Treatment Research News

Alcohol, Drugs and Addiction

December 2001 *Newsletter of the Treatment Research Interest Group* **Vol 5 No 3**

EDITORIAL

Thank goodness it is summer again. Somehow life and work seem that little bit easier when the sun is shining and the birds singing. I for one, am enjoying weekends pottering around the garden and having fresh cut roses in every room. Furthermore, (and you know I had to go here people) Canterbury is basking in the afterglow of a superb NPC trophy win. What an experience to be among the constantly yelling and screaming crowd (from both sides) at Jade Stadium.

I have been enjoying the A&D link on the internet recently. For those of you who don't know about it, the A&D link (http://lists.netlink.co.nz/mailman/listinfo/aandd) is an email discussion group around alcohol and drug issues. As a member you receive any messages another member of the group posts and can reply to the discussion group. A lot of interesting information comes your way with this. In particular, Suzanne Jones of ALAC provides regular updates of research going on here and world-wide. The breadth of study in the A&D field is truly staggering. Many a lively debate is also held in the email discussion group. Topics of debate range from needle exchange programmes to the issues surrounding pregnant women drinking.

TRIG held its AGM at the recent Cutting Edge conference in Napier. As usual it was sparsely, but keenly attended. A new executive committee was elected consisting of Doug Sellman (also elected new Chairperson), Lindsay Stringer, Peter Adams, Meg Harvey, Alistair Dunn, Robert Steenhuisen, Simon Adamson, Gerard Dolan, Lee Nixon and Helen Moriarty.

There was also discussion of TRIG's fragile financial position and whether membership fees should be introduced. This issue is discussed further by Doug in his chairperson's address and the newsletter insert. Vigorous debate was also held over the national research strategy and the role TRIG should play in this. Some talk centered around the strategy maintaining a clinical focus. This lead to discussion on a national organisation to represent professional clinical A&D workers and how this may relate to the National Treatment Forum or APSAD in Australia.

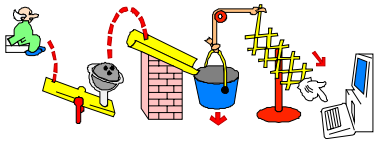
Now to the matters at hand! This issue of TRN is full of updates from the research field. We are starting an update on what is happening in Opioid Treatment, the first column being from David Benton - the Chairperson of the National Association of Opioid Treatment Providers. We are also kept posted by Peter Adams on how the Research Strategy for the addiction realm is going. Another posting comes from Justin Pulford at RADS on what research they have been conducting of late. Doug Sellman additionally provides us with the latest news from the NCTD and a description of a number of PhDs underway there. Doug also settles into his revisited role as the new TRIG chairperson and updates us on where the Group is. Of course we are also faithfully kept informed by Fraser Todd on what is happening in the literature on alcohol and drug treatment research.

"What's new on the street?" takes a break this issue due to the wealth of contributions from the field. With this end of year issue there is a brief report on the Cutting Edge conference held in Napier in September. Sadly, soon after the conference, John O'Hagan passed away and we have included some words to remember John by. There is also a letter to the editor (if only there were more!) that I think raises an important issue in our field – the lack of communication that exists between groups/services. This is also an issue Peter Adams touches on.

I really enjoyed Cutting Edge this year and being able to discuss with so many of you articles for this and up coming issues of TRN. When hunting down articles for the TRN one can be moved to believe there is no research going on out there. However, it only takes sitting through a couple of sessions at Cutting Edge to realise that there is a mammoth amount of work being

done. We have far to go, but should also be proud of how much we are already doing.

Meg Harvey
Editor
20 November 2001



TRIG NAMES & FACES

Cutting Edge gave us a good opportunity to add to the file of photos for Names & Faces. This month we feature Robert Steenhuisen. Robert is from the TRIG executive committee and is the Director of Higher Ground in Auckland.

Robert Steenhuisen

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

IS THE FIELD ASLEEP?

In July, I expressed concern about the lack of any appreciable pharmacotherapy research or pharmacotherapy practice occurring in New Zealand at the current time, in relation to helping people with alcohol abuse / dependence, when internationally, this exciting new treatment development area is surging ahead. Unsurprisingly there have been no New Zealand developments since July, but I have been surprised by the total lack of comment on this issue from anyone. This newsletter goes out to over 4000 people who represent the treaters, funders and policy developers in our field. Does anyone else think there is cause for concern?

The NCTD has been unsuccessful with two previous grant applications to the HRC and ALAC for funding of randomized controlled trials involving naltrexone in the treatment of alcohol abuse / dependence. Both were proposals examining ways of improving naltrexone treatment through the addition of serotonergic agents. The first was to study people 18 years and over with the addition of fluoxetine and the second proposal was to add ondansetron to naltrexone in a sample of adolescents. We have recently submitted a third proposal and this time, instead of adding a further medication to naltrexone, this proposal aims to examine whether providing an individualised dose of naltrexone in the range 25-200mg improves the benefit gained from the standard 50mg dose. This will be a study of 14-34 year olds with alcohol abuse / dependence and in the first instance, half of the sample will be Maori. A Pacific arm to the study is being planned as a Phase 2 addition if the initial proposed is supported. Time will tell.

PhD WORK

The driving force behind research centres such as the NCTD is the stimulation, challenge, energy and hard work of PhD students. Along with current academic staff who are engaged in PhD work, well known to the field, (Fraser Todd, Daryle Deering, Simon Adamson, and Paul Robertson), we are fortunate to have a further five PhD students currently undertaking doctoral research through the NCTD. *Philip Townshend* is investigating conflict in the relationship between health providers and consumers, the ethical issues involved, and the relevant law on treatment. The focus of this work has been a series of surveys within methadone programmes along with in-depth analysis of two judicial reviews. Inappropriate paternalism and the low level of partnership in some programs have been identified as important factors driving conflict. In terms of client variables, underlying cognitive impairment appears to be a more important contributor to conflict than personality disorder in these clients. In terms of staff variables, the lack of knowledge of patients' rights is correlated with conflict. Three publications have been completed and Philip is on track to finish the first draft of his thesis this year for submission in 2002. *Michael Baker's* PhD work consists of a study of spirituality in relation to treatment outcome and has been venued in three residential programmes in Canterbury – Salvation Army Bridge, Taha Mäori, and Queen Mary. The primary question is whether the presence of spirituality either at baseline or developing as part of treatment is important in determining treatment outcome. Baseline data collection is completed (n=90) and the nine-month followup data is more than 70% completed. Over a third of the participants are Mäori and differences between Mäori and non- Mäori in terms of spiritual beliefs at baseline have been noted. Whether these differences are important in determining outcome will be of considerable interest in the final analysis. *Ian Sheerin* is engaged in an economic evaluation of methadone treatment for Mäori and non-Mäori. A primary interest is in investigating potential differences in costs and outcomes for Mäori compared with non-Mäori. The research has begun with completed interviews of 33 Mäori and 50 non-Mäori (randomly selected), who are receiving methadone treatment in Christchurch, obtaining information on drug use, health status, crime, family status, history of utilisation of health services and other outcomes. Preliminary findings are that treatment has been highly effective in a range of domains. It has also been noted that most methadone clients have hepatitis C, but there is low awareness of the diagnosis and the need for monitoring and treatment. Initial statistical modelling work shows that hepatitis C treatment is cost-effective. *Meg Harvey* is studying the effects on cognitive function (memory, attention, concentration) of cannabis use in adolescents. Two hundred adolescents seeking treatment for psychiatric problems will complete a comprehensive assessment of drug use and a battery of cognitive tests including a computerised package known as CANTAB. The relationship between cannabis use and cognition will be analysed in the context of potential mediating variables including personality, mood state and psychiatric functioning. Provisional ethical approval has been given and pilot testing of the interview is largely completed. The interview originally took up to 3 hours to complete, but has been brought down to within 2 hours. It is hoped that data collection proper will commence before Christmas. *Karen de Zwart* has very recently enrolled and begun planning a four-year follow-up of a group of 90 adolescents who had previously presented for treatment at the Youth Specialty Service in Christchurch (a specialist mental

health service for 13-18 year olds) from whom nicotine use data had been obtained. The key questions related to these adolescents are: what is the smoking prevalence rate now? What is the natural history of smoking? What are the determinants of nicotine dependence? What are the interrelationships between nicotine dependence, other drug dependence (particularly alcohol, cannabis and inhalents), other psychiatric conditions and treatment outcome?

The history of our treatment field in New Zealand is almost completely devoid of the presence of PhD level clinical researchers. The fact that this past five years has seen a surge of new PhD students engaged in treatment research projects bodes well for the future.

Doug Sellman
31 October 2001

Currently In Opioid Treatment

Recently I attended the 2001 Summer Clinical Institute of the University Of California, San Diego, and listened to a number of fine presentations. Tom McLellan in particular caught my attention, and placed methadone treatment squarely within the mainframe of addiction treatment. This is important, given some negative feedback at the Cutting Edge that there was "too much methadone".

A summary of that presentation follows: *Problem-service "matching" in addiction treatment (A. Thomas McLellan, PhD).* Over the past 20 years substance abuse treatment researchers have shown consistent, experimental evidence that many of the traditional forms of substance abuse treatment can be effective. Though this conclusion is important, it is not adequate to inform important clinical or social policy questions such as (1) what are the "active ingredients" of multi-component treatments, (2) how long or at what level of intensity should these ingredients be delivered, or (3) how can the public tell good from bad treatment? Treatments can be evaluated using the same scientific methods used by the FDA, school evaluators and economic evaluators. Experimental and field studies in "real world" settings have shown that individual counselling, a few anti-craving medications (methadone, naltrexone), family/couples therapy, social services (housing, job placement, medical care, and psychiatric care) and continuing care (ANNA or continuing group counselling) have been shown to be "active ingredients" of treatment. Most contemporary treatment programs do not have these ingredients in sufficient quality or quantity. Reasons for this include funding restrictions, ideology differences and management problems. All forms of addiction must be viewed as chronic conditions where the patient will either have some symptoms (craving, lower levels of use) or some continuing vulnerability to relapse for many years. For this reason, acute care treatments (detoxification, inpatient or residential care without follow-up, or medication alone) will not be effective. Like hypertension, diabetes and asthma, addictive disorders can be managed effectively and economically with continuing outpatient monitoring and management.

At the same Conference, H. Westley Clark, CSAT Director, spoke about the research and efficacy of Buprenorphine. His general comments actually echo the state of play in New Zealand: it is there, it is available, it works, but it is expensive and there is no indication of when the Government in either country will bow to the evidence and fund it.

In summary he stated: While the ultimate decision concerning safety and efficacy rests with the Food and Drug Administration (FDA), the U.S. Department of Health and Human Services (HHS) has funded many studies that support the safety and efficacy of buprenorphine and the buprenorphine/naloxone combination for the treatment of opiate dependence. During the time the HHS has studied this medication, we have been impressed with its safety and efficacy as a treatment for opiate dependence. Over the last five years HHS has worked with Reckitt & Colman Pharmaceuticals, Inc., under a Co-operative Research and Development Agreement in an attempt to bring buprenorphine (which the FDA has designated as an orphan product), to a marketable status in the United States. These studies have been submitted by Reckitt & Colman to the FDA in support of a New Drug Application for buprenorphine products in the treatment of opiate dependence. The major studies of relevance have shown that buprenorphine is more effective than a low dose of methadone (Johnson et al, J.A.M.A., 1992), and that an orderly dose effect of buprenorphine on reduction of opiate use occurred (Ling et al, Addiction, 1998).

In regard to opioid dependence treatment, a number of topical articles can be found on the Web. Here are two, which stood out to me:

An article entitled: *Methadone medicine, harm reduction or social control (Peter Vanderkloot, Harm Reduction Communication, Spring 2001, and available in its full version through the Lindesmith Center website,* http://www.lindesmith.org) makes some interesting and challenging points. In summary, he has this to say: The reality is this - methadone is a safe and effective medication which has provided immeasurable benefit to hundreds of thousands struggling with the consequences of opioid dependency in a society which has labelled the opioid-dependent criminals. For chronic heroin users living under prohibition, methadone represents the most effective means known of reducing risk. It reduces risk of death due to overdose, disease or violence. It reduces risk of incarceration and homelessness. It can be used at a moderate dose to enable greater control over heroin use, or at a higher dose to cease use altogether. The reality is also this: the system through which methadone is provided is a uniquely oppressive bureaucracy that greatly reduces the benefits of the medication and generates harm where none existed before. Methadone itself is a tool of harm reduction; the system that controls methadone is a system of harm production.

And in the light of the disturbing news about the closure of Needle Exchange Programmes due to lack of funding, another challenging article can be found at the website http://www.hivdent.org/publicp/ppebsotsr062000.htm#sum and is entitled: *Evidence-Based Findings On The Efficacy Of Syringe Exchange Programs: An Analysis From The*

Assistant Secretary For Health And Surgeon General, Of The Scientific Research Completed Since April 1998. After reviewing all of the research to date, the senior scientists of the Department agreed that there is conclusive scientific evidence that syringe exchange programs, as part of a comprehensive HIV prevention strategy, are an effective public health intervention that reduces the transmission of HIV and does not encourage the use of illegal drugs. In many cases, a decrease in injection frequency has been observed among those attending these programs. In addition, when properly structured, syringe exchange programs provide a unique opportunity for communities to reach out to the active drug injecting population and provide for the referral and retention of individuals in local substance abuse treatment and counselling programs and other important health services. The scientific evidence accumulated to date provides a basis on which municipalities that are heavily affected by an HIV epidemic driven by injection drug use should consider syringe exchange programs as a tool for the identification, referral and retention of active users of injection drugs into these services, as part of a comprehensive HIV prevention plan.

David Benton
Chairperson
National Association of Opioid
Treatment Providers.

We are appreciative of the additional sponsorship for this newsletter provided by **Biomed Ltd**, New Zealand.

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 2001/2002 year. I understand this will entitle me to three editions of the Treatment Research News (TRN) and a reduction in the registration fee at the Annual Treatment Conference 2001.

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)

PROGRESS TOWARDS A NATIONAL ALCOHOL & DRUG STRATEGY

We have a lot to learn regarding reducing problems associated with alcohol and drug use, and future planning will require quality information and understanding. We have relied heavily on international research but how well are we equipped to answer questions about our own environment?

Following my presentation at last year's *Cutting Edge* conference on the need for a national alcohol and drug research strategy, I stumbled across the activities of a working group in the process of formulating a research and development strategy for mental health. In response to pointing out that we have a similar need, the mental health section of the Ministry of Health agreed to provide financial support for us to develop a strategy advisory document on alcohol and drug research. From then we decided to develop the strategy in two phases. The first phase engages an advisory group in putting together a discussion document for wider circulation and consultation. The second phase will pursue the consultation and finish with a completed strategy advisory document.

We have so far held three meetings of the Advisory Group and we are in the process of finalising the draft of the discussion document. The document has been divided into four sectors: tobacco, alcohol, other drugs and gambling. It reviews common and unique issues affecting the development of research in each sector. In this update I want to share three important issues that have emerged from the Advisory Group discussions: How broad does our field extend? How much emphasis do we put on priorities? And, in what way should we deploy available development funding?

All-in-together vs Separate Enclaves

Splits within the alcohol and drug field have provided reasons for researchers to work in small enclaves: Public health people remain separate from treatment people; twelve step people move in different circles than harm reduction people; tobacco people have little to do with alcohol and drug people who, in turn, have little to do with gambling people; Mäori seek separation from Pakeha researchers; practitioners keep separate from academics; qualitative researchers cluster separately from quantitative researchers. There are many reasons to divide off from each other.

Over the last few years, I have had the opportunity to move between these different enclaves and it is my impression they have more in common than the reasons to see themselves as essentially different. As far as research goes, they all share common difficulties in obtaining funding, they have troubles maintaining a critical mass of research activity, they struggle to obtain recognition in the broader health sector and they cry out for greater use of findings within policy and agency settings. Given that each sector shares a common policy reference point with the National Drug Strategy, are we not more likely to achieve both greater specialist and collective gains by planning research development as a block rather than in bits?

Priority-Driven versus Negotiated Goals?

At this year's *Cutting Edge* I likened the business of producing research to the operation of a machine. A machine needs its component parts; it needs a purpose and a design; it needs raw material, fuel, maintenance etc. Without these ingredients it is unlikely to come up with the goods. The priority-driven approach treats the machine as an input-output device, where an authority tells it what it should be producing, throws money in that direction and waits for suitable outputs. However, our research machine has tended not to operate well that way: First, the machine itself is not adequately constructed for what is needed; secondly, the key components, the researchers themselves, tend to be independent thinkers and have strong ideas on their own direction; and thirdly, it is unclear who is in the best position to ultimately decide on research priorities. Should it be Government agencies, or the public, or researchers themselves? The "negotiated goals" approach seeks to set up systems where key-stakeholders (researchers, funders, end users, and policy makers) work together in negotiating key priorities. This would require some form of properly constituted co-ordinating committee where not only outputs are negotiated, but the fitness and maintenance of the research machine is examined.

Spring-boards versus Fertiliser

A number of agencies (ALAC, HRC, FORST, MOH) have invested in the development of alcohol and drug research. This development funding has taken the form of programme grants, scholarships, seeding grants, commissioned research and teaching programmes. The "spring-board" approach involves concentrating this investment into one geographically located specialist centre that gathers together available expertise and has enough critical mass to provide the platform for growth. The "fertiliser" approach identifies nodes of promise where research is showing early signs of growth then funding support is provided to assist development. This approach is more organic and has the advantage of promoting multiple centres with differing research methodologies and competing theoretical perspectives. Which model should we employ in the future?

Next Steps

We plan for the discussion document to be available by the end of the year. From there we would aim to distribute the document widely and seek as much feedback as possible on the key issues.

Peter Adams
Applied Behavioural Science
Auckland University

CUTTING EDGE 2001

This year over 300 people gathered at the Napier War Memorial Conference and Function Centre from September 13 to 15 for the 6th

Cutting Edge conference. This is the annual treatment conference on alcohol, drug and addictive disorders. The theme of this years conference was involving family in the treatment of addiction. Overall feedback on the conference was positive. Most people felt the conference met their expectations and people enjoyed the venue and the food.

There were a wide variety of presentations largely around alcohol, but ranging from gambling and cannabis to Pacific communities and methadone maintenance. For the first time the conference featured a Research Stream (sponsored by TRIG) which was well received. Presentations were of a high standard – Ian Sheerin won the John Dobson Memorial prize for an opioid presentation for his paper on Hepatitis C. The John O'Hagan prize for presentations by someone under 35 years was jointly won by Lana Perese for her paper on gambling amongst Samoan people and Meg Harvey for her paper on cannabis and cognition.

ALAC are producing Cutting Edge Proceedings from the conference and TRIG (under the guidance of Doug Sellman) are putting together a Monograph from the research stream.

A Message From The New Chairperson Of TRIG

I've recently taken over the job of TRIG Chairperson from Raine Berry. It must be remembered that prior to Raine becoming Chairperson, she had been the TRN editor for several years. So we owe Raine considerable thanks for her longstanding contribution to both the establishment and the maintenance of TRIG as an ongoing, valuable organisation for the workers and supporters of the alcohol and drug treatment research field in New Zealand. I hope I can now contribute as effectively and I look forward very much to working in this role with colleagues of the new TRIG executive, over the next year or so.

There are two significant issues facing TRIG over the next year or so. Firstly is our ongoing funding situation. Given that this is an issue partly brought about by the discontinuation of a direct NCTD donation at this time, perhaps it is only fair that I get to have this job again! You will find an insert in this edition of TRN inviting members to send in their 2001 membership donation. Explanation about this donation is given there so I'll not repeat it here. Please read this insert carefully and then reach for your chequebook. If we all donate $20 each, all will be fine. Remember, if one of us doesn't send in $20 then another member will need to send in $40. A $60 donation will cover two less fortunate TRIG members. The second issue is the fact that TRIG is one of a number of A&D groups within the overall treatment field. At the National Treatment Forum (NTF) meeting prior to the Napier Cutting Edge Conference, the new NTF executive was charged with the job of exploring the development of a new overriding Society which could have a number of arms to it. One of these arms was suggested to be a research one and TRIG was specifically named as forming this arm. Obviously we don't want to collapse TRIG into a non-existent new Society, but on the other hand we need to be prepared to actively assist the NTF in their exploration of this important issue for the good of the field as a whole.

Since the last TRN in July, Dr John O'Hagan died. For those of us who had the privilege of knowing him, John's warm and encouraging smile will be with us all our lives. But it is his challenge to the field articulated at the Cutting Edge conference in 1999, which must be acted upon ASAP. This challenge was precisely about the same two issues discussed above. He exhorted us to dispense with the "soft" TRIG membership we have at present and establish a proper membership fee. John saw this as each of us making a real commitment to the field. Personally, I think the annual membership donation decision is still pretty soft, but nevertheless a step in the right direction. Secondly, John challenged us to get more unified as a field. It was from the ashes of the former National Society on Alcohol and other Drugs that TRIG arose. However from the outset there has been serious talk of TRIG being just one step towards the establishment of a new Society, which has more than the primary research focus that TRIG has. Maybe the time has come to take the next step. Watch this space and please, contribute any comments or suggestions you have on this or any other issue by writing them down and sending copy to Meg Harvey, our hardworking TRN editor.

Doug Sellman
TRIG Chairperson
31/10/01

Note From The Editor

LETTERS TO THE EDITOR

Dear Meg,

I was glancing at a copy of your Treatment Research News that came to our Department and was curious about something.

In August, the New Zealand Psychological Society brought out from the USA one of America's leading researchers in the treatment of alcoholism and other addictions. This is Professor Damaris Rohsenow, who is a Career Clinical Scientist at the Centre for Alcoholism and Addictions at Brown University Medical School, a senior advisor to NIAAA (NIDA) in Washington DC, and she is a highly published scholar in the behavioural treatment of addictions.

We invited her because we felt that it would be useful for clinical and other psychologists here in NZ to learn something more about treatment approaches, and she gave two workshops, one in Auckland at the annual Society conference, and one in Christchurch.

We were frankly surprised that her workshops created little or no interest around the country in the drug addictions research community, and were very poorly attended.

Thus I am curious. Were your group and others nationally informed of this visit, and if not, I wonder why? Perhaps you can pose this question to your executive committee. Is there some way in the future that people interested in treatment research, particularly work in CBT, can collaborate more effectively with psychologists working in this area?

Thanks for your attention.

Yours sincerely
Ian Evans
Prof. and Director of Clinical Training
Department of Psychology
University of Waikato

As always we welcome letters to the editor and would love to hear what you have to say about TRN and the field in general.

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

TRIG was established in 1997 to promote research in the alcohol and drug field in NZ.

The **executive committee** are: Doug Sellman (Chair), Lindsay Stringer (Secretary), Peter Adams, Meg Harvey, Alistair Dunn, Robert Steenhuisen, Simon Adamson, Gerard Dolan, Lee Nixon, Helen Moriarty.

Please direct **enquiries to Lindsay Stringer**,
PO Box 2924, Christchurch,
Phone (03) 364 0480, email:
lindsay.stringer@chmeds.ac.nz

CURRENT RADS RESEARCH IN AUCKLAND

BACKGROUND

Earlier this year the Auckland Regional Alcohol and Drug Services (RADS) were successful in obtaining 'one-off' research funds to investigate the mental health needs of their CADS client population. At the time, very little information was systematically collected on the mental health needs of clients presenting to the Auckland CADS units, and that which was collected was not readily quantifiable. Funding was sought to remedy this situation as both the research literature (with consistently high levels of psychiatric comorbidity reported among A&D clients) and the concerns of CADS clinicians suggested the need for a clearer client mental health profile.

THE PROJECTS

Once funds were secured for the project, and following an initial scoping exercise, three separate projects were approved. An important guiding principle in shaping these projects was that of 'the least intrusive procedure', i.e. we wanted to collect data in a way that minimally disrupted the clinical environment. As will be evident below, the projects investigate more widely than just mental health, although this remains the primary focus. The three projects are:

Client File Sample:

This is a retrospective sample of consecutive clients reporting to all the Auckland CADS units over a three-month period. Information pertaining to A&D use, mental health, 'other needs', and service use will be collected from standard CADS clinical forms and entered onto an SPSS database for subsequent analysis.

Brief Screening Inventory (BSI) Project:

This project will provide a reliable and objective impression of client mental health distress. The BSI, as the name suggests, is a brief, multi-dimensional, self-report questionnaire that measures distress levels along nine separate dimensions of mental health (N.B. it is not a diagnostic tool). The BSI will be administered in all CADS units for a short period of time to obtain a 'snapshot' view of clients mental health distress levels.

Needs Assessment Focus Groups & Survey:

Following the collection and analysis of the client file data, client & clinician focus groups will be held to discuss the results and allow for client/clinician interpretation and feedback. In addition, the areas of client need (i.e. issues of concern for a client upon presentation to our service), client motivations to seek assistance from our service, and client expectations of our service (in relation to meeting their needs) will be explored. Whilst these groups will provide valuable information in their own right, it is hoped that the results will inform the construction of a client needs & expectations survey planned for wider use in early 2002.

PROGRESS

At this stage, the client file sample is nearly completed, the BSI project is set to begin and the recruitment for the focus groups has begun. The expected date of completion for all three projects is May 2002. Whilst some results will be available internally early next year it is expected that the findings will be reported at the 2002 Cutting Edge Conference.

Justin Pulford
RADS Researcher
E-mail:
Justin.Pulford@WaitemataDHB.govt.nz

JOHN O'HAGAN REMEMBERED

It was with sadness that the field learnt of John O'Hagan's passing on September 23, 2001. Two members of the field have taken time to remember John.

From Geoff Robinson

John O'Hagan first developed an interest in alcohol-related medical complications during his earlier years as a physician in Invercargill. He showed the initiative to be the first author of "Handbook on Alcoholism for Medical practitioners" (ALAC – 1982). This handbook was a standard text in alcohol and drug clinics, medical centres, and for medical students.

John had a wonderful ability for pragmatism, practicality and brevity. John was a true leader with the ability to inspire those around him, and he led with great enthusiasm. He was an excellent communicator and a master in the art of medical education with his legendary efforts from the Post-Graduate Office at the Christchurch School of Medicine. John remained active in medical practice up until about a year before his

death at the age of 70 from cancer.

From Doug Sellman

John has undoubtedly been one of the key forces driving the accelerated development of the treatment field in the past 10 years. His infectious energy and encouragement of both medical and non-medical colleagues is legendary. Of particular note to me was his leadership in transforming the old New Zealand Medical Society on Alcohol and Drug Dependence into the multidisciplinary New Zealand Society on Alcohol and Other Drugs, and his leading role in organising the memorable Autumn Schools, which were the forerunners of the current Cutting Edge conferences.

John had some great personal qualities. He was a humble yet confident man, and ever the optimist. I'm not surprised, but some may be, that despite being a medical specialist, a male and elderly he remained to the end, open to new ideas. I think it will take a number of years for us to realise the significant influence he has had on the development of the A&D field in New Zealand, and continues to have.

I've Been Reading . . . . . .

This time of year always brings lots of new and interesting things to think about. Digesting the rich pickings from Cutting Edge, the buzz of marking exam papers from our Postgraduate students, which always teaches me something new, and issues of some of the major mental health journals which tend to focus more on the addictions about now. With so much else to dwell on, it becomes difficult to pick out research articles from recent journals that have an impact on clinical practice. The temptation is to pick up abstracts and reviews unquestioningly, a dangerous habit at the best of times and something that can lead to wrong assumptions passing into the body of knowledge of the field. So in this column I want to start by highlighting some extremely important papers which, while on the surface of it may appear a little esoteric, but qualify some of our assumptions.

It is assumed that public health measures to reduce the prevalence of cigarette smoking will significantly improve health outcomes. There seems to be good evidence that the number of people regularly using cigarettes has decreased over the past decade in a number of countries and that this has been due in large part to public health measures discouraging smoking. I think this is a reasonable assumption. However, a study by Breslau and colleagues (Archives of General Psychiatry 2001;58:810-816) raises serious questions about the impact this has had on younger users of nicotine who are likely to suffer problems from it – those with nicotine dependence. The study reported that from the 1940's through to the 1990's in the US, the number of daily users of nicotine fell. Nothing new. But the authors also noted that in the 18-24 year age group the prevalence of daily users with nicotine dependence had increased in real terms. There are a number of reasons and Hughes in his comments on the paper immediately after it raises them adequately. The point of this study is that it raises a crucial question about how we look at outcomes and what outcomes we measure. Sure the prevalence of daily nicotine use has decreased, but one plausible explanation for these results is that it may be the non-dependent smokers – those with minimal significant problems from smoking – who have stopped and it may be that the number of those with nicotine addiction has increased. This raises serious questions about the strategies we are using to deal with the biggest alcohol and drug problem we face. It should also be noted in this context that reports from the US in the period after this study suggest that in younger people, the prevalence of daily nicotine use may actually be increasing. It also raises important issues for the role of the alcohol and drug field in treatment for nicotine dependence. Firstly, it is nicotine dependence that is important rather than just nicotine use. It is commonplace to assume that regular use = dependence; not so. Secondly, while public health strategies and brief interventions are likely to help the milder forms of misuse, more intensive interventions undertaken by skilled clinicians are needed for more severe problems. Given that most interventions for people with nicotine dependence are undertaken by workers with little experience in the addiction field; and given the relatively poor outcomes from these interventions; and given that there is a good substitution treatment available for nicotine dependence, its about time the addiction field advocated strongly for it's involvement in treatment for what is probably the most problematic of all addictions.

McCann and colleagues (Archives of General Psychiatry 2001;58:907-908) comment on the current research into the neurological and cognitive deficits associated with Ecstasy use, with special reference to the paper by Reneman and colleagues in the same journal (Archives of General Psychiatry 2001;58:901-906). Reneman's paper presented results indicating that Ecstasy use is associated with persistent cognitive deficits and that these deficits are related to the degree of previous Ecstasy use and may persist for at least 12 months after use had stopped. It is tempting to grasp findings like this, especially when they support our own beliefs, without fully evaluating what the research really means. In this case, as McCann points out, most of the subjects who had used Ecstasy were also users of cannabis, and marijuana use had continued beyond cessation of Ecstasy use. There is good evidence that cannabis use is associated with a range of cognitive deficits. Furthermore, it is still unclear that the measures used by Reneman and colleagues actually do measure what they are supposed to. Reneman's study is thought provoking and adds to the questions raised about neurological damage associated with Ecstasy use. At this stage, it does no more than that and it would be premature and irresponsible to draw firmer conclusions.

The use of an integrated combination of motivational interviewing techniques, cognitive behavioural strategies and family interventions has become standard practice in the area of co-existing substance use and mental health disorders, but there have been few really good studies supporting this practice until now. Barrowclough and colleagues (American Journal of Psychiatry 2001;158:1706-1713) have performed a randomised controlled trial comparing this model of intervention with "routine clinical practice" for a group of patients with schizophrenia and substance dependence. Despite a small sample size, in part due to the high rate of refusal to participate, the study was able to find significant advantages for the integrated combination treatment after 12 months in terms of general functioning, positive symptoms, and rates of relapse. Interestingly, in most measures of substance use there was little significant difference between the two groups, though the small sample size was such that only powerful differences were likely to reach statistical significance.

Fraser Todd
Senior Lecturer
NCTD

Contact Person for Treatment Research News:
Meg Harvey
Phone 364-0480
Email:
meg.harvey@chmeds.ac.nz

Treatment Research Interest Group (TRIG)
PO Box 2924
Christchurch

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Dept of Psychological Medicine
Chch School of Medicine
4 Oxford Terrace