Treatment Research News

Alcohol, Drugs and Addiction

September 2003 *Newsletter of the Treatment Research Interest Group* **Vol 7 No 2**

EDITORIAL

Here is the second newsletter for 2003. I have had several people comment to me lately on how fast the year is going and I have to agree with them. Winter seems to have flown by and the bulk of the year has passed us by. It is great and heartening to be getting some real sunshine and warmth again.

Another successful Cutting Edge conference has been and gone too. This year's theme of the Spirit of Partnership in Waitangi was timely and captivating. An account of the conference can be found on this page. The conference is always such a wonderful opportunity to put faces to the names that you hear so often in the field or see on the A&D Link. It's also nice to be around like-minded people for a few days! It was interesting to see so few presentations on methamphetamine, given its rising status. No doubt this will come with time.

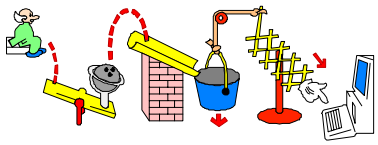
The change-over of TRN to electronic form has gone smoothly. From this issue TRN is only available via email to members of the Treatment Research Interest Group. This issue is also the first to be produced for discussion in the TRN email discussion group. This email group is available to all TRIG members – see the piece on the back page for more detail.

As well in this issue are two articles from presenters at Cutting Edge. Laura Clunie talks about methadone prescribing in New Zealand, while Alison Penfold discusses gambling and suicide. We also have the usually much anticipated "I've been reading" from Fraser Todd. Two other regular columns make their appearance, but with a new author. As the new Chairperson of TRIG we have an update from Simon Adamson, who has also taken over providing the NAC report.

Cutting Edge provided a great opportunity to see what research is being done in the field and we will be bringing you some interesting items in the next few issues. The next newsletter will be out at the end of November.

Enjoyable watching to those of you who will be following the World Cup and happy reading in the meantime.

Meg Harvey
Editor, 26 September 2003



CUTTING EDGE 2003

If nothing else we can say that the setting for Cutting Edge 2003 in Waitangi was spectacular. It was a beautiful and peaceful place to be for the duration of the conference. The conference was held at the Copthorne Waitangi from Thursday, August 28 to Saturday, August 30. Once more there were over 300 delegates in attendance.

The local Nga Puhi Iwi were wonderful hosts and made the conference something very special. The powhiri at the marae at Waitangi that launched the conference was a memorable and educational experience.

Across the two and a half days of conference there was a wide variety of speakers and topics with over 60 presentations. Well known field members such as Keith Evans and Terry Hurwai spoke as well as more distant and unusual guests like Llyod Geering and Eric Broekaert. Topics included electronic screening and brief intervention, weaving bi-cultural partnerships, minimal methadone treatment, tobacco smoking in an adolescent psychiatric population and consumer expectations and brief intervention.

The winner of the John Dobson Memorial prize for the best opioid presentation went to Alistair Dunn for his talk "Minimal Methadone Treatment". The John O'Hagan prize for the best presentation by someone aged under 35 years went to Grant Christie for his paper "Do adolescents presenting to outpatient substance use services differ from adolescents presenting to outpatient mental health services?".

The NAC are putting out the official Cutting Edge Proceedings from the conference and the NAC and TRIG (with Doug Sellman as Editor) are again putting together a Monograph from the research papers presented.

TRIG NAMES & FACES

Daryle Deering is the Director of Nursing Practice for Canterbury District Health Board and a lecturer at the National Addiction Centre.

METHADONE PRESCRIBING IN NEW ZEALAND: A NATIONAL SURVEY

Methadone has been prescribed for opiate dependence in New Zealand since the early 1970s. Since then, numbers in treatment have risen from 219 in 1979 to an estimate of over 3000 in 1999 (Preston, 1999). Methadone maintenance treatment is recognised as an integral part of the harm reduction approach to treating drug misuse.

Current national data on methadone prescribing are not able to give accurate figures on daily doses, take-away doses or even to distinguish between prescriptions for dependence and those for pain relief (personal communication – S Gustofson, T Barron, T O'Brien).

A national survey was conducted in February 2003, with the aim of presenting a 'snapshot' of methadone prescribing patterns in New Zealand. Doctors were asked to provide information on the methadone prescription for each opiate-dependent patient covering the most days in February 2003. The details requested were:

- age and gender of patient
- date that the current treatment episode started
- whether split doses (a daily dose taken in two or more portions) were prescribed
- methadone daily dose in mg
- whether the patient was on a maintenance or reduction regime
- whether the methadone was dispensed at a clinic or community pharmacy
- days on which doses were consumed under supervision
- number of take-away doses per week

Questionnaires were initially piloted with staff at methadone treatment services to establish the feasibility of collecting data and to ensure that instructions were clear and unambiguous. The intention was then to send out a survey questionnaire to all doctors in New Zealand gazetted or authorised to prescribe methadone. Methadone services were contacted first by phone or email to establish willingness to participate and to nominate a key contact person. This person was then asked how many clients were seen by the service and how many GPs were authorised by the service. Questionnaires were then sent directly to the services and prepacked questionnaires were also forwarded on to authorised GPs by the services.

Nineteen major methadone services were involved in the survey. The total reported number of patients was 4185, ranging between 29 and 958 at each service. A total of 372 GPs were authorised by services to prescribe methadone and this group was reported to be prescribing for 31% of patients.

Responses were received from 12 services and 164 GPs, giving data on prescriptions for 2200 patients. This amounts to just over half of the total reported number of patients. The average age of patients receiving methadone was 37 and 58% of patients were male.

The overall mean daily dose was 85.8mg and the median was 85.0mg. These values fall right in the middle of the dose range of 60 to 120mg, recommended in the National Protocol for Methadone Treatment in New Zealand (Ministry of Health, 1996), which was current at the time this survey was carried out. Split doses were prescribed for 5% of patients and this group had a significantly higher mean daily dose.

Maintenance doses were prescribed for 92% of patients. The mean number of supervised doses per week was 3.8, with the most common dosing regimen involving three supervised doses and four take-away doses per week. The maximum number of days between supervised doses gives an indication of the maximum number of take-away doses given to a patient at any one time. The mean of this value was 2.1 days, suggesting that prescribing practices are fairly safe in New Zealand. Considerable variations in prescribing patterns were also noted between different regions and between GPs and specialists.

While these are only provisional results, it has been possible with this study to present data on prescriptions for 2200 patients. This is over half the population receiving methadone for dependence in New Zealand.

A major limitation of this study was that some whole services were unable to respond. Some questions were also misunderstood by a number of respondents, particularly when we asked for the 'date this treatment episode started'. Problems with misunderstanding were mainly seen with GP respondents and may have been avoided if questionnaires had been piloted with GPs as well as methadone service staff.

A full report on this study will be completed shortly. This will be sent out to all services involved in the study, along with a feedback form to assess the study's methodology.
This study will provide useful baseline data against which to measure any changes in practice in future research. New guidelines on methadone treatment were released by the Ministry of Health earlier this year and a repeat of this study is planned for 2004 to assess what impact the new guidelines have had on prescribing patterns.

Laura Clunie, Janie Sheridan, Ross McCormick, University of Auckland

References:

Ministry of Health (1996). *National Protocol for Methadone Treatment in New Zealand*.

Personal communication – S Gustofson, Analyst, PreMeC. T Barron, Demand Side Manager, Pharmac. T O'Brien, Information Analyst, New Zealand Health Information Service.

Preston A (1999). *The New Zealand Methadone Briefing* (ed. R Kemp).

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: Simon Adamson (Chairperson), David Benton, Paul Duborn, Alistair Dunn, Meg Harvey (Editor), Janie Sheridan, Lindsay Stringer (Secretary)

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

Research News from the National Addiction Centre

As the dust settles from another successful Cutting Edge conference it is now time to turn to the production of the third annual Treatment Research Monograph. This monograph is produced jointly by TRIG and the NAC and provides concise summaries, of two to three pages, of most research presentations from the Cutting Edge conference. This year was a departure from previous years in that there was not a dedicated research stream. I must identify myself as having been a sceptic about this decision, fearing that the profile of research within the conference may have been weakened by not drawing registrants attention to these presentations as a core thread of the conference. Cutting Edge 2003 had a diverse array of research presentations of high quality and I have received feedback that scattering research presentations across streams may have led to greater exposure to these presentations by registrants who may have otherwise sought to avoid them. The only difficulty this caused was the inevitable clashes of two or more interesting research presentations scheduled concurrently. It is hoped that the production of the research monograph will go a long way to negating this.

In the last NAC report Doug Sellman identified a planned study intended to examine the efficacy of combined naltrexone and citalopram for depressed alcohol dependent clients. At the time of writing this, a grant application is in preparation for this year's HRC funding round. We have decided to submit the application for a Strategic Development Project grant. This means that, if funded, we will be conducting a pilot project with a sample of 80. The ultimate intention is to run an enlarged double blind, randomised controlled trial with four arms – naltrexone/citalopram, naltrexone/placebo, placebo/naltrexone, placebo/placebo. For the pilot study we will compare two arms only: naltrexone/citalopram versus placebo/placebo. There is a growing body of literature examining the utility of naltrexone and SSRI anti-depressant medication in the treatment of depressed and non-depressed alcohol dependent clients, but to date no study has examined the combination of these medications.

Two NAC papers have recently been published in Drug and Alcohol Review. In the first (**Sheerin IG, Green FT, Sellman JD. The cost of not treating Hepatitis C virus infection in injecting drug users in New Zealand. Drug and Alcohol Review 2003;22:159-167**) Ian Sheerin draws on data from his PhD dissertation, which seeks to quantify the economic cost of IVDU-related Hepatitis C in New Zealand. The paper argues that the costs of not treating Hepatitis C are substantial and so the current policy of not funding such treatment should be reviewed. The second paper (**Adamson SJ, Sellman JD. A prototype screening instrument for cannabis use disorder: the Cannabis Use Disorders Identification Test (CUDIT) in an alcohol-dependent clinical sample. Drug and Alcohol Review 2003;22:309-315**) describes the development of the CUDIT. This screening instrument was derived by modifying the AUDIT and trialling it in the sample enrolled in the Brief Treatment Programme for Alcohol Dependence, previously described in this newsletter. The CUDIT was shown to have adequate psychometric properties and the authors discussed future research directions which could improve its ability to successfully identify cannabis abusers. No such instrument has been previously published and with the high rate of cannabis use in New Zealand this is a screening tool with considerable potential.

Finally it is with great (personal) pleasure that I can inform readers that since the last TRN we have had two NAC PhDs submitted for examination. First I would like to congratulate Phil Townsend for submitting the NACs first PhD dissertation in June. Phil's dissertation is titled "Conflict between Providers and Consumers in Opioid Substitution Therapy: A Preventative Ethics Approach". The second PhD dissertation, my own, was submitted in August and is titled "Clinical Predictors of Treatment Outcome for Alcohol Misuse Disorders". These dissertations represent the first two of six PhDs undertaken within the NAC that we anticipate will be completed within the next six to 12 months. Completion of this crop of PhDs represents a substantial milestone for the NAC and for the addiction treatment field in New Zealand.

Simon Adamson
Lecturer, National Addiction Centre

TRN EMAIL DISCUSSION GROUP

The Treatment Research News email discussion group has been active as of September 24. This is a group similar to the AandD netlink, though obviously concentrating on research issues and questions. Any member of TRIG is able to join the discussion group at no extra cost. The aim is to provide a forum to discuss any alcohol and drug treatment research matter and it is envisaged that the TRN will provide some starting points for discussion with each new issue.

Unlike the AandD link it is anticipated that the TRN email discussion group will not have a large number of postings. Given the topics are restricted to research issues and that membership is limited, the site will necessarily have fewer posts than other sites. This is not to say that it won't be stimulating and interesting!

If you wish to be part of the discussion group, but are not a TRIG member, you will need to fill in the membership form in this issue of TRN and send this with your subscription fee to the address listed on the form. There is a box to tick on the membership form, which indicates you would like to be part of the email discussion group. If you are already a member of TRIG and are not part of the discussion group, but wish to be simply email Lindsay Stringer and let her know. (lindsay.stringer@chmeds.ac.nz)

Look forward to hearing from you on the web.

Meg Harvey, TRN Editor

There is little research in the area of problem gambling and suicide. The research that has been undertaken has been from the perspective of screening those who present for treatment in respect of their gambling problem and identifying the proportion of these who have either considered suicide or made a suicide attempt. Studies investigating suicidality in treatment populations establish strong links. The Australian Productivity Commission (1999) in tabling evidence from the literature on suicide thoughts and attempts among problem gamblers report figures of between 4 to 31 percent attempted and 17 to 80 percent who had suicidal ideation.

While some general population studies have been undertaken investigating the links between reported suicidal thoughts and pathological gambling it would seem that no research has resolved to determine what part problem gambling plays for those presenting to hospital following deliberate self-harm.

Further to this a study by Ciarrocchi (1987) noted that clients dually addicted to gambling, alcohol and/or drugs were at a greater risk of suicide. He reported that 100 percent of chemically dependent pathological gamblers were diagnosed with major depression and of those 42 percent had made a serious suicide attempt. This was five times the frequency of the chemically dependent alone group. While this particular study was again undertaken within a treatment population it would seem important to investigate whether an alcohol and/or drug problem was likely to coexist when a gambling problem was identified in investigating a population who present to hospital following deliberate self-harm. In addition, the seriousness of the attempt requires investigation to determine the association between problem gambling, chemical dependence and deliberate self-harm.

New research is investigating the association between problem gambling and suicide attempts and the role of alcohol in this from the perspective of screening those who present at emergency departments following an episode of deliberate self-harm for problem gambling and alcohol misuse

BACKGROUND

Suicide in New Zealand

Suicide trends in New Zealand show an upward trend overall with an increase of 72% for the male suicide rate from 1978 to1998, although the female rate has in fact decreased by 14% over the same time period (NZHIS, 2001). This places New Zealand males with the second highest suicide rate in the world behind Finland. Deaths for Maori by suicide accounted for 18% of the total indicating an over representation. The most common method of suicide for both males and females is hanging with this accounting for over 40% of suicides in 1997 (NZHIS, 2001).

The statistics for suicide attempts or deliberate self-harm indicate that this is a different group. The most recent figures for hospitalisation for self-inflicted injury are 1999/2000 in which there were 1389 male hospitalisations in New Zealand and 2378 female hospitalisations, indicating a ratio of almost 1:2 male to female (NZHIS, 2002). It is important to note that there is not accurate data on all suicide attempts as records are only kept on those who are admitted to hospital or seen as day patients for longer than three hours.

Suicide and Problem Gambling

The research that has emerged in this area has spread across many layers, from a societal level, attempting to, for example, determine the impact of casinos on suicidality in a region, to general population studies, to studies of those in treatment and finally analysis of individual gambling related suicides. No previous research has attempted to identify the incidence of problem gambling in those who have either attempted or completed suicide.

The Australian Productivity Commission (1999) in their report on Australia's Gambling Industries attempted to estimate gambling related suicides for the population of Australia and appear to have taken a considered approach to this. They investigated case studies of individual gamblers and surveys of problem gamblers both in treatment and as identified as part of a general population. It was commented that it is probable that a proportion of suicides of problem gamblers reflect wider problems and may have occurred anyway, but equally many suicides may be misdiagnosed as car accidents, drowning, or other forms of death. The Commission, using epidemiological evidence, determined a figure at around 400, but acknowledged that this was probably an overestimate and that the figure was probably between 40 and 400 a year. Their concluding comment was that there is little doubt that suicides are linked to gambling.

Studies investigating suicidality in treatment populations establish strong links, as would be expected. A study by Sullivan (1994) in New Zealand stated that over 80 percent of problem gamblers reported suicidal ideation as a solution to their gambling problems during the first twelve months operation of a Gambling Problem Hotline. While it might be expected that a new, potentially anonymous service may attract those with the most serious of problems in the initial phase it highlights the way in which those with serious gambling problems identify suicide as a solution.

A further way of approaching and understanding the link between gambling and suicide is by psychological autopsy. Blaszczynski and Farrell (1998) undertook an analysis of completed gambling related suicides and evidenced that almost a third had previously attempted suicide, and one in four had sought mental health assistance for their gambling problem. This descriptive study highlights the overlap between gambling, psychiatric disorders, as well as other life problems and suicide. It also may suggest that there is an important link between problem gambling and serious suicide attempts.

Suicide, Problem Gambling and Alcohol Misuse

While the exact role of alcohol in suicide is also unclear, a strong association certainly exists. Welte et al (1988) and Berkelman et al (1985) report that between 18% and 66% of suicide victims have alcohol in their blood at the time of death. A clear connection also exists between alcohol and gambling problems with Crockford and el-Guebaly (1998) finding in a review of the literature that rates of lifetime

Continued on page 5

substance abuse disorders among pathological gamblers ranged from 25-63 percent. The connection of both of these together with suicide has, however, not been clearly investigated.

Beautrais et al (1996) determined in their study that the risk of a suicide attempt increased with increasing psychiatric morbidity, and that subjects with two or more disorders had odds of serious suicide attempts that were 89.7 times the odds of those with no psychiatric disorder. Pathological gambling, a diagnosable psychiatric disorder under DSM-IV in itself, is often seen with other psychiatric disorders, notably depression and substance misuse. This indicates therefore that this is a group of clients who are significantly at risk. Blaszczynski and Farrell (1998) comment that given that the variables of major depression, alcohol and substance abuse, and marital dysfunction which are considered risk factors for suicide in both the general population and among psychiatric patients, it is surprising that only a few studies have investigated risk factors associated with suicide in populations of pathological gamblers.

The Gaps

While there has been research undertaken as outlined previously, attempting to understand the connection between problem gambling and suicidality this has not been from the perspective of identifying problem gambling as a factor in either those who have attempted suicide or those who have completed. Further, while there has been a considerable body of work on the connection between alcohol and suicidality, problem gambling has never been taken in to account as a part of the equation that may contribute to a suicide attempt and particularly the seriousness of a suicide attempt.

THE PRESENT STUDY

The Aims

1. To investigate the incidence of gambling problems in a population who have presented to hospital following an episode of deliberate self-harm.
2. To compare the prevalence rate of problem gambling identified in the study to the general population using currently available statistics in sub-groups of age, gender and ethnicity.
3. To investigate the affect of alcohol and gambling on the seriousness of suicide attempts.

The Process

Participants in a survey to investigate the aims will be drawn from patients who present at Auckland and North Shore hospitals following an episode of deliberate self-harm. The gambling eight (early intervention gambling health test) screen (Sullivan, 1999) used to identify problem gamblers will be administered along with the CAGE alcohol screen and the Beck Suicidal Intent Scale (Beck et al, 1974). This information will be collected along with demographics including the preferred form of gambling.

Conclusion

The information accessed in this survey will enable the prevalence of gambling problems within the population of those who present to hospital following self-harm to be identified. Further to this, it will be possible to establish whether an alcohol problem has been a contributing factor in association with this. The Beck Suicidal Intent scale will also allow for the investigation of the relationship between the seriousness of the attempt and whether a gambling problem has been identified. It is expected from anecdotal evidence from counselling within the problem gambling field that this will be the case. It could in fact be deduced that those who complete suicide, match well the profile of problem gamblers who present for treatment, indicating that problem gambling does indeed impact upon the seriousness of the attempt. The association of this in connection with more recent suicide statistics as they become available will require further investigation.

Alison Penfold,
Director, Abacus Counselling and Training Services Ltd

References

Beautrais, A., Joyce, P., Mulder, R., Fergusson, D., Deavoll, B. and Nightingale, S. (1996). Prevalence of Comorbidity of mental Disorders in Persons Making Serious Suicide Attempts: A Case-Control Study. Am J Psychiatry 153 : 8

Beck, A., Schuyler, D. and Herman, J. (1974). Development of Suicidal Intent Scales. In: The Prediction of Suicide (Beck, A., Resnik, H and Lettieri, D., eds), Charles Press, Maryland

Berkelman, R., Herndon, J., Callaway, J., Stivers, R., Howard, L., Bezjak, A. and Sikes, R. (1985). Fatal Injuries and Alcohol. American Journal of Preventive Medicine 1:21-28J

Blaszczynski, A. and Farrell, E. (1998) A Case Series of 44 Completed Gambling Related Suicides. Journal of Gambling Studies Vol 14 (2) Summer

Ciarrocchi, J. (1987) Severity of Impairment in Dually Addicted Gamblers. Journal of Gambling Behaviour. 3 (1):2 16-26

Crockford, D. and el – Guebaly, N. (1998). Psychiatric Comorbidity in Pathological Gambling : A Critical View. Canadian Journal of Psychiatry. 43:43-50

New Zealand Health Information Services (2002). Suicide Attempt www.nzhis.govt.nz/stats/suicidefacts3.html 16 May

New Zealand Health Information Services (2001). Suicide Trends in New Zealand 1978-98 www.nzhis.govt.nz/publications/Suicide.html 30 May

Productivity Commission (1999). Australia's Gambling Industries. Draft Report, Canberra. July

Sullivan, S. (1994) Why Compulsive Gamblers Are a High Suicide Risk. Community Mental Health in New Zealand Vol 7, No 2. May

Sullivan, S. (1999). The GP "Eight" Gambling Screen. Doctor of Philosophy Thesis. University of Auckland

Welte, J., Abel, E. and Wieczorek, W. (1988). The Role of Alcohol in Suicides in Erie County, NY, 1972-1984. Public Health Reports. 103(6): 648-652

A NOTE FOR READERS

Doug Hendrie, author of the Rational Recovery article from the last issue is no longer at Nova Lodge, he is now at Rata Alcohol and Drug Service Westport.

What responsibility do researchers have for the use their research is put to? Traditionally, researchers have been trusted to honestly report their data and to evaluate the contribution their findings make to the body of knowledge in an even and impartial manner. While peer review provides some checks and balances to this process, it is limited in its ability to identify falsification of results, and frequently fails to question inappropriate conclusions or wild speculations. A number of pressures on researchers place this trust in question. The academic focus on quantity over quality of publications, the increasing influence of pharmaceutical companies on the publication process and the facilitation of public recognition researchers can gain with the political misuse of "evidence" all serve to threaten the primacy of scientific knowledge and patient care in the research process. In other words, it seems that there is a trend for research to be used not to inform a base of knowledge or to enhance patient care, but to enhance the fame of the researcher, the financial ends of drug companies and the political arguments of interested parties. In the process, the way in which research findings inform a body of knowledge is being forgotten. Researchers are drawing unjustified conclusions from their data, editors and journals are sometimes overstating research findings when reviewing or promoting their publications, and ghostwriting by professional writers appears to be able to influence the rates of citation of a paper regardless of the quality of its contents.

The recent embarrassing retraction of a previously published paper by the journal Science has served to highlight some of these issues. For those not aware of the situation, my understanding of it is as follows. Ricaurte and colleagues **("Severe dopaminergic neurotoxicity in primates after a common recreational dose regimen of MDMA ("ecstasy")" Science 2002;297:2260-2263)** published the findings of a study in which they administered MDMA (ecstasy) to primates in doses purported to be typical of those used recreationally in humans and found that this caused significant damage to dopamine neurons, and to a lesser extent serotonin neurons – something not previously found. Recently, the researchers discovered, after failing to replicate the findings in their own laboratory, that what they thought was MDMA had in fact been methamphetamine, which is well known to damage dopamine neurons. To their credit, the researchers informed the journal and the paper was retracted. Now, this in itself is embarrassing for all concerned, however, attention has now been drawn to a number of other problems with the paper that had been commented on previously, but had not received widespread publicity. Firstly, authoritative commentators pointed out that the doses used and the route of administration (parenteral) was not typical of recreational ecstasy use by humans. In fact, it is reputed that a significant number of the animals died, certainly not typical of recreational ecstasy use. Secondly, in publicizing that issue of the journal, Science overstated the results by stating that MDMA destroyed rather than damaged dopamine neurons, leading to speculation that ecstasy use could be associated with parkinsonism. Thirdly, the paper was influential in government debates about drugs, being used to indicate that ecstasy was dangerous to humans in recreational doses, despite the fact that the findings had not been replicated. Perhaps a bit more integrity from the authors and the journal at the time of publication might have avoided some of this embarrassment. And it might be a bit much to expect integrity from crusading politicians, but neither the authors nor the journal appear to have spoken out about the unreasonable interpretations being placed on the research data.

Healey and Cattell **(British Journal of Psychiatry 2003;183:22-27)** have undertaken an intriguing study of published studies involving the antidepressant Sertraline, comparing those written by a medical writing agency associated with the pharmaceutical company that makes the drug with those papers written by independent authors. Agency-linked articles had a greater number of authors per paper, the authors tended to average a greater number of prior publications, the papers themselves were significantly longer and had much higher subsequent citation rates. Now, the explanation may well be that researchers of high standing produce papers with a higher citation rate and also tend to use ghostwriters for efficiency. However, the authors conclude that most published drug trials are now not only funded by, but also designed, analysed and written by pharmaceutical companies. It is also well known that pharmaceutical companies tend not to publish research that does not support their product. Given that these papers tended to be published in journals with a higher impact factor, serious questions about the impartiality of the papers and the transparency of the process are raised. In an editorial of the same issue entitled "Increasing the trust in scientific authorship", Lagnado discusses the pros and cons of Healey and Cattells' findings **(British Journal of Psychiatry 2003;183:3-4)** and some of the solutions to the problem of undisclosed ghostwriting and gift authorship (the naming on papers as authors of people, often prominent in the field, who have had little to do with the research or the preparation of the paper).

Even when a study appears impartial and measured, making sense of the implications can be difficult, requiring knowledge of study design and appropriate statistical analysis techniques. Two articles by the same group provide a very useful overview of how to critically appraise randomized controlled trials and interpret their relevance to clinical practice **(Porter et al Australian and New Zealand Journal of Psychiatry 2003;37:257-264 and Mulder et al Australian and New Zealand Journal of Psychiatry 2003;37:265-269)**. The issues discussed are also generally applicable to other kinds of trials and while many researchers will be aware of the issues, these papers are very useful for those people wanting to make more sense of the research they read. Well worth checking out and recommending.

Continued on page 7

I've Been Reading Continued from Page 6

In this context it is interesting to note the study by Cunningham and Liu **(Addiction 2003;98:1229-1237)** investigating the effects of the US government's regulating of the supply of ephedrine and pseudoephedrine, precursors of large scale methamphetamine manufacture, on acute hospital admissions related to methamphetamine use. There have been few previous studies published on the impact of regulating drug precursors on health outcomes. Regulating occurred in stages over an eight year period, presumably each subsequent regulation adapting to drug manufacturers ability to find ways around the regulations. The authors provide evidence that each new regulation was followed by a dramatic decrease in methamphetamine -related admissions and their abstract claims that regulations targeting large scale manufacture reduced hospital admissions substantially. Their results and discussion also acknowledge that after each decline, admission rates increased again steadily, but they do not mention this in the abstract. Overall, the study is valuable in indicating that there may well be an association between regulating drug precursors and reductions in hospital admissions. However, it should be noted that these effects were temporary and that while it is likely that regulations played a part in the reductions in hospital admissions, I am not sure that their data justifies the authors' certainty that regulations were the cause of the reductions. I would feel much more comfortable about their conclusions if there had been some acknowledgement of the funding sources for their research.

Finally, while on the topic of methamphetamine, Sekine and colleagues **(American Journal of Psychiatry 2003;160:1699-1701)** present the findings of a controlled study of the association of methamphetamine use with reduced dopamine transporter densities in the orbitofrontal and dorsolateral pre-frontal cortices, supporting previous work examining densities in the nucleus accumbens and striatum **(American Journal of Psychiatry 2001;158:1206-1214)**. Together, their studies confirm widespread reductions in dopamine transporter (reuptake) densities in these regions and found an association between this and the degree of positive psychotic symptoms. Also of interest is the finding that no significant recovery in dopamine transporter densities had occurred with up to six months of abstinence from methamphetamine. Volkow and colleagues **(Journal of Neuroscience 2001;21:9414-9418)** have previously shown that dopamine transporter density may show significant recovery with prolonged abstinence (on average 17 months) from methamphetamine. This research provides possible mechanisms underpinning amphetamine associated psychosis, and may also provide an explanation for the commonly observed prolonged duration of amphetamine induced psychosis.

Message from the Chairperson

Last month the 2003 AGM for TRIG was held at the Cutting Edge Conference, Waitangi. The meeting was well attended, despite timing difficulties with some of the streams, which saw a number of conference delegates not leaving their session until the meeting was nearly over.

TRIG has continued its process of evolution, with the election of a new executive and new chair. The new executive, voted at the recent AGM, are:

Simon Adamson (Christchurch, Chairperson); David Benton (Tauranga); Paul Duborn (Hamilton); Alistair Dunn (Whangarei); Meg Harvey (Christchurch – Editor, TRN); Janie Sheridan (Auckland); Lindsay Stringer (Christchurch – Secretary/ Treasurer)

It is with real pleasure that David, Paul, and Janie are welcomed as new executive members. I'd also like to express gratitude at the contributions of outgoing executive members (choosing not to stand this year): Peter Adams, Helen Moriarty, Lee Nixon, Doug Sellman, and Eileen Varley. Particular acknowledgement must be made of Doug's contribution as outgoing Chairperson and as the person who was the driving force behind the establishment of TRIG. Stepping down from the executive does not, of course, equate to leaving TRIG altogether and we look forward to the contributions of these members to TRIG discussions and activities in future.

This edition of the TRN coincides with the start of the TRIG email discussion group, with participation by paid-up members only (for a mere $20 annually!). I believe that this discussion group has the potential to be a key component in the ongoing relevance of TRIG as an organisation. It provides the opportunity for focussed discussion of matters of interest to the group (i.e. research on treatment of addiction and related areas) without the distraction of large volumes of situations vacant postings and similar material, which at times seems to make up the bulk of the AandD netlink discussion group. It is my intention to remain enrolled in both of these discussion groups, but I am certain that it will be the less frequent postings on the TRIG discussion group that will draw more of my attention. I am optimistic that other members will find the discussion group equally valuable.

Membership remains an issue. I'd like to challenge each member to consider inviting a colleague to join. TRIG membership is sufficient to remain an active and relevant organisation, but can only be improved by greater participation from clinicians who are interested in research, and researchers working on clinical issues.

Simon Adamson
23 September 2003

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)