all the busy researchers who have taken their time to contribute to this edition; your ongoing commitment to addiction treatment research is greatly appreciated.

Happy Reading

Ria Schroder
ATRN Editor

ABACUS REPORT

Future Shock? The addiction competencies

What we see depends mainly on what we look for.
John Lubbock

The committee developing and aligning the treatment competencies for AOD, Smoking Cessation (SC) and Problem Gambling (PG), have recently released the draft competencies for sector review. Each sector has their own draft specialist competencies (which are remarkably similar), but share in eight generic 'foundation' competencies. One of the AOD and PG competencies defines a requirement of knowledge of common pharmacological interventions for AOD and PG, or for coexisting tobacco use. It is unusual in the PG sector to consider a pharmacological intervention, other than to refer a client to a GP for consideration of medication for anxiety or depression, and therefore perhaps less buy-in for such a competence for the PG sector. Therefore motivation may differ between the sectors on relevance of pharmacological interventions, and why a competence across the sectors, might be appropriate.

Alcohol and other drug treatment competencies

Compared with PG, AOD appears to strongly integrate pharmacology with talking therapies in its treatment of clients. Specialists within AOD may prescribe medications, this ingredient can be an important element of AOD intervention plans. Knowledge of the effects of alcohol, and medications to address harm are an important part of assessment and therapy. An understanding of the need for some clients to supplement their diet with folic acid and thiamine, the need for medication when symptoms of severe withdrawal arise, and the use of medication to reduce urges, would be bread and butter to AOD practitioners. However, to most PG therapists, this would be a completely different world.

AOD therapies and models evolve

Talking therapies that may either complement pharmacological interventions, or substitute for them, are also an evolving process, with many of the current approaches (e.g. DBT, ACT) being unknown twenty or so years ago (1).
Models of treatment continue to develop over time, driven by research, experience, and funding with its accompanying direction as to use. A recent exemplar is the move towards alignment of addictions and mental health (MH) services, with the recognition that addiction clients commonly present with coexisting mental health problems. The model also advocates that treatment of addictions in isolation to co-existing MH problems may not be best practice. The ability to identify and address issues that may impact upon the AOD issue, may require substantial and new knowledge, skills and attitudes (i.e. competencies), and illustrates the ongoing change that occurs with competencies over time.

Tobacco smoking cessation may be future-proofed

Tobacco cessation, although effectively a subgroup of AOD, has been treated separately from AOD. The high mortality rate due to smoking of tobacco may be a reason, with the perception that specialised services are warranted to ensure a smoking focus is maintained. When over 4000 people die each year in NZ from their own smoking, and additional numbers from inhaling the smoke of others', a solution is likely to eventually evolve (2). A range of possibilities have been suggested, including gradual reduction in nicotine levels, the tightening of the

Smoke-Free Environment Act, increased tax, and legalisation of non-combustible tobacco such as snuff (3). Tax increases on tobacco commenced again this year, identified by the WHO as the most effective tool for reducing tobacco use (4). If successful, competencies for SC may become less relevant over time, as smoking of tobacco becomes a behaviour of the past. There is a strongly held belief that this could occur within a decade, provided some or all of the above strategies are introduced (3). This is perhaps the ultimate future-proofing of competencies – removing the problematic behaviour altogether.

Meanwhile, in tobacco cessation, the current emphasis is upon a pharmacological approach, with awareness-raising of the high costs of smoking, supported by subsidised replacement chemicals, and social and financial pressures. A motivational element is appropriate to pass the information to the smoker, but tends not to use the Stages of Change approach commonly accepted in AOD (5). Whereas this is a simplistic description of the differences of approaches used in smoking cessation, it does highlight that competencies do vary with models accepted by different fields, and sub-fields.

Problem gambling competencies

Being the new kid on the block, problem gambling has less history to review around effective therapies, generally adopting the talking therapies of AOD treatment providers. However, possibly due to the absence of an introduced drug to the body, problem gambling has identified relatively few pharmacological interventions that may assist in the treatment of gambling problems. Antidepressants, such as SSRIs have been found to have some positive effects in the past, but often where there are underlying mental health issues such as depression or anxiety (6, 7). Naltrexone also has had some effects in reducing the urge to gamble as have mood stabilisers, with a large research study on the effects of naltrexone on problem gambling currently underway at Yale (8). Knowledge of pharmacological interventions in problem gambling treatment appears to be relatively low amongst specialist problem gambling treatment providers. This may be due to the fact that PG is a behavioural addiction, or to the fact that the clinicians have entered the field from a wide range of health fields, with little tertiary specialist training available until recently. There appears to be some confidence that a pharmacological part-solution may become available for PG over time, but in the meanwhile, the focus has been upon talking therapies. A NZ trend however, is now arising for a wider approach of environmental impact, in addition to counselling (i.e. a biological, psychological and social approach). As an example, one expectation for PG treatment practitioners who are funded for facilitation, is a requirement to attend another service that has resources the client needs with the client ,and 'facilitate' their access to the resourced service.

Many AOD and PG clients overlap

Clients are often affected by multiple addictions, as well as co-existing MH problems. Approximately 20% of AOD community clients have been found to have gambling problems, mostly at the severe end of the continuum. Approximately 40%-70% of PG may have AOD problems, and approximately 60% of PGs have been found to smoke tobacco (9, 10). Research suggests that multiple addictions appear to be correlated with more severe conditions and poorer outcomes (10).

Conclusion

This brief meandering through the three addictions whose competencies are being aligned (AOD, SC and PG), illustrate that there are some differences currently occurring within each sector, but that many of our clients may be experiencing problems from all three addictions and MH issues. MH issues aside, it is likely that addictions other than that specialised in the presenting service, will in most circumstances be dealt with on site by the presenting therapist or other therapists that specialise in one or other of the other addictions within the service. The alignment of the competencies will assist in clients receiving treatment for all addiction problems from each service, or referral to other services where strong networks have been established. Changing approaches to treatment across the three addictions will be complex and challenging at first. There is now growing evidence of the benefits of addressing our clients' commonly multiple MH and addiction issues in an integrated approach, and expectation of applying this understanding to practice (11, 12, 13). The alignment of addiction competencies, identification of (other) commonly coexisting MH issues, and the ability to work across these issues, referring when appropriate, is a major structural step for the addiction field and perhaps reflects what many practitioners have intuitively done to date on an ad hoc basis.

Having competence to address these wider issues is in the best interests of our clients, our profession, and ultimately the realisation of our own ability.

Sean Sullivan
ABACUS

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CANNABIS AND MOOD DISORDERS

While there is a considerable amount of research information on the relationship between cannabis use and major depression in the general population, there is very little information on cannabis use and bipolar disorder and even less on the clinical impact of cannabis use on the outcome of treatment for mood disorders. My PhD programme therefore firstly aimed to investigate the impact of cannabis use and lifetime cannabis dependence on the presentation of and outcome of treatment for major depression and on the presentation and course of bipolar disorder, and secondly to examine the course of cannabis use before and after first admission for a psychotic mood disorder.

The research involved two studies, drawing on data obtained from the Christchurch Outcome of Depression Study (CODS) and specifically incorporating questions of interest into the Christchurch First Hospitalisation for Psychosis Study (CFHPS). The CODS was a randomised trial of 195 outpatients with major depression comparing predictors of outcome of treatment with fluoxetine or nortriptyline. Baseline data included DMSIV diagnoses, depression severity (MADRS), current psychiatric symptoms (SCL-90), measures of temperament and character (TCI) and self-report data on cannabis use. Outcome measures included treatment response and recovery. The CFHPS was a naturalistic study of 48 patients between the ages of 13-35 years admitted for the first time with psychosis followed over 18 months. Data included DSM-IV diagnoses, measures of temperament and character, estimates of weekly

cannabis use before admission and for 18 months after admission and questions on the effects of cannabis use on mood and psychotic symptoms.

The following key findings were reported:

- While on the face of it those with Cannabis use in the past week and lifetime cannabis dependence had more psychotic symptoms, this effect was explained away by common confounding factors such as cannabis users being younger, more severely depressed, having higher rates of social phobia and the personality variables of paranoid and schizotypal personality disorders, lower self-directedness and higher self-transcendence. Cannabis itself was not directly related to increased psychotic symptoms.
- Lifetime cannabis dependence was associated with treatment drop out in those prescribed fluoxetine but not nortriptyline.
- For those who completed an adequate trial of treatment, cannabis use during the study period and a lifetime history of cannabis dependence did not impact on treatment response or recovery once confounding factors, especially cluster A personality traits, were taken into account.
- Half of those admitted with bipolar disorder had used cannabis leading up to admission. The most characteristic feature of cannabis' effect on symptoms was its variability. The most consistent finding was that cannabis reduced both manic symptoms and levels of sadness but again, different people experienced different effects.
- Cannabis use did not impact on number of readmissions or mean days spent in hospital.
- Cannabis use decreased markedly during the index admission and remained significantly lower than before the index admission.

Conclusions and Clinical Implications

The low recruitment for the CHFPS study and the low numbers of cannabis users and small amounts of cannabis being used by subjects in the CODS study limited the extent to which these findings could be generalized.

Lifetime cannabis dependence may impact on engagement with treatment for major depression in those prescribed fluoxetine but not nortriptyline. For those who do engage in treatment, cannabis use does not impact on treatment response or recovery from depression. Cannabis use does not impact on outcome in those with bipolar disorder and often has little effect on the symptoms of bipolar disorder. When it does it appears to improve the symptoms of mania and sadness.

Clinicians should therefore treat mood disorders as they usually would regardless of the presence of cannabis use or lifetime dependence. They should, however, anticipate that depressed patients who use cannabis may be more likely to drop out of treatment especially if prescribed fluoxetine. It is unclear if this finding applies to other serotonin specific reuptake inhibitors. While it might appear that the use of other antidepressants would be indicated, there is a small amount of literature that helps make sense of this finding. There may be an interaction between fluoxetine and cannabis that people find unpleasant. Some people may drop out of treatment but it is also possible that some reduce their cannabis use and stay in treatment. Fluoxetine should therefore be considered appropriate in cannabis users who wish to reduce cannabis use and are highly engaged in and motivated for treatment.

They should also anticipate marked and sustained reductions of cannabis use during and after admission for bipolar disorder when there is a window of opportunity to target cannabis use in an attempt to minimise the extent of reinstatement.

Finally, more clinical attention could be given to the role of cluster A personality traits, especially schizotypy, in mediating the comorbidity between cannabis use and mood disorders especially when psychotic symptoms are present.

Acknowledgements

The Health Research Council of New Zealand provided significant funding for the two studies. My primary and secondary supervisors, Professor's Peter Joyce and Doug Sellman respectively need special thanks for their support and advice.

Fraser Todd
National Addiction Centre

MESSAGE FROM THE CHAIRPERSON

Cutting Edge 2010, our national alcohol and addiction treatment conference, organisation is well underway this year with a great line up of presenters and abstracts. It is the 15th year of this fantastic opportunity to not only listen to a great line up of speakers but to network and liaise with our colleagues and agencies up and down the country. Hosted once again by DAPAANZ (Drug and Alcohol Practitioners Association) and with the sponsorship and support from the Ministry of Health and ALAC (Alcohol Advisory Council) the focus this year is "3D: Development Diversity Direction for a new Decade."

The conference is also the time that the Addiction Treatment Research Interest Group (ATRIG) gets together for its Annual General Meeting. This will be held on Thursday 23rd September as a lunch time meeting from 1.00-2.00pm. I look forward to seeing many of you there. If you would like to become more interested in the workings of ATRIG you might like to consider joining the Executive so just come and talk with myself, Simon Adamson, Ria Schroder, Janie Sheridan, Robin Shepherd or Terry Huriwai about what it may entail or ideas that you may have. Also look out for copies of the Research Monograph from the 2009 Cutting Edge conference. Simon and Ria have done some fantastic work putting this together with the contributions from the research presentations and posters last year. All delegates from last year will be emailed out a copy of this and can be sent a hard copy if they request. In addition, we will have a number of these available at the conference.

At Cutting Edge this year we are reinstating the Young Researchers Prize. This is an opportunity to recognise the contributions and efforts of a young researcher (someone under the age of 35 years) in putting together and presenting their research work, which is often undertaken within their capacity as a clinician. We are looking forward to awarding this on behalf of the members of ATRIG. Furthermore, based on feedback we have received, we are reviewing the publication of ATRN and are currently working closely with DAPAANZ to formulate a collaborative publication, one that retains the identity of both organisations but that works to attract a wider readership and also promote the research that is happening within the addictions field.

As an aside, I was interested to see the development of the Addiction Research Symposium held at the University of Auckland at the beginning of July. This is a great effort to engage people in discussion about developing an addiction research workforce and had an interesting array of speakers from around the country. I am looking forward to the continuation of this initiative and the resulting publications that come from it.

Klare Braye
ATRIG Chairperson

ATRIG AGM

The Addiction Treatment Research Interest Group (ATRIG) will have its Annual General Meeting at the Cutting Edge conference being held at the Rendezvous Hotel in Auckland from the 23rd-24th September 2010. The AGM will start sharply at 1.00pm on Thursday 23rd September, 2010. Elections will be held for all Officers and members of the Executive. All past, present and future members are warmly invited to attend this meeting, regardless of whether or not you are a delegate at the conference. If you have any further queries about this meeting please contact the ATRIG secretary, Lindsay Atkins, on (03) 364 0480 or lindsay.atkins@otago.ac.nz.

UPDATE: WELLINGTON SCHOOL OF MEDICINE, UNIVERSITY OF OTAGO, WELLINGTON

Addiction researchers in Wellington continue their informal collaboration across multiple organisations.

Researchers in the Department of Medicine have recently completed two small pilot studies, one looking at a metered dose inhaler containing nicotine using the standard aerosol propellants. This small pilot study showed that nicotine was aversive to the upper airway in a dose dependant manner and produced blood levels less that half those from smoking a cigarette (1). Despite the aversiveness, many smokers said they would be keen to persevere if such an aerosol was available. We are now planning a larger trial looking at whether aerosolised nicotine offers anything over and above current nicotine replacement therapies.

We have also recently completed and published a small trial looking at the acceptability of snus, a nicotine only form of snus called Zonnic and nicotine gum (2). Snus is a Swedish tobacco in which the nitrosamines have been largely removed making it considerably less carcinogenic. It is widely used in Sweden instead of smoking and indeed has been used by many smokers in Sweden as an aid to smoking cessation. In this initial small pilot we showed that both Snus and Zonnic were found to be acceptable for a brief three week period with both being more acceptable to smokers than the nicotine gum. All three agents reduced cigarette consumption during the treatment period. We are now preparing to start a larger acceptability trial amongst hospital patients, hospitalised with smoking related diseases to compare the acceptability during the three month period of snus and the Zonnic nicotine pouch.

We also have underway a randomised control trial of 1500 participants looking at an oral spray form of nicotine. This is being undertaken in Wellington, Christchurch and at Tu Kotahi Marae in the Hutt Valley. The study is placebo controlled and both groups also receive nicotine patches. We have currently recruited over 300 participants to this trial.

In terms of future studies we hope to investigate the possibilities of using nicotine replacement in the long term in those subjects who have repeatedly failed to quit smoking.

In the Department of General Practice where the UOW Addiction Medicine research team is based, several projects have just been completed: The Use of Opportunities to Discuss AOD in General Practice report is available on the NDP website (3) and a journal paper is pending. Collaborative work on the use of injecting drugs by OST clients has been published (4). A paper on NZ women managed by OST in pregnancy is now published in NZ Family Physician (5). Research on NZ Families Living with Addiction will soon be available on the Families Commission website. Research into the Undie 500 and student drinking events is being written up and has been presented at the recent ALAC conference (6). Ongoing work into Brief Intervention has resulted in one video resource so far (7). Interested clinicians and health professional educators are welcome to use this free video resource. Users are invited to complete a brief online evaluation.

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7. Learning to Portray Empathy http://akoaotearoa.ac.nz/projects/learning-portray-empathy

I'VE BEEN READING …

As usual, and like most of you, I've been multi-tasking and trying to prepare for numerous deadlines. In doing so I have found myself reading diverse literature around substance misuse and treatment. Commentary on some of these studies will follow, but one thing that struck me (and it's certainly no 'eureka' moment, not a new idea of mine, and indeed not a new concept at all), but strike me it did. It reminded me of the tension between academia and the real world; of the conduct of research which seeks to develop and understand treatments and (and this is what struck me) the lack of generalisability of trial findings to real clinical practice. I don't need to rehearse the need for inclusion, and more importantly, exclusion criteria in clinical trials. The safety and ethical treatment of participants is paramount. But on reading the exclusion criteria for a modafinil trial I began to wonder – for whom might the study results be beneficial? If I use some of these criteria to describe a typically 'excluded' person, what we end up with is a methamphetamine dependent individual with any of the following: elevated liver enzymes, schizophrenia or bipolar disorder, a history of suicide attempts or current serious thoughts of killing one's self, taking any prescription medication which can't be used with modifinil, current dependence on alcohol, cocaine or benzos, a history of alcohol dependence, raised systolic blood pressure above 160 and raised heart rate and 'any other circumstances, which in the opinion of the investigators, would compromise participant safety' (1). Now, don't get me wrong – I'm not criticising the authors – far from it – we are currently conducting a trial with methylphenidate which has similar exclusion criteria and for good reason. But it's difficult to recruit (not surprisingly) and it just got me thinking – is this really the best way? I found myself getting rather despondent. So I had some stimulants (nice mug of Gold Blend), and then regrouped my thoughts. I guess there's obviously no other way, and the gold standard RCT is gold standard for good reason.

Anyway, enough of that and on with some of the papers I've been reading. The RCT of modafinil in question wasn't the first to explore the drug's utility in methamphetamine dependence, but was undertaken as previous trials using the licensed dose of 200mg of modafinil (for narcolepsy) showed no statistically significant effects, although trends towards reduced subjective effects (2) and trends towards reduced methamphetamine use were observed (3) as was self reported stimulant use (3). The authors of the new trial hypothesised that a 400mg dose was warranted due to the high levels of methamphetamine use likely by potential participants. Participants were randomly assigned to placebo or intervention drug in conjunction with cognitive behavioural therapy (CBT) or contingency management, for 12 weeks. Findings were not promising, with no significant effect on methamphetamine use, cravings, depressive symptoms or retention, although those with higher baseline methamphetamine use and lower attendance at CBT showed trends towards an effect. Not surprisingly more research was called for.

I've also been reading up about treatments for cannabis dependence and withdrawal in preparing to give a talk to pharmacists who work in mental health. Cannabis is the most widely used illicit substance in New Zealand – over 46% of people aged 16-64 years in New Zealand have ever used it in their lifetime (4) and rates of dependent use in a New Zealand birth cohort study have been estimated at 12.5% (5); however, anecdotally, treatment seeking for cannabis dependence is low, as of course is the case for dependence on many other drugs, and this may be in part due to the lack of effective pharmacological interventions for cannabis dependence. The list of trial drugs which showed little or no effect include buspirone, nefazodone, divalproex sodium and bupropion sodium (6, 7, 8, 9). The logical choice I guess is a trial of tetrahydrocannabinol, along the lines of methadone for opioid dependence. Budney and colleagues (10) (2007) undertook a small trial amongst eight cannabis dependent individuals who were not seeking treatment. They were given placebo, 30mg THC/day or 90mg THC/day in an ABACAD trial design, where A was cannabis as usual and B, C, and D were placebo and the two, different total daily doses of THC (see full paper

for a thorough description of this study design). As you'd expect the exclusion criteria were extensive and included the consumption of more than 20 alcoholic drinks per week and the use of any illicit substances other than cannabis during the last month (10), again begging the question – is this your typical cannabis user? Mind you, despite the findings of this study indicating that THC shows promise in terms of reducing withdrawal symptoms, the development of this into a treatment is unlikely due to its misuse liability, and the lack of any coherent public health harm reduction message in relation to cannabis, as we have in the case of methadone in the treatment of injecting opioid use. One promising drug, however, is lithium. At first glance this might seem an odd choice, but studies in rats have shown that when lithium is injected into cannabis dependent rats, cannabis withdrawal can be prevented. The authors hypothesised that lithium stimulated a rise in oxytocin levels, and that this was possibly responsible for the effect (11). An open label trial in Australia by Winstock and colleagues (12) (2009) has since found there was a significant reduction in cannabis dependence, cannabis related problems, depression and anxiety. The study, set in an in-patient unit, gave lithium carbonate 500mg twice a day for seven days to 20 adults with a DSMIV diagnosis for cannabis dependence. I understand the same team is now conducting a full RCT.

For those of us charged with translating research evidence into practice, the issue still remains – to what extent are these trial findings relevant to my patients? Of course it's not just RCTs that we use to guide us, but studies of safety and adverse effects, although again exclusion criteria apply. There will also be those who trial treatments in subgroups, for example, those with co-existing mental health problems. Finally, there is the issue of finding the time to read all this evidence. One fantastic resource I often turn to is 'Effectiveness Bank' (http://findings.org.uk/index.php) and another of course is 'Cochrane Reviews' (http://www2.cochrane.org/reviews). It's great to know that someone out that has done all the hard work for me!

Janie Sheridan
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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.

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Cutting Edge 2010
Te toka tū moana

Cutting Edge 3D
Development Diversity Direction for a new Decade
Thursday 23rd – Friday 24th September 2010
Saturday 25th September 2010 – Post conference workshop with Dr Richard Velleman

Rendezvous Hotel, Auckland, NZ Details available online at: www.cuttingedge2010.org.nz

Cutting Edge is the annual national addiction treatment conference, covering alcohol, smoking cessation, other drug and gambling interventions held in New Zealand. It is the gathering of around 400 practitioners, consumers, researchers, leaders, funders and planners, managers and policy writers. Those working in the allied sectors of mental health, justice, corrections, primary health, education, and who have an interest in addiction interventions, are welcome.

Speakers include:
Richard Velleman, Professor of Mental Health Research, University of Bath
Robert Williams, Professor, Alberta Gaming Research Institute, Canada
Ross Bell, Executive Director, NZ Drug Foundation
Tame Iti, (Tūhoe), Alcohol and drug practitioner
Dr Grant Christie, Auckland CADS
Pulotu Bruce Levi, Service Manager, Takanga a Fohe, Waitemata DHB

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)

The objectives of ATRIG are:

- *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 remainder of 2010 and the 2011 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)