# Treatment Research News

Alcohol, Drugs and Addiction

**May 2003** *Newsletter of the Treatment Research Interest Group* **Vol 7 No 1**

## EDITORIAL

Though it seems very late in the year to be saying it, 'Happy New Year" to you all. TRN starts off the year on an exciting foot by this being the first of our electronic issues. From now on the Treatment Research News will only be available through email and the Internet.

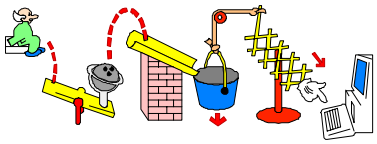
While the year started well with a spectacular summer (too good for those of you in the Manawatu), recent months have sadly seen another war breaking out in the world and a new health threat emerging. New Zealand can seem very far away and isolated from these international events until one of them arrives on our doorstep.

The news from the A&D field so far this year may seem tame in comparison, yet carries its own significance. As Fraser Todd alludes to in "I've been reading", the issue of cannabis use and depression has been highlighted by a number of new studies. The use of P (methamphetamine) is steadily increasing in New Zealand, with this concern being brought to the public's attention by the links of P to the sword attack on two women in Pipiroa earlier in the year. There has also been fierce debate raging over the A&D link about the position ALAC is taking on alcohol advertising. On a more positive front the National Research Strategy for Tobacco, Alcohol, Other Drugs & Gambling Advisory Group is about to hold its final meeting and recommendations are in the pipeline.

This first electronic issue of TRN is full of reading and information. We have features on gambling and violence, Rational Recovery and the use of music in A&D recovery therapy. As well as Fraser's customary piece we have the regulars of an update from the newly renamed National Addiction Centre and a message from the TRIG chairperson. There is also news about the new ADOPT study underway nationally and of a new research group in Christchurch.

Once more I encourage letters to the editor as well as feature articles if people have something they want to share with the field. Enjoy bundling up for the increasing cold. Happy reading.

Meg Harvey
Editor, 1 May 2003



## TRIG NAMES & FACES

Meg Harvey is a researcher at the National Addiction Centre in Christchurch, a member of the TRIG Executive Committee and editor of the Treatment Research News.

## MESSAGE FROM THE CHAIRPERSON

We are now truly in a new era with TRIG becoming an organisation with a properly paid membership and an electronic publication. Thanks must go to all of those who have steered and ensured these developments, particularly Meg Harvey and Lindsay Stringer.

You'll recall the new Executive of TRIG voted in at the last AGM were:
Peter Adams (Auckland)
Simon Adamson (Christchurch)
Alistair Dunn (Whangarei)
Meg Harvey (Christchurch – Editor, TRN)
Helen Moriarty (Wellington)
Lee Nixon (Nelson)
Doug Sellman (Christchurch - Chairperson)
Lindsay Stringer (Christchurch – Secretary/Treasurer)
Eileen Varley (Nelson).

Since then, Peter Adams has resigned from the Executive, as he needs to deal with important changes and responsibilities within the University of Auckland. Peter has been a staunch supporter of TRIG from its outset and a leading voice advocating for its continuance in the most recent discussions about the predicament of TRIG. We thank Peter for all of his TRIG work and support, but also know he will continue to make important contributions in the days ahead, albeit a little more behind the scenes in the immediate future.

TRIG membership is now $20 per year (see new Membership Form in this edition). This entitles members to regular copies of TRN personally distributed via email, continuing discounted Cutting Edge registration fee, and the opportunity to take part in a potential TRIG email discussion group. This latter idea is growing and virtually all new members have indicated their interest in being involved. We will be making a decision about this at the next Executive meeting.

Doug Sellman, 16 April 2003

# NATIONAL ADDICTION CENTRE

### Research News from the National Addiction Centre

It feels there has been a lot of water under the bridge since the last edition of TRN, when the NAC was still the NCTD and the future somewhat uncertain, particularly in the light of ALAC core funding ceasing at the end of 2003. Since then, the University of Otago (the host University for the NAC) has come in behind the Centre with some solid ongoing funding for a proportion of the academic salaries. These positions, which are termed confirmation path positions (the new form of "tenure"), have been recently widely advertised. Further, the NAC has entered into positive discussions with the Ministry of Health regarding funding, particularly related to workforce development. Thirdly, there has been an invitation for the NAC to be a collaborating group within a new national Mental Health and Addiction Research Centre (MHARC), headed by Professor Peter Joyce. This Centre will be "virtual" with the five or six collaborating research groups, across three Universities, maintaining separate autonomy, while contributing to a larger collegial collaboration with the capacity to undertake major clinically orientated research projects of international importance.

From the respondents of the Cutting Edge 2002 survey, we are now aware that there is strong endorsement within the treatment field for there to be a National Centre and that the NAC (formerly NCTD) has been useful to the treatment field over the past six years. Further, in the event of losing ALAC core funding nearly two-thirds of respondents in the survey thought the NAC should remain a National Centre, whereas less than 20% thought it should revert to being a local teaching and research group.

The three recent developments described above, in the light of these survey findings have been a great morale boost for us at the NAC and energy has returned.

Of the eleven PhD students currently being supported by the NAC, six will submit dissertations within the next 18 months (four before the end of this year, two of which are Maori), which will more than double the existing numbers of people in the treatment field who currently hold this prestigious top-shelf research qualification. This is really exciting and important for the field as a whole, as a treatment research community begins to take shape in New Zealand with these graduating researchers in a position to make a major contribution to ongoing guidance and leadership of clinical research into the future.

The addiction treatment field is in a rapidly expanding phase in terms of research generated knowledge and associated credibility. The way in which addiction is increasingly being demonstrated - to be like an invasion of interconnecting brain pathways between the limbic system (nucleus accumbens, amygdala, hippocampus), the motor system (pallidum and thalamus) and conscious executive structures (prefrontal cortex) - is bringing about a revolution in thinking about effective treatment. This revolution is not dissimilar to the transformation of tuberculosis treatment early last century following the identification of the tubercle bacillus. Fresh air and group therapy in Tb asylums, the mainstay of Tb treatment at the time, was superseded by effective pharmacotherapy.

One of the new large studies now being planned by the NAC as part of MHARC, is a randomised controlled trial of pharmacotherapy in the treatment of people with alcohol dependence/cannabis dependence and depression. This is one of the commonest clinical scenarios we face on a daily basis in the treatment trenches around New Zealand and yet we do not know what the best treatment is for such people (even if we had naltrexone funded through Pharmac).

I will write more about this study in the next TRN and hope to stimulate discussion on the upcoming email discussion group for TRIG members. I will also outline information about the Cannabis Use Disorders Identification Test (CUDIT) an instrument we have derived from the AUDIT for cannabis screening, soon to be published in the Drug and Alcohol Review, which could be of considerable interest both to researchers and clinicians.

Doug Sellman
Director, NAC
16 April 2003

# THE FORUM

This Christchurch group was started from a concern that the current inservice programme within the Alcohol and Drug service CDHB was not able to address broad research and topical issues, which impact upon our daily clinical practice in A&D.

The Forum was brought forth in June 2002. The prime goal is to focus on research in a broad way, which promotes and enhances the professional practice of Alcohol and Drug workers.

We meet on a monthly basis for one hour and the activities have included thus far:

- Review of A&D research articles relevant to practice
- Obtaining feedback from courses/conferences
- Allowing discussion of current issues in the A&D field
- Promoting a pathway for conference presentations that allows peer review and sharpening of presentation skills

A long-term plan is to encourage the blending of the research and clinical cultures and practices, and to promote a place to bring forth ideas and concepts relating to how we can provide a better service. This will also mean encouraging individual staff to see research as part of their daily professional work.

The Forum has been running for about 12 months and is well supported by staff. It chaired by Peter Freeman a senior nurse based with the Christchurch Methadone Programme.

# GAMBLING AND VIOLENCE: AN EMERGING CYCLE

Problem gambling is usually thought to be a non-violent activity and when criminal offending is involved it is often expected to be fraud or theft. In 1996, McGrath et al noted: "although violent crimes connected to gambling appear to be rare, the list of such incidents is growing …[although] sometimes gamblers are the victims of violent crimes".

In 2001, $1.5 B was lost by New Zealanders in legitimate gambling (Dept of Internal Affairs, 2002), with up to 40% of this by problem gamblers (Australian Productivity Commission, 1999). As stress increases, so does the gambling of problem gamblers and for many this is accompanied by anxiety, depression, anger, and in some cases, violence. (DSM-IV, 1994).

Gambling-related violence may not just be the domain of males, as may be assumed. Women are the fastest growing group of problem gamblers, increasing from 15% of help-seekers in 1996 to almost 50% in 2002 (Paton-Simpson et al, 2002). They also noted that 51.3% of female problem gamblers accessing face-to-face treatment in New Zealand scored more than 11 on the SOGS screen, compared with 42.8% of males. This could be an indication of a more problematic effect on women that could disproportionately contribute to criminal offending. In addition, almost one in three females in New Zealand prisons are estimated to be problem gamblers compared with one in four males (Abbott and McKenna, 2000). If violence is included in the offending, it is a further concerning association between violence and gambling.

There is a strong association between alcohol and violence, and Abbott et al (2000), observed that 76% of male problem gambler prisoners were hazardous alcohol users, compared with 61% of non-problem gambler inmates. Abbott and McKenna (2000) found that over half of the female problem gambler inmates were hazardous alcohol users, but not statistically more than non-problem gambler prisoners. They also noted that problem gambler inmates who misused alcohol were more likely to be Mäori and more likely to be serving sentences for violent offences.

There are many dimensions to violence connected with problem gambling. The DSM-IV (1994) notes that 20% of pathological gamblers, both males and females, may have attempted suicide as a result of their gambling, while other research reports that gamblers may choose more violent means to take their lives (such as vehicles) and therefore may be more likely to complete the attempt. Tragic stories like the following in the NZ Herald (2000) also tell a grim story: "Three females and two children are dead after their men snapped over gambling debts. Two of the three gamblers tried to take their own lives after murdering their loved ones."

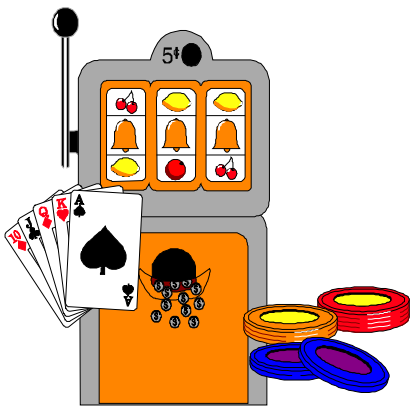
When legitimate sources of money run dry, problem gamblers may resort to violent means to obtain money. The Christchurch Press (2002) reported that a man "in the grip of a fierce gambling addiction" tried to hold up a woman with a pitchfork "because he had hit rock-bottom" and offended three times in three days. In research conducted in a medium security prison, problem gamblers who didn't misuse alcohol were more likely to commit violent offences such as armed robbery, than problem gamblers who did misuse alcohol, suggesting that although alcohol may often be an aggravating influence, gambling problems for some, may even exceed this factor. (Sullivan et al, 2002.)

Domestic violence is also associated with problem gambling. The American National Research Council noted that between one-quarter and one-half of spouses of compulsive gamblers have been abused, while the Maryland Attorney General noted that domestic violence shelter requests increased between 100% -300% after Casinos were introduced there. An Illinois mother was sentenced to 21 years in prison for suffocating her infant daughter in order to collect insurance money to continue gambling (Copley News Service, Oct. 1999). Violence affects all ethnic groups: Tran (1999) stated: "This report has found that gambling related violence has become increasingly common in Vietnamese families and is one of the most damaging results of problem gambling." Family violence can also rebound on the problem gambler. The Gambling Problems Resource Centre reports: "The family members of alcoholics may have reason to fear violence from their alcoholic, but the family members of a pathological gambler seem to be more likely to perpetuate the violent acts."

Non-payment of gambling loans is a common threat for problem gamblers, often leading to violence against them. Loan sharks are a particular threat because of the exorbitant interest charged and the means employed to collect defaulted debts: "One man who had to pay $250 per week on a $5000 loan had to flee Auckland after he was beaten up for not keeping up payments" (N.Z. Herald, 2000). Also in Auckland recently, syndicates operating in the Casino made threats to other players. The N.Z. Herald (2002) reported: "Two regular gamblers say their lives were threatened because they competed against the Wu family for slot machine jackpots".

In conclusion, violence appears to be an important and perhaps growing factor in gambling, and can have consequences clinically and socially. Violence programmes are overstretched and under-funded, but may have to work in concert with the treatment of problem gambling behaviour. In addition to problem gamblers using violence on others, they are likely to experience traumatic violent events either by their own hand or from others and this may have to be incorporated in therapy plans.

Mike Goulding
Abacus Counselling & Training Services Limited



# RR - An Educational Approach to Aid in the Process of Self-recovery from Addiction

RR is a New Zealand development based on the Rational Recovery movement pioneered by Jack Trimpey in the United States.

We all know that the majority of people who have a problem with an addiction, in whatever form, move past that phase of their life in their own time and for their own reasons without any help from "professionals". Our aim is to help those individuals who do require some help and guidance to achieve the same end. RR is an abstinence based programme as our individual experiences have taught us that "controlled" use is not a practical option for those who have had a serious addiction problem.

Our group meetings are informal discussions chaired by a co-ordinator who understands the process and attended by an advisor from a professional organisation (in our case a C.A.D.S. counsellor) whose role is to offer assistance to any individual who may require specialist help. Each meeting is based around one of the seven major themes that we have developed from the original Rational Recovery material. There are no rules on the wall as we believe that each of us is there to develop our own individual set of beliefs that we can live functionally by. The group itself has no power and we encourage people to move on after they have the confidence and knowledge to lead their own life in whatever manner they see as "safe".

RR is based on a Cognitive-Behavioural approach, which emphasises the development of positive values, beliefs and behaviours. It is designed to engender hope, provide knowledge, give encouragement and foster enthusiastic attitudes to living. We have developed our own Workbook, "24/7 Straight", which is intended for use as a guide for individuals or groups and which starts to develop the seven major themes or discussion points of RR.

**A. Total Personal Responsibility**
T.P.R. is central to the process of self recovery as it involves the key idea that we are responsible for our own behaviour and it follows that we alone can find solutions to the problems that we face. There is plenty of "specialist" help available for dealing with specific problems but ultimately we must face the consequences of our own actions. There is plenty of room inside this idea for each of us to develop our own spirituality. T.P.R. actually gives the individual **freedom** to make their own choices as it removes any restrictions that may come with staying tied to other peoples values or problems.

**B. Addiction is learned.**
This discussion centres round the fact that the development of an addiction is a natural progression through the **Pleasure – Habit – Obsession – Addiction** sequence. It is used to point out that there is nothing inherently bad in the pursuit of pleasure, which is natural, and after an addiction has been left behind there are other kinds of pleasures well worth pursuing safely.

**C. Challenge the beliefs that govern our behaviour**
We behave according to the beliefs that we have about what is appropriate in any given situation and what is best for us as individuals. In this forum we challenge what it is that we really believe about ourselves, our using, and our relationship to the world and others. Our behaviour won't change unless we change our beliefs.

**D. The Structural Model.**
Here we look at the actual make up of the brain with the two major parts that play a part in our addiction. The Mid-brain (or "pleasure centre" as it is sometimes called), which is the origin of the survival instincts, and the Cortex, which processes those urges into behaviour. In the grip of an addiction we are often unable to separate out the addictive urge from those useful urges that keep us alive and so a key to beating the addiction is the recognition of that addictive urge. Once we can separate it out we can start to alter our behaviours so that it eventually will no longer appear to control our lives. **"I"** takes control over **"It".**

**E. Recognising our Addictive Tricks & Strategies (RATS).**
This follows on from the discussion of the Structural Model and is a look at the practical ways we can go about dealing with the urges, emotions and behaviours that have been a negative influence in our behaviour. It points out that there can be an end to the addictive phase of our lives and it is not a problem that we have to carry around with us for the rest of our lives.

**F. Blueprint**
Planning and goals. This is another practical discussion about the ways and means we have at our disposal of getting back to leading constructive, functional and pleasurable lives.

**G. Living with Myself**
In this forum we take a closer look at ourselves and in particular our "comfort zone". We discuss the necessity for our comfort zone to be flexible and yet dependent for its strength on our own resources. As with T.P.R. we look at the dangers of relying on outside influences, which may collapse and leave us unable to cope adequately.

RR meetings are open to people who are wanting to leave behind addictions of any kind. In our Christchurch group just last month I sat back for 15 minutes while a group which included alcoholics, ex IV users, gamblers, cannabis abusers, a man coming off methadone and a young lady with an eating disorder had a free flowing discussion on a topic of common interest. All were heavily engaged in the learning process. To me there could be no better advertisement as to the value of the RR approach for some individuals many of whom are able to combine it constructively with other similar approaches.

**FOOTNOTE**
Groups are currently running in Dunedin, Oamaru, Timaru, Christchurch, Nova Lodge and Nelson. Groups are in the process of setting up in Tauranga and other North Island centres and Doug is considering a trip north early next year if there is sufficient demand for his help in developing RR off the mainland. Please contact him (West Coast Nova Lodge) if you are interested.

**REFERENCE**
"Rational Recovery: The New Cure for Substance Addiction" by Jack Trimpey. ISBN 0-671 52858-0, Simon & Schuster Inc. USA. Pocket Books Publication.

Doug Hendrie
Nova Trust

# MUSIC AS A TOOL FOR SOCIALISING CLIENTS INTO PSYCHO-EDUCATIONAL PSYCHOTHERAPY

Evidence based brief intervention strategies are employed in nearly all sectors of the alcohol and drug field. Many of these strategies have been influenced by cognitive affective behavioural theories and, more recently, motivational interviewing theory. I am of the opinion that brief interventions can result in long-term behaviour change as long as the client remains an 'active' participant, and becomes their own 'ongoing' therapist. To better tailor the treatment plan to the individual, music and other creative approaches, can augment the structured psycho-educational plan. Albert Ellis, recognised as a seminal thinker in the cognitive behavioural camp, himself, has employed 'rational' songs for his 'beneficent' teaching style of therapy. More than adding light relief or some entertainment aspect to the therapy, I believe that music (and other artistic endeavours) can communicate at an individual level. In his recent autobiography, the actor Michael J. Fox attributed his motivation to address his addiction to a song written by the American songwriter James Taylor. Several other biographies that I have read recently have reinforced the significance of how music can communicate at an individual level.

A key research interest of mine is to explore how music can indeed help increase the efficacy of brief intervention by making the therapy more interesting for clients, and enhancing the motivation to keep working at achieving their therapy goals. For most of this year I have been engaged in some action research as part of my doctoral studies using original and more well known songs in an aftercare programme. I have found that these narratives set to music have stimulated discussions in the group and helped some clients to find their own meanings in the words. The 'Socratic' nature of cognitive behavioural therapy and motivational interviewing can help the client find personal meaning and a unique pathway to their behaviour change. This idiosyncratic experience, I believe, enhances the client's self-efficacy. It is therefore important that the theme of the song or songs employed in therapy is consistent with the self-efficacy and self-responsibility aspects of cognitive behavioural therapy and motivational interviewing.

I have come across many clients who although contemplating change around their substance use, present as unprepared or pre-contemplative about actually becoming an active participant in a psycho-educational programme. Music may be a way to help sell the idea of partaking in a structured brief intervention programme. This 'priming' process can also counteract the possible negative reaction some clients have to the formal assessment process (that can appear somewhat reductionist and dehumanising to some individuals). Personally, I am all for structure and efficiency, these are sensible aspects of any case management plan. Music can however, help socialise the client into the process of psycho-educational therapy in a more Socratic manner. Unfortunately, music, or perhaps the style of music can also elicit negative reactions and it is therefore important to have a menu of options (another Motivational Interviewing principle) with regards to the music genre. Indeed, it would be very naive to assume that any one song could strike a chord in all listeners! Below are the lyrics of a song that attempts to capture some of the key elements of psycho-educational therapy.

<u>"WRONG"</u>
There is a place where I can go
Where nobody can hurt me anymore
There is a place deep inside my own head
Where I am the captain of my soul.

I can learn to change the way I feel
I don't need the magic, I want to be real
There is a place deep inside my own head
Where I can be my own healer to be healed.

So leave the past where it belongs
I can't have what's already gone
*I have a weakness for thinking I'm not strong*
*Now I'm proving to myself that I've been wrong.*

I can choose to run
I can choose to hide
I can even ask the good Lord to be by my side
I can choose to blame
I can stay the same
I can turn the breeze into a hurricane
I can tell myself that it's meant to be
I can even change my own chemistry
I can fly on the wings of my ancestry

So leave the past where it belongs
I can't have what's already gone
*I have a weakness for thinking I'm not strong*
*Now I'm proving to myself that I've been wrong.*

Paul Schreuder
Senior Lecturer
Wellington Institute of Technology

Paul Schreuder has completed his second year at The University of Waikato where he is enrolled in the Doctor of Education programme. He has recorded three albums of original songs and was the winner of the APRA silver scroll, New Zealand's premier song-writing award in 1980.

**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), Meg Harvey, Alistair Dunn, Eileen Varley, Simon Adamson, Lee Nixon, Helen Moriarty, Simon Adamson.

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

## ALCOHOL & DRUG OUTCOMES PROJECT (ADOPT)

How do we measure alcohol and drug treatment outcomes in ways that are useful and meaningful - for consumers, workers, managers and funders?

Recent developments in the mental health field with the Classification and Outcomes Study have highlighted the potential for research around outcome measurement for alcohol and drug services.

A project has begun that will be exploring a range of issues around measuring outcomes for alcohol & drug services. The project will also be attempting to identify underlying principles that could help guide the practice of outcome measurement. It is hoped that these will provide a basis for developing frameworks for outcome systems that make sense to those who use them – consumers, workers, managers, funders.

The year-long project will be as inclusive as willing participants can make it. Both the project team & its reference group reflect the collaborative nature of this work, covering clinical, academic & non-governmental organisations across the whole of New Zealand*. To ensure the project is representative of all the alcohol & drug sectors, we aim to consult with as many people in the field as possible. This in turn will give you the chance to express your thoughts on:

- What are 'outcomes'? What areas are important to measure?
- What systems are already in place & how well do they operate?
- What are the key issues to implementing & sustaining outcome measurement?

We will soon begin this consultation process & we encourage you to take this opportunity to inform & shape future practice.

If you'd like to be involved or want further information, please contact the research officers:

Gareth Edwards
(Clinical Research & Resource Centre)
Gareth.Edwards@WaitemataDHB.govt.nz

Meg Harvey
(National Addiction Centre)
meg.harvey@chmeds.ac.nz

* Principal Co-Investigators: Dr. Gail Robinson (Clinical Research & Resource Centre, Waitemata DHB) & Daryle Deering (National Addiction Centre) Investigators: Dr. Helen Warren (Division of Applied Behavioural Science, University of Auckland), Paul Robertson (NAC), Dr. Grant Paton-Simpson (CRRC) Simon Adamson (NAC) & Amanda Wheeler (CRRC)

## CUTTING EDGE CONFERENCE

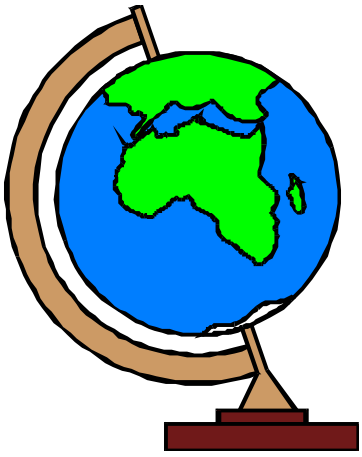
**Spirit of Partnership**
**Waitangi**
**28-30 August 2003**

Cutting Edge is an annual treatment conference in the alcohol, drug and addictive disorders field. ALAC is the primary sponsor. Cutting Edge 2003 will be the 8th Cutting Edge conference held so far and Pam Armstrong (Whangarei) is the chair of the organising committee. In response to a range of northern voices and in recognition of the commitment of the Far North's alcohol and drug services to past Cutting Edge conferences and the field in general, including work force development, the organising committee has decided to hold Cutting Edge 2003 in Waitangi. The theme "Spirit of Partnership" has evolved from thinking and sentiment associated with holding the Conference in such a special symbolic place, as Waitangi is. Keynote speaker Pa Henare Tait from Te Tai Tokerau will open the conference.

Residential treatment has been identified as a neglected area for attention in recent Cutting Edge conferences. Dr Eric Broekaert from Brussels, an international figure in the area of therapeutic communities, will fill that gap. Two other well known people will be keynote speakers this year. First is Professor Ann Roche, Director of the National Centre for Education and Training in Addiction (NCETA), Adelaide. Second is Mr Keith Evans, former CEO of ALAC and now Chair of the Intergovernmental Committee on Drugs based in Canberra. One of the Cutting Edge conference traditions has been the invitation of an academic keynote speaker from outside the alcohol, drug and addictive disorders field. Professor Lloyd Geering has confirmed his availability recently. His expertise is spirituality and religious studies. The Pacific keynote speaker is Brother Stephen Tipene Filipo who currently teaches at Hato Petera College and the University of Auckland in the School of Education. His interests lie in Maori and Pacific education

Cutting Edge 2003 will once again be organised by the indefatigable Lisa Andrews and Lindsay Stringer of the National Addiction Centre. Conference materials have recently been widely distributed. If anyone has queries meantime, don't hesitate to contact Lisa or Lindsay directly at lisa.andrews@chmeds.ac.nz or lindsay.stringer@chmeds.ac.nz

Assoc Prof Doug Sellman
Director
National Addiction Centre
www.addiction.org.nz



I was intending to take an even-handed gallop through various articles that have been published over recent months, but after a wee think, I figured that if I am going to get on a horse it may as well be a high one! As usual, research is misused to support the beliefs and prejudices of the various interest groups. The recent tabling in parliament of an editorial by Professors Joseph Rey and Christopher Tennant (*British Medical Journal 2002;325:1183-4*) in which they overview recent evidence on the association between cannabis use and mental health will no doubt fuel the debate on cannabis law reform. Their overview discusses recent research into the relationship between cannabis use and schizophrenia, and cannabis use and depression, and is a worthwhile read. But I am sure the article will be either unfairly dismissed, rubbished or excessively lauded by the various polarities of that debate. As the authors themselves state, the evidence they cite is early evidence based on a small number of studies. And these studies are epidemiological rather than clinical samples. Furthermore, they do not discuss the numerous studies suggesting that the relationship between cannabis and depression may not be causal but may be due to the existence of common vulnerability factors. At this stage, the nature of the relationship between cannabis use and depression remains unclear and any conclusions must be drawn very cautiously.

Regarding the debate about the legal status of cannabis, whom are these debaters trying to help feel better? Those that would be our patients, or themselves? Griffith Edwards in his editorial (*Addiction 2003;98:142*) refers to the political misrepresentation of scientific evidence regarding the harms of cannabis in his prelude to the late Robert Kendell's paper analyzing the process by which Cannabis was subjected to the international narcotic legislation of 1925 (*Addiction 2003;98:143-151*). Kendell paints a depressing picture of bluster and pomposity in the League of Nations decision to subject opium to international controls, and how cannabis was drawn into this on grounds that had very little empirical support. While this process occurred over 75 years ago, Edwards cautions us:

"No sensible person expects science to dictate policy, and one should ever beware the bombastic expert. Note, however, that the English government authorities, while declaring themselves shocked by the public disorder created across the land by young people's drunkenness, favour 24 hour drinking and the proliferation of drinking outlets as the remedy."

In the same paddock is the Dutch harm reduction initiative around heroin prescribing for people on methadone maintenance treatment who continue to use heroin on top of their methadone. Lemmens (*Addiction 2003;98:247-249*) discusses this randomized controlled study, supported by the Dutch government with the intention of broader implementation if successful, which it was. Despite the success of the intervention across a number of important outcomes, a shift to the right in government policy saw the initiative discontinued, presumably on moral grounds. We can't let a successful treatment get in the way of a good moral, after all.

While on the topic of cannabis and opioid dependence, there has been controversy about how cannabis use by people receiving methadone maintenance treatment should be dealt with for some time. There is a suspicion that cannabis has received such prominent consideration mainly because it was easily detected in urinary drug screens. While cannabis dependence is undeniably associated with harm in its own right and needs to be dealt with, it appears that cannabis use does not undermine the effectiveness of MMT per se. Epstein and Preston (*Addiction 2003;98:269-279*) performed a retrospective analysis of three clinical trials of patients in MMT, followed over 12 months. They found that cannabis was not associated with retention, use of other drugs such as cocaine, or any other outcome measure during or after treatment. These findings suggest that cannabis use in people with MMT should be given the attention it deserves; when causing cannabis dependence, somewhere after problems of much greater morbidity such as nicotine dependence.

Nicotine dependence and depression seem to co-occur frequently, may share common genetic predispositions and anecdotal reports suggest that stopping smoking may be associated with depressive symptoms. Killen and colleagues *(Addictive Behaviors 2003;28:461-470)* monitored 224 smokers over the course of nicotine patch assisted smoking cessation to examine the incidence of new episodes of depression. Subjects were also randomized to receive paroxetine at varying doses or a placebo. Twenty percent of their sample had a previous history of major depressive disorder. Of their sample, 4% experienced the onset of major depressive disorder during the 10 weeks of follow up, most frequently meeting criteria for this diagnosis more than 4 weeks after stopping smoking. Eighty percent of those developing major depressive disorder had no past history of it and paroxetine appeared to make little difference to the occurrence of depression. While this study needs replication before firm conclusions can be drawn, it would appear that a small but significant number of subjects experience major depression concurrent with smoking cessation, that this is not predicted by a past history of depression, and that paroxetine does not protect against its onset. Furthermore Pomerlau and colleagues *(Addictive Behaviors 2003;28:575-582)* compared a sample of 931 women divided into never-smokers, ex-smokers and current smokers and found that ex- and current smokers were more likely to suffer depression than never-smokers, but did not differ significantly from each other, suggesting that depressive symptoms while smoking tended to persist after cessation. Malone and colleagues *(American Journal of Psychiatry 2003;160:773-779)* investigated the relationship between smokers and non-smokers with psychiatric disorder and suicidal behaviour, and looked at serotonin function in a subgroup with depression. Across all patients,

*CONTINUED ON NEXT PAGE*

smokers were significantly more likely experience suicidal ideation, to have made a suicide attempt and to have a lifetime history of aggression. Smoking was also associated with lower brain serotonin function and the authors proposed this as a mechanism to explain the association. However, it is likely that serotonin function is only part of the picture given the lack of efficacy of SSRI's in smoking cessation compared to nortriptyline and bupropion (Zyban).

Having just waded through a number of long and dense research papers recently, it is sobering to note that arguably the single most influential research paper of the past century was only one page long. It is the fiftieth anniversary of Watson and Crick's paper ***(Nature 1953;171:737)*** and to commemorate this, the American Journal of Psychiatry has re-published the original paper alongside several papers discussing the future impact of genetics on psychiatric practice. Merikangas and Risch (***American Journal of Psychiatry 2003;160:625-635***) provide an interesting overview of the role of genetics in the causation of psychiatric disorder (including substance use problems) and discusses the implications of future research for the field. Gottesman and Gould (***American Journal of Psychiatry 2003;160:636-645***) discuss the idea of endophenotypes and their utility in mental health research. Endophenotypes are traits of people with certain illnesses or problems, be they neurochemical, biological, behavioural or self-reported attributes that are thought to be a more direct expression of underlying genetic factors. Examples include circadian and sleep patterns in depression. This area of research promises to help in the identification of the underlying causes of a variety of mental health problems, including addiction. In the same edition of the journal, Kendler and colleagues report on further findings from their Virginia Twin Registry study (***American Journal of Psychiatry 2003;160:687-695***). Using multivariate techniques to investigate the role of genetic, shared environmental factors or unique environmental factors on substance use and abuse/dependence, they report that the genetic risks are not for specific substances but rather for drugs in general, helping to clarify some of the contradictory research on this published over the past few years.

There is a lack of empirical evidence regarding the treatment of co-existing substance use and serious mental health disorders and treatments are often transplanted from other areas. To help clarify the validity of this approach, Bradizza and Stasiewicz (***Addictive Behaviors 2003;28:157-169***) undertook a series of focus groups to obtain qualitative data on high risk situations for relapse. While many of the situations precipitating relapse were similar to those usually found in people with uncomplicated substance use problems, there were a number specific to those with co-existing disorders. Specifically, people with co-existing disorders reported a vulnerability to relapse in the face of negative mood states and depression, anxiety and boredom, loss, receiving money and loss of appetite. The presence of psychotic symptoms appeared to be less important than anticipated. The authors anticipate that this information will be useful in guiding future quantitative research, but in the meantime these findings provide a valuable guide to relapse prevention strategies in this group. While group approaches are also used with this population, many people struggle to engage in AA and NA approaches. Specific dual diagnosis 12-step self help groups have been established in many places, often known in the United States as Dual Diagnosis Anonymous or double trouble groups. Magura and colleagues (***Addictive Behaviors 2003;28:399-412***) attempted to identify the effective components in such an approach. They report that helper-therapy and reciprocal-learning processes were important in predicting abstinence but emotional support was not. In other words, helping others (helper-therapy) appeared to strengthen a person's commitment to change, and the process of information sharing and role modeling (reciprocal-learning) assisted in learning new attitudes and skills, but the emotional support provided by such a group was unimportant in achieving abstinence. The authors speculated that this population may well need much more intensive emotional support than such groups can provide. Regardless, these findings suggest important processes to encourage in other group-based treatments.

Finally, if you sometimes think that working in the A+D field is a bit chaotic, you are right. Warren and colleagues (***Addictive Behaviors 2003;28:369-374***) examine the use of non-linear dynamics – akin to chaos theory - in understanding addictive processes and find it superior as a model to our usual linear (A causes B) models. There have been several attempts to understand addiction in this context over recent years, and they appear particularly promising in predicting outcomes and the effectiveness of particular interventions. Unfortunately, their usefulness is undermined by the complexity of the mathematics involved that is well beyond my capabilities anyway. Still, perhaps it is the way ahead for our field. Maybe we need to start developing our next postgraduate paper at the National Addiction Centre:

**PSME $\Delta It = a \pm b\Delta It\text{-}1$ Alcohol and Drug Disorders: Chaos and Mayhem**

Any takers?

**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**

**TRIG is sponsored by the National Addiction Centre**
**Dept of Psychological Medicine**
**Chch School of Medicine & Health Sciences**
**4 Oxford Terrace**
**PO Box 4345, Christchurch**
**Phone 364-0480, Fax 364-1225**
**www.addiction.org.nz**

# Treatment Research Interest Group (TRIG)

## Alcohol, Drugs and Addiction

# MEMBERSHIP RENEWAL FORM

**Please note all individuals wishing to be a member of TRIG must join by completing this form regardless of current membership status.**

**Membership in TRIG entitles you to the following**

- three issues of the Treatment Research News via email
- a reduction in registration fee at the 2003 Annual Treatment Conference
- membership in a potential TRN email discussion group

**PLEASE ENROL ME AS A 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 _____

**(NB - You Must Provide An Email Address If You Wish To Receive A Copy Of TRN)**

***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 2003 calendar year. I understand membership fee is $20

Signed _____ Date _____

Please make cheques payable to: TRIG

☐ I am interested in participating in an email discussion group around TRN

---

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)