Addiction Treatment Research NEWS

NEWSLETTER OF THE ADDICTION TREATMENT RESEARCH INTEREST GROUP

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TABLE OF CONTENTS

MESSAGE FROM THE ATRIG CHAIRPERSON

Where is the year going? Already we are half way through February! While that signifies that summer holidays are over, kids are back at school and that the weather is still great (I'm a glass half full kinda girl!), this year, February, or February 22nd to be precise also marked one year since the devastating earthquake in Canterbury that took 185 lives, caused serious injuries and left Christchurch, and the surrounding region, dealing with ruined buildings, broken infrastructure, enormous community disruption, emotional trauma, an uncertain future and ongoing quakes. Somewhat poignantly I note, that this date is also the Girl Guide and Scouts World Thinking Day and reflect on the disastrous events that have occurred throughout the world recently. Although I am writing this prior to February 22nd, this will not be printed until after. I am hoping that you managed to spare a thought for those still living with the many ongoing, traumatic situations arising from it, and have managed to commemorate the day in a way that suits you. My thoughts are with you.

Moving back to the humdrum of everyday life and work, I notice that February and March are particularly busy months for events in the addiction field. I realise that a number of these will be over by the time that this goes to press, however, they are still worth alerting you to, either as encouragement to seek out what is available throughout the year (you can check this information on the addiction sector calendar on the Matua Raki website: http://www.matuaraki.org.nz/ ; as a prompt to go and google updates and reports or to stimulate discussion with colleagues who may have managed to get to any of these event. Whilst many of these events are practice based, they are invariably informed by research and evidence that supports best practice. February 20th saw a research symposium focusing on Addictions and Families being hosted by Addiction Research Network (University of Auckland) and Kina Families and Addiction Trust. The 4th International Gambling Conference was held in Auckland 22-24 February 2012 hosted by Hapai Te Hauora Tapui Maori Public Health, the Gambling and Addictions Research Centre at Auckland University of Technology (AUT) and the Problem Gambling Foundation of New Zealand (PGF). The Health Promotion Forum of New Zealand and the Centre for Development Studies of the University of Auckland hosted The Right to Health Workshop - in Auckland on February 22nd. Age Concern Manawatu, in partnership with Best Care Whakapai Hauora Kaumatua Service offered a one day conference for professionals to help them understand the dynamics and complexities of Elder Abuse and Neglect in Palmerston North on February 29th. The Alcohol and Other Drug Treatment Courts (AODTCs) Conference was held March 1-2 in Auckland. March 7-9th brought the Motivational Interviewing (MI) symposium to Auckland providing interactive presentations and

evidence based practice. The third Alcohol Action NZ conference is to be held in Wellington on March 22 titled "Babies, Children and Alcohol". Moving into April, the Growing Pacific Solutions for our Families conference will take place in Auckland. This conference will provide a unique opportunity to bring together champions that lead innovative and evidence-based integrated solutions to meet the needs of our Pacific families in New Zealand, particularly across the mental health, addictions and disability sectors. Get out there - share your experience, network with you colleagues and absorb the plethora of information that others have to share. And on a final note-Look out for the call for abstracts for the Cutting Edge Conference, to be held in Wellington September 6th - 8th 2012. We would love to see some more research in the programme this year and be able to award the ATRIG Young or Emerging Researcher Award.

Klare Braye
ATRIG Chairperson

ATTACHMENT AND ADDICTION CONFERENCE, MUNICH, GERMANY 2011

In October, 2011, I was invited to an Attachment conference which is organised annually by Dr Karl Brisch, the Associate Professor of Ludwig-Maximilians-University, in the Pediatric and Psychotherapy department. This year's focus on "Attachment and Addiction" involved topics ranging from substance disorders through to problematic gaming and excessive working. The link between each of the presentations was of Attachment as a contributing factor in the development and management of such difficulties.

Firstly, what is Attachment?

Attachment Theory[1] explains that we are born with a system designed to activate under distress or separation to protect and promote our survival, providing a template for our future relationships[1]. The early caregiving we receive combined with our biological predisposition will result in a secure or insecure attachment. Secure attachment is associated with consistently attuned caregiving where the individual feels loved, appropriately comforted, validated, and competent. They learn others are available, cooperative, and dependable, and perceive the world as safe[1]. If caregiving is inconsistent or unattuned then one of three insecure styles[2] of attachment can instead form; preoccupied, dismissing, or disorganised attachment.

Preoccupied attachment is associated with separations from care-giver/s or inconsistent care and involves high-need behaviour (e.g. reassurance seeking, hypersensitivity, anxiety) [2-3]. The individual feels worthless, ineffective at sourcing comfort, and dependent, while perceiving caregivers as neglecting, insensitive, and unreliable[2-3]. In contrast, dismissing attachment, associated with rejecting or unavailable caregiving, involves minimising needs[3]. The individual feels unloved but self-reliant and perceives others as rejecting, intrusive, and unable to meet their needs[3]. Lastly, disorganised attachment results from abuse, neglect, or trauma, whereby the caregiver is also a source of threat. Heightened arousal and distress occurs, and fluctuations between anxious and avoidant behaviour result[4]. The individual feels unloved, and views others as rejecting, threatening, and unpredictable, and so limited attachment is formed[4].

Emerging research suggests that these attachment experiences influences brain development, life-long relationship behaviours, and the capacity for healthy psychological functioning[4-6]. Insecure attachment has been found to be higher in those with substance use disorders[8] and compulsive sexual behaviour[9-10] than in the general population; hence the rationale for researching attachment and addiction.

The Conference Itself

An opening presentation was by Philip Flores, an American researcher who authored the book "Addiction as an Attachment Disorder"[11]. His paper described the link between the "emotions that get stirred by the uncertainty of human contact and substance use". Flores suggested that not everyone with insecure attachment will experience addiction but that everyone with addiction has insecure attachment. He argued that this might be partially because the presence of a secure attachment was a protective factor against risky addiction genes. Another key point Flores made was that the toxicity of substance use will deteriorate the skills the person had before the beginning of their drug use career and that once addicted the attachment to the drug becomes stronger and more reinforcing than attachments to people. He suggested that renewing human connection is vital to therapeutic change and that a long-term rather than short-term therapeutic relationship is necessary, such as that provided by groups like AA. The mechanism of such groups is to provide a human connection or attachment that then becomes stronger than the pull to the substance.

Jaak Panksepp, an Estonian-born experimental researcher, has focused his life's work in the area of affective neuroscience. Panksepp's paper was on linkages between social bonds and psychiatric disorders including substance dependence. Panksepp discussed how social bonding is, in part, an addictive process based on endogenous opioid and oxytocin dynamics within ancient brain systems. These systems have been studied in animals and humans to provide brain imaging evidence. Panksepp compared opiate use and social dependence. He likened dependence to bonding, tolerance to estrangement, and substance withdrawal to the separation distress experienced in attachment systems. He suggested that oxytocin prevents the development of tolerance. A point Panksepp emphasised was that addiction is not just a reward process but also involves the seeking system – the system responsible for sourcing comfort and closeness. The note that Panksepp finished on was that laughter can help reconsolidate psychotherapeutic gains by reducing the pain associated with hurtful memories. He advised ending therapy sessions with a smile or a joyful moment to maximise the opportunity for change. By doing so painful memories recalled during the session will be less painful the next time they are recalled.

Klaus Wölfing, the head of the Outpatient Clinic for Gaming Addictions in Mainz, presented a paper on his group-work with those experiencing internet and gaming addiction. He reported that 3-4.7% of boys and .3-5% of girls were found to have internet addiction. Wolfing's group-work is with virtual-reality gaming addiction where there is a real life gamer behind the figure, and says an attachment and identity forms with the virtual avatar. Group members were invited to bring in their avatar to show the group therapeutically. The avatars were each put virtually into the chair and brought into the therapy. Partly Klaus believes this works as exposure therapy but it also affects the group dynamics and process. Wölfing found in his group that those who excessively online game tended to be thin and had reduced health/nutrition – in particular low vitamin D. He recommended that physical and nutritional interventions be considered, such as exercise. Wölfing found that these gamers could not easily return to unproblematic levels of gaming and found permanently deleting the gaming account a key treatment step.

Karl Brisch finished the conference with a presentation on how Addiction can begin as a response to the stress of emotionally difficult developmental conditions. He says that rather than drawing on attachment figures, an individual will instead learn to turn to an external source to self-soothe. This begins, in infancy, where oxytocin and opioids released during attachment will soothe and regulate feelings of distress, and physical contact is necessary for this to occur. He discussed how this is required from caregivers in order to teach infants and children how to regulate distress during emotionally stressful times. If not, then things such as TV, food, masturbation might be initiated as an attempt to self-soothe and so the child learns to regulate without the attachment. Brisch described how withdrawal from the substitute attachment (e.g., substance use) can't work without therapy because the attachment figure is withdrawn without an alternative supplement, and people cannot survive without attachment.

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TOBACCO CONTROL AND SMOKING CESSATION AT THE FACULTY OF MEDICAL AND HEALTH SCIENCES UNIVERSITY OF AUCKLAND

Academics in the Faculty of Medical and Health Sciences at the University of Auckland are involved in a wide range of research into tobacco control and smoking cessation. Below are summaries of some exciting studies which are taking place.

Tobacco Control Research Tūranga

Dr Marewa Glover, Associate Professor Chris Bullen

In 2010 the New Zealand government set an ambitious goal of reducing tobacco smoking prevalence to less than 5% by 2025. Recognising that research would be vital to ensure the policies and programmes to achieve the goal are based on the best evidence of effectiveness, the Ministry of Health and Health Research Council (HRC) Reducing Tobacco-related Harm Research Partnership awarded $5 million in mid-2011 to the University of Auckland to establish the New Zealand Tobacco Control Research Tūranga.

The Tūranga is a multi-disciplinary network of researchers from across New Zealand led by Co-directors Associate Professor Chris Bullen (National Institute of Health Innovation) and Dr Marewa Glover (Centre for Tobacco Control Research), both at the University of Auckland.

The Tūranga is charged with leading and undertaking a comprehensive suite of research projects that address the 'grand challenge' of dramatically reducing tobacco smoking in New Zealand. The research projects are to be innovative, pragmatic and carried out over relatively short timeframes. Māori, Pacific Island peoples, pregnant women and mental health consumers are priority population groups.

Four projects are already underway and a further two are preparing to start later in 2012. The four projects currently in progress are shown below.

Reducing Demand for Tobacco	Reducing Supply for Tobacco
WERO (Whānau End smoking Regional whānau Ora challenge) Investigating if a culturally-embedded smoking cessation challenge would be effective in triggering mass-quitting, utilisation of subsidised NRT and sustained quitting among Māori and Pacific Islanders.	***Trade Implications*** Analysis of the trade and legal consequences of some measures to reduce supply of tobacco.
Nicotine Reduction Trialling a nicotine tax and nicotine sinking lid policy for reducing tobacco dependency in smokers.	***Economic Modelling*** Economic modelling to determine the timing and size of steps required to reduce tobacco supply to zero and scarcity effects on price and consequent price changes on demand.

To enhance the rapid translation of research findings into policy and practice, the Tūranga is building strong linkages with a wide range of stakeholders, from policy makers and programme funders and planners to researchers and healthcare providers.

A priority for the Tūranga is to contribute to the growth of New Zealand's tobacco control research workforce. To achieve this, Tūranga Scholarships have been established to fund one Doctoral student and up to four Master students over the life of the programme.

The Tūranga has also set aside a contestable Emerging Issues Fund of up to $100,000 per annum to enable the tobacco control sector and researchers to respond rapidly to new challenges and opportunities as they arise.

Follow the Tūranga on Facebook: Tobacco Control Research Tūranga NZ or Twitter: https://twitter.com/#!/TūrangaNZ

For further information about the Tūranga contact: Chris c.bullen@auckland.ac.nz or Marewa m.glover@auckland.ac.nz

Niue Tobacco control: a Niue community perspective.

Dr Vili Nosa, Dr Judith McCool, Associate Professor Chris Bullen, Josephine Gray.

Tobacco was introduced into the Pacific region by European settlers such as whalers, traders and sea farers.[1] Tobacco is now one of the leading causes of mortality and morbidity in the region.[2] Despite this, tobacco control research in the Pacific is very limited.

Niue is a small self-governing isolated island state located in the Western Pacific region with a resident population of around 1200 people. The Secretariat of the Pacific Community (2008) report indicated that 31% of males and 16% of females were current tobacco smokers. Compared with previous censuses there was a higher number of Niuean adolescents who reported smoking, suggesting that initiation is still occurring at high levels.

Very little current information about smoking trends is available from Niue. This research, carried out by Dr Vili Nosa, Dr Judith McCool, Associate Professor Chris Bullen and Josephine Gray, examines tobacco use in Niue and provides an insight from a community perspective about a tobacco plan to reduce smoking rates in Niue. A total of twenty qualitative face to face interviews were conducted with ten males and ten females aged 16-65 years. Initial findings indicate that initiation of smoking was related to peer pressure, stress, friends and people who smoked. Factory made cigarettes was the preferred cigarette rather than roll your own cigarettes. Participants understood that smoking was not good for them and affected their health status. The relationship between alcohol and smoking was strongly linked together. The Niue government and Niue health departments were identified as key organisations for smoking policies and smoking cessation programmes.

For more information please contact Dr Vili Nosa on: v.nosa@auckland.ac.nz

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Very low nicotine cigarettes

Dr Natalie Walker

A smoking cessation trial has recently being completed by Dr Natalie Walker and her team in the Addiction group at the Clinical Trials Research Unit (University of Auckland), looking at the combined effect of very low nicotine content (VLNC) cigarettes and usual Quitline care (nicotine replacement therapy (NRT) and behavioural support) on long-term quit rates.

Sensory and behavioural cues appear to provide additional reinforcement of smoking behaviour, but are rarely addressed when treating tobacco dependence. There is some evidence that cigarettes with reduced nicotine content, used in combination with NRT, may help reduce withdrawal symptoms and increase quit rates. However confirmatory trials are needed. For this reason, the CTRU undertook a parallel group, single blind, randomised trial. Participants were identified through a telephone-based Quitline cessation service, and randomised to receive 1) VLNC cigarettes (Quest 3) to use after their quit date, whenever they had an urge to smoke, for 6 weeks in combination with usual Quitline care or 2) usual Quitline care only. Usual Quitline care consisted of 8 weeks supply of NRT patches and/or gum or lozenges, plus behavioural support.

In total 1,410 smokers were randomised (705 in each arm). Participants were moderately dependent (mean Fagerström=6.2, SD=1.7) and smoked on average 22 cigarettes per day (SD=10). Participants in the intervention group were significantly more likely than the usual care group to have quit smoking at 6 months (7-day self-reported point prevalence abstinence 33% vs 28%, RR=1.18, 95%CI=1.01–1.39, p=0.037; continuous abstinence 23% vs 15%, RR=1.50, 95%CI=1.20–1.87, p=0.0003). Participants in the intervention group had a median time to relapse of 61 days compared to 13 days in the usual care group (p<0.001). No difference in symptoms of withdrawal or serious adverse events was found between the groups.

In conclusion, use of VLNC cigarettes in combination with usual Quitline smoking cessation support may help some smokers become abstinent. This intervention provides a possible second-line approach for smokers when standard treatment methods have failed. The trial findings were presented at the Society for Research on Nicotine and Tobacco Europe 13th Annual Meeting, Antalya, Turkey in September 2011. Some background reading to this study, the trial protocol and a poster of the results can be found on this webpage: http://www.ctru.auckland.ac.nz/index.php/research-programmes/addiction-research/181-reliq. A journal publication is in preparation. The trial was funded by a Health Research Council project grant, and undertaken in conjunction with researchers from the Quit Group (Wellington), Health New Zealand (Christchurch), the Centre for Tobacco Control Research (University of Auckland) and the UK Centre for Tobacco Control Studies (Queen Mary University of London, England).

For more information please contact Dr Natalie Walker on: n.walker@ctru.auckland.ac.nz

I'VE BEEN READING …

Over the preceding 18 months, involvement in several research projects has focused my attention on opioid use and treatment, in particular where different services within the support and treatment sectors intersect. This has led me to revisit long-held assumptions concerning what are broadly thought of as harm reduction initiatives (minimisation). More specifically, critical re-engagement with literature examining needle exchange programmes (NEPs) and methadone maintenance treatment (MMT) has offered me greater insight into the complexities facing those working in these interrelated fields. For example, with NEPs on the one hand seeking to provide injecting drug users (IDU) with clean equipment and safe use information, and with MMT programmes on the other aiming to stabilize and ultimately reduce recreational (injecting) opioid use, one may wonder at the potential for tension between these state-funded programmes and their respective intended outcomes.

With around 4600 New Zealanders receiving methadone and eighteen specialist MMT services, a diversity of opinion concerning the experiences of both patients and clinicians could be anticipated. Data from a recently published census of 18 specialist treatment providers and a survey of 85 regular (daily or almost daily) opioid users[1] confirm this. Nonetheless, these authors note that almost half (48%) of the opioid user sample they surveyed considered that clinicians' 'judgement and stigma' created a barrier to people taking up MMT. Of surveyed clients previously but not currently receiving MMT (19%), over half (55%) identified 'conflict with service requirements' as a major factor in their leaving treatment. Twenty-five opioid users surveyed (29%) had never received MMT, with 36% of these perceiving MMT services as 'too controlling'.

These issues of stigma, and Services' control and conflict with clients are acknowledged by John Caygill (2011)[2] in an as yet unpublished paper, *Methadone Maintenance and the Problem of Limited Trust: one caseworker's experience*. Caygill reframes these under the broader term 'paternalism', referencing Townshend, Sellman and Coverdale (2001, p.7)[3], who argue that service providers "are open to charges of paternalism as they exercise power in what they perceive as the best interests of their clients." Caygill[2] notes the potentially inflexible and socially invasive nature of MMT programmes, highlighting the focus of some on harm elimination rather than reduction, where programmes merely assume clients' accept abstinence from drugs other than methadone.

In shifting his perspective to that of the caseworker, however, Caygill[2] acknowledges the compassion and therapeutic inclination of those working in this sector. Of particular relevance to the issues being discussed here, he suggests that, despite some focusing on harm elimination, many caseworkers in MMT services also recognise the "obvious…compelling logic and evidence of harm reduction".

The 'compelling logic and evidence' of harm reduction is also very much the cornerstone of our Needle Exchange Programme (NEP). Commenced in New Zealand in 1987 and subsequently expanded both here and in many parts of the developed world, NEPs are widely credited with significant reductions in blood borne viruses (BBVs) such as HIV and HCV (hepatitis C), and injecting risk behaviours (IRBs). The New Zealand NEP is justifiably proud in noting we have one of the world's lowest seroprevalence rates for HIV amongst IDU, consistently less than 1% of this population[4].

Paradoxically, however, while both MMT programmes and the NEP claim the common ground of harm minimisation, there does exist the view, more commonly encountered within MMT than NEP, that these two strategies for reducing drug harm are incompatible where they intersect in the lives of those who inject drugs. One argument sustaining this position is that NEPs, in New Zealand and internationally, have in fact, been less effective than is claimed. If this is the case, then should not the aims and protocols of MMT take priority where clients might be utilising both services? For example, if the efficacy of NEPs is limited, is it appropriate that MMT clients be encouraged by their caseworkers to use NEP services which maintain IDU in active use and its associated milieu, to the detriment of recovery?

While this may seem like heresy in a country whose National Drug Policy[5] has harm minimisation as its fundamental principle, a critical reading of literature examining NEPs' efficacy does at least superficially lend some support to those seeking to prioritise MMT protocols where these might conflict with those of the NEP.

With HIV and HCV being linked to significant morbidity and mortality[6], reducing the spread of BBVs and changing injecting risk behaviours (IRBs) provides much of the rationale for NEPs. A large body of published literature reports on the success of NEPs, with a number of review articles examining the entire field at the time of their publication.

An oft-sited review claiming compelling evidence that NEP services reduce HIV infection substantially is Wodak and Cooney's (2004)[7] review of 38 studies. As Palmateer et al. (2010)[8] observe, however, the authors did not separately consider NEP effects on HIV vs IRB. The former suggest Wodak and Cooney[7] may have made assumptions about NEP efficacy on HIV based on reductions in IRB. Moreover, Palmateer et al[8] comment that of the 38 studies reviewed, 10 focused solely on HIV, with five reporting positive findings (i.e. association between NEPs and reductions in HIV), two showing negative findings and three no association between NEPs and reduced HIV infection. Of the five positive studies, four had weaker methodological designs.

Palmateer et al's[8] meta-review (i.e. review of reviews) raises the important point of the quality of reported data: has an acceptable threshold of evidential quality been reached by a given study? Their useful paper also critiqued other reviews. For example, their assessment of Gibson et al's[9] review of 32 NEP studies highlighted the latter's focus on experimental bias in studies reporting negative findings but noted the same attention was not paid to those indicating protective effects of NEPs. Moreover, while one meta-analysis of three studies showed a protective effect of NEPs, two studies showed increased risk of infection associated with NEP services and three showed no association.

A more recent meta-review of 26 studies[10] analysing NEP efficacy regarding HCV, a virus far more commonly contracted by IDU than HIV (in New Zealand, 52% vs <1% respectively[4]), reported similar findings to Palmateer et al.[8], whose analysis it also assessed. Within their study Hagan et al.[10] noted only one of the seven North American studies they assessed as reporting a lower risk of HCV being associated with NEP participation.

In summing up all of the studies discussed above three important points may be made. First is that generally: for NEP efficacy in reducing HIV there is tentative evidence; for HVC there is insufficient evidence; but that for IRBs, the evidence of NEP efficacy is strongest and is actually sufficient to substantiate a causal association.

Second, the *lack of evidence* linking participation in NEPs with reduced seroconversion of HIV and HCV, and reductions in IRBs, appears to have less to do with NEP efficacy than with the methodological and therefore evidential quality of studies assessing such associations. For example, Palmateer et al.[8] claim that self-reported IRBs have been studied more frequently than either HCV or HIV outcomes associated with NEPs.

Finally, and of greatest relevance to the present discussion, according to Hagan et al.[10] the strongest evidence associating reduced BBV seroconversion with health services, and therefore better client health outcomes, is found in multicomponent programmes including those which *combine* MMT and regular attendance at NEPs (e.g. van den Berg et al.[11]).

Thus we return to the issues of control and paternalism examined by Caygill[2] and Townshend and colleagues[3]. As someone who prefers to see bridges built rather than resources being siloed, I wonder whether the discrete aims of separate but intersecting services might be better met if a more integrated approach to health services is adopted. Certainly this appears to be the case in Dunedin where I reside. Having an on-going involvement with the local needle exchange and periodic contact with Dunedin's CADS, I am aware of each of these organisations' commitment to nurturing a mutual relationship which confers joint benefits to the two services and to clients participating in both.

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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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Addiction Treatment Research Interest Group (ATRIG)

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

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

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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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