Treatment Research News

Alcohol, Drugs and Addiction

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EDITORIAL

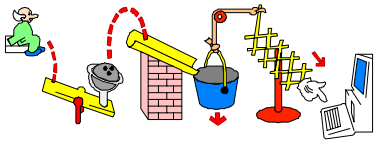
After the late summer we experienced and the continuing unseasonably warm weather I refuse to make any more seasonal predictions. I will however estimate that the A&D community will continue to be as busy and challenging as it has so far in 2002. The National Treatment Forum, Ministry of Health, ALAC, NCTD and A&D Link have all been pumping with changes and evolution. Almost as exciting as the Tri-Nations is shaping up to be!

The A&D treatment sector is in a phase of reorganisation and it is pleasing to be able to report on some of the changes and ensuing research in this issue of TRN. Peter Adams has written a report on establishment of the Centre for Gambling Studies in Auckland. Dominic Lim from Christchurch also writes about gambling problems and where this emerging field is currently at. Ian MacEwan writes about Treatment Evaluation research and Alistair Dunn has an update of some pharmaceutical interventions. We also have a report from Karen De Zwart on her Masters thesis topic around smoking cessation.

TRIG has had it's second executive meeting for 2002. The continuing funding issues mean that TRIG is likely to wind up at this years AGM and Doug Sellman gives more detail of this in his Message from the Chairperson. As always we also have the familiar regularity of Doug Sellman reporting on the NCTD and Fraser Todd offering up the latest in literature in the A&D field. This month the Name and Face of TRIG belongs to Alistair Dunn.

As is outlined in the Message from the Chairperson, TRN is likely to come to an end after this years Cutting Edge conference in Nelson. We are hoping that we will be able to bring you one more issue of TRN to report on the conference and wrap up the newsletter. So that means that you only have ONE chance left to have your opinion expressed or bring an issue to the fore in a Letter to the Editor! In the meantime happy reading.

Meg Harvey
Editor
26 July 2002



CURRENT PUBLIC KNOWLEDGE AND ATTITUDES TO TOBACCO SMOKING AND SMOKING CESSATION TREATMENTS

The following research was conducted by Karen De Zwart as a Masters thesis. The study consisted of a telephone survey of 250 individuals randomly selected from the Christchurch Electoral Roll and assigned into one of three groups: current, ex and life-time never smokers.

Significantly more current than ex-smokers cited habit as a major reason for continuing to smoke and a greater number reported using nicotine transdermal patches during a cessation attempt. Fewer ever smokers than never smokers stated health as a likely major motivation for cessation by smokers and believed doctors' advice and illness of a significant other highly influenced quit attempts. The survey found 55.7% of respondents believed nicotine patches to be the most effective smoking cessation method followed by "cold turkey" (49.4%) and hypnotherapy (33.9%). While the majority of participants supported banning tobacco advertising (69.6%) banning tobacco sponsorship (59.6%), lower insurance rates for non-smokers (89.1%) and fully subsidised smoking cessation programmes (71.9%), significant differences were detected between groups regarding attitudes to tobacco control initiatives.

This sample were relatively ill informed regarding smoking practices in New Zealand and unaware of useful information to aid cessation. While evidence emerged to support current smokers being slightly better informed regarding proven strategies for cessation than ex-smokers, generally few current smokers were aware of efficacious interventions for smoking cessation.

TRIG NAMES & FACES

Alistair Dunn works at the Whangarei Alcohol and Drug Service and has been a member of the TRIG executive committee.

Our credibility as a treatment field here in New Zealand depends on two main things. Firstly it depends on our ability to deal with the most complex cases that present clinically. This requires an expert clinical workforce. Thus the emphasis given by the NCTD to clinically orientated postgraduate courses on Addiction and Co-existing Disorders. Secondly, our credibility as a field depends on our ability to advance knowledge in New Zealand relevant to the clinical work we are engaged in. This is the clinical research domain, and it similarly requires an expert clinical research workforce.

Building a clinical research workforce takes time. In fact it takes a considerable amount of time, when as a field we are starting virtually from scratch. Decades is the appropriate timeframe to think within. It is not until we have a consolidated group of appropriately trained and experienced researchers who are regularly publishing research in internationally recognized journals, will we be able to say "we've arrived!" as a field.

A Masters degree involving a research-orientated thesis is the starting point for training as a researcher, although a PhD is generally considered the benchmark qualification. A key marker for the success of a PhD, which is not as necessary a requirement for a Masters degree, is the production of original and publishable research. The minimum full time required for a PhD is two and a half years (within the University of Otago), but most students involved in clinical research PhDs complete the degree part-time, which is a minimum of five years. A PhD is a supervised doctorate, so not only is the time commitment (including financial considerations) a major barrier for many, the relative absence of qualified supervisors is also a serious issue for our field.

As most know, the NCTD is into its final 18 months of the ALAC core funding and a transition is now being negotiated. Where we will be in two years time is an unknown. Undoubtedly, one of the key successes of the NCTD has been the numbers of PhD students who are currently enrolled in a variety of alcohol, drugs and addiction projects and over the next few years will be graduating. Progress reports of these pieces of work have been highlighted in this column over the past few years.

As this may be the last TRN, the end of an era is in the air and it is pertinent that the first PhD directly associated with the NCTD is now only a few months from submission. This is the work of Phil Townshend, who is well-known in the field and currently works as a clinical psychologist in Nelson, including sessions at the Alcohol and Drug Service of the Nelson/Marlborough Health DHB.

His thesis will be titled "Conflict in opioid substitution programmes: A preventative ethics approach" and he provides us here with an early overview of his work of the past five years.

Phil Townshend

Preventative ethics involves the recognition of the potential for ethical conflict in all human social situations including health care and the ethical justification of strategies designed to prevent conflict from occurring and for managing it where it does occur. Conflict between consumers and providers of health care is not uncommon. In opioid substitution treatment there may be more conflict than in mental health generally and when it occurs this conflict may be more intense. I have identified a number of sources of conflict in the provision of health care in general including, an increasing value placed on pluralism and individualism, technological changes and the cost of treatment.

I have examined conflict in opioid substitution treatment through two types of data. The first is through case studies taken from various programmes in New Zealand. These are not necessarily extreme cases. They are included because they each provide unique opportunities to examine the kinds of conflicts that occurs in opioid substitution treatment along with the kinds of issues that arise and the dispute resolution methods used in resolving this conflict. With conflict in opioid substitution treatment thus framed, the second data type is presented through three pieces of research investigating various aspects of this conflict in opioid substitution treatment. One source of conflict identified is the ignorance of providers regarding the rights of clients. This blind spot in the vision of providers is revealed in data from a telephone survey of providers of Alcohol and Drug Treatment Services and when these data are compared with data from a general sample of health providers the possibility emerges that ignorance of the rights of clients is widespread amongst the providers of health in New Zealand.

The second survey examines the clients' perspective of opioid substitution treatment programmes. This is achieved through a census of clients that identifies a number of potential sources of conflict in the structure of programmes and reveals that approximately half of clients are dissatisfied with their treatment. The main predictor of dissatisfaction is found to be the length of time clients have been on the programme. The final survey (also a census) examines the effectiveness of informed consent in opioid substitution treatment. The data from this survey suggests that the main emphasis in informed consent is on the rules of the programme whereas from an ethics perspective this emphasis should be on the risks and benefits of the treatment.

Finally, I have explored the ethical issues in the way opioid substitution treatment is currently offered in New Zealand and make a number of suggestions for changing the structure of this treatment to improve the provision of it from an ethics perspective. A key change identified is for providers to separate the informed consent clients give to the lifestyle aims of programmes from consent clients give to the pharmacological aspects of opioid substitution treatment. At present both consents are simultaneously obtained and from the desperate client's perspective this may constitute consent obtained under duress.

I would welcome any comments but can't guarantee quick replies in the next few months as I finish writing up and submitting.
Email: townshendfamily@xtra.co.nz

Doug Sellman
15 July 2002

SETTING UP THE CENTRE FOR GAMBLING STUDIES, UNIVERSITY OF AUCKLAND

Gambling consumption in New Zealand has escalated over the last decade. Annual gross turnover in New Zealand has crossed the ten billion dollar mark. The increase is propelled by greater availability of new forms of gambling, particularly continuous forms of gambling such as electronic gambling machines ("pokies"). Over half the money we lose is done so on pokies. Despite this proliferation we know little about the medium- and long-term consequences of sustained higher levels of gambling on our quality of life. Where is this taking us? How will it interact within the social and economic fabric of our communities? How will our younger people grow up and cope in a society with high consumption of gambling. We currently have few sources of information. Future management of the positive and negative aspects of our intensified relationship with gambling will require knowledge and understanding based on quality research. The Centre for Gambling Studies was established with the aim of bringing together a critical mass of researchers, teachers and practitioners who will progress our understanding of the impact of gambling on our quality of life.

Over the last five years, several researchers associated with the Faculty of Medical and Health Sciences at the University of Auckland have pursued a variety of small research projects on gambling. With increasing demand for information on the impacts we became increasingly aware of the need to develop a more substantial platform for research productivity. We identified the establishment of a Centre as a means to create a sufficient critical mass for sustained quality research programmes that advance our understanding of gambling behaviour and its effect on people. In May 2001, the meeting of the Faculty of Medical and Health Sciences approved the formation of the Centre. Its establishment was announced publicly at the Second International Conference on Gambling held in Auckland in July 2001. The location for the Centre in Grafton was formally opened by the Deputy Prime Minister, the Right Honourable Jim Anderton, on 26th October 2001.

The Centre is nested in the Faculty's Discipline of Applied Behavioural Science from which the post-graduate programme in alcohol and drugs and mental health are run. The Centre defines its vision and purpose as:

. . . to undertake quality research to minimise harm from gambling and promote community wellbeing

This statement signals the Centre's intention to not only address harm from gambling as a specific issue, but also to pursue strategies that build the strength of communities to live with high intensity gambling. An executive board of eight directors oversees the Centre's activities. Each director will manage the development of research in their sector with input from an advisory committee. The director portfolios include the following: public health research, treatment research, policy research, Mäori research, Pacific research, Asian research and external relationships. The Centre has established an external advisory committee involving academics and researchers from other New Zealand Universities who have an interest in gambling research.

The three medium term objectives of the Centre are to:

- Establish a critical mass of research activity and skilled personnel to maintain a viable and identifiable research centre.
- Attract funding for ongoing research projects into the impacts of gambling on individuals, families and communities and approaches for dealing with these.
- Continue to establish relationships with universities and other research institutions both in New Zealand and world-wide.

The directors and research staff of the Centre have an extensive background of research in the public health, policy and gambling fields. They are particularly keen to collaborate with people on research into the social and economic impacts of gambling on Mäori, Pacific, Asian, youth and older people. The Centre is active in organising a number of special events. In March it ran a national two-day workshop on responsible gambling and will be holding an international conference in February 2003. Other activities include the hosting of visiting professors, research seminars and training programmes. If you are interested in the activities of the Centre, you are more than welcome to visit, alternatively you may wish to visit our website and make contact with the director active in the area you are most interested in.
Phone: 368-1520
Website: www.gamblingstudies.co.nz

Peter Adams
Director Centre for Gambling Studies

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to what is considered as more urgent assessment, clinical and advocacy needs as opposed to equally vital treatment and research development.

The current areas of interest in gambling research seem to be on youth and problem gambling, on the impact on family and psychological mechanisms associated with gambling behaviour, while moving away from epidemiological related work. Quality treatment research remains few and scarce, despite more than twenty years of research development in gambling behaviour, and there remains huge knowledge gaps waiting to be explored and bridged. New research tools are being developed which may not be disseminated to different centres and countries quick enough. This may further compound problems with meaningful comparisons of research findings.

As in any evolving field, it is easy to lose focus on treatment co-ordination and overall direction. The tremendous challenge of meeting diverse needs while maintaining co-ordination and collaboration to achieve a collective overall perspective may also be difficult to meet. In addition, treatment and research direction seems to remain unclear at the moment as well,

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HARM MINIMISATION & PROBLEM GAMBLING-STRATEGIES AND IMPLICATIONS

Problem gambling is fast becoming a public health issue globally. As awareness heightens and the magnitude of gambling problem enlarges, the potential multi-fold increase in the newly identified problem gambler population and in help seekers are likely to strain already resource-scarce services. Hence, the focus of intervention focus will likely shift from an abstinence / treatment based model to one of harm minimisation.

The concept of harm minimisation is not new to the drug and chemical dependence arena. For problem gambling, it has a wider implication in view of the fact that legislation, public policies, research and treatment strategies seem to trail behind the rapid proliferation of gambling activities and their wide exposure to broad sectors of the population. Promoting harm minimisation therefore requires urgent, concerted, systematised approaches and wise utilisation of limited human and material resources. Government authorities, legislators, the gambling industry, consumers and treatment providers all play important roles in the successful implementation of harm reduction strategies. Through consensus and ongoing collaborative association of all parties, hopefully trust may be nurtured while suspicion diminished.

Some alarming and worrying facts concerning problem gambling include: an increased prevalence of youth gambling, earlier exposure and introduction to video gaming and gambling, the impact of familial/ environmental influence of current gamblers on their family, collaboration of gambling and the liquor industry in mutually beneficial business arrangements, and failure and slowness of legislation in curbing ever increasing gambling outlets and activities. Acceptance and popularisation of gambling has resulted in it being viewed as a legitimate introductory activity into adulthood. Rampant proliferation of internet, online gambling opportunities, poker machines and casinos continues to threaten effective surveillance and regulation of the problem. Furthermore, rapid disappearance of and lack of definition of gambling products impede effective information gathering before licenses are being granted. Most countries in the world that endorse gambling as legal activities adopt varied legislative controls over gambling operators.

In view of the above, effective harm minimisation strategies should therefore be multi-pronged in approach and comprise the following essential elements:

A re-orientation of health services to incorporate both broad-ranged prevention programmes and specific treatment facilitation for existing and emerging problem-gambling groups.

In reality, in many countries, services are often haphazardly and inconsistently planned and organised, partly due to a lack of scientific, demographic and prevalence data and unavailability of accurate, up-to-date statistics. It is common-sensical to target the problem population, employ a public education approach, and institute secondary and tertiary preventive strategies, aimed at raising awareness, producing cognitive and attitudinal shifts; and promoting behavioural changes. However, health funding issues, distribution of resources and competition for funds invariably slow the process of effective service provision. The promotion of responsible gambling in some countries, though attractive conceptually, also remains largely unknown in terms of its effectiveness amongst at risk populations. Therefore, a balanced, broadband focus to slow down the growth in gambling is often required, instead of focusing only on selected gambling modalities or at risk population groups.

Identification of risk and protective factors associated with gambling

To date, there remains very little information regarding etiological factors contributing to the development of gambling. Epidemiological data are often limited by problems with the representativeness of sample populations and the various studies suggest different at risk populations such as the indigenous peoples, youth, women, unemployed individuals and those with earlier and familial exposure to gambling. Availability of gambling outlets co-relate with gambling prevalence. Personality factors contributing to gambling include low harm avoidance and high thrill seeking traits. Protective factors associated with gambling remain largely unknown. Thus, continued research in this area would, one hopes, increase knowledge and understanding which would aid harm minimisation strategies.

Effective, and swift legislation changes against the rising tide of gambling

The implementation of the above would take political determination and foresight, as well as commitment to reducing dependence on gambling derived revenue sources. The economic gain from gambling revenue should not be at the expense of other social opportunities and social costs, which include loss of jobs, output and working days; indebtedness, mental disorders, psychological distress and family dysfunction. The long term impact of unchecked gambling opportunities beyond the sustainability of a nation is likely to be major and costly to the general public. A luke-warm government that equivocates over gambling issues, compromised regulators that are reluctant or unable to enforce the rules, policies driven by hidden agendas, a gambling industry that pays lip service to the notion of social responsibility and gamblers who want more from nothing are certainly factors working against effective implementation of harm minization strategies. Unfortunately, this is one area into which clinicians may be unwilling or unprepared to venture, preferring to stick to conventional clinical niches. Paradoxically, they are the people with the expertise to advocate sound and meaningful dialogues with legislators, with a view to bringing about attitudinal and legislative changes.

Coordination of research and treatment strategies

Treatment of problem gambling is itself an emerging and evolving field in New Zealand. Existing alcohol and drug treatment services can and should no longer ignore the co-existence of gambling addiction although current funding for both services remains separate. Within the gambling treatment arena, competition for funds is likely to intensify from different treatment providers and agencies, catering for the ever-increasing and diverse needs of different ethnic groups and sub-populations. Priority may be allocated

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MESSAGE FROM THE TRIG CHAIRPERSON

TRIG has now been in existence for six years since its inaugural meeting in July 1996. Its primary activity during this time has been producing regular editions of the Treatment Research News (TRN), and collaborating with the NCTD in producing a first treatment research monograph, following the Cutting Edge conference in Napier, September 2001.

However, the financial position of TRIG is dire and there is only enough money left for one more edition (ie this edition) of the Treatment Research News, with no immediate prospects of improvement. A call for an annual voluntary membership fee to be paid has yielded only $960, which pays for about half the cost of producing and distributing one edition of the TRN. Further, ongoing sponsorship from pharmaceutical and/or other companies has not been able to be secured. At the most recent Executive Committee meeting, the future of TRIG was discussed and a decision was made, to propose at the upcoming AGM of TRIG at Cutting Edge 2002, for TRIG to be wound up.

This may not be a bad thing, because there is now considerable enthusiasm building for the development of a new Association within the treatment field. TRIG developed out of the ashes of the old New Zealand Society on Alcohol and other Drugs which had recently folded and from the outset it has been anticipated that TRIG might help to bridge the gap to the renewal of such an organisation. It appears that time has come.

The future of TRIG within the context of the development of the new Association will obviously be the key item for discussion at the upcoming AGM in Nelson.

In the meantime enjoy this newsletter; it may be the last, although the current Executive remain hopeful that in the event of the proposal being accepted at the AGM, that monies will nevertheless be found for a final TRN following the Cutting Edge Conference this year.

Doug Sellman
TRIG Chairperson
10 July 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**,
PO Box 2924, Christchurch,
Phone (03) 364 0480, email:
lindsay.stringer@chmeds.ac.nz

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5. The cost-effectiveness of meeting health needs by funding pharmaceuticals rather than using other publicly funded health and disability support services
6. The budgetary impact (in terms of the pharmaceutical budget and the Governments overall health budget) of any changes in the pharmaceutical schedule
7. The direct cost to health service users
8. The Government's priorities for health funding, as set out in any objectives notified by the Crown to PHARMAC, or in PHARMAC's Funding Agreement, or elsewhere

Please also let Baxter know if you have sent in a submission.

2. Buprenorphine

Company: Reckitt Benckiser (contact: Louise Rushworth; louise.rushworth@reckittbenckiser.com)
Product: Subutex and Suboxone

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: Still unavailable. An application was made to MedSafe in March 2001 to admit Buprenorphine into NZ. MedSafe declined Subutex (citing concerns about its abuse potential in NZ - given Temgesic hx in past) and Suboxone (citing concerns about the pharmacological stability of the combination - also rejected by equivalent Australian body). ReckittBenkiser are currently preparing another application. They are also waiting for FDA in USA who are currently considering Suboxone, if approved this would provide a powerful precedent.

What to do ?

a. Submissions to MedSafe addressing their concerns about Subutex
b. Work with Reckitt on their submissions
c. In the future, we should work collaboratively with Reckitt in their application to PHARMAC for funding on the schedule.

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, and proactively play our part to facilitate their introduction.

Please give serious thought to writing to the appropriate people listed above in support of these medications.

Alistair Dunn

SOME IMPLICATIONS FOR TREATMENT EVALUATION RESEARCH

Treatment funders' tendency to be more interested in being seen to provide, than the quality or outcome, has contributed to a low priority being given to service evaluation, and monitoring, especially when incorporating consumer feedback. Moreover the criteria that determines the continuance of a project will often have little to do with any measurable impact on the client and rather more on the project's political value or promotional capacity.

The classical approach to the evaluation of alcohol and drug work is to assess it in terms of formally or explicitly stated goals. It is not usually the business of the researcher to reflect on why the work is or is not achieving its objectives.

I have been mulling much over this recently and given some structure to a number of observations:

1. Not every service is able to be sufficiently clear and specific about its goals and priorities;

2. Knowing that a service does not do what it originally said it would is not of great value to staff, managers or funders, (unless they are keen to close it down) if not attended by some analysis of why not;

3. If the findings of a piece of research are to be generalised beyond its subject then the service concerned must be true to some type or model of approach to treatment that is recognised and clearly stated. Hence given the eclectic approach of most services, studies of them can only comment on the effectiveness of the work in question.

4. A service must be sufficiently well resourced to function as an effective organisation with its particular goals. If it is not then all the research can reasonably conclude is that the service lacks the means to attempt to achieve its goals. Paradoxically the research will probably have cost more than what was needed for the service to do its job properly.

The majority of services are therefore inappropriate subjects for evaluation studies. It might be more instructive for the Ministry and DHBs to systematically describe the treatment systems in each district and the organisational and political relationships that inform purchasing decisions. The complexity of the alcohol and drug treatment task needs recognition, not only from funders and over-managers but by A&D workers as well.

Ian MacEwan
ALAC

YOUR CLIENTS NEED YOU! (TO DO THE FOLLOWING) - UPDATE ON ACCESS TO MEDICATIONS FOR THE TREATMENT OF A&D DISORDERS

In a previous TRN issue I outlined the current availability (or rather lack of it) of four medications in New Zealand: Naltrexone, Acamprosate, Buprenorphine and LAAM. Acamprosate and LAAM still appear a long way off, with neither being currently considered for introduction into NZ by any pharmaceutical company. This article will therefore focus on Naltrexone and Buprenorphine, outlining the current status of each drug, and then suggesting ways YOU THE READER can help lobby to improve access to these medications.

1. Naltrexone

Company: Baxter 0800 229837
(contact Carol Gunther
carol_gunther@baxter.com)
Product: "ReVia"

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 this is still 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. PHARMAC's PTAC committee declined, stating it was "difficult to establish the potential place of naltrexone in the treatment of drug addiction or alcohol dependence", but conceding it "might be successful in specific cases with restricted use". The committee recommended that "PHARMAC staff seek further opinion from specialists in the field of A&D addiction", but to date I don't think PHARMAC have consulted at all with specialists in the field. Baxter have reapplied to PHARMAC, having modified their application and it will be considered on AUGUST 2002.

What to do?

a. Submissions to PHARMAC addressing their concerns. Send to Martin Szuba, Therapeutic Group Manager, PHARMAC, PO Box 10-254, Wellington
tel: 04 460 4990, fax: 04 460 4995
Email: martin.szuba@pharmac.govt.nz

Concerns include:

- the paucity of medications currently available in treatment alcohol problems
- restricting use to A&D specialists will ring fence costs
- for alcohol indication first (evidence stronger)
- only to be used with appropriate proven counselling package
- point out MOH focus on mental health/alcohol/Mäori health

The decision criteria that PHARMAC are guided by are:

1. The health needs of all eligible people within NZ
2. The particular health needs of Mäori and Pacific peoples
3. The availability and suitability of existing medicines
5. The clinical benefits and risks of pharmaceuticals

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Fads come and go. The history of treatment approaches for alcohol and drug problems, as for many other health problems, is one of changing paradigms about the nature of the problems clinicians deal with and therefore ways of dealing with them. While it has often been the beliefs of prominent individuals or groups that have determined which belief system holds sway at any one time, good research is able to temper the biases of powerful lobbies. Well, so long as the good research is adequately evaluated and people are open to the possibility that they may have to change their perspective (read beliefs) in the face of evidence challenging those perspectives.

Brief intervention, case management and early intervention strategies (especially school based education programmes) are three interventions which have become very important in the alcohol and drug field, and which in their various ways command a lot of scarce resources

Wutzke and colleagues (Addiction (2002);97:665-675) have evaluated the long-term effectiveness of brief interventions for unsafe alcohol consumption ten years after the intervention was undertaken. Their Australian multi-site study of 554 non-dependent hazardous drinkers recruited into the WHO collaborative project added confirmation to the evidence indicating that brief interventions significantly reduce alcohol related problems in the medium term (nine months) but is the first good study that looks at the sustained impact of such interventions. Their findings indicate firstly that 5 minutes of simple advice about a subjects alcohol intake compared to that of the general population, highlighting the problems the alcohol use is causing and giving advice to cut down to specific safe drinking limits was more effective than the control condition of no intervention. Further, the addition of 15 minutes of brief counselling on problem-solving skills, exploration of alternative activities and keeping a diary of alcohol intake, and two further counselling sessions over the following six months added nothing to the outcome. Secondly, ten years after the intervention, there were no differences in drinking behaviours and related problems between control and intervention groups. In short, brief interventions can be very brief, and are effective over the medium term (maybe 12-24 months according to some other studies) but have little sustained value compared to the control condition. It is very important to note, however, that the control condition is not the same as no intervention. Controls all received an assessment which involved an initial self-report screening of alcohol and general health related problems, and then questions about general health, nutrition, smoking and drinking habits, a range of blood tests and a baseline assessment which presumably included questions about symptoms of abuse and dependence and other complications of alcohol use. So this study compares the addition of simple advice to this assessment battery, and finds that giving advice makes a difference to drinking outcomes in the medium term but that this is not sustained over a decade. Now, realistically it would be very difficult to do such a study on a control group that did not receive a baseline assessment. You wouldn't have any results to compare the intervention group to. The key issue other than the failure of brief interventions to give added benefit to assessment on drinking behaviour in the long term is that perhaps simply asking people to think about their drinking patterns is as effective as more intensive interventions.

Whether or not case management in its various forms is effective is controversial. A Cochrane review (a meta-analysis of randomised controlled trials using exacting procedures) several years ago concluded that there was not evidence to support case management, and in fact concluded that "case management is an intervention of questionable value, to the extent that it is doubtful whether it should be offered…" . **Ziguras and colleagues** (**British Journal of Psychiatry (2002),181;17-21**) discuss the Cochrane review in the context of their own meta-analysis which included non-randomised controlled studies and used a broader range of outcome measures, which found significant benefits from case management approaches. Their support of case management may provide some relief to those clinicians working in systems which embrace such an approach. However, at best the efficacy of case management must be considered unproven.

Most early intervention strategies for substance use in younger people involve education about the harms of drugs delivered close to the age at which most people initiate drug use. Considerable financial resources are devoted to such programmes despite numerous studies which question their effectiveness. **Spooner and Hall's** editorial **(Addiction (2002);97:478-481)** discusses the issue of drug use prevention from an evidence base drawn from research on the aetiology of problematic drug use, on childhood developmental and on macro-environmental influences. They reiterate the need for drug prevention programmes to address specific known risk and protective factors for a range of problematic behaviours which includes drug use and which is delivered much earlier than adolescence. Of equal importance is the point they make about macro-environmental factors. Specifically, many of the important social factors acting on a public health level appear to be broader than those focused on in addiction research. These include the increasingly wide socio-economic gap between wealthy and poor, education and employment issues, safe and well policed physical environments and the weakening of shared social values by the emphasis on individual liberty. This makes sense to many clinicians working with young people with substance use problems, where a general lack of social cohesion seems to lead to a lack of meaningful connectedness and sense of place in society and therefore a sense of alienation. The subsequent disconnectedness from pro-social attitudes and role models seems to be an important factor in a range of problematic behaviours in younger people, including substance use.

How effective are these interventions? Do they deserve the resources put into them at the expense of other approaches? And further, who precisely are they effective for? Are they designed to make the people seeking help for substance use problems feel better or are they really serving to make clinicians, managers, politicians and parents feel like they are doing something about alcohol and drug problems? My belief is that some are probably effective, some need tweaking to make them enduring and others serve merely to make people other than those seeking help feel they are doing something beneficial

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regardless of the effectiveness of what they do. Good evaluation and dissemination of the literature that exists and then new research for further clarification is likely to provide some clarification. Whether or not that will influence the prominent individuals and groups who control the resources is another issue.

There have been several other interesting papers published over the past few months which I will briefly mention.

Several studies have suggested a suspected shared aetiology between nicotine use and depression. **Dierker and colleagues (American Journal of Psychiatry (2002);159:947-953)** report on their study of the association between depression and cigarette smoking, exploring the apparent common aetiology between these two conditions and finding that there is evidence for a shared genetic aetiology between nicotine use and dysthymia and mild depression but not for more severe depressive disorders.

Most studies of the effectiveness of anti-craving drugs such as naltrexone and acamprosate have combined medication with psychological interventions such as CBT. Perhaps this has something to do with the ethics of not offering treatments that have been shown to be effective (CBT for example) when using medication, but I suspect it also has something to do with widespread criticism of medical models and the un-PC nature of the use of prescribed medication without psychological treatment. Well, **De Wildt and colleagues (Alcohol and Alcoholism (2002);37:375-382)** compared a combination of acamprosate plus motivational interviewing or CBT to acamprosate alone for the treatment of alcohol use disorders and found that adding MI or CBT did not add significantly to the effectiveness of acamprosate. So there we go.

Depressive disorders and substance use disorders co-exist at rates greater than chance. In other words, there is a causal relationship between them. A range of hypotheses have been suggested to explain this, including the self-medication hypothesis and shared predisposing factors. Of increasing interest is research indicating that substance use problems and a number of mental health disorders share common neuropsychological abnormalities. Of particular interest is the brain reward system which appears to mediate the reinforcing (or pleasurable) effects of drugs and is also involved in the causation of certain symptoms of depression. **Tremblay and colleagues (Archives of General Psychiatry (2002);59:409-416)** compared the rewarding effects of amphetamine between depressed patients and non-depressed controls, and found that depressed patients reported significantly rewarding effects (3.4 times greater) than the non-depressed controls. Furthermore, the more depressed the subject, the more rewarding (or pleasurable) the amphetamine was found to be. This adds further to the small but emerging and exciting body of research linking the brain reward pathway with certain symptoms of mood disorders, especially those related to levels of activation and anhedonia (inability to experience pleasure).

Finally, in a somewhat courageous article, **Watt and Naidu (British Journal of Psychiatry (2002);181:3-5)** set out their argument for selective prohibition of alcohol. What they are suggesting is that the purchase of alcohol should require Government Issue identity cards, and that people such as criminals with a history of alcohol related crime or those under the legal drinking age *should be prohibited*. The ideas in this paper are certainly not new, and such schemes have previously been proposed from time to time often stumbling at the public's lack of support for an identity card scheme. For me, the importance of the paper is less in its content than in its position – a lead article in a major psychiatric journal not known for controversy. Perhaps this is an indication that the social climate is changing, at least in the UK, in a direction where such a scheme might be possible; a fad whose time has come again? Or perhaps the journal was short on articles this month.

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both nationally and internationally; and co-ordination and collaboration remain generally lacking; with different countries, centres and academic institutions doing different things at different times. Commercialisation of treatment or assessment development products and tools may erect further barriers to cross border/ centre collaboration. Countries seem to differ in the availability of resources and the research emphasis, while roles of government and treatment providing agencies in advancing the course of treatment and treatment research remain debatable, and at times questionable. On the other hand, researchers are faced with the multiple challenges of identifying research trends, recognising relevant contextual treatment needs, confirming efficacy of existing treatment modalities and developing cutting edge or innovative research tools and treatment strategies. Obviously, researchers would once again be limited by the availability of resources. Hence, planning and co-ordination amongst research bodies, both nationally and internationally, will go a long way to minimise duplication of research tasks and ease pressure from wastage and competition.

In conclusion, the effective implementation of harm minimisation strategies requires a more thorough understanding of the multi-dimensional complexities associated with problem gambling, thereby reducing unnecessary competition for funds while facilitating smoother implementation of public health policies, as well as treatment and research activities.

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