

Treatment Research News

Alcohol, Drugs and Addiction

March 2002

Newsletter of the Treatment Research Interest Group

Vol 6 No 1

EDITORIAL

Well it seems I was premature to be enjoying summer as I wrote the last editorial of 2001. Starting the rugby season in February doesn't seem as strange when it feels like autumn or winter anyway. With the end of daylight savings chilly nights in the Stand are not far off.

Once more we have a bumper issue of TRN to kick off 2002. Looks to be another busy year; I think that it will never look to be a quiet year again. Cutting Edge 2002 in Nelson is steadily approaching. The Proceedings and Monograph from Cutting Edge 2001 are due out any day. Universities are back into the swing of things with lectures and block courses well under way and there have been some lively debates on the A&D link already around residential treatment and adolescents.

TRIG has had its first executive meeting for 2002. As usual one for the big topics up for discussion was funding for TRIG and several alternatives were examined. One option is continuing to ask TRIG members for donations; consequently there is another request from our Chairperson Doug Sellman in this issue. Also deliberated was the research stream at the up coming Cutting Edge and how TRIG is to be involved.

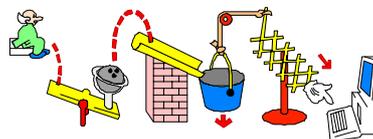
In this issue we have the regulars of Doug Sellman reporting on the NCTD and giving his Chairperson's report for TRIG. Fraser Todd offers up the latest in literature in the A&D field and What's New on the Street? makes an appearance to consider the drugs that may or may not be entering New Zealand. This month the Name and Face of TRIG belongs to David Benton. TRN needs to amend last issues Name and Face - Robert Steenhuisen (a

member of the TRIG Executive Committee) has moved on from Higher Ground and is now at the Problem Gambling Foundation.

We also have two interesting and useful articles. The first is from Anne-Marie Rowe of the Christchurch School of Medicine Research Office offering some helpful hints in filling out grant applications. The second article is from Kyp Kypri of the Injury Prevention Research Unit in Dunedin on his follow-up of university students and hazardous drinking.

Additionally there is a note from the John Dobson Memorial Foundation about scholarships. Finally we have a letter to the editor regarding Justin Pulford's article in the last issue of TRN. As ever comment and discussion on TRN and research in the A&D field are more than welcome. Happy reading.

Meg Harvey
Editor
28 March 2002



LETTER TO THE EDITOR

Dear Editor

I was impressed by the article in the last TRN by Justin Pulford in which he outlined the clinical research being undertaken by him with the Auckland Regional Alcohol and Drug Service (RADS). Justin describes the current research underway as stemming from one-off funding, but in fact RADS deserves credit for

having a history of supporting ongoing research prior to this current set of projects. The size of RADS gives it an obvious advantage in being able to fund such a position, but I believe that RADS track record of clinical research is also a reflection of an attitude amongst management and staff that supports the value of clinically oriented research. A crucial ingredient for success of the RADS approach has been to employ staff to undertake such research as their sole function, thus avoiding erosion of research time due to a high caseload or burnout. Such a position needn't be full-time however, and can be seen as being cost effective where energy goes in to practical research that will have immediate benefits for that service. I hope that Justin keeps us informed of progress and that other services consider the potential for dedicating staff time to research tailored to their own needs.

Simon Adamson
NCTD

TRIG NAMES & FACES

This month's friendly face belongs to David Benton. David is the Chairman of the National Association of Opioid Treatment Providers. David has a clinical load in the Bay of Plenty area.



DAVID BENTON (NAOTP)

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

The NCTD is a University-based academic unit dedicated to the improvement of treatment for people with alcohol, drug and addictive disorders in Aotearoa/New Zealand. The two main contributions to achieving this vision are through the provision of education programmes and undertaking clinical research. These two enterprises are highly interrelated but have different time frames. We expect to see results from the provision of clinically focused postgraduate level papers, as a major contribution to workforce development, within months to a few years. The four postgraduate papers offered nationally by the NCTD are now well established and provide clinicians with a flexible range of opportunities to both increase their addiction and co-existing disorders knowledge as well as upskill in this expanding health arena.

Clinical research, however, in which new treatments and ways of intervening are developed and tested in the New Zealand environment, involves a longer time frame. This work represents a longer-term investment in the development and improvement of treatment for people with addictive disorders and therefore demands a hefty helping of both patience and persistence, not only on the part of researchers, but also on the part of funders. It is not surprising therefore that a key driving force behind the completion of successful and significant research within units such as the NCTD is the presence of PhD research. Some of the NCTD PhD work was outlined in the last edition. The PhD work of four of the academic staff of the NCTD is briefly outlined below.

Fraser Todd is investigating interactions between cannabis use and major mental disorders. The primary data set is that of a prospective study of people admitted for the first time with to the regional acute psychiatric unit. Initial findings are that most people stop cannabis use completely after admission but that cannabis use has different effects on different people. It appears to both reduce mood symptoms in some people and intensify the same symptoms in others. The study points to the interaction of cannabis with mood disorders being both significant and complex, neither of which has been given sufficient attention in the international literature to date.

Simon Adamson is studying psychological predictors of treatment outcome for alcohol use disorders drawing data from two major projects undertaken by the NCTD. The first, the

Brief Treatment Programme for Alcohol Dependence (BTP) provides the opportunity to examine predictors of treatment outcome for a clearly defined and relatively homogenous research sample. The second, the Naturalistic Treatment Outcome Project (NTO) in which a representative sample of people presenting for help allows for the examination of predictors of treatment outcome for a randomly selected, heterogeneous ("naturalistic") clinical sample. It is anticipated that by using similar predictor and outcome measures across two quite different outpatient samples Simon will be able to identify robust predictors that are likely to be relevant in other samples also.

Paul Robertson is engaged in a qualitative study of Māori men recovering from alcohol and drug problems who were initially identified undertaking treatment at a Māori alcohol and drug treatment programme. Along with the final data collection, his main focus currently is further developing and refining his knowledge of discourse analysis and associated conceptual frameworks. This latter process has been significantly aided by his attending a recent conference in Perth entitled "Talking Race and Prejudice: Talk in Interaction". The conference was focused on use of discourse analysis by psychologists and included several leading figures in the area including Jonathan Potter and Derek Edwards.

Dominic Lim is studying the phenomenology and treatment of pathological and other addictive behaviours. The first part of the study relates to co-existing addictive behaviours in a sample of people being treated for pathological gambling. The aim is to explore the relationship between common psychiatric comorbidities and coexisting addictive behaviours and to describe the nature of the co-existing addictive behaviours. The additional addictive behaviours being investigated include use of the internet, electronic games and telephone, as well as buying, compulsive eating and sexual overactivity. The second part of the study will evaluate the treatment of pathological gambling with naltrexone, the same opioid antagonist that has been shown to be effective in people with alcohol dependence. This treatment will be offered to a subgroup of participants from Part one who remain symptomatic with conventional psychosocial treatment. The effect of naltrexone on the co-existing addictive behaviours will be of additional interest.

Mo Pettit is leaving the NCTD

Mo began work at the NCTD as a Research Assistant in 1997. Having been a senior nurse clinician at the Community Alcohol and Drug Service in Christchurch, she brought great skills and perspective to the research position. Mo quickly demonstrated her immense organizing talent and within a year or so she was promoted to a new position titled Project Coordinator, following her completion of a Master of Health Sciences with Credit. Along with Alison Pickering, Mo was the driving force behind the remarkably good follow-up rate in the Brief Treatment Programme study (randomized controlled trial of motivational enhancement therapy), and she has subsequently become involved in the co-ordination and data collection of the majority of research and teaching activities within the NCTD. The most public of these has been her role as part of the Cutting Edge Conference Secretariat (along with Lisa Andrews) over the past 5 years. Mo will be greatly missed, not only for her conscientiousness and very high standards of work but her sharp wit and humour, loyalty to the NCTD team and dedication to the alcohol and drug treatment field as a whole. We all wish her the very best in her new enterprise.

NCTD name change

The NCTD is intending changing its name in the not too distant future. The name "National Centre for Treatment Development (Alcohol, Drugs & Addiction)" has been a fairly cumbersome one and many people still can't easily say the acronym N.C.T.D. With the change in the core funding of the NCTD next year, we feel it is an opportune time to consider changing the name to something that is essentially easier to say while retaining our position as a national academic centre in the field dealing with alcohol, drugs and addiction issues. We view NCTD as having been an important establishment name, which focused us very squarely on treatment development and strongly connected us with the alcohol and drug treatment field. This primary focus will continue but with a somewhat broader perspective. At this stage we favour "National Addiction Centre, Aotearoa/New Zealand" as the new name. However we intend to continue a process of consultation and deliberation, for several months at least, before final decisions are made.

Doug Sellman, 26 March 2002

Injury (unintentional and intentional) is the leading cause of adolescent mortality, and accounts for a substantial proportion of adolescent hospitalisations in New Zealand. Misuse of alcohol is a contributing factor to many such injuries, and is of major concern to government, as reflected in official reports and strategy documents. Accordingly, the Injury Prevention Research Unit (IPRU) initiated the Early Intervention Project, with an overall objective of *developing interventions to reduce hazardous drinking among young people*.

The early phases of the research focus on tertiary students. A proposal was developed in 1999 and funding was awarded by the Health Research Council, the Alcohol Advisory Council, and the Harold Richardson Trust for preliminary research, conducted in 2000. The results of this research led to the development of a proposal for more comprehensive study, including a randomised controlled trial of opportunistic screening and brief intervention. The proposal was included in the IPRU's Program Grant application to the Health Research Council (November 2000), and was approved for funding in June 2001, for the period July 2001 to June 2004. Below is a summary of preliminary results followed by an outline of the proposed work and a timeline.

The Early Intervention Project: Tertiary students

Background

Tertiary students are renowned for their drunken exploits, yet there are surprisingly little New Zealand data available on their alcohol consumption and its consequences. More information is needed on the prevalence and persistence of various student drinking behaviours and related health outcomes, together with the means for accurate identification of at-risk youth drinkers.

In the last two decades there has been a proliferation of brief intervention (BI) technologies with demonstrated efficacy in reducing alcohol consumption and its harmful consequences (see Bien et al. (1993) for a comprehensive review). Such interventions are now being used in some New Zealand healthcare settings for reducing hazardous drinking. BI is most effective when problem drinking is at an early stage and there is some evidence that it can be used proactively, i.e. in the absence of a precipitating condition, such as an injury or heart disease.

Given the high rates of hazardous drinking among youth it is important to consider whether this group can be

successfully targeted with screening and brief intervention. To date there have been only a few studies of such interventions for youth hazardous drinking. Routine screening followed by a brief counselling intervention has been found to yield modest but sustained reductions in the alcohol consumption and related problems among university students.

More recently there have been some studies examining the effectiveness of screening followed by personalised motivational feedback – which required minimal client/clinician contact – and was also found effective in modifying university student drinking. This approach involves assessment of a person's alcohol risk followed by feedback, tailored to the individual and delivered by mail or computer. As a starting point, there is a need for research on the acceptability of such screening and brief intervention to tertiary students in New Zealand. Additionally, it would be necessary to determine the feasibility of conducting a trial of this intervention in a naturalistic setting.

Aims

The aims of the EIP are to:

1. Estimate the prevalence of hazardous drinking among tertiary students
2. Examine the persistence of hazardous drinking among tertiary students
3. Develop and pilot a method of opportunistic screening and brief intervention
4. Implement and evaluate the intervention assessing program reach and accessibility
5. Evaluate the longer term outcome of the intervention

Aims 1-3 were addressed in the preliminary research.

Results of preliminary research

The Alcohol Use Disorders Identification Test (AUDIT) was included in two large surveys of student drinking in University halls of residence (February and August 2000; N=1,529 and 1,748 respectively), for the purpose of determining the prevalence of hazardous drinking and its harmful consequences. The results indicate that 63% of males and 48% of females scored 8+ (in the hazardous range), and 26% of all respondents reported that they had been injured as a result of their drinking.

A series of focus groups was conducted after the first survey to examine students' perceptions of problematic drinking, their interpretation of AUDIT questions, and to explore their views on

a range of intervention approaches. Students expressed concern that they might be unjustifiably considered problem drinkers and were circumspect about talking with a doctor about their drinking. However, many expressed interest in receiving non-judgemental feedback concerning their personal risk and safe drinking levels.

Additional focus groups involving tertiary students were conducted to assess the feasibility of routine screening and brief intervention in the following contexts: the Student Health and Counselling Service; the Halls of Residence; and via email and the World Wide Web. Students were particularly positive about the prospect of completing computerised questionnaires and receiving confidential feedback on their drinking.

Aims 4 and 5 will be addressed in the main study.

Main study

In the main study, a recognised model of program development and evaluation is employed. This model identifies four stages in the evaluation process:

1. *Needs assessment and development of the intervention.* This would include identifying the size of the problem; identifying student/youth wishes and concerns about any intervention, and selection of an appropriate theoretical model(s) to guide any such development (formative evaluation)
2. *Process evaluation of the intervention,* including: (a) appraisal of program delivery, (b) assessment of the quality of methods used (c) determination of whether the intervention reached the intended audience and was acceptable to this group.
3. *Impact evaluation,* which includes an assessment of the immediate effects of the evaluation including: changes in the target group's knowledge, attitudes, intentions, and behaviour.
4. *Outcome evaluation,* which includes an assessment of longer term effects, e.g. hazardous drinking and related problems at 6 and 12 months post intervention.

From July 2004 the intention is to extend the work to other groups and settings, e.g. Accident and Emergency departments, work places, and secondary schools.

Kyp Kypri
Research Fellow
Injury Prevention Research Unit
University of Otago

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 \$ _____

SUBMITTING GRANT PROPOSALS – 'PAIN' RESEARCH ?

Having just completed the 2001 Health Research Council project grant round, I am reminded of how tedious the grant application process is for researchers. As satisfying as it is to receive a grant, there is often a blood-letting process involved in getting to that point - and at the back of one's mind is always, "all this effort, and perhaps a 20% chance of actually receiving a grant". Application forms are becoming more complex, criteria set by funding organisations are becoming more stringent, and host institution requirements appear to be becoming more demanding.

The best advice I can give researchers who are considering submitting a grant application and who wish to avoid some of the panic that is associated with producing one is: *prepare as much as you can in advance, and consult with people who can help*. This is particularly apt advice for researchers who are new to the grant application process, or who have had little success in grant rounds.

"Chance favours only the mind that is prepared" -Louis Pasteur
For new applicants in any grant round, mentoring is important. If you can, find someone who works in your field who can advise you on how best to approach the task. You'll find people are generally willing to offer some assistance if you approach them early enough; conversely, busy people will not look kindly upon anyone who thrusts a proposal under their nose with very little notice. It's best not to bug mentors about budgets and other details unless your mentor is your supervisor or works closely with you. Staff of Research Offices can assist with budgets and other details; mentors can help with the science.

"I thought I sent that already..."
Sometimes the major hurdles encountered are the very matters that appear at the outset to be quite insignificant, like getting CVs, signatures and supporting letters from collaborators. These details are of the utmost importance, and should not be left until the last minute; you'll usually find that

Murphy's Law will ensure that the person from whom you need input has left for overseas for an extended period moments before you try to contact them. Grant applicants should remember the general rule that collaborators will invariably find the task less urgent than you do, and will need **lots of time** to provide you with the documentation you need. An extreme example recently was the anxious researcher who waited more than two weeks for two signed documents and a letter of support from a collaborator, which he had requested a month in advance. It took numerous phone calls to a variety of people before the documents eventually were faxed on the day before the grant application had to be in Auckland. Never assume you will be immune from that type of hold-up.

"You mean there are guidelines?"
Read application guidelines. Follow the instructions to the letter. Although some of the rules appear to be quite tedious and pedantic, there are often good reasons for them which aren't self-evident. For example, character limitations on titles relate to the amount of space available in data entry fields in the funding organisations' databases. Page limitations are to ensure nobody is disadvantaged by another applicant being able to squeeze in an extra page or two. Font size requirements are to save reviewers' eyesight, and to ensure the amount of information supplied on a page is similar for each applicant. It goes without saying of course that much of the information supplied in guidelines is extremely useful, and not following the instructions can seriously harm an application. A good strategy to use when wondering whether some seemingly superfluous rule is necessary, is to remind yourself that the funding organisation has some money that you want, and it isn't obliged to give it to you.

Budget Blues

Just when you think it's almost over - you've been awake for 3 nights in a row while you've agonised over the scientific proposal which you've managed to reduce from eight pages

down to five. You've got everything you need from collaborators and supporters, things are starting to show up with actual signatures on them and you're beginning to feel as if you're getting somewhere, when the prospect of the budget looms like a terrifying spectre. These are becoming more and more complex especially as full cost recovery has become part of the equation for some granting organisations, and even where funding is marginal (i.e. only direct costs are paid, no overheads), the budgeting process contains a huge number of pitfalls. The bad news is that you have to do it right, and around 90 - 95% of pre-checked budgets are incorrect, even those completed by senior researchers. The good news is that staff of Research Offices are grant budgeting experts whose job it is to assist researchers in completing budgets (and other details) on grant applications. Make full and frequent use of these people *prior* to submitting the application and the pain will be much lessened. If you don't have a Research Office at your institution, get a second person (if possible, someone who has been successful in getting grants) to look at it and at least add up your columns of figures.

And please remember, Research Office staff *like* to receive phone calls and email messages from people needing advice about grant applications. We *relish* the opportunity to meet with researchers at your place or ours to go over details and application drafts - this is our core business and what we are here for - please make use of us.

Good luck!

Anne-Marie Rowe
Research Manager
Christchurch School of Medicine and Health Sciences

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MESSAGE FROM THE TRIG CHAIRPERSON

TRIG has now been in existence for nearly 6 years since its inaugural meeting in July 1996. Its primary activity during this time has been the publication of over 20 editions of the Treatment Research News, and more recently, collaborating with the NCTD in producing a first treatment research monograph, following the Cutting Edge conference in Napier, September 2001. These publications have provided an ongoing documentation of New Zealand developments in clinical research as well as the documentation of important international findings and their applicability in the New Zealand context. The newsletters have been widely circulated both within the field, as well as to key and interested people not actively engaged in treating people with alcohol and drug problems. In so doing TRIG has contributed to an ongoing flow of high quality, relevant information about treatment research and helped maintain a strong sense of collegiality amongst workers in the treatment field, during these years of change and upheaval in the provision of alcohol and drug services. TRIG, through the TRN has also been a mechanism for informing people outside the field about treatment issues, from a research perspective. The lack of a strong financial base, however, has limited TRIG's ability to function in any more of a leadership or advocacy role.

In 1996, the New Zealand Society on Alcohol and other Drugs had been "dead" for several years and a small amount of the money left over from the old Society was accessed as seeding money for TRIG. It was also talked about actively at the time, that TRIG may in time develop further back into some type of new Society or Association. Discussions at the Cutting Edge 2001 conference, during the National Treatment Forum day, have sparked renewed interest in this idea; the development of a "peak body" for the treatment field and it is very likely that a new body will be formed within the next 12 months or so. I think it is vital that we as TRIG are actively involved in these discussions so that whatever is the outcome of the proposals and decisions, the goals of TRIG can be continued within the constitution of the body.

The goals 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 in New Zealand;
To support the development of improved treatment services for people with alcohol and drug-related problems in New Zealand.

In the meantime, we've got a job on our hands maintaining TRIG and its primary function of producing three newsletters a year, while, now, also supporting the publication of the second New Zealand treatment research monograph which will follow the Nelson Cutting Edge conference, in collaboration with the NCTD. To do this we need money. Remember from the last TRN, we have decided to operate a donation system like that in State schooling. Officially, like State schooling, membership of TRIG is free. However, like State schooling, we now actively invite members to contribute an annual donation. No donation and you can still go to school and be a member of TRIG, but hopefully you may feel a little guilt at not being more actively supportive and do better next time. You will see the previous annual donation insert has now become a regular half-page feature in TRN. The TRIG membership is now 367. Only 21 (5.6%) have responded so far. If you are one of the 94.4% of TRIG members who have not yet responded, reach for your chequebook right now; or if you're not very good at responding to directives, consider meditating over the next week or so, on the good and the not so good consequences of withholding your financial support of TRIG.

Doug Sellman
TRIG Chairperson

WHAT'S NEW ON THE STREET? KNOWING WHAT'S NOT GETTING IN

"What's new on the street?" is aimed at, from time to time, informing clinicians and researchers about what drugs are being used in New Zealand and some information on those drugs. In this issue of TRN we take a look at what Customs has been *stopping* getting into New Zealand. This assumedly reflects what *is* getting into the country and also how patterns of drug demand may be changing.

Something that becomes evident when one reads overseas research in A&D treatment and try to relate it to NZ is that the land of the long white cloud has very different patterns of drug use. A recent American article on Methadone Maintenance Treatment assured opioid and cocaine levels were measured, but made no mention of cannabis. Daryle Deering's recent research with MMT clients in Christchurch has shown that up to 75% use cannabis.

NZ has typically been a country with a different drug culture to the USA, UK and even Australia. We have higher

levels of cannabis use and Ritalin abuse. Ecstasy, cocaine and heroin are meant to be harder to come by, the difficulty increasing the further south in the country you go. Opioid users are seen as mainly using homebake and MST.

But are traditional NZ drug patterns evolving? Are we catching up to other countries in terms of cocaine, Ecstasy and heroin use? The short answer is no - we are no where near the levels of hard drug use seen overseas. However, there is increasing appearance of drugs traditionally scant in NZ.

"Word on the street" is one way of learning what is out there, as is interviewing drug users on what they have been using. Another way to determine which drugs are making their way into NZ is to chat to the Police or Customs and see what raids have uncovered of late.

World-wide the amount of drugs being seized is increasing. In the 2000-2001 year Customs processed almost 7 million air passengers and crews and

the passengers and crews of nearly 3000 ships. Here heroin and cocaine seizures are low enough to indicate that perceptions of these drugs being scarce in NZ are true. In 1998 Customs seized \$50million of heroin, but this was in transit destined for Australia. Cocaine seizures have been small too, though a distribution ring was broken in Dunedin last year (against expectations?). Customs has raised minor concern over the importation of Khat, a Class C stimulant traditionally used by East African communities.

The biggest concern Customs raises is in regard to Ecstasy. This drug is being seized more frequently and in larger quantities (such as the 25,000 tabs in a Belgian gearbox in January of 2001) indicating an increased demand for amphetamine-type substances. Given recent findings of potentially permanent brain damage inflicted by ecstasy this would seem to be a trend to be aware of.

Meg Harvey
NCTD

JDMF SCHOLARSHIPS

Annually up to three scholarships to the value of \$1000 each are awarded by the John Dobson Memorial Foundation (JDMF). These scholarships are awarded to people who are judged to present the best application in furthering the aims of the JDMF. The JDMF was set up following the death of Dr John Dobson in 1998, to perpetuate the values, energy and personal qualities he brought to bear in the care and treatment of people with drug and alcohol and broader mental health problems, and to the public advocacy of their plight.

The two main aims of the JDMF are:

1. To foster the professional development and leadership potential of people working in the drug and alcohol and broader mental health fields in New Zealand, including clinicians, teachers, researchers, consumer advocates, managers, policy developers and primary care workers;
2. To foster ongoing development of treatment services for people with drug and alcohol related

problems in New Zealand, through supporting a variety of activities including teaching, research, policy development and consumer advocacy, which combine a scientific approach and a focus on individual patient needs.

This year two John Dobson Scholarships of \$1,000.00 each were awarded to:

- Karen de Zwart (Christchurch) is doing her PhD – *“Nicotine Dependence in Psychiatrically Disordered Adolescents”*
- Sally-Ann Hammond (Palmerston North) is currently studying towards a Diploma in Heke Matauranga Mauriora which will enable her to work with people and their whanau who are experiencing alcohol and drug related problems. She is also a volunteer worker and driving force behind the new “consumers for consumers” initiative Te Whanau Manaaki O Manawatu Trust

Scholarship applications for 2002 are available from Mo Pettit, c/- NCTD, Terrace House, Christchurch School of Medicine, PO Box 4345, Christchurch. Applications will close on September 30th, 2002 and a decision made by November 10th, 2002.

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**,
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 Phone (03) 364 0480, email:
 lindsay.stringer@chmeds.ac.nz

ANNUAL MEMBERSHIP DONATION

In our December 2001 issue of Treatment Research News, we informed our members of the decision made at the TRIG AGM at the Napier Cutting Edge 2001 conference that a system would begin of annual membership donations, rather than establish a formal membership fee. This decision was made in response to the NCTD discontinuing its seeding funding to TRIG and the need to receive \$6,600 to fund three editions of the TRN each year.

Thank you to those who responded. For those who did not get an chance to respond, we give you another opportunity to do so. Below are the details to include with your 2001/2 donation.



As an ongoing member of TRIG, I wish to make the following donation for 2001/2, in order to support the ongoing work, especially publication of three editions of TRN over this next 12 months.

\$10
\$20
\$30
\$40
\$50
>\$50

(Please choose one and enclose a cheque made out to the Treatment Research Interest Group and post to Lindsay Stringer, Secretary, Treatment Research Interest Group, PO Box 2924, Christchurch with YOUR name and address).

Let's be honest, summer isn't the best time to keep in touch with the latest offerings from the addiction literature and there are times when we all delve into esoteric areas that may not be of interest to many others - such as the molecular bases of the actions of cannabis! So the pickings for this column are a little thin. Nevertheless, there are a number of recently published articles that I think will be of interest and that I will briefly outline.

One of the more important emerging debates in our field is the relationship between cannabis use and depression. Clinical views differ on whether cannabis causes depression or improves depressive symptoms. Three recent epidemiological studies have added to the debate. The first two are cross-sectional in design and therefore are unable to cast light on the direction of causality; in other words, does cannabis cause depression or does depression lead to increased rates of cannabis use. Rey and colleagues (*British Journal of Psychiatry* 2001:180:216-221) report on findings from Australia's National Mental Health and Wellbeing Survey. Thirteen to seventeen year-olds and their parents were questioned about a range of mental health measures. Twenty-five percent had tried cannabis, 11% had used on more than 10 occasions, and 3% on more than 100 occasions. The study found a significant association between cannabis use and depression, as well as between cannabis use and disruptive behaviours/conduct disorder as might be expected. Conversely, Degenhardt and colleagues (*Addiction* 2001:96; 1603-1614) reporting on results for all age groups from the same study found that cannabis was not associated with anxiety and depression when demographics, neuroticism and other drug abuse was controlled for. The third study by Bovasso (*American Journal of Psychiatry* 2001:158:2033-2037) took a longitudinal perspective by comparing baseline epidemiological data from the Baltimore site of the ECA study with follow data collected 14 - 16 years later on the same subjects. Their findings indicate that for those people without depressive symptoms at baseline, those with cannabis abuse were 4.49 times more likely to develop depressive symptoms in the ensuing 14 - 16 years than

those without cannabis abuse. This study could not indicate whether cannabis abuse caused the increased rate of depressive symptoms or whether some common factor, that was associated with the onset of cannabis abuse, also predisposed people to the later development of depressive symptoms. The study did exclude such factors as alcohol abuse, age and life stresses. Overall, these studies inform the debate regarding the relationship between cannabis and depressive symptoms, and add some weight to the view that cannabis may lead to depression. I must admit that my clinical impression remains to the contrary; that cannabis use improves the symptoms of major depressive disorder, and a number of my colleagues also support this view. The issue remains far from clear and the message at this stage must be to make no assumptions based on the findings of isolated studies.

A similar national epidemiological survey of psychiatric morbidity has been undertaken in the UK. Farrell and colleagues (*British Journal of Psychiatry* 2001:179:432-437) discuss the results of the study from the perspective of nicotine, alcohol and drug dependence and psychiatric comorbidity. This paper may be worth looking at, but unfortunately I couldn't bring myself to read beyond the third paragraph in which they described their "national survey" as representing all of Great Britain except the Highlands and Islands of Scotland! Hmm, a bit like a national survey of New Zealand that forgot to include Otago and Southland!

The misuse of amphetamines has always been much more prevalent in Australia than New Zealand, but amphetamine dependence certainly appears to be on the increase here. It is timely therefore that two recent Australian studies do more than simply identify rates of misuse, and actually examine strategies for doing something about these problems. Baker and colleagues (*Addiction* 2001:9:1279-1287) compared a two to four session CBT approach consisting of motivational approaches and skills training, with a control condition where patients were offered a self-help booklet. Both groups reduced their amphetamine use, suggesting some gains may be achieved through brief self-help

interventions, but the CBT group reduced their use significantly more and showed significantly more abstinence at 6-month follow-up. Thus, there is empirical support for a two to four session CBT based intervention for amphetamine abuse.

Shearer and colleagues (*Addiction* 2001:9:1289-1296) reported on a pilot study of a randomized controlled trial of amphetamine substitution therapy compared with counseling. This pilot was unable to provide clear results, though patients did appear to have a preference for counseling based approaches. However, that an RCT of amphetamine substitution therapy prescribing is planned indicates the direction in which treatment approaches are heading.

Finally, if you haven't subscribed to the A+D netlink, you will be missing the excellent service provided by Suzanne Jones from ALAC in bringing to peoples attention recently published articles of interest to the alcohol field.

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