Treatment Research News

Alcohol, Drugs and Addiction

April 2000 *Newsletter of the Treatment Research Interest Group* **Vol 4 No 1**

Dear Readers

Another lively discussion about the need for the development of a national strategy for alcohol and drug research was had at the last meeting of the TRIG executive. What are the priority areas for alcohol and drug research and what might it take to support and sustain research? Alongside these questions are the related workforce development issues about how the research sector can be developed, how to retain researchers in the field and sustaining clinicians interest and support for research. TRIG has welcomed the opportunity to host a session at the Cutting Edge Conference in August to further discuss these issues. Peter Adams further outlines ideas on the content of a National Research Strategy on page 5.

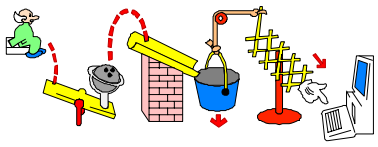
Fran Lowe also raises the issue of research priority and relevance in her letter to the editor. Grant Paton-Simpson, in his reply to Fran, emphasises the need for the continued development of an addictions research culture in NZ. Stuart MacKinnon discusses the complexities of conducting research in a clinical setting while Daryle Deering comments that NZ is behind in terms of resourcing and implementation of outcome research highlighting the need for services to support and sustain routine collection of clinical or treatment outcome information. We have also included information about ALAC's Research and Evaluation approach.

Also in this issue Gavin Cape gives us his interesting perspective on the "misinformation" of drug use. In addition, Anastacia Earnslaw has provided a summary of the very interesting findings from her MSW thesis. It is great to see some qualitative research being conducted. I was interested to read about the negative impact of family on women seeking change especially in light of the common belief that family/SO involvement is an integral part of alcohol and drug treatment. Perhaps the importance is less for women. What do you think?

Finally I wish to pay tribute to two regular contributors to TRN who have now moved away from the alcohol and drug area. Kate Cosgriff is now the Regional Manager for CCS Waikato/Bay of Plenty. Thank you Kate for your support of TRN and your huge contribution to the alcohol and drug field over the years. Grant Paton-Simpson is now at Mental Health Services, Waitemata Health. Again thanks Grant for always getting your articles in on time and your willingness to contribute comments at short notice. You will both be greatly missed.

Raine Berry
Editor

Deadline for the next issue is 19 May.



LETTERS TO THE EDITOR

Dear Editor

I recently obtained Grant Paton-Simpson and colleagues' paper "Towards an Inclusive Understanding of Alcohol and Drug Problems in New Zealand." from the ALAC web site. I have great respect for Grant's research work, and was perplexed to find that considerable time and expense had been devoted to a piece of research which concludes that alcohol and drug problems are heterogeneous in nature. As this result is self evident to those in the alcohol

and drug industry one could be forgiven for thinking that the research was undertaken for political reasons, or the qualitative nature of it precluded any useful conclusions.

The researchers did not include a complete literature review, and the few papers cited overwhelmingly state that alcohol and drug problems are diverse in their etiology and impact (this does not come as a surprise). The samples of individual stories are mildly interesting, but no more than counsellors routinely hear from their clients. The report was well written and the research was obviously well executed, which adds to the sense of waste.

Could those who initiate research projects please keep in mind that the industry needs studies which provide clarity and information. For instance New Zealand has a particular problem with the use of cannabis oil, and yet I know of no studies undertaken locally of the long term health implications for New Zealanders. A pertinent question might be; what is the relationship between chronic use of cannabis oil and the incidence of pneumonia?

Fran Lowe
Systems Developer, NSAD

LETTERS TO THE EDITOR CONTINUED

Dr Grant Paton-Simpson, Mental Health Services, Waitemata Health (formerly of RADS Clinical Information & Research Unit (CIRU)) replies:

Fran raises a number of important points in her letter, many of which I completely agree with. For example, there can be little doubt that there are numerous areas of alcohol and drug studies which need further research - particularly within a New Zealand context. I also empathise with the underlying frustration I detect about the scarce research resources available for alcohol and drug research in New Zealand. I agree that we all have a responsibility to ensure that any research we are involved with does not duplicate existing research and serves some important purpose. This is not in dispute.

The point at which Fran and I part company is on the cost-benefit merits of the particular piece of research in question. Looking at benefits first, I (predictably) disagree that the findings of the paper were self-evident. The paper explicitly presented the alcohol and drug problems perspective in opposition to the "alcoholism" and the "alcohol dependence syndrome" perspectives. These latter perspectives are still widespread in New Zealand and I have been party to and overheard numerous discussions about the nature of alcohol and drug problems which were at odds with the "self-evident" position taken. The American Institute of Medicine clearly felt the need to elaborate and clarify an alcohol and drug problems perspective in the American context and I felt the same was true in New Zealand.

It should also be stressed that the paper cannot be summarised in a single statement without it sounding trite. Like most papers, especially those based on qualitative research, the details and nuances are a critical part of the overall value. I agree that a broad finding that “alcohol and drug problems are heterogeneous in nature” would be of limited value – but the paper goes far beyond this bland statement. I expect that there are many aspects of the paper which will be controversial or challenging in some settings.

Regarding the value of individual client stories it should be recognised that not all intended readers of the paper are working directly with clients or with sufficient numbers of clients to form a broad perspective. In addition to specialist alcohol and drug clinicians the relevant audiences include students contemplating careers in alcohol and drug treatment or relevant professions such as guidance counselling, other health workers e.g. GPs and Practice Nurses, and policy-makers/funders. We should not underestimate the role they play or will need to play as we respond to alcohol and drug problems. This is especially true of the latter group – policy-makers and funders. They typically cover alcohol and drugs as a small, and sometimes temporary, part of an over-stretched portfolio and I believe there are significant advantages to the field in being able to orient such influential people quickly and well.

Turning now to costs, the paper "Towards an Inclusive Understanding of Alcohol and Drug Problems in New Zealand" was not the only outcome of the empirical research it was based on. The phone contact with clients was conducted primarily as an in-house attempt to better understand the clients of our service and to validate (as much as practical within available resources) our client outcome and satisfaction reporting. We did this within the scope of our contract with North Health and not as pure research. The objectives of our study were achieved to our satisfaction and the paper was in some senses a by-product. Furthermore, this research did not receive any funding from funding bodies such as ALAC or HRC - it was simply fitted in with existing activities at RADS. The project was one of the first at RADS and was not without its faults. It would be an exaggeration, however, to suggest that it drew scarce resources away from other researchers.

Although I disagree with the central thrust of Fran's letter, I am pleased that the alcohol and drug field is starting to debate some of these issues in a semi-public way. As the struggle to sustain and develop an addictions research culture in New Zealand continues it is critical that the field weighs its priorities carefully.

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VISIT TO LANGTON CENTRE

Langton Centre in Surrey Hills, Sydney is a long established comprehensive alcohol and drug service staffed by multidiscipinary teams involved in intake, assessment, detoxification including ambulatory (majority), non-medical and medical inpatient via 6 hospital beds, methadone treatment, counselling, case-management, medical management, needle and syringe programmes and clinical research. Psychosocial services include individual, group and family counselling, targeted therapy groups, child protection services, 16 medium-term supported accommodation beds and case-management and on-site welfare assistance. The Centre provides services to several hospitals ie Sydney Hospital- medical in-patient detoxification, consultation and liaison; Royal Hospital for Children – Chemical Use in Pregnancy Service; Prince of Wales Hospital – consultation and liaison service. The centre also has teaching and research links with the National Drug and Alcohol Research Centre (NDARC), Turning Point Drug and Alcohol Centre in Melbourne, and the University of Western Sydney. The service has an academic role in the Masters of Narrative Therapy course at the University of Western Sydney. I spent a number of hours with manager Jennifer Holmes, a nurse who is the current manager. Jennifer has a long history of working as a clinician and manager within a range of alcohol and drug services, including a specialist Mothers and Babies Methadone Treatment Programme and general adult programmes in Christchurch.

Current clinical trials include an evaluation of the treatment of benzodiazepine dependence. This trial entails randomization to either single day dosing or split dosing regimes. Once a dose of 30mgms per day is achieved, patients have 3 options: 1) Progressive, gradual reduction to zero; 2) Maintenance on 30mgms daily or if stable on 20mgms

daily return to GP for continued management; 3) Daily dispensing of 30mgms if unable to achieve stability but some treatment benefit is achieved.

Other medications available include Chlormethiazole (acute alcohol withdrawal), Naltrexone (adjunct in treatment for alcohol dependence, maintenance of abstinence following opioid withdrawal), Acamprosate and Disulfiram (maintenance of abstinence in alcohol dependence), Buprenorphine and clonidine (opioid detoxification).

In relation to outcome measures, Staff within the Methadone Treatment Programme had commenced routinely collecting information on drug use, and health status welfare and legal issues and treatment plan options. Of note was the range of pharmacotherapies and psychosocial interventions available to clients.

Daryle Deering
Lecturer, NCTD.

RESEARCH NEWS FROM THE NATIONAL CENTRE FOR TREATMENT DEVELOPMENT (NCTD) (ALCOHOL, DRUGS, & ADDICTION)

Dear Colleagues

You may recall that at the last time of writing this column the NCTD was on the brink of its first major review. I am pleased to say that the review was successful and core funding from ALAC (now contributing about 60% of the total NCTD budget) has been confirmed through to mid-2003. This time frame gives us the space to not only complete all the projects currently in the pipeline but also embark on new ones. In future columns this year I will outline a number of ideas being considered and welcome feedback. One of these is a Youth and Cannabis project focusing on the association between cannabis use and mood, cognition and general functioning in a clinical sample of adolescents being treated for cannabis dependence. We are also planning work on pharmacotherapy in alcoholism and cannabis dependence. In relation to this work, I was very fortunate to be awarded the Gary Harrison Memorial Scholarship this year and will be using this to increase my knowledge and experience in the use of various medications in the overall treatment of people with addiction problems. I will be attending two conferences: the 62nd Annual Scientific Meeting of the College on Problems of Drug Dependence (CPDD), San Juan, Puerto Rico; and the International Congress of the Collegium Internationale Neuro-Psychopharmacologicum (CINP), Brussels. I will also be consulting colleagues at three addiction research centres (London, Leeds and Sydney). During the course of this five weeks of travel and for several weeks after, I will be writing a review paper in this area, which I hope to make widely available.

As an aside, I was recently shocked to hear reported that alcoholic patients in Australia only pay $3 a month for either acamprosate or naltrexone as both medications are now registered and funded there. Here in New Zealand these medications are not even registered for use in alcohol dependence let alone funded. Therefore they are only available here, privately through a handful of medical practitioners and at full cost ie in excess of $200 a month. There is clearly as much political work to be done here in New Zealand as there is further scientific and treatment development work as we enter this exciting new era of anti-craving medications.

A parallel to this new era is the development of anti-tuberculous drugs. Prior to the advent of the new medications treatment of florid cases of tuberculosis often involved a period of inpatient care in Tb sanitoria, not unlike some of our residential treatment programmes for severe alcohol and drug dependence. However, I suspect that the complexity and severity of the health and social problems of people for whom residential treatment remains appropriate will still be there after their first dose of naltrexone!

In the last TRN I outlined eight clinical research projects the NCTD have been involved in over the past three years: Brief Treatment Programme for alcohol dependence; Collaborative Maori Project; National Telephone Survey of alcohol and drug treatment workers; Telephone survey of school guidance counsellors in the Christchurch area; Ongoing national telephone survey of alcohol and drug treatment workers; Validity study of the Degree of Drug Use Index (DDIVS); Health behaviours (including alcohol and nicotine use) and acculturation in a diabetic sample of Samoan; and National Treatment Outcome Project – Part One (NTOP-I).

We continue to welcome any direct enquiries about the progress of these studies.

The results of the Brief Treatment Programme for alcohol dependence, a randomized controlled trial of motivational enhancement therapy (MET), will be presented at this year's Cutting Edge Conference. We are on the brink of "opening the books" on this study to examine the six-month treatment outcome data of MET versus two other treatment arms. The first was person-centred therapy (PCT), which for the purposes of this study was a "cut down" version of highly non-directive Rogerian counselling. The second was no further therapy (NOT) other than the initial comprehensive assessment, a feedback session and a six week followup session, received by all patients in the study. We will be examining both reductions in alcohol use as well as general life functioning in the consideration of treatment outcome.

Here I want to outline some work we've done in conjunction with Sean Sullivan of the Auckland Compulsive Gambling Society (CGS) and John Coverdale of the Auckland Department of Psychiatry, examining gambling behaviour from the baseline data of this study. Although there is a growing literature related to the overlap between gambling and substance use, there are no published data of gambling in an alcohol and drug outpatient sample, except for one from a methadone maintenance sample [Spunt et al 1995]. We investigated the rate of gambling in a research sample of alcoholic patients presenting to the Community Alcohol and Drug Service (CADS) in Christchurch. We used the South Oaks Gambling Scale (SOGS) [Lesieur & Blume 1987], a central instrument in the field for measuring potential problem gambling, modified for the New Zealand gambling environment. We also obtained demographic data and a diagnostic profile using the Diagnostic Interview for Genetic Studies (DIGS) [Nurnberger et al 1994], a structured clinical diagnostic instrument. We found a 19% rate of problem gambling and a 4% rate of pathological gambling, which are about 10x and 3-4x the community rates respectively. This means that nearly 1 in 4 alcohol dependent patients presenting for help, with their alcoholism, will additionally have problem gambling if not pathological gambling. Given that the sample included only people with mild-moderate alcohol dependence, these rates of problem gambling

are likely to be less than those found in more representative outpatient samples eg from the Simon Adamson's National Treatment Outcome Project. There are clinical implications of these findings, which parallel a number of other situations of coexisting disorders in our alcohol and drug patients, the most relevant to the alcohol and drug treatment field currently being coexisting psychiatric disorder. What is the justification for having separate specialist services? What are the general training needs for staff working in both sets of services? When should a patient be referred for specialist assistance? These are some of the questions we will no doubt need to wrestle with as a field as we continue to try and improve our services for the people who turn up for help at them.

Doug Sellman
Director, NCTD
19/3/2000

Over Reaction To Drug Use?

Nietzche said that "the whole history of narcotica… is almost the history of culture, of our so-called higher culture".

Society has responded to the problems of drug use differently at different times. I present an argument that it is culture not policies which determines the use of drugs and what may seem reasonable at one time seems unreasonable at another. A lack of knowledge or blatant misinformation on drug use has influenced generations of politicians and peoples. This in turn has created an often unreasonable fear and over-reaction to the so called 'drug menace'. Drug use is an integral part of society and has been so since the earliest records of humankind. There is no sign that humans will forsake the pleasures (and the pain) of alcohol, tobacco, cannabis and other intoxicants. Drugs are too popular, too effective and too lucrative to be banished; the 'war on drugs' is a non-starter.

According to the WHO there is a worldwide increase in the use of a number of drugs including the amphetamines, hallucinogens and cannabis with the age of initiation declining. This leaves us with many questions: are the young truly at risk from this upsurge in drug culture? are they in more danger than previous generations? can these hazards be eliminated? A counter-argument follows the words of Nietzche: "The secret of reaping the greatest fruitfulness and the greatest enjoyment from life is to live dangerously". Life without an element of risk is not worth living — the difficulty is achieving a balance.

To illustrate the above I wish to discuss some aspects of one of the most powerfully addictive drugs known—tobacco. A description of this power that tobacco has over people is summed up by a Mr. Oscar Wilde who said "a cigarette is the perfect type of a perfect pleasure. It is exquisite, and it leaves one unsatisfied. What more can one want?"

Through the painstaking research of Doll and Hill we know there is a strong association between tobacco smoking and ill-health, yet it remains to a degree a socially sanctioned, recreational drug which is firmly embedded in social custom—it is normal behaviour. One view which is rarely articulated goes as follows:

Tobacco smoking is a potent addiction, difficult to stop and in the long run affects health. Apart from some evidence of harm from passive smoking in restrictive environments it affects no-one else. It may be beneficial and help people work, being a stimulant. Smokers die up to 15yrs prematurely but in the meantime they have contributed to the revenue and if they die early do not collect their pensions. The overall burden of old-age on society is thus lessened. (A formidable dilemma for social policy and governments).

In the past in some cultures tobacco use was judged, much as heroin is now, e.g. the Czar in Russia in 1634 issued laws against the use of tobacco, with first offenders having their noses slit and repeat violators put to death. Similar severe penalties were imposed in other countries in an attempt to suppress the use and selling of this substance. These harsh penalties however, have had little effect on tobacco use.

Cannabis, whilst having a long history of use in Eastern cultures is a relative newcomer as a recreational drug to the Western world. It has enormous ability to divide governments and peoples and perhaps influence elections — even before it's been inhaled. Over-reaction and ignorance has plagued the debate over whether to legalise or decriminilise this popular drug. Indeed, it is the third most popular drug in NZ and has been tried by half of 15 – 45 year olds in a 1998 NZ survey. On balance I would say that it is probably not as dangerous as generally thought and according to a recent WHO paper is simply not in the same harm-producing-league as alcohol or tobacco. I hasten to add that there are dangers with misuse. The point I wish to make is that it is possible to over-react to its use.

A Commissioner of Narcotics for the USA and on the United Nations for many years —Mr. Harry Anslinger declared in 1953 that "*marijuana is one of the most dangerous drugs known… a small dose taken by the subject may bring about intense intoxication, raving fits, criminal assaults…the moral barricades are broken down and often debauchery and sexuality result… the drug has a corroding effect on the body and on the mind, weakening the entire physical system and often leading to insanity after prolonged use."*

The kindest way to describe this information is that it is incorrect. Overstatement of the dangers and harms of a drug which large proportions of the population use, tends to ridicule reasoned health education and debate. A further example I remember at school is being told that smoking tobacco "stunts growth". Prolonged tobacco use does many things but there is no evidence of retarded growth in those who smoke.

Within certain boundaries there appear to be little harm from regularly using a powerful hallucinogen. A church congregation which has been established for over 100 years in Brazil has a distinctive and ritualistic weekly service with the consumption of a form of DMT (dimethyl tryptamine) — a short acting powerful hallucinogen (known as the businessman's LSD). Psychometric, neurological examination and investigation

compared with a matched population revealed no significant difference apart from concentration which was better in the regular drug using congregation.

In summary I have attempted to outline some of the over-reactions of society to a perceived drug menace. I leave the reader with this from Giffiths Edwards Edward Stevens' lecture on 'Unreason in an Age of Reason', where he said "The unreason of the previous generation is abhorrent, while the irrationality of one's own time is most usually unperceived".

Gavin Cape
Dept of Psychological Medicine,
Otago University, Dunedin

Treatment Research Interest Group (TRIG)

Alcohol, Drugs and Addiction

NEW MEMBERSHIP FORM

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

Surname _____ First Names _____

Postal Address _____

_____

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Daytime Phone Number _____ Fax Number _____

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The objectives of TRIG are:-

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

Declaration

I support the objectives of TRIG and wish to be a member of TRIG for the 1999/2000 year. I understand this will entitle me to four editions of the Treatment Research News (TRN) and a reduction in the registration fee at the Annual Treatment Conference 2000.

Signed _____ Date _____

☐ I would like to make a donation to TRIG of $ _____

Thank you for completing this form and sending it back to:
Lisa Andrews, PO Box 2924, Christchurch (Phone 03 364-0480, Fax 03 364-1225)

NEWS FROM
THE DRUG AND ALCOHOL RESEARCH AND TRAINING TEAM (DART)

How Might We Develop A National Research Strategy?

In the previous issue I argued for the need to develop a strategy for both the promotion and organisation of alcohol and drug research. During the last TRIG Executive Meeting we identified the need for work on drafting a national strategy that could be used as a basis for discussion at the upcoming Cutting Edge Conference in August. Part of a strategy document involves defining the space or matrix of possibilities that describe the scope of future research activity. The matrix can then be used for both the planning and monitoring of progress in each area. Without it, it would be easy for certain sectors to be missed out and never attract the attention they deserve.

The following are a few ideas on the content of a strategy. To start with, the idealised space created by this matrix could be characterised as comprised of three major dimensions. For convenience I will label these as: "Focus", "Type" and "Context".

Focus

This dimension varies according how one conceives the target; at one end the target is the population as a whole, at the other end the target consists of individuals with specific problems or acute needs. In between exist various combinations of social networks and groupings, such as communities, workplaces, institutions and families. The four largest clusters on this dimension are: populations as a whole, at risk populations, at-risk individuals and individuals with problems. Population-based research focuses on monitoring overall patterns of consumption, identifying at risk populations, and examining social viewpoints that influence broad trends in behaviour. The Alcohol and Public Health Research Unit have provided strong leadership in this area, particularly with their national surveys of alcohol and drug consumption. Research on at-risk populations focus on factors which generate the risk and on identifying possible moderating and protective factors. For example, investigations on heavy alcohol consumption by younger people may identify levels of socialisation or broader supports for youth culture as important in reducing harm. Research on the identification of at risk individuals focuses on the potential role health practitioners and community workers could have in assisting at-risk drinkers and drug users in making decisions and initiating lifestyle change. The WHO Collaborative Project on brief intervention has provided the central leadership in this area. Research on individuals with problems focuses on the development and evaluation of effective strategies for intervention. This area has in the past attracted little research activity but the NCTD is currently initiating projects to fill the gap.

Type

People develop addictive behaviours across a wide range of substances and processes such as tobacco, alcohol, cannabis, tranquillisers, gambling and sex. Each behaviour type shares family resemblances with each other in areas such as their mutual potential for harm to relationships and health. However, for a variety of reasons, issues for each type will vary according to the nature of the substance or process. Moving across this dimension, at one pole, the behaviour in question could be strongly influenced by the extent that biological aspects of the drug contribute to the form of addictive behaviour. For example, the physiological dimensions of nicotine dependence play an important role in shaping the range of issues confronting the smoker. At the other pole, some addictive behaviours are less influenced by biological and more affected by psychological and social processes. For example, gambling on electronic gambling machines are strongly shaped by psychological processes relating to perceptions regarding the odds, rates of reinforcement and size of the wins.

Context

Addictive behaviours do not occur in a vacuum and a person's experience will at least be moderated and for many strongly shaped by their position within so culture, gender, sexual preference, physical location, socio-economic status, and a range of other important categories. One issue for a small country like New Zealand, a place with limited research funds, it could be seen as unwise to invest in the large-scale exploratory research. We simply cannot afford to sink all our resources into tightly controlled outcome studies. Instead we could capitalise on research advances in larger countries with bigger budgets and focus our modest resources on exploring how to match or convert these discoveries into the New Zealand context. For example, instead of repeating the controlled trials on the effectiveness of methadone maintenance therapies, we could focus attention more on strategies to improve access to methadone in specific New Zealand contexts such as in isolated rural contexts. Discourse analysis and other

qualitative research methodologies are well suited for exploring this dimension. They offer a means to explore both the complexities and subtleties of culture and context and how. For instance, we could begin exploring more closely the social viewpoints which influence younger people in their cannabis use.

Sectors

A sector for research can be identified as an intersection point of these three dimensions. For example, research on an important area such as Maori smoking cessation is characterised by its focus on individual treatment, the addictive behaviour type of nicotine dependence and the context of Maori health initiatives. Through examination of sectors such as this we can begin to ask: What progress has been made to date? What needs to happen? And what resources are needed to establish ongoing research activity? In such an analysis it will emerge that some sectors are arguably of lesser urgency than others. For example, population research on tranquiliser or amphetamine use might be deemed of less interest than identifying patterns of cannabis use. However, the relative importance of a sector may change over time, as in parts of Asia where concerns regarding amphetamine use are rising. To cater for these changes, we will need processes to regularly review both the comprehensiveness of the matrix and the relative priorities in the current New Zealand scene.

Peter Adams

With Ourselves And Each Other

Women's Experience of Personal Change Where Past Alcohol and/or Other Drug Use Has Been Problematic. A Feminist Social Work Perspective

Using the qualitative method of grounded theory an analysis of conversations, held with women who worked in human service organisations and who had past personal experience of problematic use of alcohol and/or other, informed a discussion related to the advantages of utilising a feminist social work perspective for work with women whose life issues are complicated by alcohol and/or other drug use.

Briefly, the influencing factors on early change decisions included health issues, life chaos and internal resilience. One significant aspect that emerged was that of the alternative perspective. This occurred when a set of circumstances presented another perspective from which to understand the situation. This was not a time where women consciously considered another view but were actually involved in an action and through doing it gave themselves something else to consider and contemplate.

Seeking change, and accepting change were the two following conceptual categories in the early change process. In seeking change women tried many different strategies some of which had very negative consequences and others that lead on to positive change happening. The negative impact of family on women seeking change is an area that could be further investigated especially as the family is often the first group professionals call on to support women when they are involved in changing problematic alcohol or other drug use.

Acceptance of change leans towards the transition point where the early change process merges into maintenance of change. What is significant in this conceptual category is that all the women developed the ability to thoughtfully consider information other than their subjective reaction to a given situation or event.

The analysis related to change and it's effects indicates that change endures because of a complex interaction of differing aspects, including the support of external structures and the entities of serendipity and hope. Women indicated that they had integrated the personal and professional in terms of their work with people, yet analysis contradicted this and it considered the possibility that women may still be cautious or unaware of the contribution of self in practice.

Women themselves held positive attitudes in relation to change. Families were more likely to hold negative attitudes because of the association with past questionable behaviours and women's difference.

While for women in this study the perspectives of change were very personal and introspective processes, a feminist social work analysis would argue that for any work in this field there must be not only an understanding of the personal agendas women bring, but also an awareness for working towards solutions that are cognisant of the systems and structures that impact on women, construct community and implement social policy. The feminist social work context that politicises practice to empower women can enrich the process and take the work from the purely personal to one that explores the macro issues. A social work perspective could be viewed as an essential component of any work at policy or service development levels. This assertion comes because in the social work analysis of the issues related to women who have life issues that are complicated by alcohol or other drug use account is taken, not only of the plethora of issues associated with practice and service delivery, but in putting women at the centre of the analysis it is able to view all aspects of this field of work and make connections that are relevant also for women in our wider community.

Anastacia Earnshaw

Conference Report

Report on 3rd National Getting Better Conference – Measurement, Money and Mental Health in the New Millenuim (Sydney 18.2.2000 – 19.2.2000).

This is the third Australian conference in a series focussed on improving the quality of care within mental health services. Since the 1998 conference, which I attended with NCTD colleague Simon Adamson, considerable funding has been allocated to the development of outcome measurement systems within mental health services. Topics addressed included improving efficiency in mental health service delivery, the need for qualitative and quantitative approaches to measuring treatment outcomes, health economics, the impact of information technology on clinical pratice, multicultural research issues, the "global scene", changing clinician behaviour, case-management and workforce issues.

The conference was smaller in attendance than the previous conference with a smaller attendance of New Zealand clinicians and policy personnel. This may have been due to it not being so widely advertised. From my perspective it was well worthwhile attending. It was noteworthy that papers were presented by a range of clinicians, including, psychiatrists, nurses, psychologists and academic researchers. It was also noteworthy that there was no debate about whether services should utilize outcome measures but rather issues raised were in relation to experience with certain measures, concordance between clinician and consumer perspectives and the experience of implementation. In this regard, we in New Zealand are somewhat behind in terms of resourcing and implementation. However, we are also grappling with similar issues such as the need for an infrastructure to support and sustain routine collection of clinical or treatment outcome information and the need for measures to be meaningful and useful to both clinicians and the client group. We also have the advantage of a less fragmented mental health care system and appear to be ahead in addressing cultural issues. The future of tele-medicine is clearly here to stay and information technology will continue to bring about increasing change in relation to clinician education, ways of delivering more efficient services and public access to information. Clear messages were given in relation to the urgent need for public education about effective treatments for such commonly experienced disorders such as depression, the need to engage people with significant mental health problems, including alcohol and drug problems into treatment, service accessibility, how to increase clinician competence and the important role of consumers in demanding effective treatments. In addition, the importance of delivering effective treatments efficiently within primary and secondary care settings and the need

to attend to the continuum of care from health promotion through to residential and hospital based care using a stepped-care model.

Implications for services in relation to outcome measurement include the need to involve clinicians and consumers in the development and implementation of outcome measurement systems, which should be part of an overall quality improvement system and the need for standardized, brief measures that are multidimensional and locally and culturally useful. It is clearly important to be able to demonstrate symptom change and changes in overall health and personal and social role functioning and also to collect on occasions more in-depth qualitative information to more fully understand client's and significant other's experience of services provided. Adequate resources are essential to ensure that an infrastructure is in place to enable outcome measurement to evolve, to be useful and to be sustained.

Daryle Deering, Lecturer, NCTD

RADS Clinical Information & Research Unit (CIRU) Update

Something happened on the road to Damascus: Some revised thoughts on the role of clinicians in research.

A couple of years ago I had very strong thoughts about the use of clinicians to (reluctantly) gather research data. I thought it was a great idea – and that any clinician who disagreed should be taken for a ride "down to the river" in a black limousine.

I spoke of clinicians being overly concerned about "rapport" and considered them ungrateful for the prestige and honour afforded by having researchers tinkering with their daily work.

Why? With the great wisdom of hindsight, I think the RADS research unit struggled at times with it's brief to attempt to be very clinically relevant on one hand, and to attempt to produce academic-type work on the other. Now of course this can be done but "clinically relevant" can easily become "clinically disruptive" once the demands of academia are woven into a project.

What has become known as the "Leeds project" is an excellent case in point. While most clients enjoyed being involved in the extensive research based-assessments which formed the basis of the study, many clinicians were openly scathing - not of the Leeds Dependence Questionnaire itself, but of the huge amount of disruption to their work that the study forced upon them.

Many clients are only ever seen once. It is hard to get the feeling that you have added something to someone's life when all you do during your one opportunity is get them to answer research questions – no matter how cool the researchers think the questions are.

From a research point of view, the Leeds project was a great success. When it came to the relationship between researchers and clinicians however, times were tense and harsh words were spoken.

Clinicians will continue to be asked to complete administrative forms and standardised clinical assessments – this is a certainty. People with a research interest will continue to sniff around real-life clinical processes because those are the ones that are the most interesting. For researchers to continue to be welcome in applied settings however, the approach to high-impact studies must be more consultative with clinicians, rather than dictatorial.

Where academic issues of exactness and thoroughness must take precedence over acceptable clinical processes, we need to consider the benefits of employing independent researchers. There is no formula for deciding which is the right way to go but there are limits to the extent that clinicians can be pushed. Happy is the researcher who is never involved in pushing clinicians to this limit.

Hope the weather's nice in Damascus.

Stuart MacKinnon, CIRU, Regional Alcohol & Drug Services, Auckland

The Alcohol Advisory Council of New Zealands Research and Evaluation Strategy

In the 1998/1999 financial year out of a total direct cost budget of $6,241,234 ALAC spent $1,046,532 on research and evaluation. This represents 16.8% for research and evaluation of ALAC's total budget. These figures reflect ALAC's ongoing yearly budget allocation.

ALAC's Strategic Plan 1999-2003 for Research and Evaluation states: Policies and strategies to reduce alcohol related harm should be underpinned by sound evidence and best practice. ALAC will promote and support high quality research to evaluate the effectiveness of strategies employed to reduce alcohol-related harm and to ensure that prevention and treatment approaches remain at the cutting edge of best practice.

In addition, ALAC wishes to support and expand the pool of research skills and capabilities within NZ through supporting researchers to obtain postgraduate qualifications and to gain recognition through the publishing of articles in peer reviewed journals and the presentation of material before ones peers.

ALAC's Strategic approach 1999 – 2002 identifies that ALAC will:

Maintain an up to date directory of New Zealand based research and researchers and make this available via the internet.

Fund research through:
- Commissioned research to support ALAC's priority project area
- Researcher initiated proposals
- Research scholarships

In 1999/2000 ALAC's research funding supported:

1. Commissioned research aimed at identifying high risk behaviour and ensuring both prevention and treatment approaches to alcohol related problems are evidenced based. In 1999/2000 the priority areas were:
- Maori
- Young people
- Pacific peoples
- Sports people and sporting environments
- Licensed Premises and risky environments
- Problem drinkers

2. The Alcohol and Public Health Research Unit (APHRU) core funding.

3. The tenth year of funding for the Auckland Tracking Survey (APHRU)

4. Researcher initiated proposals:
- Associate Professor John Bushnell *Common mental disorders in primary care.*
- Dr Dorothy Begg *Risky motor vehicle traffic behaviour among young adults.*
- Elaine Mossman *An evaluation of The Adventure Development Programme.*
- Professor Sally Casswell *Continuation of a longitudinal study of alcohol use in a sample now aged 26 years.*
- Dr Carolyn Coggan *Structured conversations with youth to enhance knowledge of ways to reduce adolescent risk taking behaviours.*
- Dr Karen France *Alcohol use amongst teenage girls who engage in unplanned sexual intercourse.*
- Nadim Khan *Patterns of alcohol use in a community based sample of people aged 65 years and older.*
- Whariki/APHRU *Facilitating a formative evaluation for community action to reduce alcohol-related harm amongst young Maori.*
- Simon Adamson, National Centre for Treatment Development. *National Treatment Outcome Project.*
- Michael Baker, National Centre for Treatment Development. *An empirical evaluation of the contribution that spirituality makes to the treatment outcomes of clients with alcohol and drug dependence.*

5. Three PhD Research Scholarships and two Maori and one Pacific summer studentships.

Information about making an application for ALAC's Research Funding is available on ALAC's website www.alcohol.org.nz. For further information contact Valerie Norton, Manager Research and Evaluation. Email

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