Treatment Research News

Alcohol, Drugs and Addiction

December 2000 *Newsletter of the Treatment Research Interest Group* **Vol 4 No 3**

Dear Readers

The new TRIG Executive Committee had it's first meeting in September and elected new officers (detailed in the chairpersons report page 7). As part of the changes I have taken over from Raine Berry as the new editor of the TRN. So first of all I should introduce myself. My name is Meg Harvey and I have been a Junior Research Fellow with the NCTD in Christchurch, for about a year and a half. I look forward to continuing to bring to you the latest and most interesting research in alcohol, drug and addictions treatment. Next year I am hoping to help the TRN further its potential and offer workers in the Alcohol & Drug research field plenty of information, encouragement and the odd chuckle.

Well, as always seems to be the case, the end of the year is here before we have time to blink. It feels like we've all just recovered from Cutting Edge (and NPC disappointment for all aside from Wellington) and already the office is heating up with summer sun and Christmas is mere weeks away.

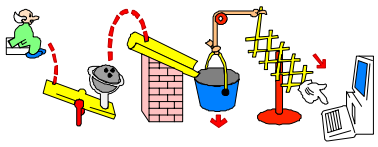
This issue of the TRN is full of reports on how and where the A & D field has been moving and developing in 2000. Our feature article is a review of the Cutting Edge conference consisting of a summary of the feedback from participants and details of the prize winners. We also have a report of a different nature on spirituality from Michael Baker. Doug Sellman updates us on the NCTD and the grant proposals that they submitted to the HRC. There is a summary of Peter Joyce's speech from Cutting Edge on treatment of alcohol dependence related to the treatment of depression. We also have the first report from new TRIG chairperson Raine Berry and of course Fraser Todd updates us on some of the A & D literature. Finally we have the first of a new column looking at what drugs are emerging in the NZ scene. Unfortunately, the Auckland report was not received in time for our printers deadline.

I am anticipating the challenge of keeping the TRN strong next year with anxiety and excitement, and would like to ask for your input. Please send us letters to the editor about any issue of concern in the A & D field. We also welcome warmly any articles people would like to write about research in the A & D field. Fresh perspectives are always stimulating. So send us your letters and pieces and we can all enjoy a TRN reflective of the whole eclectic A & D field.

I hope the close of the first year of the millennium goes smoothly for everyone. On behalf of the TRN – happy holidays and have a great summer.

Meg Harvey
Editor
13 November 2000

Deadline for the next issue is: Friday 23 February 2001.



LETTERS TO THE EDITOR

Dear Editor

I am taking up Dr Peter Adam's invitation to continue discussion about the need for a national alcohol and drug research strategy in relation to the ideas and proposals outlined in his paper titled "Towards a National Alcohol and Drug Research Strategy" presented at Cutting Edge, National Alcohol and Drug Conference, Rotorua 2000.

Peter's challenge to the alcohol and drug field to consider a national alcohol and drug research strategy that incorporates programmes of

research is timely. It is also important, as he pointed out in his paper, to build in flexibility in order to undertake research designed to provide information and assist with effective treatment provision in areas of changing or emerging concern. Thus a mix of qualitative and quantitative methodology is required.

The need for strong linkages and partnerships to be developed between researchers, service providers and consumer groups is essential. Partnerships require strong commitments from funders of services, service providers and researchers. Service funders and providers need to make a real commitment to evidence based practice in addition to building in resource requirements, such as clinician time for involvement in research projects and for gaining an understanding of what a partnership can offer in improving treatment and care for their client groups. Researchers must put time into developing an understanding of the clinical context, to meaningful consultation with clinicians, and to involve clinical staff and consumers in meaningful partnerships.

In relation to the context, while we can in New Zealand “make use” of international efficacy research findings, controlled effectiveness studies still have a critical place in

Continued on Page 4

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

The NCTD has submitted two grant applications in the November Heatlh Research Council Grant Round. Both are in the youth area. The first is investigating the relationship between cannabis use and cognitive functioning. The second is investigating the effectiveness of naltrexone/ondansetron in the treatment of alcohol dependence. These will be described in more detail below, followed by a startling initial finding from the Rolling Telephone Survey.

Cannabis Use And Cognitive Functioning In Community And Clinical Adolescents

Cannabis use amongst adolescents appears to be increasing in New Zealand despite several decades of efforts from various groups to curb this activity through a variety of education programmes. There is compelling research indicating the potential health risks associated with heavy chronic cannabis use including cognitive effects such as impairment of memory and attention. These cognitive effects may have severe implications for adolescents who are at a critical stage in life when the accumulation of information and acquisition of personal and social skills are at the fore. There is, however, surprisingly little good information about the effects of cannabis use on adolescent cognitive functioning internationally and certainly not in New Zealand. This project aims to contribute to filling this gap in knowledge of such a relevant contemporary health issue.

200 adolescents from a community sample (Secondary Schools) and 200 from a clinical sample (Youth Specialty Service – Christchurch) will be recruited and information collected to investigate the relationship between cannabis use and cognitive functioning. A key part of the design is investigating a range of variables, which may be important in intervening between cannabis use and cognitive functioning. The variables we will be investigating including demographics (age, gender, ethnicity etc), extent of other substance use, mood, personality, general personal functioning and psychiatric disorder. We are also going to be investigating steroid hormones because of existing information indicating these may be important in mediating between stress and impaired cognitive functioning. Cannabinoids and steroid hormones are similar in chemical structure. We are also going to specifically study the relationship between cannabis use and cognition in Maori and will be employing a Maori research assistant as part of this study when funded. The subjects will be aged 14-17 years and the primary method of assessing cognitive functioning will using the Cambridge Neuropsychological Testing Automated Battery (CANTAB). This is a computer-assisted set of tests involving a touch screen.

A Double-Blind, Placebo-Controlled Trial Of Medication In Alcohol Dependent Adolescents

Following the naltrexone-an-effective-pharmacotherapy-for-alcohol-dependence-breakthrough, reported by both the Volipicelli and O'Malley research groups in 1992, in the Archives of General Psychiatry, a next step in treatment development occurring is combinations of anti-craving medications for alcohol dependence. One of the most promising of these medication combinations is naltrexone combined with ondansetron. Ondansetron is a post-synaptic 5HT3 antagonist and appears to act by stabilizing the functioning of serotonin (one of the key neurotransmitters) in the brain. The most common side-effect of naltrexone is nausea. As ondansetron is also an anti-nausea medication (in fact most commonly known for its use in controlling vomiting in cancer chemotherapy treatment) not only does it seem to increase the effectiveness of naltrexone as an anti-craving medication, but it also alleviates this side-effect. A very good combination by the looks of things, but never been tested in adolescents. We plan to recruit, treat and follow up 120 alcohol dependent adolescents presenting to the Youth Specialty Service in Christchurch, whom have not responded adequately after 4 weeks of a comprehensive psychosocial treatment. Subjects will begin this psychosocial treatment and then at 4 weeks, those who are not responding will be randomised to pharmacotherapy consisting of either naltrexone/ondansetron or placebo, as additional treatment to the psychosocial treatment. About 70% of the adolescents with alcohol dependence will also have significant cannabis use. We will therefore be in a position to not only investigate the effectiveness of naltrexone/ ondansetron on alcohol use, but also its effect on cannabis use. Double-blind means that neither the subjects nor the investigators will know whether the subjects are receiving naltrexone/ondansetron or placebo. Identical looking and identically sour tasting capsules will be specially prepared and in each capsule will be a small amount of the vitamin riboflavin which can then be

traced later in urine to check for compliance. Compliance is a critical aspect of this study and great effort will be directed towards achieving an acceptably high compliance rate. A group of UK researchers have recently shown that for the naltrexone effect to be seen (ie halving the relapse rate over placebo), there needs to be an 80% compliance rate.

Startling Initial Finding Of The Rolling Telephone Survey

The NCTD is now underway with the so-called Rolling Telephone Survey in which 50 alcohol and drug workers in New Zealand will be randomly selected in waves over the next 5 years or so. This is in order primarily to track changes in the drug use of people presenting for assistance at alcohol and drug services. A startling initial finding is the number of alcohol and drug workers who no longer work as alcohol and drug workers. About 25% of those on updated staff lists when contacted were no longer working for the service and most had moved on out of the alcohol and drug treatment field. So far only about 30 people have been fully surveyed so it is early days in data collection, but this finding has immediately stood out to Mo Pettit and Meg Harvey who are undertaking the interviewing. By the time of the next TRN a more definitive comment on this finding, which potentially has considerable implications for our field, will be possible. Watch this space.

Doug Sellman
Director, NCTD
1/11/00

Letter From The Chair

Dear Treatment Research Interest Group Members

A new executive was voted in at the TRIG AGM held on 31 August 2000 at the Cutting Edge Conference in Rotorua. The new executive are: Peter Adams, Michael Baker, myself- Raine Berry, Alistair Dunn, Doug Sellman, Robert Steenhuisen, Lindsay Stringer and Meg Harvey. In addition we have co-opted Gerard Dolan as we did not have representation from the lower North Island and have made an approach to a potential Wellington executive member. Sandy McLean resigned as chairperson and I have taken on this role. Lindsay Stringer is the secretary/treasurer and Meg Harvey is the new editor of Treatment Research News (TRN). On behalf of TRIG I would like to thank the outgoing members of the executive, Sandy, Goldie May and Steve Scott, for their time and input over the last year.

TRIG has identified two primary roles over the coming year. These are maintaining TRN and facilitating the development of a national research strategy.

Our biggest achievement to date has been producing 14 issues of TRN (this is issue 15). TRN has been sent out to 4,700 people via our membership list, and as an insert in the ADA connection and ALAC's newsletter. The cost of producing each issue is now around $2000. Over the last two years we have received $5000 each year. This has come from the National Centre for Treatment Development (NCTD) who have contributed between $2-3000 per year and from TRIG members opting to forgo their $25 discount when registering for Cutting Edge. NCTD offered to provide financial support three years ago as an initial seeding gesture. This is the last year that they will be offering financial support. They will however continue to support TRIG by providing administration and staff time. The question now is how will TRN survive in the future? At the present time we have around $2700 and will receive another $5000. This is enough to produce another four newsletters but what then? It was decided at the AGM to reduce the number of TRN's from four a year to three however we are still going to have to look at ways of attracting ongoing funding. The AGM also voted to continue our zero membership fee and to look toward sponsorship. I feel we need more discussion on this. Some ideas that have been put forward by the executive are:

- We print copies for our members only.
- We revisit the idea of charging a membership fee
- We look for sponsorship (any ideas?).

The need for a national research strategy has been highlighted over the last two years in particular. Peter Adams has convened discussions at the last two Cutting Edge conferences on this issue. The AGM resolved that TRIG was the appropriate body to take an active role in advocating for and co-ordinating the development of research in the alcohol and drug treatment area and that development of a national research strategy should be one of our primary roles. We will keep you informed of progress in this area.

We would be keen to hear your ideas about either of these two issues.

Raine Berry,
(raine.berry@chmeds.ac.nz)

What's New On The Street: Had A Good Fantasy Lately?

This is the first of a new column for TRN which is aimed at updating researchers and those interested on new drugs emerging (or gaining popularity) in the New Zealand drug scene. The idea is to provide some background research on drugs that may start to be encountered in research and practice. Your comments, requests and questions are encouraged.

As reported on TVOne earlier this year, a new drug is emerging into the NZ drug scene called Fantasy (or GBH or liquid ecstasy). This is gamma-hydroxybutyrate, a depressant drug once available in health stores and popular for its euphoric and sedative effects. At least six people have been admitted to Auckland Hospital due to overdosing on GBH in the last year.

GBH works by slowing down the activity of the brain and central nervous system. It was discovered in the US in 1961, first used as an anaesthetic and has been investigated as a treatment for alcohol and opiate dependence. Currently in the US there have been at least 48 reported GBH related deaths and more than 100 suspected overdoses. The US Government banned the sale of GBH (unless under medical

supervision) in 1990 and possession of the substance is illegal in many states. Currently in New Zealand, GBH is not registered as a medicine and thus, theoretically, legally available.

The drug comes in the form of a powder, capsule or (most commonly) a liquid. It takes effect in about 15-60 minutes and lasts from one to three hours. Ten to twenty mg produces analgesic effects and amnesia, while 50mg or more can result in general anaesthesia with respiratory depression and coma. The effects are like those of alcohol, producing sedation, euphoria, disinhibition, giddiness, silliness and (in large doses) difficulty in thinking. Adverse effects include trembling, loss of co-ordination, nausea, headaches and vomiting. Being a sedative, GBH is very dangerous when taken in combination with alcohol or other depressants.

Due to its potential to cause blackouts and amnesia at high doses it has been used as a “date-rape drug”. The Internet freely offers instructions to make or buy GBH and several sites endorse its use. Interestingly, Lycaeum (one of the more liberal Internet sites) warns against the addictiveness of GBH.

Meg Harvey
NCTD

LESSONS FROM DEPRESSION FOR THE TREATMENT OF ALCOHOL DEPENDENCE

This lecture proposed that there are many lessons to be learned for the treatment of alcohol dependence from what is currently known about the treatment of depression. The audience was challenged to substitute a diagnosis of alcohol dependence for a diagnosis of depression, to see whether any of the following findings may be applicable for thinking about treatment issues in alcohol dependence.

Despite the existence of effective treatments for depression, the long term outcome of depression is frequently characterised by relapses, recurrences and chronicity. As patients undergo successive episodes of depression, the underlying neurobiology of the disorder may change. The best documented clinical data for this is the finding that in patients with bipolar disorder, Lithium and Valproate were approximately of comparative effectiveness and more effective that placebo. Only Valproate remained an effective anti manic drug for those who have multiple prior episodes.

One of the best conducted studies on the treatment of major depression was the NIMH collaborative treatment study of depression. For those completing an adequate treatment trial between 50% and 60% of patients responded well to Imiprimine, interpersonal psychotherapy or cognitive behaviour therapy and this was considerably better than the 20% or so who responded to placebo plus clinical management. This study along with other findings, produced the suggestion that for depressed patients who were in a single episode of short duration and that is mild in severity, there is adequate response to clinical management (ie assessment, diagnosis, education, symptom monitoring) that specific treatments such as antidepressants or a specific psychotherapy may not be necessary. Conversely, while those with chronic more severe depressions may have a slightly less good response to treatment. The differences over placebo are greater in those with chronic and / or severe depressions.

Many studies suggest that treatment outcomes in research studies are considerably better that in "usual care". In one randomised controlled trial in primary care of patients, at follow up after eight months, the advantages of either protocol Nortriptyline or interpersonal psychotherapy over usual care were marked with 46 to 48% of those in Nortriptyline or interpersonal psychotherapy being asymptomatic compared with only 18% of those allocated to usual care (Ref 1). Findings such as these challenge services to think about the ingredients of care missing from the care delivered in research studies.

It is often tempting to think that if there is apparent cause for an episode of depression, that it is appropriate to treat this cause. However, "common sense" may not always be right. This is best exemplified in a study of bereavement related depression in later life when 80 depressed patients were randomised to 4 groups. The best outcome was received for those who were randomised to Nortriptyline plus interpersonal psychotherapy where 69% remitted: the worst outcome was in those who received interpersonal psychotherapy where 29% remitted. In statistical analysis, only Nortriptyline was significantly better than other treatment but the common sense belief that perhaps an interpersonal psychotherapy would be the best treatment was clearly shown to be incorrect (Ref 2).

The general conclusion of the studies in adults (but not in the elderly) is that combination treatment is no more effective than a single treatment approach with either antidepressant or psychotherapy. Given the costs of delivering two treatments for little additional benefits, this has got to be a very questionable practice. However, a new study suggests that sequencing of treatments may be more effective than combining treatments.

Many clinicians believe that a comorbid personality disorder especially a cluster B personality disorder such as borderline personality disorder, adversely affects the outcome for the treatment of depression. While many papers have supported this, studies with prospective assessment of personality disorder comorbidity and random allocation to proper treatment, suggest that this is not at all the case. Our own data suggests that the response of depressed patients with borderline personality disorder to Fluoextine is comparable or even better than the outcome of depressed patients without a personality disorder.

It is also proposed that factors such as age, sex and culture may be more important in the outcome of depression than previously recognised. Our own studies, suggest that for younger patients, adolescents and young adults up to the age of 25, that serotoninergic antidepressants should be clearly the first line of treatment. Our data also suggests that women differentially are unable to tolerate an adequate trial with a traditional tricyclic antidepressant and that this differential drop on tricyclics be gender is also relevant to thinking about treatment planning for depression.

A recent study of IPT and CBT in Puerto Rican depressed adolescents also raises the issue of the adaptation of the Psychotherapy for different cultural groups. Both interpersonal psychotherapy and cognitive behaviour therapy were significantly superior to a wait list control as regards treatment of depression. On measures of self-concept and social adaptation, interpersonal psychotherapy was superior to wait list control but this did not generalise to cognitive behaviour therapy. In this study, the authors adapted both IPT and CBT for cultural factors. The comments of the authors were that IPT had a greater degree of compatibility with Puerto Rican cultural values which places interests of the family over interests of the individual (Ref 3).

There is increasing evidence that "the treatment that gets you better, keeps you better". Similarly, changing treatment strategies at different phases of treatment may be associated with worse outcomes. This has been illustrated in a study of patients with bipolar disorder where those staying with the same psychosocial intervention were more likely to remain stable than those in whom the psychosocial intervention was altered during the course of management.

In the data we have from our outcome of the depression study in Christchurch a comorbid alcohol dependence diagnosis does not overall adversely affect the outcome for treatment of depression. However, current alcohol consumption if it is greater than 28 drinks per week, is associated with a slightly worse outcome for treatment of depression.

Cannabis comorbidity is also common in our depressed patients. It is very clear that depressed patients who use cannabis are more paranoid than those depressed patients who do not use cannabis. Although cannabis may make

depressed patients more paranoid, our data does not suggest the presence of cannabis use or dependence adversely affects the outcome for the treatment of depression. However, there was little change in cannabis use over the month and years of our follow-up of these depressed patients.

References:

- *Schulberg HC et al; Treating Major Depression in Primary Care Practice, Either-Month Clinical Outcomes. Archives of General Psychiatry 1996 Vol 53 Pages 913-919.*
- *Reynolds CF et al; Treatment of Bereavement Related major Depressive Episodes in Later Life: A Controlled Study of Acute and Continuation Treatment with Nortriptyline and Interpersonal Psychotherapy. American Journal of Psychiatry 1999 Vol 156 Pages 202-208.*
- *Rosssello J and Bernal; The Efficacy of Cognitive Behavioral and Interpersonal Treatments for Depression in Puerto Rican Adolescents. Journal of Consulting and Clinical Psychology 1999 Vol 47 No 5 Pages 734-745.*

(Adapted from Keynote Lecture)

Professor Peter Joyce
Christchurch School of Medicine

The Spirituality of Alcohol & Drug Workers

At the Cutting Edge Conference this year, I gave a presentation about research that I have begun looking into spirituality and alcohol and drug treatment. With a cross-section of alcohol and drug workers in the audience, I took the opportunity to take an informal survey of the attitudes and beliefs of New Zealand A & D workers. I was intrigued by American studies that suggested that mental health professionals may be less religious than the normal population, and less spiritually-inclined than their patients (Goldfarb, et al., 1996; Weaver, et al., 1998; Galanter, 1999). These studies were limited to medical students, psychologists and psychiatrists respectively.

Recent surveys in New Zealand have indicated that 60% of the population believe in God and a further 20% believe in some sort of higher power. One-fifth of New Zealanders pray daily and attend religious services more than once a month, while nearly a third never attend services of worship. While we are less religious than the United States where about 90% of its citizens believe in God, we are similar in religiosity to the United Kingdom (Greeley, 1993). At the conference I presented data collected from the first 39 participants in my project. They showed similar patterns of belief in God, daily prayer and attendance of religious services to the normal population, but there was a slightly larger proportion believing in a higher power and noticeably more who never attended services of worship.

Ninety surveys were handed out at Cutting Edge and 58 were returned, resulting in a 60% return rate. The A & D workers surveyed reflected the normal population in their belief in God and daily prayer, and similar to the clinical sample they had slightly more belief in a higher power. While the proportion of the professional sample who did not attend religious services reflected the normal population, there was nevertheless about twice the rate of attendance to worship by A & D workers. When the professional and clinical samples were compared on more specific variables, the evidence suggested that clinicians may in fact be more spiritually inclined, as a group, than their clients. There was a greater proportion of professionals who identified themselves as religious or spiritual and who meditated on a weekly basis or more regularly. Both groups had about 10% who read spiritual literature on a daily basis, but the clinical sample had significantly more who never read spiritual literature.

The survey used was based upon a scale developed by Scott Tonigan and Bill Miller of the University of New Mexico, and had a range of possible scores from 0 to 40. Using the score as a measure of spirituality, I was able to look more closely at the professional sample. Out of a total 56 respondents, the mean was 24.7 and its standard deviation 10.2 (Min=3, Max=41). (Two people declined to answer stating that the survey was biased in its use of "God".)

The comparison showed little difference between gender (males slightly higher), or between Maori and Pakeha, but the few Pacific Islanders involved had noticeably higher scores. There was a trend that means of spiritual scores increased with age. But most interesting of all was the difference of means between the professions. Medicine, nursing and social work had markedly lower means than counselling and psychology; and the largest mean belonged to A & D clinicians who were working in the field because of their personal experience.

The survey has limitations: one being that the scale used was more a measure of religiosity than spirituality, and another was the small numbers involved. But the results are informative. In general A & D workers do not seem any less religious than the normal population, nor less spiritually inclined than the clients they treat. In fact, with respect to meditation and attendance of worship they seem to be more active than the clinical population. However, some professions seem to be less religious than others, notably medicine and nursing. My thanks to everyone who took part in the survey.

Michael Baker

- Galanter M; Research on Spirituality and Alcoholics Anonymous. *Alcoholism: Clinical and Experimental Research*. 1999, 23(4): 716 - 719.
- Goldfarb L, Galanter M, McDowell D, Lifshutz H & Dermatis H; Medical Student and Patient attitudes Toward Religion an Spirituality in Recovery Process. *American Journal of Drug and Alcohol Abuse*. 1996, 22(4): 549 - 561.
- Greeley A; Religion Not Dying Out Around the World the World. *Origins*. 1993, 23(4): 49 - 58.

order to develop effective treatments within the New Zealand clinical setting and cultural context. For example, to add to Peter's example in relation to methadone programmes, research is required not only in relation to improving access but also in relation to developing effective service delivery and treatment models. In addition, we are somewhat behind in New Zealand in addressing the issue of outcome measurement, both at the level of the individual within a particular treatment context and at a more aggregate level. Such research activities are in accordance with the Health Funding Authority National Alcohol and other Drug Services Funding Strategy Discussion Document, "A Strategic Framework for the Funding of Alcohol and Other Drug Treatment Services". This document notes the need for "advances in knowledge regarding what constitutes best practice….. to be brought forward and incorporated into alcohol and drug service delivery at a local, regional and national level".

The Discussion Document also suggests possible ways forward for New Zealand based outcome research in the area of brief interventions for different age, gender, and ethnic groups, optimal treatment interventions for Maori, Pacific peoples and youth. Other research areas of suggested focus include investigating treatment provision in rural areas and longitudinal research projects at both an individual and community level.

Daryle Deering,
13/11/00

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)

Cutting Edge Awards

Each year at the Cutting Edge conference two awards are given out. The first is the John Dobson Prize for the best opioid presentation at the conference. The second is the John O'Hagan Prize for the best presentation by a junior researcher (that is, under 35 years).

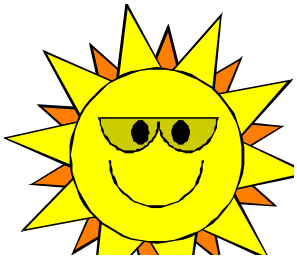
In 2000 the John Dobson prize was shared between David Benton of the Lakes Methadone Service in Rotorua and Daryle Deering of the NCTD in Christchurch. The John O'Hagan prize went to Kyp Kypri from the University of Otago.

David Benton's presentation was on "Not doing urinanalysis - does this allow clients to feel safe enough to be honest with staff about drug use?" and questioned client honesty in the absence of urine test with encouraging results. The Lakes Methadone Service decided not to use urinalysis and rely upon client report. To test this surveys were undertaken comparing reported drug use and urinalysis results. In order to make it safe for clients to report, treatment consequences (e.g. losing takeaways) were suspended. This paper outlined the policy and practice adopted, the results of two surveys of clients, and the result of an anonymous urine sample requested of all clients in a one-week period. This test was compared to clinician's prior estimate of client drug use. Results were almost identical with the figures staff had estimated. The interesting conclusion was that all three surveys conducted by the Lakes Methadone Service were consistent, and support the hypothesis that if clients are asked to be honest, and their treatment will not be affected by an honest reply, most in fact will be honest.

Daryle Deering spoke about initial results from a study investigating the validity of a measure of drug use, the Degree of Drug Use Index (DDI). The DDI was designed to provide a brief measure of drug use over the preceding month and to comprise one aspect of a clinical outcome measure for opioid substitution treatment; most importantly to provide a structured approach to reviewing individual patients' progress during treatment, to which they can directly have an input. The overall goal of the study is to recruit and collect information about recent drug use from a representative sample of 105 people currently receiving methadone maintenance treatment; 35 Maori and 70 non-Maori. The study had a high recruitment rate, with participants very willing to be involved, with comments such as "to help others…give something back". In relation to answering each questionnaire, participants to date reported feeling comfortable with both questionnaires. With regard to drug use, preliminary data indicated that participants used a range of drugs, particularly cannabis, nicotine, and opioids at a reduced level. Forty-five percent of participants were parenting children under 16 years, over 60% received a sickness or unemployment benefit and almost half rated their health as fair or poor.

Kyp Kypri discussed the Early Intervention Project (Injury Prevention Research Unit of the Dunedin School of Medicine), which seeks to develop and test an intervention to reduce youth alcohol-related harm. The present focus of the study is on tertiary students who are renowned for high levels of hazardous drinking (HD). 1,533 students from halls of residence were surveyed for the purpose of examining the prevalence of HD and other health behaviours. The mean age of respondents was 18.3 years and 60% were female. One out of two students was a HD, i.e. scored 8 or higher on the Alcohol Use Disorders Identification Test (AUDIT). A large portion of students interpreted certain AUDIT items in unexpected ways. It appears that due to the ambiguity of questions, some respondents are getting higher scores than they ought to. False positives matter where the AUDIT is used as a self-completion epidemiological measure as is increasingly the case. Students gave mixed responses to the prospect of routine screening (using AUDIT) and brief counselling intervention administered by GPs, clinical psychologists, counsellors, or nurses. Where the relationship with a health professional was well established, resistance to the idea of intervention was less marked. It is safe to say at this stage, that screening and brief intervention, as it is used in the wider community will have to be carefully remodelled for testing with this population.

Congratulations to this years recipients.



Cutting Edge
Evaluation Feedback

These are the results (courtesy of Ian MacEwan) of the feedback questionnaires handed out at Cutting Edge for those attending to tell the organising committee what was and wasn't working. In all 90 questionnaires were returned (31% of conference attendees). 51% found the conference to be very valuable and 97% found it to be moderately to very valuable.

Most valuable aspects pointed out included – having everything on one site, the variety, cultural input, networking opportunities and having both research and treatment papers.

Least valuable aspects pointed out included – no conference bags, too many streams (and people walking in and out), cellphones going off and too much research not enough practical papers.

Recommendations for future conferences included – keep Cutting Edge going, having set presentation times within streams, written copies of papers, more culture and spirituality, and giving up on after dinner speakers.

I've Been Reading

With the lengthening warm evenings and the promise of the distraction of Christmas pulling the thoughts onto more esoteric matters, it is timely that there have been several thought provoking articles published over recent months.

Dickerson and Baron, in their review of Contemporary issues and future directions for research into pathological gambling ***(Addiction 2000;95(8):1145-1160)*** begin by criticizing current DSM-IV definitions of the concept of pathological gambling. Firstly, being preoccupied with and having an excessive need for something does not logically imply a mental disorder. Secondly, gambling as a way of escaping from problems or relieving dysphoric mood (criteria 5) could equally apply to a range of other leisure activities such as going to a football match (well, for those south of Taupo perhaps). And finally the last four criteria all refer to various forms of social conflict, "exactly the kinds of social conflicts that are insufficient for diagnosis of disorder according to DSM-IV's definition". The criteria are therefore seen as over-inclusive and unable to distinguish disorder from non-disorder. Furthermore, not only is the DSM-IV construct of pathological gambling problematic, but so too are many of the tools used for identifying cases and therefore prevalence rates, based as they are on similar constructs. Dickerson and Baron's solution is to focus on the construct of self-control of gambling, or rather loss of control. They then discuss the implications of this approach and some of the related research findings.

The applicability of these arguments to the area of substance use disorders and the constructs of abuse and dependence further heighten the importance of this article.

Related to the above review article, Maddux and Demond in the editorial of the May 2000 edition of Addiction ***(Addiction 2000;95(5); 661-666)*** discuss the history and use of the terms dependence and addiction. They make some interesting comments on the history of these terms and on the subtle differences in meaning between them without supporting one or the other. Popularised in the late 19th century, the term addiction has always had connotations of a lack of control and compulsive use. Dependence however was a much broader and less precise term. The crux of their argument seems to be that addiction, by capturing the notion of loss of control, is more clearly describing a behavioural disorder. The concept of dependence includes this and a range of other types of problematic substance use which are better thought of problematic substance use rather than specific behavioural disorders. I must admit from my point of view that there is some merit in this position, and it seems to me that there are important qualitative differences between excessive or problematic use and severe dependence or "addiction", with its marked lack of control and frequent relapses.

Morgenstern and Longabaugh ***(Addiction2000;95(10):1475-1490)*** review studies on the mechanism of action of cognitive-behavioural treatments for alcohol dependence. Their hypothesis is that CBT works by enhancing coping skills, but after evaluating the existing studies looking at this mechanism, they conclude that there is little support for their theory. In doing so, however, the authors discuss important methodological issues and summarize some interesting models.

The study by Stenbacka ***(Addiction 2000;95(10):1573-1581)*** looks more at which individual competences at age 18 predict or protect against future risk of substance misuse. Good emotional control and cognitive and social skills reduced the risk of adult adult drug use. The protective effect of individual competences was most pronounced in those at high-risk of subsequent substance misuse. These are important findings for the prevention of substance misuse and have significant implications for high-risk young people. Of course, this group is easily identified not least by the fact that they are the children of the people we are seeing clinically with addiction problems!

Addiction 2000;95(8) has a several research papers on treatments for nicotine dependence. Of note is the finding that the dopamine agonist bromocriptine is reported to increase rates of nicotine cessation (Jarvik and colleagues, pp1173-1184). One factor that possibly confounds this finding is that bromocriptine, like bupropion has antidepressant effects and the study did not appear to control for these. However, it does raise the possibility of another medical adjunct to smoking cessation interventions. Shiffman and colleagues (pp1184-1196) report that 24-hour transdermal nicotine patches are associated with less craving then 16-hour patches. Wallstrom and colleagues (pp1161-1172) report on a sublingual nicotine tablet which while developed for people undergoing facial surgery has some advantages for others seeking a less obvious mode of delivery than chewing gum or spraying fluid up their noses.

And finally and excellent study by Corrao and colleagues ***(Addiction 2000;95(10):1505-1523)*** looks at the degree of protection against coronary artery disease alcohol affords. A meta-analysis of published studies concluded that where alcohol offers protection, it does so most between daily doses of 20-72grams per day but that specific groups were more helped than others. Alcohol appears less protective in women and in men not living in Mediterranean countries! That is most of us. There is also evidence that the cardio-protective effects of alcohol is mediated by alcohol dehydrogenase, and that most of the protective effects are limited to people with a specific subtype of this enzyme. The authors sensibly recommend caution with our advice on the protective effects of alcohol consumption.

And that's it from me for this year. I hope you all have an enjoyable Christmas and New Year.

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