Addiction Treatment Research NEWS

NEWSLETTER OF THE ADDICTION TREATMENT RESEARCH INTEREST GROUP

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MESSAGE FROM THE ATRIG CHAIRPERSON

It seems like an age ago that the 16th Cutting Edge Conference 'Recovery and Wellbeing' was held in Auckland in September, although my diary clearly indicates that was less than three months ago. The conference was to have been held in Christchurch but the damage incurred from its earthquakes prevented that. Regardless, it was a wonderful event hosted by DAPAANZ, sponsored by the Alcohol Advisory Council, with support from 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. In addition there was also the pre conference proceedings including site/agency visits, withdrawal management and the recidivist drink driving seminar.

Sadly, the Young or Emerging Researchers Award recently reinstated and supported by the Addiction Treatment Research Interest Group was unable to be presented this year. This award aims to provide an incentive to young and emerging researchers in recognition of the work that goes in to preparing and presenting a piece of research in poster or presentation format. Partially due to the format of the conference, but also due to the alarmingly small number of presentations with any research content to them, we were unable to identify an appropriate recipient for the award. I would encourage any of you out there reading this or working with colleagues who are involved in research to provide an abstract to Cutting Edge, especially if you are either young or emerging. The conference committee are mindful of the fact that that results are not likely available, particularly at the time of abstract and take this in to consideration. It would be great to see more input on research that informs practice, guides the way that we deliver treatment and that identifies the directions we need to be going or the gaps that we are missing.

Cutting Edge is also the time that we have the ATRIG AGM. By contrast to 2010 the turnout this year was light. However, we had a fruitful AGM with two eager attendees putting their names forward to contribute to the direction and aims of ATRIG by being on the executive- welcome Catherine Lowry Hanlon of Waitemata DHB and Anna Nelson of Matua Raki. After getting through the AGM business we moved on to discussions and ideas about ATRIG and how/if we could better

meet the needs of its members. This included discussions around the continuation of the Research Symposium, initiated by David Newcombe of University of Auckland in 2010; research within Cutting Edge including the feasibility of continuing the Research Monograph publication; the utility of the Researchers Award being applicable to both the symposium as well as Cutting Edge presentations; whether the name Addiction Treatment Research Interest Group could more widely encompass addiction research generally and the notion of an addiction research database.

And I just need to add, moving on from Cutting Edge, that I was lucky enough to also recently attend the Australasian Professional Society on Alcohol and other Drugs (APSAD) Conference in Hobart. Apart from the outstanding surroundings the conference reflected its goals 'raising awareness about the problems related to the use of alcohol and other drugs and promoting improved standards in clinical practice and in research into this and allied subjects'. Apart from the great array of presentations they had also introduced a late breaking research section offering five minute segments for up to the minute feedback on research developments. A conference well worth attending.

Klare Braye
ATRIG Chairperson

ABACUS REPORT

A reflection on addiction

Grasp the subject, the words will follow. ~Cato the Elder

As 2011 draws to an end and one reflects upon the last 24 months in the addiction treatment field, several related issues appear to distinguish them from other years. From a problem gambling treatment perspective they are:

- The roll-out of the co-existing addiction and mental health problems ('CEP') strategy
- The alignment of alcohol and other drug disorders (AOD), problem gambling and smoking cessation competencies with skills across addictions
- The proposed move in DSM-V of Pathological Gambling from an impulse disorder to Addiction and Related Disorders (formerly Substance-Related Disorders)

Prior to the current year, problem gambling has readily been referred to as an addiction by practitioners, while publications have had a bob both ways. Te Ariari[1] does refer to problem gambling, but is titled 'The Assessment and Management of People with Co-existing Mental Health and Substance Use Problems 2010', while its companion publication, Integrated Solutions[2] specifically stated

> 'Problem gambling is one of a range of behaviours falling within the scope of addiction and CEP' p7. (*my underlining*).

While not wishing to dwell on the finer points of nosology, none of the publications appear to state outright that problem gambling is an addiction, and it can equally be referring to problem gambling as an addiction or as a co-existing mental health problem, which of course, it is.

Problem gambling and coexisting mental health problems

Identifying and addressing problem gambling and co-existing problems in an integrated approach, appears to make good sense when such co-existing issues are highly correlated with problem gambling, and have clinical implications upon remaining in treatment, motivation and compliance with behaviour-changing strategies, and are likely causative factors for problem gambling. From an enhanced risk level, over 93% of pathological gamblers have been identified as meeting at least one co-existing mental health disorder, with three quarters of these preceding, or developing at the same time as their gambling problems[3]. In addition, those affected by psychiatric disorders have been estimated to be 17 times more likely to develop pathological gambling problems when compared with those not so affected[3]. Addressing gambling problems, while ignoring the effects of the co-existing problems, will in all likelihood result in poorer outcomes[1].

This is compounded by the low identification and treatment-seeking levels of problem gamblers. Due to a range of issues, including shame, hope to remedy problems through further gambling, and fear of disclosure, problem gamblers are notoriously reluctant help-seekers. Kessler and Merikangas[4] noted none of the problem gamblers had ever sought help for their gambling, while Slutske[5] identified in another population study that just 5.5% of pathological gamblers had received professional help for their gambling. This contrasted with 49% of pathological gamblers having received help for their other mental health disorders, albeit without identifying their gambling disorder[3].

Rationale for alignment

Problem gamblers have been found to have high levels of coexisting AOD issues. Petry and colleagues[6] identified that three-quarters of pathological gamblers may have an alcohol disorder, 38% another drug disorder, and 60% may have nicotine dependency. Quite apart from the high coexistence of AOD, problem gambling and smoking, with the opportunity to cross screen, addictions may be not only grouped together in the future because of similarities around categorisation, but also because their relationship may be even more fundamental. Shaffer and colleagues[7] posited that there are shared neurobiological, psychological, and social risk factors that influence the development and maintenance of different addictions, and once an expression of the addiction syndrome develops through exposure, then idiosyncratic issues/objects relevant to the specific addiction then develop. Their view, supported by neurobiological research, is that addictive disorders (which include behavioural addictions) might not be independent, and that the specific objects of an addiction may be less important developmentally, requiring a broader view of addiction. Although a behavioural addiction, problem gambling like AOD addiction, has been identified as having a high genetic risk factor, with 50%-60% of the variation in risk for pathological gambling accounted for by genetics[8]. Therefore, the alignment of addictions appears to make good sense both from a perspective of coexistence and well as process.

DSM-V: A closer relationship?

The move of Pathological Gambling from an impulse category to 'Addiction & Related Disorders' with AOD, appears to follow in some part, the syndrome model of addictions. Pathological gambling appears to be the only behavioural addiction so included at this stage, and may further emphasise the growing acceptance of problem gambling as an addiction, and that similar processes may underlie addictions.

However, once again, the wording leaves problem gambling straddling the fence as possibly a 'related disorder' associated with addiction, but perhaps not an addiction in its own right. Overall though, it has been a memorable couple of years for problem gambling treatment.

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THE CUTTING EDGE CONFERENCE 2011

Recovery and wellbeing – was what brought us together this year at the 2011 Cutting Edge Conference in Auckland. The conference was once again a great opportunity for the addiction sector to participate and be informed on developments in the field of addiction and to network with colleagues sharing similar interests, skills, knowledge and passions.

This two day conference started with a Powhiri and warm welcome by the people of Auckland. This set the scene for an exciting programme which skilfully explored and unfolded the main theme – Recovery and Wellbeing. The sharing of information on this theme occurred in a number of ways – there were key note speeches, poster presentations, concurrent sessions, lunchtime meetings and tea and lunch break conversations. The sector was also exposed to a number of stalls which described the role of various organizations within the addiction treatment system in New Zealand. A conference dinner on the evening of day one provided opportunity for people to have fun capturing group photos wearing different hair-do's.

The selection of speakers and presentations was well thought of and provided an interesting and balanced understanding of Recovery and Wellbeing.

Three of the key note speeches discussed the meaning of Recovery and Wellbeing within the context of culture. Di Grennell led us through an understanding of the role and contribution of Whanau Ora in facilitating recovery and wellbeing. The Whanau Ora service model supports whanau to engage with each other, other whanau, communities and providers, to move towards greater resilience, capacity, capability and self-reliance. Manase Lua, in his key note speech on Engaging Pasifika, described the importance of capturing cultural knowledge, social structures, socio-historical background and epidemiological data to promote Recovery and Wellbeing within the Pacific populations in New Zealand. Initiatives such as, the Pacific Addictions Workforce Strategy, Real Skills Plus Seitapu, Le Va and a number of other initiatives played an important role in 'creating space for culture and care to connect'. Some concurrent sessions also discussed the relevance of recognizing culture in engaging with Pasifika people ('Sift through eurocentrism to focus on our Pasifika people'; 'Can you smell what the youf are cookin?'). Associate Professor Elsie Ho presented some interesting data on the health profile of the Asian population in New Zealand and how cultural values within this population impact on treatment engagement and effectiveness. Differences between Asian and Western values could serve as barriers to treatment. The importance of understanding these values and building on strengths to facilitate change are key to recovery and wellbeing. The value of a non-threatening approach to problem gambling within the Asian population in facilitating wellbeing was also discussed in a concurrent session.

Problem gambling was recognized as significantly impacting on public health. In his key note speech Graeme Ramsey, described how raising awareness through campaigns and clear linkages to treatment are likely to result in better outcomes. Outcomes were also a focus of concurrent sessions and poster presentations such as 'The big boys and big girls club' discussing obesity and addiction to food; 'Mortality in methadone maintenance clients' looking at mortality trends and what these tell us; 'Recovery and Wellbeing' describing treatment model, outcomes and client feedback in dealing with offender populations; the 'Monarch modular program' showing outcomes linked with program delivery; 'Best things about geese - a year of groups' presenting details on outcome data following a year of group work; 'Are you a parent? Parenting, recovery and wellbeing' highlighting effective responses support both child and parent wellbeing involving parents accessing alcohol and other drug treatment; and 'The Visual ADOM - making outcomes meaningful' describing the development of the visual version of the ADOM.

The concept behind 'Recovery and Wellbeing' and how this translates into the clinical field was the essence of a number of other presentations. Professor Tom McLellan provided us with two very interesting key note speeches – 'What is Recovery? Can we measure it?' and 'Reconsidering Substance Abuse Treatment – have we been thinking correctly?' It is not easy to narrow down Professor McLellan's presentations into a few sentences but these were a few of his key messages:

- prevention and early intervention were as important as addiction treatment and screening, brief intervention and motivational work saved money;
- addiction treatment should be thought of in the light of the continuing care model, with treatment spanning between primary care and speciality care and that when treatment stops symptoms did come back;

- recovery is a 'state' not a 'method' with its elements including a voluntary standing, a maintained state requiring ongoing maintenance, abstinence, good health and 'citizenship' (living with regard and respect for those around you).

My presentation, 'Wellness and Recovery – what is the meaning behind these two powerful terms', also looked at the conceptual understanding of wellness and recovery. The key message was that recovery and wellness are defined by the client and our role was to instil hope and facilitate the process through treatment delivery as well as commissioning for recovery. Presentations that highlighted the consumer perspective such as 'Walking with the Taniwha', 'Many journeys, one voice', 'Living well – a consumer's perspective' and the poster on "AOD Peer Support- a new approach to an age old problem' brought to reality the concepts behind recovery and wellbeing.

Comorbidity, another perspective impacting on wellness and recovery, was brought to the audience by Professor Sandy McFarlane in his key note speeches 'The complexities of the relationship between alcohol consumption and psychiatric disorder' and 'The comorbidity of alcohol and trauma'. Professor McFarlane highlighted the importance of treating mental health and alcohol and drug problems simultaneously. The role of self-medication with alcohol and/or drugs should also be taken into consideration especially in the development of public campaigns. Successful campaigns need to have a strong understanding on who the target population is. A poster presentation ('Coexisting Disorders – Clinical Solutions!') described the effectiveness and practicability of a skills framework for assessing coexisting disorders clinicians.

The role and impact of treatment interventions on wellness and recovery was another theme resonating through a number of other presentations. 'Ways OST services can support client recovery and improve treatment effectiveness' presented findings from consumer surveys on their experiences of OST treatment. Issues for improvement included 'better treatment by staff', 'more flexibility', 'better takeaway arrangements' and 'less waiting time' with the latter two considered as barriers to treatment. In another presentation, Dr. Alistair Dunn, recognized the increase in prescribing of oxycodone and requested a 'call for action' to prevent the emergence of oxycodone related harm. The potential role of Ibogaine as an alternative biological treatment option was also presented. A debate on 'Compulsory Treatment Orders' in the light of the 'Alcohol and Drug Addictions Act' review brought up some interesting issues related to the application of an Act aiming to give stronger legal safeguards whilst respecting autonomy. More psychosocial interventions were also presented – such as, 'Contingency management in the New Zealand context' showing how a low cost effective intervention could be linked with improved outcomes; a presentation on the role of therapist mindfulness in the context of a therapeutic relationship and how this impacted on therapist wellbeing; 'Straight Up – a therapeutic workshop' incorporating cognitive behavioural therapy, strength based approaches, motivational interviewing and narrative therapy; 'Where three roads meet – violence, criminality and addiction' talking about an evidence-based psychodynamic therapeutic model for individuals with violent, criminal and addictive traits; and 'Social work is effective AOD work' highlighting how an effective AOD intervention must recognize the context that addiction occurs in.

The role of the 'Alcohol Advisory Council of New Zealand' in treatment was discussed by Tuari Potiki. This presentation provided some interesting historical issues related to alcohol and drug treatment provision and how this linked in with more recent initiatives. Raine Berry also provided an interesting key note speech on 'Addiction Workforce development in New Zealand'. Raine explained the relevance of workforce development in the context of increasing demand for treatment and increased complexity of presentations, influx of referrals from corrections and justice, ageing population and workforce and an increased focus on effective evidence-based practice.

This article only gives a flavour of what was discussed at the conference. For a more detailed account, presentations and abstracts can be found on the Cutting Edge website. Presentations were truly 'Cutting Edge' – opportunistic for the treatment sector and clients journeying through the sector. I look for to next year's conference and I look forward to see you there.

Susanna Galea
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THE CHRISTCHURCH EARTHQUAKES: EFFECTS ON SMOKING RELAPSE OF PARTICIPANTS INVOLVED IN A RANDOMISED CLINICAL TRIAL

Smoking remains the single biggest cause of preventable death in New Zealand (NZ), with approximately 5000 deaths annually, attributable to direct smoking or second hand smoke[1]. While the evidence shows that Nicotine Replacement Therapy (NRT) improves quit rates when compared to placebo, only 10% of people who use NRT to quit smoking remain abstinent at 12 months. The effectiveness of NRT may be further undermined when coping with a major life event during a cessation attempt. Exposure to stress and its influence on smoking relapse has been the subject of a number of studies, with 40-50% of smokers reporting that stress has contributed to a relapse during a cessation attempt[2-4].

While many studies have examined the increase or decrease of substance abuse and prevalence following traumatic events, only two have examined the influence of such events on relapse rates of participants involved in a smoking cessation attempt at the time. A study examining relapse as a result of the September 11, 2001 terrorist attacks of participants involved in a clinical trial investigating the effectiveness of a nicotine inhaler found no statistically significant change in smoking or relapse rates compared to relapse rates prior to the event[5]. Conversely, having conducted a longitudinal study of tobacco use at the time of the 2003 Canberra bushfires, Parslow et al (2006)[6] reported a 13.2% increase in the number of people who had either begun smoking, relapsed after being previously quit, or increased their current tobacco consumption compared to prior to the fires.

During the past year, Christchurch has experienced one of the worst disasters in the history of New Zealand. Since September 4th 2010, Christchurch has experienced more than 7605 earthquakes with two major events occurring on 4 September 2010 (7.1 Richter scale) and 22 February 2011 (6.3 Richter scale). While the city sustained significant damage to property, land and infrastructure during the September earthquake, there was no loss of human life. However, in comparison, not only did the February earthquake cause extensive damage to the city, it was responsible for the deaths of 181 people and a further 164 individuals received serious injuries.

At the time of these events a multi-site double blind pharmacotherapy trial was being conducted in Christchurch and Wellington to examine the effectiveness of the Zonnic nicotine mouth spray and nicotine patches. The simultaneous occurrence of the Christchurch earthquakes and a multi-centre research study investigating smoking cessation provides a unique opportunity to explore the effect of a natural disaster on quitting behaviour.

Method

A total of 557 participants were recruited on the Zonnic™ study in Christchurch with 117 participants actively involved in the trial at the time of the September earthquake and 169 during the February earthquake. Each potential participant underwent a telephone screening before entering into the study. Inclusion criteria were being aged between 18 to 80 years, smoking a minimum of 9 cigarettes daily and having a score of 3 or more on the Fagerstrom Test for Nicotine Dependence (FTND)[7].

The study comprised five visits to the clinic and two phone calls during the 13 month trial. During the six month treatment phase all participants received five months' supply of active nicotine patches and were instructed to use a daily 21mg patch for four months and 14mg and 7mg for two weeks respectively. Participants also received six months' supply of either active (contains nicotine) Zonnic™ mouth spray or a placebo mouth spray (without nicotine), based on computer randomisation. Directly following the earthquakes, a number of additional questions were added to the Christchurch assessment, in an attempt to ascertain the effect of this event on relapse rates amongst the participants involved in the trial.

Results

Socio-demographics

Of the 557 participants involved in the trial, 51.8% were female. The majority (82.9%) of the study population identified themselves as New Zealand European with 81.3% of the group being in paid employment at the beginning of the trial. Most (43.5%) participants had either no formal education or had completed School Certificate level only (3 years secondary school) with a trade qualification being the second most popular education experience (13.1%). At their baseline visit, the majority of study participants smoked between 20-24 cigarettes a day, had a medium FTND between four and seven with the time to their first cigarette being less than five minutes after waking.

Relapse effects

The September earthquake cased a large degree of smoking relapse of participants involved at the time of the event with 46.2% of those quit prior to the event smoking at least one cigarette in the week following the earthquake. In comparison to this, the February event caused a larger degree of relapse with 62.7% of all prior abstinent smokers relapsing following the event. Participants who had relapsed were asked how many cigarettes they had smoked in the week following the earthquake to examine the extent to which they had relapsed. Table 1 presents the percentage of participants who relapsed and the number of cigarettes they smoked. It shows that not only was the likelihood of relapse greater in the February event, the degree of relapse was also greater. The majority of participants were unable to control their cigarette intake and smoked more than 31 cigarettes in the week following the event. One point of difference in relapse rates was that in September, while participants did relapse, they were able to control the extent to which they did with 23.3% of participants smoking less than 10 cigarettes in September compared to 15.5% in February.

Table 1: The rate and degree of relapse of participants during the September and February earthquakes

	Sept 2010 (%)	**Feb 2011 (%)**
Did the earthquake cause you to relapse after you had quit?	N=117	N=169
Yes	46.2	62.7
No	53.8	37.3
In the week following the quake how many did you smoke?	N=54	N=106
1	3.3	6.8
2 to 10	20.0	8.7
11-20	5.6	3.9
21-30	10.0	5.8
31+	60.0	74.8

Conclusion and Implications

Both the September and February earthquake events have had a noticeable influence on the participants involved in Christchurch, causing a high level of smoking relapse as people attempted to cope with a highly stressful situation. The specific causes and mechanisms of this relapse or increase of cigarette intake is not examined. Whether it is the magnitude and severity of the events or the cumulative effects of two earthquakes rather than a single event is unknown, however it is apparent that such an event can have a significant influence on smokers attempting to quit. Early results of this study concur with much of the literature examining substance abuse response as a result of a significant traumatic event with a large percentage of the study population relapsing and increasing their cigarette intake in both the September and February events.

An important distinction between this and other studies examining smoking relapse following a disaster is that this study was able to examine two similar events of different magnitudes and how this can influence a smoker's quitting behaviour. While the September earthquake may have been larger in magnitude, the proximity of the February earthquake to the centre of the city caused a greater level of devastation and had a more significant effect on the number of people relapsing during their cessation attempt. This indicates the need for further research to understand how the experiences of individuals can influence the likelihood of relapse and that takes into account that a 'one size fits all' approach may not be a suitable solution when a disaster occurs.

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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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On behalf of the ATRIG Team we wish everyone a happy and safe Christmas and New Year. See you in 2012.

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.

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The objectives of ATRIG are:

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Declaration

I support the objectives of ATRIG and wish to be a member of ATRIG for the 2012 calendar year. I understand membership fee is $20.

Signed _____ Date _____

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