Addiction Treatment Research NEWS

NEWSLETTER OF THE ADDICTION TREATMENT RESEARCH INTEREST GROUP

March 2013 ISSN 1177-8083 Vol 17 No 1

TABLE OF CONTENTS

ATRIG EXECUTIVE PROFILE – JANIE SHERIDAN

I was born in Earl's Court, London and so I guess I was always destined to have connections with the antipodes! Soon after I was born my family moved to North London where I lived until I was 18 and went to university in Bath, to study pharmacy. I didn't want to go to university, but if push came to shove, I had a strong urge to study art and music. However, my father's a pharmacist, and my parents felt it made more sense for me to get a professional qualification, which would then allow me to earn money whilst pursuing my other interests. Moving from London to live in Bath – a smaller city in the beautiful Cotswolds region of England, was my first experience of living closer to nature and in a more compact and friendly city. After finishing my degree I reluctantly returned to London. But London has this knack of sucking you back in and I began to really enjoy being right in the middle of the excitement of punk rock, outrageous fashion, and cutting edge arts. So I decided to do a year at art college, to satisfy my hunger for a bit of creativity. I'd only intended just to do the year, but was persuaded that I should apply for a bachelors in art, specialising in, of all things, fashion design! I loved it – it was a fantastic opportunity which allowed me to exercise the creative side of my brain. But like many others before and since, once I left Uni I was unsure what to do next, and after working in a fashion company as a junior designer (read: general dogs body and chauffeur) and then running my own millinery business for a short while, drifted back into the world of pharmacy undertaking locums. Soon after that, the company I was locuming for was purchased by Boots the Chemist. As luck would have it, they decided to fund positions for pharmacists whose work was split between academia and practice. I was lucky enough to get one of these positions and was encouraged to undertake a PhD. And so began my research career.

It was the era of the HIV/AIDS 'panic' and injecting drug use was at the forefront of many policy makers' minds, in relation to the risk of the spread of the virus. Needle exchange was in its infancy, and methadone maintenance was gaining greater traction as a treatment option. Harm reduction was highly controversial and I decided that I wanted to explore pharmacists' views about HIV/AIDS and drug misuse, pharmacists' knowledge and practices, and whether educational interventions could actually enhance service provision and reduce the stigma I was certain was out there. I chose pharmacy undergraduates as my population.

Whilst doing my PhD I met an amazing pharmacist who was working at the Maudsley Hospital, London in the methadone clinic. We talked about my research, and she encouraged me to make contact with her boss – Professor John Strang. I was rather overwhelmed at the prospect, as he was someone I had cited dozens of times in my PhD. But to cut a long story short, I made contact and he offered me a job at the National Addiction Centre, Institute of Psychiatry, London, undertaking a national survey on the role of pharmacy in harm reduction for the UK Department of Health. And the rest, I guess is history.

Working for John Strang was both an honour and a huge opportunity. I was able to be part of large national research projects, as well as smaller innovative local studies. He encouraged me to become involved in policy and guideline development through a role as the pharmacy expert on the UK Clinical Guidelines Working Group. I worked with him for seven years and was exposed to cutting edge research in the field, and many of the brightest brains in the field. Whilst working there, I worked shifts at the Maudsley methadone clinic and gained an insight into the nexus between service delivery and research, whilst also getting a grass roots understanding of issues for drug users in relation to their treatment, their health and lives. It was an honour to have that opportunity, and I'm grateful to all the clients who shared their stories with me.

After seven years, I got the old 'itch' and after a trip to New Zealand, returned to London to see my current job at the University of Auckland advertised. I applied, was offered the position, panicked and then decided to give it a go. I've been in New Zealand eleven years now, and have learned so many new things since being here. Just the difference in the substance misuse landscape required me to rethink my ideas and learn new ways of undertaking research. It was the first time I had been exposed to significant issues in relation to stimulant misuse, for example. In addition, I arrived around the time that unregulated 'party pills' emerged in New Zealand and this provided me with the chance to research that emerging issue right from the start, and exposed me to undertaking research with young people. This provided me with a chance to have a potential impact on policy. Aside from new research opportunities, I've been able to feed my passion for music, and have the chance to play percussion in a New Zealand band which has toured internationally, and currently play caixa (Brazilian snare drum) in AK Samba – a Brazilian drumming group.

One of my more grand ideas, after I'd been at the University of Auckland for some time, was to create a centre for addiction research. The Faculty of Medical and Health Sciences had a wide range of academics working on a range of issues in relation to substance misuse, and their fields spanned health disciplines, as well as biomedical through to sociological research, molecular through to public health. At first, we set up a network – the Addiction Research Network, which met regularly and acted as a way of communicating with colleagues with similar interests. However, in 2011 a number of us decided it was time to formalise our collaborations, and last year the University approved the formation of a new Faculty centre – the Centre for Addiction Research, of which I am proud to be Director. Our Associate Directors are Dr David Newcombe, Associate Professor Peter Adams and Dr Natalie Walker all from the University of Auckland, and Dr Susanna Galea who is clinical director of CADS, Auckland. The Centre's members represent the breadth and depth of addiction research in the Faculty, whilst having a strong and formalised link with New Zealand's largest treatment service. Aside from the new Centre, I am Research Director for the School of Pharmacy, and Deputy Head of the School of Pharmacy. I joined ATRIG and the ATRIG executive in 2003 and work with the rest of the executive team to promote New Zealand based addiction treatment research.

So I guess it's an interesting place to be for the girl who didn't want to go to university.

Janie Sheridan, University of Auckland

A Dutch Innovation in Residential Treatment

The subject of my master's dissertation was an exploratory literature review of a long term residential addiction treatment approach that is little known in New Zealand. This treatment approach began at a government funded service called Arta in The Netherlands in 1976 (Dunselman, 2000) with similar services now established in Germany and the United Kingdom (Suggate, 2010). Research on this approach is limited but promising. In residential addiction treatment retention rates are the primary indicator of positive outcomes (De Leon & Wexler,

2009; Messina, Wish & Memes, 2000). Research on retention rates by Tjaden, Koeter, van den Brink, & Vertommen (2005) found significantly higher retention at Arta. During the first eight weeks post detox, Arta's retention rate was 88% compared with 40% at the comparative conventional service. In the initial detox phase the differences in drop-out rates between services were not statistically significant. Arta's own follow up research conducted with clients five years after their treatment found abstinence rates of 55-75% (van den Berg, 2012; Evans and Rogers, 2000) which, although not peer reviewed, is a very positive result that would appear to be worth further investigation.

My research included a thematic analysis of four client-written recovery stories, two from a local NZ 'traditional' Therapeutic Community (TC) and two from Arta. These four accounts were the only such literature located and were published on behalf of the services. The accounts were similar in length (the local service accounts were a little longer) and with no obvious differences in forensic or psychiatric severity although more mention was made of 'harder' drugs in the Arta stories. Across both services, clients mentioned positive staff support and receiving community feedback within treatment (Suggate, 2010). A notable difference was found in how recovery was discussed. In the NZ service, personal change was most often described in terms of external influences e.g. "*staff and fellow residents are constantly there to offer encouragement, pull you up when you step outside the rules, and push you forward when you are stalled*" (Odyssey House, 2009a) and that the program "*changes your whole way of life and your thinking, the way you are"* (Odyssey House, 2009b). In comparison, clients at Arta talked of the external influences leading to their own personal motives for change e.g. *"The possibilities I had as a human being were addressed, and I felt stimulated to unfold them"* and *"I learned to look at myself, I discovered that you could develop yourself, and that this was meaningful*" (Ilgen, 1990). This may indicate that the Arta program better supports intrinsic motives that would appear important when external influences are absent.

What differentiates this treatment approach and could account for these early findings?

The Arta program is based on an anthroposophical understandings which place a high value on human potential. Anthroposophy could be described as a metaphysical science and has lead to many initiatives in education, farming, arts, the sciences, philosophy, medicine etc. Arta appears to utilise aspects of the established TC model but with a greater developmental rather than behavioural focus. One perspective is that addictive behaviours often manifest when an individual's ongoing development is blocked or stalled for some reason (Dunselman, 2000). Emphasis is placed on both strengthening the autonomous self determining aspect of each individual and providing opportunities to overcome any underlying shortfalls that may impede maturation.

Utilising a developmental approach, in a manner not dissimilar to the indications of neuropsychology (i.e. the sequential development of brain stem, limbic and then cortical regions), first physical and biological aspects of the individual are given attention (Dunselman, 2000; Evans and Rogers, 2000). Here a focus is on receiving physical care and establishing a connection and recuperative rhythm within the community. New positive habits, healthy nutrition and sleep patterns are supported. Emotional, imaginative and social needs are then a focus via community involvement, artistic, experiential and therapeutic activities. Developing individual thinking, judgement and responsibility as well as the development of new skills, positive ideals and identity then become a focus. The final stage of treatment tends to be focused on individual and existential questions including the individual's potential and unique challenges, developing virtues and establishing an individually chosen, meaningful lifestyle back in the wider community.

Anthroposophical medicine, utilised at Arta, is a holistic medical approach (more common in Europe) that is linked with positive emotional as well as physical outcomes with few side effects (Esch, Marian, Busato, & Heusser, 2008; Hamre et. al., 2005). A study utilising anthroposophical medicine and art therapy treatment for chronic depression found that two thirds of participants no longer met the criteria for depression (Hamre et al., 2006). These improvements lasted the four year duration of the study. Reduced anxiety and costs of treatment have also been demonstrated (Hamre et. al., 2009; Hamre et al., 2010). Depression and anxiety commonly co-occur with addiction (Adamson, Todd, Sellman, Huriwai & Porter; 2006a).

Arts, drama, music, and story are utilised at Arta as activities with proposed broad therapeutic, social and neurological benefits. Complex neurological processes are involved in arts activities (Lusebrink,2004) which may

support the new skills, attitudes and behaviours needed in recovery. Meaningful work activities are utilised and require the individual to focus outside of her/his personal problems with the quality of work providing objective feedback on the progress of the individual. The treatment centres are situated on biodynamic (an organic method) farms. The benefits of natural settings include improved coping with and recovery from stress and mental fatigue, and enhanced physical recovery (Barnes, 2007). Both clients from Arta mentioned benefit from their nature contact: *"because of the celebration of the season's festivals I came to realise that there is a rhythm in me, and one in nature, with a connection between the two… this gives a kind of peace"* (Ilgen, 1990). Noticeably fewer mentions were made in the Arta client stories of rules, consequences and confrontation (Suggate, 2010). Confrontation could contribute to women receiving fewer benefits in TC's than men (Eliason, 2006). One of the Arta clients who had previously participated in a traditional treatment mentioned: "*because of the absence of compulsion and punishment I could grow, and show who I was in my own good time and the way I wanted"* (Ilgen, 1990).

The available information reviewed indicated to me that this model of treatment may add to the diversity and success of addiction treatment in New Zealand. Retention for Māori is particularly low in addiction treatment (Adamson, Sellman, Deering, Robertson, de Zwart; 2006b) and differences in approaches to healing are a possible reason for this (Durie, n.d.). The holistic view of the person and their development, with less emphasis on change via confrontation, more use of natural medicines and body therapies, connection to nature, storytelling and the arts alongside talking therapies may mean improved retention for women, Māori, and other cultures.

Contact gabsuggate@hotmail.com with any queries.

Gabriel Suggate, AOD Clinician

A full reference list can be obtained by contacting the editor ria.schroder@otago.ac.nz

UNIVERSITY OF OTAGO, WELLINGTON MEDICAL SCHOOL UPDATE

We have many researchers within the school active in research related to addiction. Our researchers often work in collaboration with other departments within the university as well as external organisations and health service groups.

ASPIRE2025

A key example of this collaboration is ASPIRE2025, a partnership between major NZ research groups carrying out research to help achieve the government's goal of a tobacco-free Aotearoa by 2025. Our ASPIRE2025 researchers have recently completed work in relation to seven primary tobacco control research themes:

- Smoking cessation systems, led by Julian Crane
- Smokefree communications, led by Janet Hoek
- Policy and regulatory research, led by George Thomson
- Research on smoking among young people, led by Rob McGee
- Māori public health and tobacco misuse, led by Heather Gifford
- Smokefree Pasifika, led by Stephanie Erick
- Research capacity development, led by Chris Cunningham

The following review outlines work completed in each of these areas that was led by University of Otago researchers. For more information on recent projects, visit http://aspire2025.org.nz/2012/11/20/aspire2025-research-at-tobacco-free-aotearoa-conference-2012/ to view the 18 presentations given at the recent Tobacco-Free Aotearoa conference. Further details about ASPIRE 2025's work can be found at: http://aspire2025.org.nz

Smoking cessation systems

Julian Crane and Brent Caldwell completed a large HRC funded Randomised Controlled Trial (RCT) of a combined nicotine mouth-spray and patch versus a placebo mouth-spray plus patch; findings will be submitted for publication

shortly. In February, Julian and Brent will commence a second RCT of nicotine metered dose inhalers. They have established a working group of CCDHB and Hutt Valley cessation staff and researchers to help improve cessation services. Julian and Brent have also completed a pilot study of snus acceptability amongst hospitalised smokers at CCDHB. This work was presented at the European Respiratory Society annual meeting in Vienna.

Smokefree communications

We continued work on an HRC-funded project examining plain packaging. Four papers from this study have been published and another is currently under review. This final paper, reporting on a study led by Phil Gendall, addressed a crucial gap in existing knowledge and makes an important contribution to pending international litigation. We also completed a major piece of work funded by the Ministry of Health that examined new smokefree messages. Janet Hoek led this project, which comprised three phases an initial exploratory qualitative phase, development of new imagery and messages, and quantiative testing of the new messages. Ben Healey has prepared an analysis of smokefree 2025 discourse by politicians. He is also examining patterns of interaction among Quitline quit blog users. Anaru Waa has commenced work on a project to examine the advertising campaign undertaken by British American Tobacco to oppose plain packaging. This will conclude in mid-2013.

Policy and regulatory research

George Thomson led several studies into smokefree places. Together with Vimal Patel and Nick Wilson, he further developed observation methods to determine the prevalence of smoking in outdoor places and cars, and butt littering. In collaboration with the Department of Information Science, the group developed a smartphone app to help record the extent of smoking in cars worldwide. Phil Gendall led an online survey testing arguments advanced by tobacco companies in relation to plain packaging and other tobacco control measures. We propose repeating this survey to monitor changes in public opinion over time. Louise Marsh led research examining the implementation of smokefree policies at tertiary institutions and assessing the extent to which staff and students at the University of Otago supported a completely smokefree campus. Two papers from this research will be submitted in early 2013. Richard Jaine led a project examining retailers' views on the legislation removing point of sale displays of tobacco products, before this was implemented. This was funded by Regional Public Health. Louise Marsh and Lindsay Robertson also undertook retail research and examined the spatial characteristics of tobacco retailers in New Zealand.

Research on smoking among young people

Janet Hoek and Richard Edwards secured a Marsden grant to explore the degree to which young adults starting smoking are exercising true 'informed choice'. Interviews are underway as part of the first phase of this project. Rob McGee and Louise Marsh also undertook research around young people and smoking. This involved three studies examining trends in smoking among young people. Qualitative research with young people explored social supply and smoking cessation. Ben Healey has analysed ASH Year10 data (a set of cross-sectional surveys) to estimate exposure to second hand smoke in cars. A brief report outlining the findings, which reveal high levels of exposure, has just been submitted, and these results will be written up for publication in 2013.

Department of General Practice

The Empathy Project, a longitudinal cohort control study of Empathic Brief Intervention skills established in 2009, has continued researching and publishing outputs. This research group earlier found that an intervention: a short but dedicated tutorial on empathic alcohol and drugs interviewing significantly improved student brief intervention skills, and that impact was sustained for more than a year. The most recent publication from this group is: Moriarty et al "How well do medical students recognise and rate clinical empathy?" Medical Teacher Sept 3rd 2012. It has also discovered that for medical students now going through a new medical school curriculum the impact of the intervention seems to be more moderate. Funding has now been obtained to run an educational RCT during 2013 to ascertain how much of that impact can be attributed to the new curriciulum or to the innovation itself.

Prescription drug misuse has also been a focus of research activity in recent years. A project funded by Health Quality and Safety Commisison has been completed on opioid prescribing for chronic non-malignant pain. A research paper for publication is in progress but the research report can be found on the HQSC website http://www.hqsc.govt.nz/our-programmes/other-topics/quality-and-safety-challenge-2012/projects/prescription-

safety/ Further funding is currently being sought to implement the recommendations for a benchmarking audit of opioid prescribing arising from this quality and safety research project. Several clinical sites in New Zealand have already volunteered to trial the prescription quality audit, and the research team are happy to liase with other interested clinical sites.

Fran Wright, Department of Public Health, University of Otago, Wellington

A full reference list can be obtained by contacting the editor ria.schroder@otago.ac.nz

I'VE BEEN READING …

There I was, wondering what the best medication would be to help a 15-year-old whose mood had significantly improved on 40mg of Citalopram but who had developed really uncomfortable sweating. I had a couple of alternatives in mind but thought I'd check this situation out with my colleague *Fraser Todd.* And that is why I'm *going* to be reading large sections of *Stephen Stahl's (2011) "The Prescriber's Guide: Stahl's Essential Psychopharmacology"* over the next few months, particularly with our postgraduate course on pharmacotherapy just about to begin. This was the book Fraser immediately reached for and the recommended Clonidine 25mcg twice a day has worked a treat in my patient. My new copy of the book was waiting for me when I got home this evening. But this is a world away from where my reading has been over the last three months.

Addiction and addiction treatment occurs in a social context, a modern social and economic context, a context which up until recently I've been… well I wouldn't say totally ignorant, but I certainly have felt behind the eight ball on.

I've previously talked about the truly remarkable shift for H. sapiens, some 13,000 years ago, when farming led to a more steady supply of food freeing up members of the clan to conduct experiments on how to do things differently. The rest is the history of technological advancement culminating with the development of an intensely hedonic, consumer-based "addictionogenic society". But what has happened in more recent times to bring this about, specifically in New Zealand?

Over the past thirty years various corporations have ascended to a position of great influence in the life of New Zealanders, including our personal and social lives, media and Parliament, turbo-charging consumption and therefore addiction and other harms. How has this happened?

When I began working in the addiction treatment field in 1985, New Zealand was experiencing a similar trend to other similar countries; a dropping of the per capita drinking in the population, driven by, no doubt, a range of factors, but including greater awareness of the potential harms from alcohol, especially greater awareness of the dangers of drink-driving. However, despite an aging population and increasing immigration of Asian and Pacific peoples, all of which would get you predicting a continuing fall of the per capita drinking level, the level began to increase from 1998 through the next decade to the global economic crisis in 2007/2008 and subsequent global recession, including in New Zealand. One of the key drivers of this increase has been the deregulation of the alcohol industry in 1989 with a new liberalising Sale of Liquor Act, brought about by a revolution in economic direction beginning in 1984. We remember the night a drunken Rob Muldoon appeared on national television and with grossly slurred speech announced a snap election. But I'm getting ahead of myself in what "I've been reading…"

One Saturday morning near the end of last year my ears pricked up when I heard Kim Hill beginning to interview the outspoken Australian Professor of Economics and Finance, *Steve Keen.* He seemed quite irritated about the current neo-classical theory of economics, also known as the neo-liberal model. This is the standard economic theory, championed by the Chicago School of Economics and currently taught all around the world by academic economists. Keen seemed particularly agitated about the lack of a solid mathematical foundation within

traditional neo-liberal economics. He also seemed to rather enjoy exposing those in power and influence economically who didn't see the global financial crisis coming, having been among the 12 or so economists around the world who had predicted it (in writing). He argued that the crisis was not possible within the neo-liberal theory and continues to be bewildering for many of the leaders of neo-liberalism. So that morning, I bought a copy of *"Debunking Economics: The Naked Emperor Dethroned" (2011) by Steve Keen* and read it over the next couple of weeks. Real World Economics Review writer, *Edward Fullbrook,* has stated "No book poses a bigger threat to the faith of economics". Although I understood only about a third of Keen's book, which includes large sections of mathematical exposition, it was clear there are alternatives (the title of the final chapter) and Keen outlines five. I ended feeling excited at the likelihood of a new economics on the horizon that moves beyond the extreme GDP-obsessed, unregulated free-market approach we are following at present, in which all business products are treated similarly, whether they are vegetables or coca cola, fruit or guns, clothes, books or alcohol; they're all just business products bought and sold in a free market, or as free from state regulation as can be lobbied for, which has increasingly been at the extreme end over the past few decades.

Two further books reinforced the negative impacts of neo-liberal economics on the lives of ordinary people. These were (the much more readable than Keen's): *"The Price of Inequality" (2012)* by ex-Chief Economist at the World Bank, *Joseph Stiglitz,* and *Jeffery Sachs' (2012) "The Price of Civilisation."* These two books focus on the rich/poor divide (child poverty), and destruction of land and sea ecosystems as key examples of the folly that has been the outcome of out-of-control, unregulated markets, but I would add the obesity epidemic and the alcohol industry driven alcohol crisis as obvious additional examples. Both books point to a new economic direction, which balances wise State intervention with the efficiency of markets. Having been convinced there is a better way ahead and that the Global Recession could very well be seen in retrospect as a huge wake-up call and major stepping stone to this new economic era, I felt drawn to read about how we got into the mess in the first place.

Walking around a second-hand bookshop in Nelson over the Christmas holidays I came across a political section and before I knew it, I was walking out with a bundle of books, including authors *John A Lee* and *Gareth Morgan,* which I'm working through at present. But first was the *(1974) "The Rise and Fall of a Young Turk" by Rob Muldoon.* This book details Muldoon's rise to power within the National Party under the wing of his mentor, *Keith Holyoake*. He was to become one of the most overtly aggressive and controlling Prime Ministers (and Minister of Finance) in our history. He had a detailed and very hands-on approach to economic management and financial regulation was the order of the day. It is no wonder *Bob Jones* got politically active. His 1978 book *"New Zealand the way I want it"*, paints a picture of what Jones felt was holding him and New Zealand back from exploiting opportunities and amassing greater wealth. I've just finished *Roger Douglas' (1987) "Toward Prosperity: People and Politics in the 1980s"***,** which outlines the heady days when Rob Muldoon was finally defeated and nearly brought NZ to a state of bankruptcy through delaying a devaluation of the NZ dollar during the transition of power to the incoming *David Lange*-led government. *Roger Douglas, Richard Prebble* and *David Caygill* were now at the financial wheel and "Rogernomics" used the financial crisis to quickly usher in a new unregulated neo-liberal agenda into New Zealand over the subsequent six years. The revolution increased in intensity with "Ruthanasia" during the first term of the next National government (1990-1993). The top 10- 20% of New Zealanders haven't stopped cheering as their personal wealth has soared. Jeffery Sachs refers to the unleashing of greed in the Western World in the book mentioned above, which has the by-line *"Reawakening Virtue and Prosperity after the Economic Fall"*. Is talk about virtues and vices going to make a comeback?

Helping people deal with overconsumption of addictive products to the point it becomes a compulsive addiction is at the heart of our work and research. Socioeconomic context undoubtedly has an impact on the development of these disorders, but equally impacts on the success or otherwise of interventions that may help people, both at a population and an individual level. We have been living in aversive, hollow economic times over the last three decades, which are now being found out. Change is coming…

Now back to Stahl; what's he got to say about Acamprosate?

Doug Sellman, Professor of Addiction Medicine,
Director National Addiction Centre, University of Otago, Christchurch

Are You Actively Engaged in and/or Interested in Addiction Research?

If you are then we invite you to **attend** the 4th National Addiction Research Symposium to be held at the School of Population Health at University of Auckland on **April 22nd 2013**. This meeting is part of a series of research symposia organised by the Universities of Auckland, Otago and Victoria, with support from Matua Raki.

The objectives of the Addiction Research Symposium are:

- To provide a forum for New Zealand addiction researchers to meet and share their work;
- To provide an opportunity for research students to present in a supportive environment;
- To allow for focused discussions on issues of common interest to addiction researchers.

Registration: **free** for higher degree research students; $45 for other delegates. To register please click on the link and complete the form - Registration - Research Symposium. For registration enquiries contact Patricia Rainey (patricia.rainey@matuaraki.org.nz)

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 members** are:
Klare Braye (Chairperson), Simon Adamson, Janie Sheridan, Robin Shepherd, Ria Schroder (ATRN Editor), Catherine Lowry-Hanlon, Lindsay Atkins (Secretary)

Please direct **enquiries to**
Lindsay Atkins,
ATRIG Secretary
PO Box 4345,
Christchurch 8140
Phone (03) 364 0480,
Email: lindsay.atkins@otago.ac.nz

Contact Person for ATRN:
Ria Schroder
Ph: 03 364 0480
Email: ria.schroder@otago.ac.nz

ATRN is the official newsletter of the Addiction Treatment Research Interest Group (ATRIG)

ATRIG is sponsored by
The National Addiction Centre
Dept of Psychological Medicine
University of Otago, Christchurch
Enquiries to Lindsay Atkins
ATRIG Secretary
PO Box 4345
Christchurch 8140

Phone: 03 364 0480
Fax: 03 364 1225
www.addiction.org.nz

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:

- Four issues of the Addiction Treatment Research News via email

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 2013 calendar year. I understand membership fee is $20.

Signed _____ Date _____

- Please make cheques payable to ATRIG and return with membership / renewal form to address below
- Payment can also be done online: **03 0855 0424992 00** (Westpac) – Reference: name and membership. If using this payment method, please post or fax membership / renewal form.

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