Treatment Research News

Alcohol, Drugs and Addiction

December 2003 *Newsletter of the Treatment Research Interest Group* **Vol 7 No 3**

EDITORIAL

At last summer is beginning to peek through all the clouds and rain and we are starting to enjoy warmer days and longer evenings. I think most people were disappointed in the All Blacks faring in the World Cup, but that was somewhat tempered by such a nail biting final. It was pleasing to have, for a short time, something that united so many New Zealanders (whether avid rugby watchers or not).

What a year it has been for the TRN, TRIG and the A&D field! The TRN is now fully electronic and available only via email to members or on the internet at the NAC website. TRIG has flourished in its first year of paying membership. There are now 59 members, most of whom are also signed up for the TRIG email discussion group.

The A&D field has had a shifting year. A lot of leaders in the field have moved jobs, either within New Zealand or to overseas posts. Ian MacEwan moved from ALAC to running DAPAANZ. Jenny Wolf is leaving CADS (nee RADS) in Auckland for the Bay of Plenty and Peter Jamieson is departing the Bridge to move into the wider mental health field. Those farewelling our fair shores include Lee Nixon, who is leaving the Nelson A&D Service for a position in Australia and John Challis, off to take up a new position in New York. In a field that loses up to 30% of its workforce each year, it is heartening that so many of the shifts occurring are within the field.

We have a bumper issue of TRN for you this month. Janie Sheridan reports on the APSAD conference in Brisbane for us. Janie is also our featured person in Names and Faces this issue. Ian Sheerin has written an article on the outcomes of methadone maintenance therapy, which expands on his Cutting Edge presentation. There are also updates regarding JDMF scholarships and the NAC. Additionally, Mary Anne Cooke from Abacus has contributed a piece about problem gambling and PTSD. Last, but never least, we have Fraser Todd's regular "I've been reading…".

I would like to take this opportunity to thank all those who gave their time and efforts for the TRN this year. It is greatly appreciated and without contributors the TRN would not exist. I wish you all very happy and restful holidays. See you next year and in the meantime happy reading.

Meg Harvey,
Editor, 25 November 2003

JDMF

John Dobson Memorial Foundation Scholarships 2004

The John Dobson Memorial Foundation (JDMF) was established in 1998 following the unexpected death of Dr John Dobson. The purpose was to perpetuate the values, energy and personal qualities John brought to bear in the care and treatment of people with drug and alcohol and broader mental health problems and to the public advocacy of their plight. The two mains aims of the JDMF are:
1. To foster the professional development and leadership potential of people working in the field; and
2. To foster ongoing development of treatment services.

Up to three JDMF scholarships ($1000) are awarded each year. This year they have been awarded to Laura Clunie (Auckland), David Benton (Tauranga), and Rhonda Robertson (Christchurch).

Laura is a final year Pharmacy student at the University of Auckland and completed a Summer Scholarship research project under the supervision of Assoc Prof Janie Sheridan and Prof Ross McCormick involving a national survey of methadone-prescribing doctors in New Zealand. Laura gave an impressive presentation of the work at Cutting Edge 2003. The scholarship will enable her to do further research work as a follow-up to the initial study.

David Benton is very well known in the treatment field in New Zealand and currently engaged in research work as part of a Masters of Health Sciences, in the area of post-traumatic stress disorder and substance dependence. The scholarship will contribute to researching a new treatment programme called "Seeking Safety" for a group of women who suffer from this comorbidity.

Rhonda Robertson has been active in the consumer movement related to opioid dependence for many years and writes "Having been fortunate enough to have been mentored by John Dobson, the opportunity to have been educated on the values of evidence-based research and concepts such as therapeutic alliance was enlightening". Rhonda will be using the JDMF scholarship to develop a consumer-based newsletter for people who are receiving methadone treatment.

Doug Sellman, Chairperson , John Dobson Memorial Foundation

Outcomes of Methadone Maintenance Therapy for Maori and Non Maori Injecting Drug Users

This study investigated changes in drug use, health status and crime in a random sample of people on methadone maintenance treatment (MMT) in Christchurch. Improvements in health are major objectives of the national methadone guidelines and are also important goals for many patients themselves. Opioid dependent people frequently have poor health status, with the most common problem being hepatitis C virus infection. Heavy drug use, tobacco smoking, respiratory problems, teeth problems, infections and injuries all contribute to poor health status.

A random sample of 85 injecting drug users was interviewed and followed up over an average 18 month period. The sample comprised 51 non-Mäori and 34 Mäori patients. Changes in health were investigated using self-reports of drug use, symptoms, and ratings using the Short Form 36 (SF-36) and also Hua Oranga, a new measure of Mäori Health outcomes. SF-36 scales measure health on eight dimensions of physical health, pain, vitality, social functioning, role emotional and mental health. The project is part of a wider economic evaluation for a PhD thesis by Sheerin (2003).

After a mean time of 57 months on MMT, There was a large reduction reported in the use of opioids and benzodiazepines. The majority of participants reported improved health, but 89% had laboratory test results showing a history of hepatitis C infection. SF-36 ratings showed that participants' mean scores on all SF-36 scales reflected significantly worse health compared with New Zealand population norms.

Comparisons with patients starting MMT in Auckland, showed that mean SF-36 scores for participants who had been on MMT in Christchurch were significantly improved in comparison (Paton-Simpson, personal communication.) This indicated that stabilisation on MMT was accompanied by improvements in physical health. Hua oranga scores also indicated moderate improvements in the four aspects of Mäori Health – Wairua, Whanau, Hinengaro and Tinana.

Participants also reported a large reduction in crime and stabilisation of their lifestyles. The main problems that were not addressed during MMT were high rates of tobacco and cannabis use, and low participation in paid employment. Also, few people had received specific treatment for their hepatitis C infection. Participation in full time work actually declined significantly while patients were on MMT. Most participants were on welfare benefits. In general, the data indicated that liver disease was not being monitored on a regular basis and that general practitioners were not usually involved in monitoring of hepatitis.

In summary, the results indicated that people who were on MMT demonstrated large reductions in the use of illicit opioids, benzodiazepines and in crime. Significant improvements in health were associated with stabilisation on MMT. The main problems that were not addressed during MMT were: high rates of tobacco and cannabis use; low participation in paid employment; and few people had received specific treatment for their hepatitis C infection.

Ian Sheerin, Terri Green, and Doug Sellman.

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.

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APSAD 2003 Brisbane

The Australian Professional Society on Alcohol and Other Drugs hosts an annual conference, venued this year in Brisbane. APSAD 2003 had three themes, one of them being the relationship between research and clinical interventions. I was only able to attend for two days, but had the opportunity to attend a number of interesting overview sessions as well as some on new research findings. Two interesting papers on naltrexone were presented. In the first (Carolyn Edmonds and Jason White, DASC, Adelaide) tested the effect of a single dose of naltrexone on alcohol consumption in binge drinkers. They chose amateur footballers (drinking in excess of 60g of alcohol at least once a fortnight) as their sample, using a double-blind placebo crossover trial design five weeks apart. Participants were given 50mg of naltrexone (or placebo) after the end of a match and asked to refrain from drinking for one hour (often difficult to accomplish)! Breath alcohol was measured and respondents were asked to complete 3 attitude statements on a 7-point likert scale about how much they liked the effect of alcohol, the taste of alcohol and enjoyed the evening. Although naltrexone reduced a "liking" for the effect of alcohol and taste of alcohol on the subjective measures, there was no impairment of enjoyment and no change in alcohol consumption. The authors concluded that there may need to be repeated doses in order to induce blockade, but more importantly the attitudes towards drinking in this group needed serious attention.

In a second naltrexone study (Jason Connor and colleagues, Princes Alexandra Hospital, Woolloongabba) health-related quality of life was measured in a matched study design of patients (43 naltrexone + 12 weeks CBT, 43 CBT only – the naltrexone group had agreed to take naltrexone) where participants were matched for age, gender, prior alcohol detox and severity of dependence. Outcome measures included the SF36 and the GHQ-28. At baseline, both groups had significantly impaired health status and after treatment there was significant improvement, but there appeared to be no additional effect with naltrexone. However, this study had small numbers.

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National Addiction Centre

Research News from the National Addiction Centre

As 2003 comes to an end staff at the NAC are preparing for the next teaching year. In addition to our four postgraduate papers we offer the opportunity for students to undertake research in the field of addiction and co-existing disorders towards a Masters degree by dissertation or thesis, or a PhD dissertation.

A Masters degree may be completed either as four 10-point papers and a thesis, or six 10-point papers and a dissertation. A thesis should "embody the results of one year of full-time or equivalent part-time supervised research", while a dissertation equates to a half-thesis. Candidates should normally include an approved research methods paper. The choice of Masters by dissertation or thesis is normally made by considering the candidates level of interest in research, academic aptitude and future intentions for study and career. Candidates considering going on to complete a PhD would normally be encouraged to undertake their Masters degree by thesis. Other reasons for choosing one over the other might be if a candidate doesn't want to limit their paper choices to only four, or if the research topic that interests them seems difficult to undertake on the reduced scale recommended for a dissertation.

Masters level graduates have a lot to offer the New Zealand addiction treatment scene. Past Masters graduates have gone on to teaching, academic, management, and senior clinical roles.

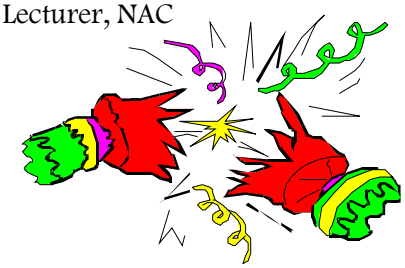
NAC staff offer a good choice of potential supervisors, collectively having experience and expertise in a broad range of subjects in the addiction and co-existing disorders field. In addition to formal supervision, all NAC academic staff make themselves available for consultation and advice to research students.

The research component of a Masters degree will often involve the planning, execution, and write-up of a student-initiated study. This is not the only option however. Research currently underway at the NAC offers the opportunity for students to incorporate their own interests into existing studies. Alternately, completed studies inevitably contain data which have not yet been fully analysed and which provide the opportunity to address a variety of questions. This option is particularly attractive when students wish to complete their research component relatively quickly, or where access to appropriate clinical samples proves difficult.

I would strongly encourage anyone contemplating a research degree with the NAC to talk to any one of the academic staff sooner rather than later, as this may help in selecting appropriate papers and will allow for preliminary discussion of research topics.

As a final note, I'm pleased to advise that interviews for the 2003 wave of the Rolling Telephone Survey (RTS) have recently been completed by Karen deZwart, NAC Assistant Research Fellow. Thank you to all who have taken part in this. The RTS has been undertaken annually since 2000 with the primary aim of tracking trends in the profile of clients attending alcohol and drug services throughout the country. In addition, the study has provided the opportunity to track staff retention. This year's survey contained a number of supplementary questions on the use of methamphetamines as part of a larger study undertaken by the Social Health Outcomes Research and Evaluation unit (SHORE). Doug Sellman will be presenting the results of the RTS, with a focus on methamphetamines, at SHORE in January next year, and will provide a summary of this material for the first TRN of 2004.

Simon Adamson
Lecturer, NAC



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In the smoking cessation section, a study carried out by Adrian Dunlop (Turning Point, Melbourne) investigated whether (I) A & D clients were interested in smoking cessation and (II) whether clinicians could be encouraged to discuss this with clients. The study was part of Turning Point's development of smoking cessation guidelines for clients in A & D treatment. The study found that 83% of staff had asked a median of 3 clients about smoking cessation, but that a few of the staff had made large numbers of these enquiries. From the 134 clients asked, 100 indicated an interest in quitting at some point. Smoking cessation interventions were initiated, but follow-up was poor. However, the study does begin to dispel the myth that these clients have no interest in smoking cessation and there is probably an important health education and improvement role for A & D clinicians.

If anyone wants further information on any of these studies, please get in touch with me and I can provide you with contact detail for the authors.

Associate Professor Janie Sheridan
School of Pharmacy
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TRIG Names & Faces

Janie Sheridan is an Associate Professor at the School of Pharmacy, University of Auckland. She is also a member of the TRIG Executive Committee.

POST TRAUMATIC STRESS DISORDER AND THE PROBLEM GAMBLER: ON THE EDGE

Similar to Post Traumatic Stress Disorder (PTSD), problem gambling received recognition by the American Psychiatric Association in the 1980 Diagnostic and Statistical Manual of Mental Disorders (DSM-III). Classified as an Impulse-Control Disorder, pathological gambling behaviour was viewed as a robust phenomenon comprising of 10 diagnostic criteria. Pathological gambling was first recognised in 1977 by the World Health Organization (WHO) in its International Classification of Mental and Behavioural Disorders.

Originally, the perception of a problem gambler was someone who was driven to gamble primarily to win money. For many problem gamblers, they never forget their first win and how it made them feel. The belief was that adrenaline surges and excitement remained unusually high throughout the gambling experience and that the decision to gamble was mostly an impulsive one. (Sullivan, 1994). Interestingly, Sullivan (1994) points out that even though pathological gambling is classified as an impulse disorder, terms used to identify addiction such as tolerance, lack of control, preoccupation and withdrawal, are also applied to understanding problem gambling behaviour.

The original perception of a problem gambler, especially within the past decade, has increasingly become a limited paradigm as significant inconsistencies have arisen. Through treatment outcomes it has been found that pathological gamblers are not deterred by consistent losses. In fact, in counselling they report an expectation of loss of money. Research has shown that there is no increase in heart rate over non-problem gamblers or greater metabolites of adrenaline. Many pathological gamblers report reduced excitement during gambling and often plan for their next gambling episode rather than it being an impulsive decision.

What may help to explain the shift in paradigm are some of the changes in the profile of pathological gamblers over the last decade. In 1992 some 80% of pathological gamblers were male, but by 2002, pathological gamblers presenting for help are almost evenly divided between men and women. During this same period modes of gambling have changed significantly with the proliferation of electronic gambling machines "pokies" into society. Gambling turnover has increased by 700% in the last decade with approximately 85% of adults seeking treatment being due to problems developed from playing pokie machines (Paton-Simpson et al, 2002). Recent research suggests (Productivity Commission,1999) that there is a significant relationship between availability and problem development.

One significant finding regarding gambling machines is that people who primarily play the pokies tend to be more depressed (Paton-Simpson et al, 2002). Individuals who are depressed can appear to be sociable in casinos or pubs, but in reality, gambling feeds their need to isolate and escape, and only relate to the repetitive mindlessness of the machines. Women with gambling problems play the pokies more than any other form of gambling. This helps to explain why women have had a raised pathological gambling profile in the past decade (Paton-Simpson et al, 2002).

With the evidence presented, it is likely that pathological gamblers are driven by negative reinforcers to escape either pre-existing conditions or the effects of gambling and that in many cases money or winning may be somewhat irrelevant while stress avoidance is a priority. It is within this complex and multidimensional paradigm of understanding a problem gambler that an association to PTSD can be made.

Since its classification in DSM-III, PTSD has also experienced limitations by the original defining features of this disorder. Complex PTSD now captures chronic life traumas, such as, childhood sexual abuse and domestic violence (Friedman 2000). Many clients of treatment providers for gambling problems describe untreated early sexual abuse, which is also a common presentation in substance abuse programmes. Subtypes of PTSD have also been questioned, similarly, Blaszczynski (2000) has examined potential subtypes and pathways for problem gamblers.

Symptoms in Common

Many symptoms of PTSD parallel the symptoms of late stage problem gambling. In both disorders symptoms of increased arousal, persistent and recurrent behaviour, and self-destructive and impulsive behaviour, are often high. These features are highlighted by the comorbid problems found in both disorders. Associated disorders such as depression, anxiety and related phobias, obsessive-compulsive, suicidal ideation and substance abuse, are common. Much like the raised profile of women diagnosed with pathological gambling disorder, limited research suggests that women also meet the criteria for on average three of the previously mentioned DSM-IV disorders comorbid with PTSD (Cloitre 1997).

Dissociation is common in both cases but clearly for different reasons. For pathological gamblers dissociation allows for escape from problems, where as for PTSD, dissociation includes a sense of reliving the trauma (Friedman 2000). Another difference for the two disorders is the way in which death is perceived. For gamblers death may be perceived as a solution rather than a traumatic threat.

Feelings of shame, despair and hopelessness are strong elements of concern, along with somatic complaints. For a gambler, they will admit to associated health problems far before acknowledging a gambling problem (Sullivan, 1994 and 2000).

Emotional numbing is strongly apparent in both disorders. In the short term it is helpful in reducing the impact level of the stressor to something bearable, but in the long term, it harmfully reinforces the symptoms of the disorder. By emotionally detaching, it allows the gambler to continue gambling to attempt to solve their indebtedness and avoid the mounting consequences of their gambling behaviour (Sullivan 2000).

The impact of gambling on the family can be a devastating by-product. Research suggests that for every problem gambler seven other people are negatively influenced (Productivity Commission, 1999). Similarly, family members of someone with PTSD are also affected. Depression, guilt and shame, substance abuse, and sleep and health problems, are common features found in family members of both disorders (Carlson and Ruzek, National Centre for PTSD Fact Sheet, 2002).

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Post Traumatic Stress Disorder and the Problem Gambler: On the Edge

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Even though the emphasis so far has been on considering the similarities between the two disorders, it is important to mention a few distinguishing characteristics. For one, re-experiences of gambling are not dysphoric. Also, stimuli that raise gambling are not avoided except in attempts of recovery. Lastly, gambling participation is usually not a traumatic event, however, how PTSD and problem gambling could potentially impact on one another will now be explored.

Risk Factors in Common

PTSD cannot be diagnosed unless an individual has had exposure to some form of trauma, and conversely, trauma alone does not predispose a PTSD diagnosis. What stands in between these two concepts is the way in which an individual processes, cognitively and emotionally, the event. Different trauma thresholds help to determine who may become more vulnerable to developing clinical symptoms (Friedman 2000).

To understand the trauma threshold further, research has examined predisposing risk factors and their synergy with traumatic events. For example, an epidemiological study conducted in the United States on the readjustment of Vietnam veterans found that risk factors such as family history of substance abuse, physical abuse and deviant behaviour as a child, negative relationships with immediate family and lower educational attainment increased the likelihood of developing war-zone related PTSD (Friedman 1998). This same study also found that cultural minorities were at greater risk of developing PTSD. Similarly, cultural minorities in New Zealand run a greater risk of developing problem gambling behaviour; Mäori are three times and Pacific People are six times more likely (Abbott and Volberg 1991). An affiliated study examining the readjustment of women veterans returning from Vietnam also found that access to high levels of social support helped to reduce the risk of developing PTSD symptoms (King and King, National Centre for PTSD,1998).

As highlighted earlier, there is consensus that problem gambling may be better viewed as an addiction rather than an impulse disorder (Sullivan 2000), therefore, it is within the addiction framework that theories of predisposition are also consulted. The General Theory of Addictions (Jacobs 1989) is widely accepted when addressing substance related disorders and has also been applied to problem gambling. This theory suggests that addiction, as a way of self-medicating, may be the result of predisposed features of anxiety, along with a self-identity of inadequacy/rejection that may have formed in childhood. Consequently, addictive responses can follow trauma as a dysfunctional adaptive strategy.

PTSD and substance abuse comorbidity has been recognised in many clinical studies, especially when testing self-medication theories. Meisler (1996) refers to one study by McFall et al (1992) in which certain PTSD patterns could predict substance use patterns. For example, alcohol problems were often associated with elevated arousal symptoms and drug abuse was often associated with heightened avoidance/numbing features.

Considering no studies have specifically investigated the relationship between problem gambling and PTSD, one can assume that findings from many studies examining PTSD and addiction equally apply. With this in mind, anecdotal evidence suggests that pathological gambling may lead to trauma. Statistically, 20% of pathological gamblers attempt suicide and 60% of pathological gamblers commit criminal offences. Within the prison system, 25% of male (Abbott et al, 2000) and 33% of female (Abbott and McKenna, 2000) inmates are problem gamblers. Domestic violence and homicide cases are increasingly associated with problem gambling. Many gamblers who rely on loan sharks live in fear and/or experience brutal retaliation when not able to pay back debts.

In one study by Cottler et al (1992) addressing the prevalence of trauma and PTSD in substance abuse patients, it was found that opiate and cocaine users reported the greatest prevalence of trauma and that women who were presenting with cocaine/opiate addictions were at risk of developing PTSD symptoms independent of trauma exposure. These types of drug use can dramatically change a persons way of life. Pathological gambling can also cause lifestyle devastation and it is hoped that future research begins to look at the uniquely associated properties between PTSD and problem gambling.

Best Approaches

Clinical experience suggests a concomitant approach for addressing features of both PTSD and problem gambling. If only one disorder is receiving intervention, symptoms of the other disorder run the risk of becoming increasingly unmanageable. Also, substitution is a common maladjustment to addiction recovery, and relapse prevention should refer to the risks of drawing towards other addictive behaviours or substances for coping management.

Similarly, PTSD and problem gambling share counselling interventions in common. Providing a safe and supportive environment is crucial for building trust. Rogerian acceptance rather than elements of confrontation allow grieving for the loss and the development of skills to enhance coping. Such cognitive-behavioural therapies as exposure, desensitization and cognitive restructuring have been highly successful, along with selective serotonin reuptake inhibitor medications (Friedman 2000). Group therapy at later stages of recovery is also highly effective and can focus on present and future aspects. Future research will significantly extend our knowledge about the relationship between PTSD and problem gambling, and enable the design of effective interventions to address both disorders.

Mary Anne Cooke, Director,
Abacus Counselling and Training Services Ltd.

Please contact the Editor if you would like a copy of the references from this article.

Message from the Chairperson

Since TRN was last published the TRIG email discussion group has been launched. Activity has been relatively light to date, but has provided the opportunity for discussion of methamphetamines, outcome evaluation in methadone treatment, and impressions of Cutting Edge 2003, including consideration of topics/speakers for next year.

In the last Message from the Chairperson I advised readers of the TRIG executive membership. Subsequently Paul Daborn has had to stand down due to workplace changes. Paul was thanked for his contribution to the executive, which although brief included an excellent recruitment drive at his service so that the Waikato is now well represented within TRIG's membership. I am very pleased to advise readers that Raine Berry has been co-opted as a replacement member of the executive. Raine is a Senior Psychiatric Nurse in the Marlborough/Nelson region and has previously been Chairperson of TRIG and Editor of TRN.

At the time of writing TRN the Mental Health Commission is in the process of updating the *Blueprint for Mental Health Services in New Zealand*. This document was published in 1998 and sought to provide a benchmark for service delivery, and explicitly includes alcohol and drug services within its scope. The *Blueprint's* population-based estimates of optimal bed numbers and FTEs for inpatient/outpatient services has informed reactions to the closure of the Hanmer residential programme, but also has been invaluable in lobbying for increased methadone provision.

An essential ingredient for policy documents such as the *Blueprint* is accurate data, in terms of prevalence rates and treatment effectiveness, to name just two broad domains. The research required to furnish these data is a combination of international and local research, with many gaps still apparent. Examples of research questions requiring New Zealand-specific answers include:

- How can mainstream treatments (e.g. 12-step, CBT) best fit with traditional practices in kaupapa Maori services?
- What are the pharmacotherapies for opioid dependence that would best fit in with the dominant service structure and best substitute for the New Zealand type and pattern of opioid use?
- What interventions will be most successful in intervening with cannabis dependent young adults and how might we identify and access this group?

The *Blueprint* is a document that has been widely used since it was first published. A revised document is likely to continue to exert a significant influence over treatment delivery in New Zealand over the coming years. I would like to encourage members to contribute to this revision process if the opportunity arises, and to do so in a way that is consistent with the ethos of TRIG, to improve treatment delivery with the assistance of relevant research findings.

Finally, I'd like to wish all readers a relaxing festive season. Whether you are spending time with family or friends, or perhaps trying to find a bit of time to yourself, may it allow you to return to the workforce in 2004 with renewed enthusiasm.

Simon Adamson
TRIG Chairperson

ADOPT November Progress Report

Following ethics approval from the National Ethics committees in the second part of this year, data collection began (quantitative postal survey, qualitative interviews and focus groups).

We would like to thank the sector for the good response rate to the treatment outcome questionnaire of treatment providers that was distributed nationally. The majority of services reported using some form of treatment outcome measure, including consumer satisfaction surveys. The services strongly endorsed the need for outcome measurement, but acknowledged a gap between what they were doing and what they wanted to do. TRANX Christchurch won the draw for the morning tea.

In conjunction, over fifty people will have provided information to this project via focus groups and individual interviews. This group comprises a mix of consumers, clinicians and counsellors, Pacific, Asian, youth workers, managers, funders and policy makers, and researchers. These focus groups highlighted a range of themes, including the challenge of capturing the diversity of outcomes for alcohol and drug consumers and service providers.

Input was also sought from a Mäori expert advisory group. A number of issues were raised, but general support for routine outcome measurement was given. Clear recommendations for development of a specifically Mäori focused process of development were given and the need for further consultation with the range of Mäori stakeholders emphasised.

Another key challenge is the use of terminology and clarity of understanding between the use of the words "outcome", "outcome measures" and "outcome measurement systems". This is not surprising given the emphasis on improving the quality of the treatment and service outputs as opposed to individual consumer outcomes.

Currently the information gathered is being reviewed and analysed. The key findings from the literature review will be drawn together with the input from the focus groups and interviews. It is planned that recommendations will be presented at key meetings early in 2004, with a final report to the MHRDS at the end of March.

The ADOPT Research Team

I've Been Reading ...

Some months it is hard to find the time to keep up with all the interesting and important publications. Thankfully there are occasional months in which the pickings are thin and there is time to catch up. And very occasionally, there are several lean months in a row. As Mr. Murphy, with whom I find myself all too frequently acquainted, has postulated, those months will usually occur when it is time to tell others of the exciting reads I have been having. So predictably, with another "I've been reading…" to write, this is one of those times.

Off the top of my head, I can think of few journal articles I have read that are worth telling you about. I could mention the paper by Haddock and colleagues **(British Journal of Psychiatry 2003;183:418-424)** describing a rather elegant randomized controlled trial of CBT + Motivational Interviewing + a structured family support package versus standard outpatient treatment for people with co-existing treatment resistant schizophrenia and substance use problems. The treatment CBT/MI/Family Intervention group had significantly better improvements in global functioning and positive psychotic symptoms over 18 months of follow-up despite no significant changes in substance use. Furthermore, they showed that the CBT/MI/Family Intervention was cost effective. Unfortunately, the study was hampered by two significant factors which severely limit the generalisability of the findings. First, an entry requirement for the study was that the subjects had to have more than 10 hours a week contact with a supportive care giver. In my clinical experience, most adults with treatment resistant psychotic disorders and substance use problems do not have the luxury of this sort of support. Second, and probably associated with the first point, while the catchments area was mental health services in the North-West of England, they were only able to find 66 pairs of suitable patient/carers, and of those, only 36 consented to be in the study, 18 in each treatment condition. So unfortunately, a rather elegant study and to my knowledge the first randomized controlled trial of psychological interventions in the area of dual diagnosis offers us little in terms of our clinical practice. Clearly the North-West of England, as close to Ireland as it is, suffers unduly from the influence of Murphy.

Leinart Heimer provides a complex update on the neuroanatomy of substance use and mental health disorders **(A new anatomical framework for neuropsychiatric disorders and drug abuse, American Journal of Psychiatry, 2003;160:1726-1739)**. He begins describing the history of research into brain structure and then outlines the current state of knowledge of the neuroanatomy of neuropsychiatric disorders and then discusses the role of the extended amygdala. The article promises much and on Murphy's recommendation I spent considerable time trying to understand exactly what Heimer was trying to say before realizing that while undoubtedly important for future brain research into the area of addiction, the current theories are still a long way from having any direct clinical relevance.

The November edition of the American Journal of Psychiatry **(160;11:2003)** has a series of articles on neuroimaging and mental functions, summarized in an editorial, Towards a Biochemistry of Mind **(American Journal of Psychiatry 2003;160:1907-1908)**. Basically, most of these articles describe studies in which subjects perform certain tasks or have certain experiences while in a PET or brain scanner or similar machine. One interesting study by Borg and colleagues **(American Journal of Psychiatry 2003;10:1965-1969)** appears to have linked "spiritual acceptance" with lower densities of the 5HT1a (serotonin 1a) receptor. While it is not yet clear what lower versus higher serotonin receptor densities mean, the link between brain and spirituality is emerging. This introduces the intriguing field of neurotheology. Perhaps more interesting is a book I have recently been reading. Eugene d'Aquili and Andrew Newberg weave an interesting series of models, which are surprisingly well founded in neurophsychological evidence, to explain the biological basis of religious experience. While the title is perhaps a little uninviting **(The Mystical Mind, Fortress Press, Minneapolis 1999)** the book provides an interesting introduction to the burgeoning area of neurotheology which, with some license, promises to inform clinical practice in an area we often deal poorly with. While they do consider the broad neuroanatomy of spiritual experience, they also take a modular and evolutionary approach to brain function which is rather convincing. All in all the book is both interesting and useful in terms of helping us to think about spiritual experience in a way that is consistent and connected with psychological and biological understandings of the brain-mind. Well worth a read for those interested in this area.

And that's it from me and Murphy for this year. Have a great Christmas/New Year.

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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 2004 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)