Treatment Research News

Alcohol, Drugs and Addiction

March 2001 *Newsletter of the Treatment Research Interest Group* **Vol 5 No 1**

EDITORIAL

Dear Readers

As time continues to speed by summer has passed by and we are into autumn. The leaves on the Christchurch trees have definitely started to change colour. In Christchurch it was a quiet and measured start to 2001 (for the A & D field and the Crusaders) though the same cannot be said of Rotorua. The NZ Herald reported on January 12 that the Addiction Resource Centre there has been swamped with referrals (4 times that for the same time in 2000) and at least half of those referred were under the age of 16, with the youngest being 11-years-old. A concerning development – especially if it is reflective of the countrywide situation.

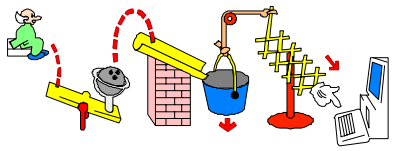
Things are now shaping up to be franticly busy for everyone. Cutting Edge 2001 is only 5 months away now, the TRIG exec have had their first meeting and here we are at the first Treatment Research News for the year already. This year we are producing only 3 issues of the TRN to maximise the TRIG budget and provide more solid reading.

This issue of TRN has all the usual favourites. Peter Adams has supplied a comprehensive discourse on the theoretical importance, and practical reality, of family involvement in treatment for A & D problems. Doug Sellman provides us with a picture of where NCTD research is at and also discusses interesting findings from the first wave of the Rolling Telephone Survey. Paul Robertson and Terry Huriwai inform us about new Maori research beginning at the NCTD. We have an article on pharmacotherapy in A & D treatment from Alistair Dunn and Fraser Todd fills us in on the latest literature in "I've been reading". We also have a great feature article from Robert Steenhuisen on using the Maudsley Addiction Profile.

Also we have the second of our new column "What's new on the street". There was encouraging and useful feedback on the first of this column in the last issue. Paul Marriott-Lloyd from the Ministry of Health pointed out that Fantasy (GHB) is in fact scheduled under the Medicines Act 1981 under its chemical name sodium oxybate (see Letter to the Editor). Thank you for the clarification Paul. After a series of enquires at the NCTD this issues "What's new on the street" looks at date rape drugs.

As always I hope the TRN provides you with interesting and useful reading. Again, I would like to encourage you to give us feedback and letters on how TRN is doing, how we can improve to meet your needs, and comments on issues and articles.

Meg Harvey
Editor
27 March 2001



LETTERS TO THE EDITOR

I was just reading the latest TRN (December 2000) and noted your article on Fantasy. I would like to correct one point made in the article about the legal status of Fantasy (GHB). It is in fact a controlled drug scheduled under the Medicines Act 1981 under its chemical name sodium oxybate. The following penalties apply:
Penalty for possession of a prescription medicine is imprisonment for a term not exceeding 3 months or a fine not exceeding $500. If the offence is a continuing one, a further fine not exceeding $50 for every day or part of a day during which the offence has continued. The offence is created by section 43 of the Act and the general penalty under

section 78 applies. The maximum penalty for supply is imprisonment for a term not exceeding 6 months or a fine not exceeding $1,000.

There is also a defence provision for wholesale of prescription drugs. Wholesale is the selling it to a person whom the vendor believes to be buying it—

(a) For the purpose of--
    (i) Selling or supplying it; or
    (ii) Administering it or causing it to be administered to one or more human beings--in the course of a business carried on by that person.

Any person who manufactures any medicine or sells any medicine by wholesale; or packs or labels any medicine otherwise than in accordance with a license issued under Part III of this Act commits an offence. Breaches of this provision are punishable by imprisonment for a term not exceeding 3 months or a fine not exceeding $500, and, if the offence is a continuing one, to a further fine not exceeding $50 for every day or part of a day during which the offence has continued.

Paul Marriott-Lloyd
Senior Analyst (National Drug Policy)
Ministry of Health

Access To Medications For The Treatment Of A&D Disorders

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The prescribing A&D clinician has historically had a limited range of pharmacotherapies at his/her disposal for the treatment of A&D disorders. However more recent research has heralded the arrival of new medications. Unfortunately these medications are either unavailable in New Zealand or restricted in their use because of cost to the patient. This article considers four such medications, outlining their use and current availability in New Zealand.

1. Naltrexone

Action: This opioid antagonist has established proven efficacy for the prevention of relapse in alcohol dependency, while its use in opiate dependency relapse is less well proven.

Current Status: Currently it is available in New Zealand but is not subsidised, costing $10.00 per tab to the patient . To be subsidised the drug needs approval from PHARMAC to be listed on the pharmaceutical schedule. The manufacturers Baxter applied to PHARMAC for listing in 2000 but the application was turned down.

2. Acamprosate

Action: This drug appears to be similar to Naltrexone for the prevention of relapse in alcohol dependent patients, although it is chemically a different structure.

Current Status: It is currently unavailable in New Zealand. To be available the manufacturer needs to apply to Medsafe to have it registered for use.

3. Buprenorphine

Action: This opiate partial agonist / antagonist has proven applications in the treatment of opiate dependency both in maintenance substitution treatment and in managing opiate withdrawal / detoxification.

Current Status: Previously available as "Temgesic-nX" (Bup + Naloxone) 0.2mg sublingual tablets, not subsidised and therefore at a cost to the patient of $0.70 per tablet (typical dose around 10-20 tabs = $7.00 - $14.00).

***NOTE:* Reckitt Benckiser has this month withdrawn this product from N.Z**.
In its place they hope to introduce "Subutex", which is pure Buprenorphine. They are currently in the process of registering it with Medsafe, and hope to have it available in June 2001, which means Buprenorphine tabs will be unavailable when current stocks run out until June. Subutex will not initially be on the schedule and therefore will cost the patient. It is designed specifically for use in opiate dependency and comes in more appropriate strengths;

Subutex 0.4mg tab @ $1.60
estimated cost to patient

2.0mg tab @ $2.70

8.0mg tab @ $7.70

"Suboxone" is a Bup-naloxone product which may also be introduced at a later date.

4. L.A.A.M.

Action: This long acting form of methadone is used in maintenance substitution programmes. Its long half life allows 3x weekly dosing.

Current Status: This drug is currently unavailable in New Zealand. No company has applied to Medsafe to register it. Recent reports of serious cardiac arrhythmia in patients on L.A.A.M., combined with its greater cost and New Zealand's small market size, do not make it an attractive proposition to pharmaceutical companies.

Clinicians remain hampered by lack of access to potentially useful medications in the field of A&D, despite good evidence establishing their efficacy. The obstacles to prescribing these drugs involve the mechanisms by which drugs are registered in this country and then listed on the pharmaceutical schedule. I believe those working in the field need to work together in a co-ordinated and pro-active way to facilitate the introduction and subsidy of these medicines. To do this, we also need to understand the commercial and political mechanisms involved.

Alistair Dunn

Continued from Page 2

A group has been meeting recently in Napier to explore ways of increasing the involvement of families in alcohol and drug service interventions. The group has identified the need for more information to understand the main reasons for low family inclusion. Research is required on; first, how frequently family members are included by services; second, a needs assessment of affected families, and, third, surveys and key informant interviews on barriers and opportunities for service staff. This information will provide the basis for developing a long-term strategy. The group is looking into the possibility of forming a national trust as a vehicle to coordinating the range of training and development projects needed to influence change. We would be keen to hear from anyone else in the field similarly interested in contributing to such a trust.

Peter Adams

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Treatment Research News is the official newsletter of the **Treatment Research Interest Group (TRIG).**

TRIG was established in 1997 to reflect the interests of workers in the alcohol and drug field in NZ.

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Maori Research Project

An important piece of research news since the last TRN has been the beginning of serious planning of a major clinical research project focused on the treatment of Maori with alcohol and drug related problems. The exact focus of this research has yet to be determined, but a number of key issues were identified at an initial hui involving several key Maori service providers from throughout Aotearoa. Close consideration of both the processes and content of practice, including specific interventions and issues of ownership / control / accountability was cited as vital. Some specific topics of importance were identified, notably the area of cannabis use. This hui, which included NCTD and ALAC staff in the latter stages, lay a foundation and identified a willingness to take the next step to develop a framework for undertaking such research. Once this framework has been explicated satisfactorily, an advisory group of service providers will work with NCTD to develop an appropriate design and methods. A number of projects undertaken by the NCTD provide a basis for the proposed work, notably those led by Terry Huriwai, as principal investigator of the Optimal Treatment for Maori project. This and other work, for example, on the history of Maori contact with alcohol and a qualitative investigation of Maori men's experience of addiction and treatment are contributing to an emergent Maori treatment literature. This literature provides support for development of treatments founded on and using Maori principles and processes to provide the means of effectively addressing the needs of Maori with alcohol and drug related problems. It is envisaged that the proposed research project will contribute significantly to the further verification of factors which contribute to effective alcohol and drug treatment for Maori.

Paul Robertson & Terry Huriwai
26 March 2001

Two HRC Grant Applications

You may recall from reading the last edition of the TRN, the NCTD submitted two grant applications in the November 2000 Health Research Council (HRC) Grant Round in the youth area. The first is an investigation of the relationship between cannabis use and cognitive functioning; the second is a study of the effectiveness of naltrexone/ondansetron in the treatment of alcohol dependence. Since then we received the reports of eight reviewers of these applications and subsequently replied to a number of queries and issues raised by them. We now await the decisions of the HRC. The peer review process utilized by the HRC is a very rigorous and testing one. By the end of it all, if you are "fortunate" to get the green light, you know you are onto a winner, in terms of a worthwhile scientific piece of work given the scrutiny that it has received. It is hoped that over the next few years a number of projects addressing addiction treatment issues from our field will be judged to be at the standard necessary to gain HRC funding.

Professor Peter Davis

It was alarming to see the recent attempted undermining of the reputation of Professor Peter Davis for the sake of political point scoring by senior parliamentarians. Professor Davis is an esteemed researcher, who is a senior colleague of ours here at the Christchurch School of Medicine, who has been successful with numerous HRC grant applications over many years through his knowledge and skill as a public health researcher. It was also concerning to observe the ignorance of senior parliamentarians who seemed to be unaware that research monies obtained through the HRC are held by institutions rather than the individual investigators themselves.

Rolling Telephone Survey (RTS)

In the last edition of the TRN, I promised to put figures around what seemed to us to be a startling initial finding of the RTS, an ongoing study of the alcohol and drug treatment workforce. In fact now that we have gathered the figures together the finding is even more startling than initially thought. Of the first 100 workers selected at random, 32 had left the service over the 12 months since the full list of workers had been updated and therefore were not available for interviewing. This is virtually 1/3 of the workforce! When we set this ongoing study up we did not think that such a massive turnover of staff was going to be a feature and therefore didn't formulate questions to capture data about where these staff had gone. Of these 32 workers who had left the service, we have only three recorded as definitely going on to A&D work. This means at worst, close to 30% of the alcohol and drug treatment workforce leaves A&D work each year and at the best that there is a

massive flux of workers in the field moving around the services. In either case, these data point to a considerable degree of instability and change within the field. A new set of questions has now been added to the questionnaire for the next wave of the study designed to capture as best as possible data related to where these workers have gone and why they have left the particular service they were previously at.

Motivational enhancement therapy (MET) is an effective psychological treatment for mild-moderate alcohol dependence

This statement may seem “old hat” to some. However, MET has never previously been demonstrated in the international literature to be effective in a randomized controlled trial which controlled for non-specific therapeutic factors. We reported our NCTD study at the Cutting Edge 2000 conference, which found that the rate of heavy drinking following MET was 49% compared with 63% for non-directive reflective listening and 65% for no counselling. However, it is only now that this work has been accepted for publication in the rigorously peer reviewed Journal of Studies on Alcohol, we can feel some real confidence that this statement is probably true. The wheels of scientific “truth” turn slowly, but surely. A four-year follow-up of the 125 patients is now underway and those who are found to be still struggling with their alcoholism will be actively assisted to receive further help.

Doug Sellman
26 March 2001

WHY ARE FAMILIES SELDOM INCLUDED BY SERVICES?

The term "family" refers to the circle of intimates who surround and care for a person. The meaning of "family" is undergoing major changes. Whereas fifty years ago European families consisted mainly in two parents and a couple of children, more recently families are taking a variety of forms and the circle of intimates may not include any blood relatives. Despite these changes, children and partners remain connected in various ways and concept of family remains valid in referring to the range of significant others that provide the network of relationships upon which identities are established.

Family members are strongly affected by the substance abuse problems of their kin. The nature of the impact can take many forms. For example, a dependency on gambling invariably cuts deep into the family's funding base and seriously reduces the time and emotional investment necessary for childhood attachments. Other forms of dependency complicate the experience of intimacy and impair the ability of social systems to respond to this damage.

Attempts to include families in treatment

I have had association with various attempts to include families in treatment for alcohol and drug problems. These have included family therapy initiatives in South Auckland and Auckland's North Shore. Another project involved attempts to set up a network of family support "Clubs" in Auckland, and whanau-based "Tatou" in Northland. I have talked with others working towards similar goals, such as the family programmes at Higher Ground and the children's programme "21 Fun Street" run by Healthcare Hawkes Bay.

In principle alcohol and drug workers indicate a strong endorsement for the inclusion of families. However as far as we can tell, when it comes to their practice, very few workers make a point of actually including significant others in assessment or counselling. Furthermore, the projects that do attempt to engage family members, despite the enthusiasm of the project workers, often end up as peripheral, vulnerable and poorly supported by the services themselves.

Explanations of low family involvement

Colleagues in our workplace, in Applied Behavioural Science, have recently discussed possible explanations for why services are neglecting to involve families. We came up with four major hypotheses:

Hypothesis 1: Dominance of Individualized-Expert Models

The strategy that currently dominates how addiction services choose to operate is driven by a focus on individual counselling. While the assistance of experts in one-to-one session environments has an important contribution in initiating a change process, it has arguably less value in the longer process of maintaining change. In many ways, the long-term success of an intervention is determined by the extent to which it integrates into the patterns and supports within a person's life. The individual counselling environment can contribute only in a limited way to this process of integration. It relies more on strategies that engage the people in that person's life in understanding and supporting the change.

Hypothesis 2: Funding strategies discourage involvement

The previous (1984) Labour government initiated major changes in monetary policy which the next National-led government turned onto the health system. One effect of the new managerialism was an emphasis on defining unitised volume outputs as the benchmark for performance. One's funding comes to depend on the number of clients seen and success relies on operating in ways that maximise the volume of clients while minimising the costs to the organisation. To go to the trouble of interviewing other family members is simply too expensive and operationally complex: it may take several phone calls to find a time that suits everyone; family members may not be available at convenient times; the sessions are likely to be longer; staff will need additional training and they might require larger offices with family-friendly features such as play areas. With the funding environment lacking any incentives for services to include family members, the services, despite staff interest, progressively phased it out of their core business.

Hypothesis 3: Services are expected to fix-it-up

Shifting from the orientation of the services to the expectations of the public, services that claim to provide expert interventions will naturally come to be seen by the public as places where problems are fixed. The moment a service undertakes to meet with an individual with alcohol and drug problems, to all those outside, particularly the family members, this signals a tacit agreement that it will be in the context of that relationship that change will be initiated. For many families, the notion that somebody is going to take the problem off their hands

and fix it up comes as a huge relief. All they need do is wait until the person returns minus the problem. However, this is seldom what happens. The changes in relationships that are required to support long-term change don't happen and problems keep recurring.

Hypothesis 4: Stigmatisation

Alcohol and drug problems are stigmatising for all involved. They carry with them a sense of failure, guilt and judgement. To engage as a family member could be perceived as drawing others into this morass and in some ways prompting a declaration of guilt. For example, a woman struggling with her partner's alcohol dependency has enough to contend with in maintaining her survival, but the idea that she might in some way be contributing to the problem would merely reinforce a growing sense of failure. Going to a service might be seen as admitting that in some way she is at least partly responsible for the dependency.

Future Directions

It seems unlikely that any single hypothesis will adequately explain our current low levels of family involvement. A combination of explanations seems more likely. Accordingly, attempts to turn things around will require a multi-layered and stepped strategy for gradually shifting from individual to family- and context-inclusive approaches.

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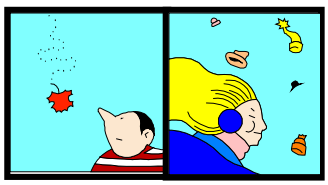

Treatment Research Interest Group (TRIG)

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:
Lindsay Stringer, PO Box 2924, Christchurch (Phone 03 364-0480, Fax 03 364-1225)

What's New On The Street? Be Sure You Know What You're Drinking

After enquiries from university campuses we decided that while they are not new on the street it may be quite valuable to look at date rape drugs in this issue of TRN. This also expands on one of the uses of Fantasy (as featured in the last issue).

Date rape drugs' amnesiac effects make it difficult for the victim to recognise what happened. While intoxicated the victim often finds they cannot speak, remember or respond. Internet sites advise if a woman wakes up with little recollection of the evening before, has a severe hangover in spite of having had very little to drink or feels like someone had sex with her (though she can't remember) she may have been drugged and raped.

Whilst several drugs have been implicated in date-rape, the two most common are GHB (gamma-hydroxybutyrate) and Rohypnol (flunitrazepam). It is less likely that Rohypnol is being used in NZ as it is no longer produced here and isn't frequently reported to be on the street. GHB is most commonly known as Fantasy, liquid x or liquid ecstasy. It is also called G-juice, Gamma 10 and cherry meth. Street names for Rohypnol include roofies, mind-erasers, roaches, forget pills or circles.

GHB is most commonly a clear, odourless, slightly salty tasting liquid, but may also appear as a white powered material. Rohypnol when dissolved is also tasteless and odourless and comes in tablet form usually white (though tablets that turn blue when dissolved have been introduced overseas in an effort to reduce its use in date rape). Rohypnol is purported to be 7-10 times more powerful than diazepam and 4-10 times as potent as Halcion. Neither drug should be mixed with alcohol, though this is most often how it will be administered. The drugs takes effect in about 15-60 minutes. They are touchy-feely compounds which typically induce deep muscular relaxation, a sense of serenity and feelings of emotional warmth. They are also purported to enhance emotional openness and the desire for sociability and act as a disinhibitor and aphrodisiac. Naïve users (or those not aware they have ingested it) run the risk of falling asleep. Side effects include nausea, dizziness, inco-ordination, slowed reaction time and lack of memory the following day. Overdose can produce unconsciousness, seizures, severe respiratory depression and coma.

Women who feel they have been drugged or violated are advised to consider taking the following steps:

- Save any and all physical evidence
- Don't change or shower
- Get urine and blood tested within 24 hours

Reducing the risk of being drugged can be helped by:

- Monitoring drinks at all times
- Not drinking from punch bowls
- Not accepting opened drinks
- Not accepting drinks from someone they don't know or trust

Meg Harvey
NCTD

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The Personal/Social Functioning domain covers days in employment, days of sickness, number of days in contact with a partner, relative, child or friend, number of days in conflict with a partner, relative or friend. The section on days committed crimes records the number of days a crime was committed and how often on a typical day. Crimes are categorised over 8 different types. It reminded me of the 12 different words Eskimo's have for snow. Marsden et al. [1998] reported that 16 % [n=160] committed a total of 1711 offences, not including selling drugs or shoplifting, in the previous 30 days.

Two simple prompt cards are used to assists the consumer and interviewer in working out the number of days for each question.

The MAP Development and User Manual [Marsden et.al. 1998] provides detailed instructions on how the interview and the scoring should be conducted. The MAP has not been used in phone interviews. I asked Professor Strange [one of the authors of the MAP] at the Cutting Edge Conference for his opinion of phone interviewing the MAP. He stated that he thought it was possible. He suggested doing a small trial with face to face interviews at 6 months post discharge and compare them with phone interviews and look for any major discrepancies or differences.

We are at the stage were we are doing more phone interviews. It is still hard to locate ex residents and get them to the phone. This is

evening and night work. Once we are talking to them they are prepared to engage. At this point I can not say that phone interviewing is as good as face to face. As with all research decisions it will be trade off: possibly loss of reliability, but hopefully improved retention rates.

The MAP is free of copyright for research purposes. All research projects at Higher Ground have been implemented with Ethics Committee approval. For further details feel free to call me.

Robert Steenhuisen Higher Ground
Email: robert.s@xtra.co.nz

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USING THE MAUDSLEY ADDICTION PROFILE

I am a novice in the field of research. It still feels like that, even now as I am doing my third year research papers at Auckland University. Four years ago I worked on an evaluation project at Higher Ground using the same instrument they had at Queen Mary Hospital at the time. Generously we were able to use their software and expertise. A pragmatic decision. The questionnaire was 8 pages and a hybrid of various other instruments, adjusted to New Zealand. It covered all aspects of alcohol and drug use and social and psychological status that seemed important in recovery. It covered the previous 6 months. In retrospect I realise that there were issues with validity and reliability, but that was not the main reason why the project failed. The questionnaire was administered on admission, and 6 and 12 months after discharge. The project provided us with a very detailed profile of the residents at Higher Ground at the point of admission. The 6 and 12 months follow up was done per mail out. Returns at 6 months were around 30% and at 12 months less than 5%. It was possible to get ex residents to complete the questionnaire as they came into the Higher Ground orbit again, but that created its own bias. It was very hard to trace our ex residents. They are a transient lot, and if we found them, they were reluctant to return the questionnaire. That may have been because it was too wordy, or it may be they felt reluctant to let us know what was happening in their lives. I definitely underestimated the effort it requires getting a person to complete a questionnaire.

I launched a second project with a psychology student from Auckland University, writing her Master's thesis. She wrote a thesis using qualitative methods, interviewing 10 ex residents. This project was much easier to implement, using a snowball technique for recruiting. We made it widely known that we were looking for participants and it was relative easy to set up the interviews. They were conducted by the student and included ex residents in recovery as well those who had returned to regular use. It was not possible to draw conclusions from the project for the total Higher Ground population, but it gave a sense of the issues ex residents faced. She presented the project at Cutting Edge 3 years ago.

Around 18 months ago we started a new project. The goal was the same: to get a better understanding of the status and issues of our ex residents. To improve on our previous experiences we looked for a brief questionnaire and moved to follow up telephone interviewing. We employed an ex resident to conduct the interviews and maintain the database. It is a paid position, giving the project status within the organisation. The Maudsley Addiction Profile [Marsden et.al. 1998] is a brief interviewer administered questionnaire for treatment outcome and research applications. The MAP was chosen over the Addiction Severity Index [McLellan et.al. 1992] and the Opiate Treatment Index [Darke et.al. 1992] on the basis of the short administration time, 12 minutes versus 40 minutes for the ASI or OTI, while still covering the same key domains.

The MAP is administered face to face on admission to treatment and by phone on exit, 6 and 12 months post discharge. We trained an ex resident rather than a staff member to do the interviews to make it easier to be honest for the participants. High expectations by staff and the need to please of participants are powerful disruptions in the research process.

The MAP covers the following sections: substance use, health risk behaviour, health, and personal and social functioning. Some adjustments were made to accommodate local circumstances. The MAP covers the previous 30 days before the interview in order to minimise recall bias. On the face sheet information about age, gender, race, length of dependence, treatment history and length of time in methadone [if applicable] is collected.

The MAP was tested on validity and reliability on 240 clients of the Maudsley Substance Abuse Services. It has a high concurrent and face validity. Test re-test reliability averaged .94 [Marsden et.al.1998]. As with all oversees instruments I wondered if that meant that it has the same validity and reliability in New Zealand. Reading the MAP it definitely has face and content validity. It covers all the aspects you would expect. But the MAP was developed in a different scene, where heroin is cheaply available and addicts live in crime riddled estates. This was developed and tested in Trainspotting territory. Can you use the same instrument on residents from Takapuna and draw the same conclusions? A certain concept of what addiction is all about permeates the MAP, possibly made stronger because it is very short. Okay for the British, okay for Kiwi's? The issue is a matter of philosophy of science. Is there a absolute reality outside us or is all reality created by how you

see it. The MAP assumes that there is such a thing as “addiction”, that it can be measured objectively [the MAP] and that it is the same everywhere. In contrast, a qualitative approach works on the basis that reality is constructed in our minds and imbedded in local cultures and power structures. The latter argues in favour of developing local approaches.

The Substance Use domain covers the main drugs of use for the target population, measured in number of days used, routes of administration, and average amounts used on each occasion. Drugs include: alcohol, cannabis, opiates, amphetamines, benzodiazipines, hallucinogens, cocaine, MDMA and “other”. An adjustment was made to accommodate local drug use.

The Health Risk Behaviour domain covers the number of days the consumer injected drugs, how often on each day and if needles were shared. In addiction the consumer is asked if they engaged in penetrative sex, with how many partners, and if condoms were used. These questions are very direct. “Did you have penetrative sex i.e. vaginal or anal during the last month”. I wondered about the need to gender match interviewer and interviewee. Debby [our interviewer] assured me that the question had so far given no embarrassment. The whole interview has a matter of fact feeling and people appear to accept it.

The 10 item Health domain is based on the 51 item Opiate Treatment Index [Darke et.al. 1991]. The physical health section covers those health areas associated with risk due to drug use and injecting. The psychological health section covers 5 items on anxiety and depression each, randomly assigned. Scoring is on a Likert type ordinal scale and provides a total score.

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I've Been Reading . . . . . .

If, like me, you read professional journals to find some answers, you will have been disappointed over the past few months. Having woken from the start of the academic year to find that it is already April, I went in search of some enlightenment and simply discovered more questions.

Addiction (the journal, not the state) made a promising start to the year with its supplement on Theories of Addiction in which there are a number of articles from leaders in the field reviewing a favoured etiological theory ***(Addiciton 2001;96:1-186)***. As a field, we have come a long way in the past few years in terms of dealing with key conceptual issues such as abstinence versus harm reduction, and the important issue of stigmatisation, and its implications, is starting to receive much overdue attention again. One of the issues just around the corner is, I think, the problem of how we think about the people we see with alcohol and drug problems in terms of how those problems arise and what they mean. Research is increasingly indicating a range of factors associated with the causation of addiction and reductionist approaches, be they a reductionist biological focus or an equally reductionist social focus, can no longer be seen as being evidence-based. While they might be supported by evidence, they are only supported by some of the evidence. It is important that all the available evidence is considered when trying to understand the complexities of a person with substance use problems. This issue of Addiction addresses a range of models with papers on "Addiction as excessive appetite" (Jim Orford), theories of drug craving (Colin Drummond), expectancy theory (Barry Jones and colleagues), receptor regulation (John Littleton), genetics GABA neurotransmitters in addiction (Buck and Finn), economics and the gateway effect (Kenkel and colleagues) and the transtheoretical model (Sutton). Perhaps the pick of the articles is the editorial by Robert West giving a useful overview of the area. A good read, a few answers, but most of all, questions. And the biggest question for me is how all these factors, which in the end simply make up a list of the factors involved in addiction, work together and interact. These articles make no attempt to integrate the genetic with the social or the biological with the economic. This may seem a daunting task, but other fields from neuroscience to evolutionary psychology have made huge gains in this area and maybe it is about time that our research in our field draws on some of the exciting developments in these other disciplines.

In a more practical key, a recent issue of the British Journal of Psychiatry has several very good review articles on cannabis. Pharmacology and effects of cannabis: a brief review by Heather Ashton ***(British Journal of Psychiatry 2001;178:101-104)*** provides a useful overview of the pharmacological effects and mechanisms of action of cannabis and Therapeutic aspects of cannabis and cannabinoids by Philip Robson ***(British Journal of Psychiatry 2001;178:107-115)*** is a thorough review of the medical uses of cannabis. The pick of the articles, however, is Andrew Johns' Psychiatric effects of cannabis ***(British Journal of Psychiatry 2001;178:116-122).*** There have been a number of similar reviews over the past few years, but this is probably the most comprehensive, balanced and thorough reviews I have seen. A must read for all involved in the assessment and management of people with cannabis use problems.

Also of note, Vielva and Iraurgi ***(Addiction 2001;96:297-303)*** report on their research into cognitive and behavioural factors as predictors of abstinence following treatment for alcohol dependence. While a number of similar studies have previously indicated the self-efficacy is an important predictor of outcome, few of these tested the assumption that self-efficacy was important because it related to causal attributions about abstinence or coping behaviours. Thus models explaining the advantages of high levels of self-efficacy have assumed that it is important because it is associated with better coping skills and with beliefs that being abstinent is 'do-able". This study explored these links and failed to support these assertions. Self-efficacy is an important indicator of good outcome, but this doesn't appear to be related to coping skills or attributions. The authors found one other variable that predicted abstinence – previous length of abstinence. It might well be that a person has high levels of self-efficacy (i.e. confidence that they can resist drinking) because they have successfully done so before! So an alternative explanation to the attribution / coping skills / self efficacy model which has some support from this study would suggest that an ability to stop drinking was associated with high self-efficacy. In other words, the people who have been able to achieve longer periods of abstinence in the past seem to be able to do so again and appear to have reasonable confidence in this. A good way to get abstinent is to increase self-efficacy, and a good way to increase self-efficacy is to get abstinent.

And finally, an interesting study on gender differences in the effects of alcohol. There is reasonable evidence that women who drink alcohol heavily are more vulnerable to physical complications such as chirrosis of the liver and cardiomyopathy, developing these earlier and after lower levels of consumption than men. Now Hommer and colleagues ***(American Journal of Psychiatry 2001;158:198-204)*** present evidence from MRI scanning that indicate that women have a greater sensitivity to alcohol neurotoxicity than men. In other words, greater structural brain damage is done in women compared to men. Maybe its sobering information like this that is needed to break that abstinence / self-efficacy cycle.

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