

Treatment Research News

Alcohol, Drugs and Addiction

August 2000

Newsletter of the Treatment Research Interest Group

Vol 4 No 2

Dear Readers

The sun is shining in Christchurch, the snow covered mountains look absolutely stunning and the trees are starting to blossom. Its Friday! In this issue Peter Adams continues the discussion around the need for an alcohol and drug research strategy. TRIG will be hosting a session at the Cutting Edge Conference in Rotorua on research that will include a brainstorming workshop on the development of a national research strategy followed by a panel discussion. We hope many of you will be able to attend.

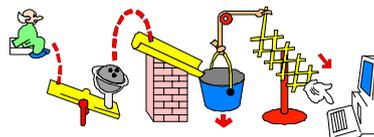
We have our regular contributions such as NCTD news including updates on two research projects, Fraser Todd's thought provoking column "I've Been Reading", news from RADS and an interesting article on gambling prevalence in New Zealand from Peter Adams. Also in this issue we have included a brief travel report from Doug Sellman, the 2000 recipient of the Gary Harrison Memorial Scholarship, of his five week overseas study trip. Doug claims to have gone to "90 meetings in 35 days" and has returned full of exciting ideas. He will be giving a presentation at the Cutting Edge Conference which I am sure you will be very stimulated by.

The AGM of TRIG will be held on Thursday 31st August at 1.15pm at the Conference. The future of TRIG and this newsletter will be on the agenda. I hope you can make it. If you are not able to get to the conference and have something you wish to contribute please let us know.

Raine Berry
Editor

4 August 2000

Deadline for the next issue is: 22 September 2000.



LETTERS TO THE EDITOR

Dear Editor

In his recent article, "Over-reaction to Drug Use?" (TRN Vol.4, No.1), Gavin Cape provides interesting examples of different attitudes towards the use of various substances at different times and in different cultures and notes that "what may seem reasonable at one time seem unreasonable at another". While snapshots of cultural diversity make fascinating viewing, this diversity is usually not as arbitrary as it might seem. Even extreme attitudes (and policies) may make sense in their particular ideational context. For

instance, in a society where smoking is a novelty and a medieval world view prevails, then the act of smoking tobacco could easily appear 'unnatural', i.e. against nature, i.e. blasphemous, hence subject to ruthless eradication by absolutist rulers - as occurred in 17th century Russia. Ironically, in the very different worldview of pre-Columbian North America, tobacco smoking was a sacred rite.

Not only does the attitude towards a drug arise out of the culture, but the actual impact of consumption (which in turn affects social attitudes) depends greatly on the real-life social conditions. Thus a change over time in "what seems reasonable" may follow from a change in the social and material conditions of existence. For instance, the major current public health issue of potential physical harm from long-term regular consumption of alcohol would scarcely feature in the debate unless the societies in question already had an average life expectancy of e.g. more than 50 years (as is the case in New Zealand today, but was not the case in Europe and North America 200 years ago, when alcohol was far more heavily consumed and somewhat less heavily regulated).

Given that drug use is indeed "an integral part of society" and the search for the pleasures of intoxication will continually evade proscriptive policies and anti-drug opinions, it was worth asking why this seeming prejudice against intoxication is so widespread

across many different cultures and times.

Firstly, there is the obtrusive reality of physical harm and social problems, both short and long-term – including the harm of addiction per se. The fact that such harm will vary from substance to substance and in different social settings, and may be partially exacerbated by prohibitionist policies, does not make it less real.

Secondly the phenomenon of intoxication perturbs the social fabric at a more basic level, temporarily undermining normal social interaction at its physical foundations of both intelligibility and predictability of behaviour, and its psycho-social foundations of implicit expectations and obligations. On these foundations each society constructs its cultural edifice of roles and norms. The novel sight of drunken anarchy among European sailors was baffling and horrifying to 'straight' Maori observers in the late

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

The NCTD has two studies in the opioid area underway at present. The first is investigating the validity of an instrument for measuring drug use, called the Degree of Drug Use Index (DDI) and Daryle Deering is the principal investigator. The second is work of Ian Sheerin, a PhD student with the NCTD assisted by a HRC Fellowship. Ian is undertaking an economic evaluation of methadone treatment, particularly from a Maori perspective. Below are update reports on these two pieces of work.

Update On A Study Investigating The Validity Of The Degree Of Drug Use Index (DDI)

The development of reliable and valid brief instruments which can form the basis for evaluating the progress of people receiving treatment for opioid dependence is essential. Such tools need to be used as a basis for reviews involving input from the person receiving treatment, their significant others/whanau and their clinicians/others involved in providing aspects of treatment.

The purpose of this HRC funded study is to investigate the validity of a brief questionnaire on recent drug use for use as one component of a clinical tool to evaluate the treatment of progress of people receiving treatment for opioid dependence. The investigators are Daryle Deering, Doug Sellman, Simon Adamson and Tuari Potiki. The Degree of Drug Use questionnaire is being tested against two other

questionnaires. The first is the Drug Use Section of the Opiate Treatment Index developed by Darke and colleagues from the National Drug and Alcohol Research Centre in Sydney. The second is the Timeline Followback Interview developed by Sobell and Sobell (1996) which involves a calendar and cues to assist people to remember their daily use of drugs during a specified time period. Demographic information is also being gathered including information about dependent children and health status using the SF-36.

The aim of the study is to interview 70 non-Maori and 35 Maori and their significant others who are aware of the participant's recent drug use. Participants are randomly selected from the current patients of the Christchurch Methadone Treatment Programme and recruited into the study by Naomi Malcolm a nurse staff member of the clinical team. Once, it is clear that information will remain confidential to the study team and that no identifying information is kept, very few people approached have not wanted to be involved.

Almost 50 interviews have been completed to date. Alison Pickering, our Senior Research Assistant completed nearly 30 interviews before she became too unwell earlier this year and very sadly, subsequently died in April. Robin Dibble, our contracted Maori Research Assistant and Meg Harvey, Junior Research Fellow of the NCTD, have continued with the interviewing. Almost all

participants have requested to be interviewed at home.

Impressions to date are that most participants consider their methadone dosage about right, cannabis is the most commonly used other drug and that most are unemployed. In relation to health status, Hepatitis C is a major issue. In relation to the OTI and the DDI questionnaires, most find neither questionnaire too much of a hassle to complete. A number of participants have pointed out that they feel the more specific questions of the OTI will provide more accurate information, some feel that this is not so. Overall the DDI seems to take about half the amount of time to complete. Preliminary results will be presented at Cutting Edge this year.

An Economic Evaluation Of Methadone Treatment: Preliminary Impression From Work In Progress

This work is being undertaken in conjunction with the study above in which interviews of 105 clients of the Christchurch Methadone Programme are being undertaken. The objective is to look at the cost-effectiveness and cost benefits with particular interest in Maori clients and potential differences between Maori and non-Maori. It is too early to be writing in any definitive way about results, but there are some preliminary impressions from the nearly forty interviews completed to date, and from analysis of the literature.

Methadone treatment is enabling many clients to stabilize their own lives as well as their families' lives. An important outcome is often to provide a more stable life for their children. Many people lose their children during their years of heavy drug use, and get them back again when they stabilize their lives. Most clients remain on welfare benefits after they stabilize their drug use. There are very few who are moving into jobs, although many would like to. Methadone treatment enables many people to reduce criminal offending and imprisonment. Most clients have

hepatitis C, but few are receiving treatment for it. There is little awareness of the need to monitor the results of blood tests in order to monitor development or more severe liver disease. A positive outcome is that most people have reduced their use of alcohol. Alcohol is a risk factor for development of more severe liver disease, notably cirrhosis. Maori have higher rates of background morbidity, mortality, imprisonment and lower life expectancy. This research project will be quantifying the benefits of treatment and will be reported in the TRN in due course.

Doug Sellman
Director, NCTD
28/7/2000

CORRECTION

In the April 2000 issue of TRN Daryle Deering in her report on her visit to the Langton Centre in Sydney wrote that Jennifer Holmes, the manager of the Langton Centre, had worked in Christchurch. This should have read Sydney.

MORE GAMBLING IS GOOD FOR YOU

On the seventh of June the Department of Internal Affairs released its long awaited results to the second national prevalence study on gambling. It forms the centrepiece of a series of research projects reputedly costing over one million dollars – a serious dollop of research funding in anyone's book. The first study in 1991 identified a current prevalence rate of 1.2% for pathology and 2.1% for problem gambling. The surprise finding was that despite unprecedented growth in gambling, by 1999 the current prevalence rate was reduced to 0.5% for pathology and 0.85% problem gambling.

Such a large reduction poses an uncomfortable dilemma. Either increases in gambling are somehow associated with reductions in problem use (New Zealand being the only country in the world who have achieved this) or the research methodology is not measuring what it claims to measure. The following will consider each possibility in turn.

The availability of more highly potent forms of gambling has increased rapidly in New Zealand over the period. The number of gambling machines in the country has increased from under 2,000 in 1991 to around 16,000 today. The gambling machine is currently the primary mode of gambling for over three quarters of those who seek help. In 1991 the annual gross turnover of gambling was around \$2 billion with annual "expenditure" (losses) of \$0.5 billion. By 1999 turnover was approaching \$8 billion and expenditure close to \$1.2 billion. In line with increased consumption, statistics collected by organisations such as the Compulsive Gambling Society, the Problem Gambling Helpline and the Committee on Problem Gambling Management have indicated steady rises in the number of people requesting help. For example, first-time callers on the National Helpline have moved from around one thousand in 1993 to 3,500 in 1999.

A fundamental principle underpinning public health approaches to risky behaviours such as smoking and drinking is that increased consumption will be associated with increases in problems. This has, in general, been the same for gambling. In a review of prevalence studies in North America, Shaffer, Hall & Vander Bilt (1997) identified that increases in gambling consumption and availability correlate on the whole with increases in problem gambling. Such increases are certainly not associated with drops in the numbers of problem gamblers. Consequently the results of the New Zealand study fly in the face of not only of local data on increases in problems, they contradict essential principles of public health perspective, and they differ from prevalence trends observed overseas. While it is desirable to maintain a critical stance on basic assumptions, on balance, the sheer weight of contrary evidence calls into question the main findings of this study. Now, let's turn to the quality of the methodology.

The study involved a large sample of 6,452 adults and a high participant recruitment rate of over 75 percent. The questionnaire was carefully constructed and a variety of pilots were conducted to test out variations in the survey methodology. Statistics New Zealand had stipulated that the eligible response rate needed to reach 75 percent. This meant they needed strategies to improve recruitment. They did this in two ways. The first way was to send a "pre-notification" letter to all eligible households stating the nature of the study and that they will be phoned in the next month.

The second strategy was to trial a series of phone introductions and to get feedback on what was most effective. Their final introduction started with: "Hello. I'm (name) from Statistics New Zealand. We're the government department which collects statistics, for example we do the census. We're doing a survey ..."

Now, imagine the likely response of a problem gambler. They may have huge debts to friends and family. They could owe considerable amounts to Inland Revenue. They are likely to have engaged in some forms of petty and possibly serious forms of property crime to maintain their gambling. They would in most cases be sitting on a variety of deceptions and have difficult relationships with several government agencies and other official bodies. Many of them would therefore shy away from official invitations and requests particularly from formal approaches involving references to government departments.

The key issue regarding the methodology is whether in a sensitive area such as illicit drug use or problem gambling people with problems will be willing to participate or, if they do, whether they would answer honestly. The Australian Productivity Commission (1999) last year conducted a similar prevalence study and also explored the accuracy at which people are likely to report on their gambling. In a companion study they asked 277 problem gamblers seeking help from specialist gambling agencies about their likely response to gambling surveys before seeking help. Only 28 percent stated they would have answered honestly, with 27% indicating they would refuse to participate and 23% stating they would either partially or completely conceal problems.

Abbott, M.W., Volberg, R.A. & Statistics New Zealand. (2000) *Taking the pulse on gambling & problem gambling in New Zealand: A report on phase one of the 1999 national prevalence survey.* Wellington: Department of Internal Affairs.

Shaffer, H.J., Hall, M.M., & Vander Bilt, J. (1997). *Estimating the prevalence of disordered gambling behavior in the United States and Canada: A meta-analysis.* Boston, MA: Harvard Medical School Division of Addictions.

Australian Productivity Commission (1999). *Australia's Gambling Industries: Inquiry Report.* Report No. 10, November 1999.

Peter Adams



GARY HARRISON MEMORIAL SCHOLARSHIP – TRAVEL REPORT – DOUG SELLMAN

At the end of 1999, I was fortunate to be awarded a \$10,000 Gary Harrison Memorial Scholarship from the Alcohol Advisory Council of New Zealand (ALAC). I knew Gary personally before he died of cancer, when I was new to the field in the mid-1980's and so being awarded this Scholarship, set up in his honour, had additional significance for me. Gary impressed me as being someone of considerable personal integrity and warmth, who had a great inclusiveness of people, and commitment to improving our field.

The primary goal of the trip was to gather up to date information about pharmacotherapy as it relates to the alcohol, drugs and addiction treatment field. The second was to have the opportunity of presenting the findings of the randomized controlled trial of motivational enhancement therapy, which we have called the BTP study, recently completed at the NCTD, along with other research and training activities being undertaken at the NCTD.

On obtaining extended study leave and further financial assistance from the University of Otago and Healthlink South, my five-week itinerary (June 16 – July 20) was as follows:

- **San Juan**
62nd Annual Scientific Meeting of the College on Problems of Drug Dependence (CPDD)
- **Cardiff**
Dr Steve Rollnick
- **London**
National Addiction Centre
- **Newcastle**
Dr Nick Heather and colleagues
- **Edinburgh**
Royal College of Psychiatrist's Meeting
- **Leeds**
Leeds Addiction Unit (LAU)
- **Brussels**
22nd Scientific Congress of the Collegium Internationale Neuro-Psychopharmacologicum (CINP)
- **Sydney**
National Drug and Alcohol Research Centre (NDARC) and Langton Centre
- **Melbourne**
Turning Point

Conclusions of my trip are as

follows:

1. From a pharmacotherapy point of view, there is no doubt in my mind now, that the emergence of the new "anti-craving" drugs for alcohol dependence, naltrexone, nalmefene and acamprosate is an important and clinically significant step forward in development of effective treatment. Without these medications in New Zealand, we are definitely at a disadvantage in terms of providing effective treatment. For opioid dependence, nothing has been shown to be superior to methadone for maintenance treatment, although buprenorphine and LAAM certainly have some logistical and clinical advantages, which could be significant for some patients and it would be helpful to have alternatives to methadone available in New Zealand. The use of naltrexone in opioid dependence has been glamorized by the "rapid detoxification industry". However, once the fluff settles, it is likely there will be a place for maintenance naltrexone in the overall scheme of treatment and probably be similar to the use of disulphiram and calcium carbimide in alcohol dependence ie supervised naltrexone. There is little evidence that the use of naltrexone in withdrawal has any long-term advantages over simple withdrawal and the use of medications such as clonidine. Lofexidine appears to have some advantages over clonidine, particularly the reduced hypotensive effect.

2. I presented the findings of the BTP study five times during the trip and each time received very encouraging feedback. Having completed a randomized controlled trial, which is going to significantly contribute to the literature on interventions in alcohol dependence along with the other important pieces of clinical research being undertaken by the NCTD certainly puts the Centre, and thus New Zealand, on the map internationally.

3. Given the trip's overt focus on pharmacotherapy, it is somewhat ironic that the time away has strengthened my appreciation of the importance of psychosocial interventions for substance dependence. My time at Newcastle and Leeds was probably the highlight of the trip as I developed ideas about the shape of an "eclectic" psychosocial intervention. I have begun to write both a paper and a treatment manual related to such an

intervention which incorporates motivational, educational and social network elements into a flexible psychosocial package, individualised to patients' needs. This psychosocial package could very well form the basis of a series of NCTD workshops in New Zealand in the not too distant future.

4. At the CPDD and CINP meetings I was confronted by the considerable amount of basic scientific work, particularly in the area of brain function that is being undertaken throughout the world but especially in the USA. Much of this work will not necessarily bear fruit in terms of improved clinical outcomes for patients with alcohol and drug problems in my lifetime, but is a long-term investment in future major breakthroughs in treatment. It does however have immediate relevance in terms of education of both alcohol and drug workers as well as informing patients and their families.

5. The most impacting address I heard on the trip was by Norman Sartorius who spoke on stigma being the biggest problem for mental health. He argued how stigma undermines staff morale, treatment effectiveness, and service funding and although using schizophrenia as the example, everything he said was applicable to alcohol and drug addiction. I will elaborate on this in my Cutting Edge presentation.

6. This period of study leave has been very helpful in confirming the primary direction being taken by the NCTD, ie undertaking a range of applied clinical research studies and providing postgraduate training programmes, supported by a University. I became aware during this trip of how relatively little treatment effectiveness study research is being undertaken, or at least, reported in these major international conferences. At the end of the day, it is the translation of more basic research and efficacy work into real life clinical settings which counts in terms of improving the treatment offered to patients and their families. The trip has renewed my enthusiasm for this type of research work within the NCTD and underlined the importance of the close connection of the NCTD with the treatment field, which has driven the Centre's philosophy from the outset.

Undertaking applied clinical

research and providing postgraduate training for the specialist alcohol and drug workforce is one thing, providing assistance to the workforce as a whole in the short term is another. The trip has reminded me of the need for the general workforce to be assisted to provide more adequate treatment to the patients who seek help from alcohol and drug treatment services these days, which not uncommonly includes those with multiple life problems and disorders. At the recent NCTD review, a decision was made for the NCTD to undertake an ongoing series of workshops on relevant clinical topics. This trip has underlined to me the importance and priority of these.

Doug Sellman
NCTD



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 _____

Daytime Phone Number _____ Fax Number _____

E-Mail Address _____

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)

In setting a direction for the future we need to examine the key medium-term (5 - 10 year) priorities for alcohol and drug research in New Zealand. To my way of thinking the following four priorities stand out.

Priority One: Increasing Resources

As discussed in earlier issues, deficits in the consistency and adequacy of funding have worked against developing active research programmes. Alcohol and drug research has an unfortunate knack of falling between multiple stools. It links in with objectives in mental health, personal health, mental health, Pacific and Maori health. All areas are interested but none take particular responsibility for its development. The following measures could increase resources in the future:

1.1 Earmarked Funding

In recognition of problems associated with the multi-sector nature of our research, we could advocate with Government for earmarked funding to enable the long-term development of research programmes.

1.2 Building up Specialist Research Centres

A discussion is required on the number and nature of alcohol and drug research centres in New Zealand. Such units tend to take on a specialist focus on a particular type of research within a limited range of content areas. If this continues we will need to encourage multiple sites in order to cover the key needs.

1.3 Assistance in Competing for Funding

Many potential research sites, such as clinical services, lack the resources and linkages to build their capacity to compete for research funding. Funding assistance could focus on assisting collections of researchers and clinicians in forming research teams.

1.4 Enabling Culturally Specific Research Activity

We need to begin examining how intervention strategies fit with and reflect cultural worldviews. This is particularly relevant to Maori,

Pacific peoples and more recently Chinese people new to the country.

Priority Two: Building an Alcohol and Drug Research Infra-structure

The key task here is to ensure the capacity for high quality research in this sector for the future. An obstacle identified in earlier issues is the low probability that researchers will look seriously at this sector as a long-term career prospect. We need to examine opportunities for attracting and sustaining a group of skilled and motivated researchers. Measures towards this goal could involve the following:

2.1 Recruiting a Suitably Qualified Research Workforce

The number of people consistently involved in alcohol and drug research is small and scattered. It would help to have people with a mix of research skills and clinical experience, but this combination of skills is very rare. Practitioners with a research interest could be encouraged to apply for post-graduate scholarships specifically designed to support clinicians into research careers.

2.2 Consolidating the Research Workforce

Some graduates are completing PhDs on alcohol and drug topics, but they often do not find work opportunities to maintain their involvement in the field. We need to find ways to support the careers of people who show signs of committing to a research career in our field.

2.3 Building International Linkages

The development of enduring international linkages could provide the base for exploring new ideas, sharing expertise and establishing collaborative projects. Funding for communication, travel and conferences would help in establishing these links.

Priority Three: Coordination of Research Activity

Resources to develop research in a small country will always remain constrained. Consequently it is

critical that the resource is used wisely.

3.1 Formation of a Research Coordinating Committee

At some point a body would need to be formed that takes a critical interest and an overview position regarding the development of research. Its functions will be to consult with all relevant stakeholders, synthesise ideas and work up a strategy document for broader circulation.

3.2 Representation in Research Planning

Key representatives of the field (such as members of the coordinating committee) should be present on committees and linked with organisations involved with research planning (such as HRC, MOH & PHA).

3.3 Development of the National Research Strategy

The National Research Strategy document will provide a reference point for setting the direction and evaluating progress over the next five years. Without it we are likely to flounder in the same disorganised fashion.

Priority Four: Identifying Key Medium Term Topic Priorities

When I began drafting out the range of key research areas, I was quickly overwhelmed by the scope and depth of important topics. Each area has issues with at risk groups, with professional training, with effective interventions and with public health and health promotion initiatives. Narrowing this broad array down to a few priorities will take considerable effort.

4.1 A needs analysis

A survey of key stakeholders is required on what they perceive as the central current research priorities.

4.2 A Consultation Process

A series of consultations on priorities could then be conducted involving representatives of the public, service consumers, policy makers, managers, public health and practitioner groups, advocacy

groups and NGOs, international experts and the community of interested researchers.

4.3 Identifying Topic Priorities

In the last newsletter I outlined a three-dimensional grid upon which we might plot out the various sectors in which research should be occurring. Priorities will change as the need for research knowledge shifts, but for the purpose of long-term development and maintenance of knowledge and skills, we should endeavour to include activities on each major part of the dimensions on that grid.

I will not pretend that these ideas are the final answer. They need considerably more processing by interested parties. Workshop time has been allocated at the next Cutting Edge conference in August to discuss the development of a National Strategy. I look forward to further discussion with anyone who is interested.

Peter Adams



I'VE BEEN READING

Its that time of year again; the neurones are supposed to be in overdrive, Cutting Edge is just around the corner as I write this with its promise of more mental stimulation, and the addiction literature has been replete with interesting and mind stretching information.

Before I discuss some of the interesting journal articles I have recently come across, let me tell you about a book I have just read for the second time. It seems to me that the next conceptual challenge the field has to face, with the increasing evidence of the genetic and biological aspects of alcohol and drug misuse and the emergence of effective pharmacological treatments, is how to understand a person and their alcohol and drug problems from spiritual, social, psychological and biological perspectives simultaneously. While biopsychosocial models claim to do this, they simply list a range of factors on each level. They do not attempt to explain how these factors interact and relate. For this, we need to follow the lead set by the cognitive neurosciences and incorporate new models emerging from non-linear systems theory. Alan Dean's "Chaos and Intoxication" (Routledge, 1997) is a paperback book published in the last few years provides a good introduction to this approach to intoxication and addiction. The author is a social worker and lecturer at the School of Social and Political Sciences at Hull, and reviews the biological basis of intoxication, addiction and consciousness, presents an overview of the non-linear theories of complex systems and finally relates these theories to a model of addiction. The book is clear, concise and in the most part written at a level that people unfamiliar with these theories can understand. I highly recommend it as an absorbing introduction to this area. I must declare my bias though - this is an area of particular interest to me.

Along the same lines is the recent review by Torrens and Martin-Santos, "Why do people abuse

alcohol and drugs?" in Current Opinions in Psychiatry (13:3;2000). They consider and make links between some of the genetic and environmental factors associated with alcohol abuse and while the article is light in its consideration of psychological, social and spiritual factors, it is a start in the right direction.

One of the arguments frequently cited in support of the decriminalisation of marijuana is that it has significant medical benefits. While claims of its usefulness are frequently and widely made, there have been few systematic reviews weighing the evidence. Watson, Benson and Joy report on the findings of an extensive review performed by the Institute of Medicine (Marijuana and Medicine: Assessing the Science Base, Archives of General Psychiatry 547-552, June 2000). Overall the authors conclude that the potential therapeutic value of cannabis is probably at best moderate, but that there are clear areas in which further research is warranted especially in the area of symptom control in AIDS and as an analgesic.

Now, please forgive me for having a rant, but amongst the interesting papers was one that annoyed me. The relationship between cannabis use and schizophrenia has received a lot of research interest over the past decade and while a number of elegant and informative studies have been reported, there have also been several poorly designed studies which draw conclusions that their data do not justify. These conclusions often then pass uncritically into the "lore" of the field. In what initially appears to be a significant addition to the literature, Hambrecht and Hafner (Australian and New Zealand Journal of Psychiatry 2000;34:468-475) have published the results of their retrospective study of 232 patients with first episode schizophrenia. They reported a surprisingly low rate of cannabis use (14.2%) by patients suffering schizophrenia, and while cannabis was used twice as often by those with schizophrenia compared to the control group, this did not reach

significance. Their comments that the low total numbers of cannabis users was the reason the result did not reach significance may have some truth to it, but nevertheless the lack of significance weakens the arguments they present. They also subdivide the group of cannabis using subjects with schizophrenia into three, depending on the relationship between the age of onset of prodromal symptoms of schizophrenia and the age of onset of cannabis use. In discussing their results, the authors draw conclusions about the causal relationship between cannabis and schizophrenia based on this subdivision. They suggest that those patients with cannabis use preceding the onset of schizophrenia might be referred to as the vulnerability group for whom cannabis use might increase the risk of developing schizophrenia. They term the second group, in whom the onset of cannabis use coincides with the onset of schizophrenia, the stress group, indicating that cannabis acts as the stress factor that precipitates schizophrenia in those vulnerable to it. The third group begins using cannabis after the onset of schizophrenia, for self-medication against the symptoms of schizophrenia.

But wait a minute; didn't their results fail to show a statistically significant difference between cannabis use rates in those with schizophrenia compared to the non-schizophrenic controls? Haven't they failed to provide evidence for a specific link between cannabis use and schizophrenia? The authors do not consider an alternative explanation for their three groups... that there is NO causal relationship between cannabis and schizophrenia. That the age of onset of schizophrenia ranges from childhood to early adulthood and the onset of cannabis use is in the early teens for most people. Therefore it is highly likely that some people will start using cannabis before they develop schizophrenia, some around the same time and some after purely by coincidence. For the authors to assert their unsubstantiated theories with such

certainty in a research-based paper is misleading to say the least. To state in the abstract at the start of the paper that cannabis was used by twice the number of subjects with schizophrenia than age match controls while leaving the qualifier, that this did not reach statistical significance until the body of the paper is also misleading. I would encourage readers to digest this paper, weigh up the claims against the evidence provided to support them, and come to their own conclusions about its value.

Well, that's enough for this issue. There are still several worthwhile articles I haven't mentioned but they will have to wait for the next TRN.

See you all at Cutting Edge.

Fraser Todd
Senior Lecturer
NCTD



LETTERS TO THE EDITOR CONTINUED

Continued from Page 1

18th and early 19th centuries. For Pakeha, while the idea of a drunken judge, for instance, could be comic, the reality would be an outrage (judges should be 'sober as.....').

This is generally not as alarming as it sounds, since cultures shape the manifestation of intoxication itself (we learn how to be drunk). When the custom is widespread, culture may give partial 'licence' to the behaviour - e.g. getting tipsy or stoned as socially sanctioned 'time out'.

It is noteworthy that tobacco, though highly addictive and certainly harmful in the long term, is not an intoxicant in the sense of rendering behaviour less predictable to others, and is not subject to the same moral ambivalence or potential social stigma as either alcohol intoxication or alcohol dependence.

Thirdly, the dynamics of dependence operate in fundamentally anti-social ways, with addictive drives often taking priority over critical aspects of social functioning, or creating a state of self-satisfaction that overrides the normal human need of people for each other. From this arise the powerful stereotypes (sometimes false) and stigma that pertain to addiction.

Finally, a fourth element is the biological imperative for each society to reproduce itself and guide its younger generation past diverse physical and psycho-social hazards. This is a function felt most acutely at the parent level, with almost instinctual intensity - which may be the point where reason goes out the window and unreason comes in. Certainly, hysterical anti-drug propaganda may add unnecessarily to the burden of concern, but even with a 'balanced view' the grounds for that concern remain.

John Caygill

* * * * *

Dear Editor

I recently made space in a day to read TRN from cover to cover - normally I just skim. I would like to congratulate you and the contributors on the quality, range of views and interest in this publication. I know from bitter experience how difficult it can be to compile a newsletter on a regular basis and keep people to time on contributions. Congratulations to all of you on a great job

Basia Arnold
Senior Advisor (Mental Health)
Ministry of Health

CUTTING EDGE

This year's Cutting Edge conference looks like being an exciting event. As I am sure you all know, it is scheduled for 31st August to 2nd September and is to be held at Rydges in Rotorua. There is more research on the programme than ever before and this is surely indicative of the growing interest in the field for evidence-based practice. John Strang an eminent researcher in opioid dependence, Wendy Swift from NDARC, Paula Snowden and Peter Joyce who are well known to us all, feature in a full and interesting programme. There is a strong representation from Pacific people and gambling issues feature frequently. Of equal importance to some of us, the conference dinner is in the hands of a couple of people who are sure to organise a lively event. If you have not already registered then now is the time to do so. See you there!

Sandy McLean
Organising Committee Member

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Dear Colleagues

Have you seen the new NCTD website. This can be viewed at www.nctd.org.nz

Simon Adamson

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RADS AND UNIVERSITY OF AUCKLAND IN JOINT VENTURE TALKS

RADS and the University of Auckland's 'Discipline of Applied Behavioural Science' team are currently discussing the establishment of a jointly funded research position. These discussions began early this year between Cathie Menzies (the previous manager of RADS), and Dr Peter Adams and have been revived under the new leadership of Jenny Wolf and Dr Adams in the last month or so.

If these deliberations are successful we would be hoping to attract an established health researcher with experience or interest in the alcohol and drug field. The researcher's role would be to develop and support a self-funding alcohol and drug research programme through collaboration between the two organisations.

This is a tough environment in which to develop and support research and the joint venture would establish a new base for Auckland A & D research. Because of its size and its access to large numbers of clients, RADS would potentially be able to support a range of funded projects. Also to its advantage, RADS has a history of high quality research activity (occurring under the leadership of Dr Grant Paton-Simpson) so a lot of the work-place cultural prerequisites are already in place to establish such a programme.

In my view, for RADS, the venture would involve a shift from fairly heavy involvement in organisationally-focused evaluation projects toward a practically exclusively funded research focus. Although "early days" the new research position would represent a positive step forward for both organisations and is cause for some tentative excitement.

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