Treatment Research News

Alcohol, Drugs and Addiction

April 2004 *Newsletter of the Treatment Research Interest Group* **Vol 8 No 1**

EDITORIAL

Who are we? Why are we here? Don't panic, this is not another editorial/review of Mel Gibson's The Passion of the Christ. It is not even asking any grand philosophical or religious questions. Actually it is addressing a theme that appears in a number of the articles in this issue of TRN – the evolving A&D field.

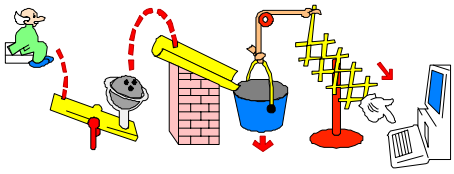
The A&D field is at quite a crossroads. Currently challenging us is the growth in the use of methamphetamines and all the issues that carries with it. As methamphetamine users start to access A&D services, A&D workers are being forced to suddenly increase their understanding of the drug and its consequences. The questions around integrating problem gambling into A&D or Mental Health services are also posing new challenges for the field. As well, a number of services are shutting down or changing names/focus. Additionally, many members of the A&D field who have been leaders or inspirations have left or shifted their focus. Have we been left with gaps or is there a new "generation" eager to come through and take over? There undoubtedly seems to be a number of keen A&D workers out there, ready to help the field prosper. The membership of TRIG is certainly growing steadily.

While that mulls over in your mind (and perhaps prompts a letter or two to the editor?) let me say welcome to the Treatment Research News for 2004. I would comment on summer, but I think we are all still waiting for it! Autumn is a wonderful season though and offers so much pleasure in its colours and sunsets. We will be bringing you three issues of the TRN this year with all the usual favourites and some very interesting articles.

In this first issue of TRN Fraser Todd provides the ever thought provoking "I've been reading…". Doug Sellman reports on amphetamine users accessing A&D services as seen in the Rolling Telephone Survey. Sean Sullivan discusses problem gambling treatment from a co-existing perspective. We also have an update from the Wellington School of Medicine on some of the research underway there. Simon Adamson provides both the TRIG Chairperson's message and an update of NAC activities.

I look forward to bringing you interesting, helpful and provoking information throughout the year. Happy reading.

Meg Harvey
Editor
22 April 2004



TRIG MEMBERSHIP

The executive committee of the Treatment Research Interest Group (TRIG) would like to take this opportunity to remind current members that membership of TRIG is annual. Currently we have 61 members most of whom need to renew their membership for 2004.

New members wishing to join TRIG are warmly invited to fill in the membership form on the last page of this newsletter. Current members are also able to use this form to renew their membership.

Membership of TRIG entitles members to an email copy of each edition of the Treatment Research News (TRN) and participation in the TRN discussion group.

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, Raine Berry, Alistair Dunn, Meg Harvey (Editor), Janie Sheridan, Lindsay Stringer (Secretary)

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Problem Gambling Treatment from a Co-Existing Perspective

The perspective of pathological gambling as an addiction is a relatively accepted paradigm, despite it being categorised in DSM as an impulse disorder. Non-chemical dependence appears to be an uncomfortable concept, and so pathological gambling has, since its inclusion in DSM-III (1980), remained described as an impulse that has not been restrained.

In New Zealand, however, problem gambling (inclusive of pathological gambling, its most extreme expression on the gambling-problem gambling continuum) has been largely accepted as an addiction, and presentations have been regularly delivered at Cutting Edge conferences over the past decade or so. In the last year addressing the issues of problem gambling passed another important milestone with the enactment of the Gambling Act in September 2003. From that date the Ministry of Health assumed responsibility for the minimisation of harm that may rise from problem gambling, for the first time bringing problem gambling under the direction of mainstream health provision.

An important question now to be answered is, how should problem gambling treatment be delivered most effectively? The placing of problem gambling treatment under the umbrella of other mental health services not only legitimises the field formerly funded directly by the gambling industry, but also raises the potential of treatment delivery through other allied addiction therapy providers. There is evidence of varying levels of persuasion that problem gambling, as it becomes more intense, will co-exist with a number of additional negative conditions, some of which will be addictions. Substance abuse, particularly alcohol, is common with findings of between 25% and 63% of pathological gamblers meeting the criteria of substance use disorder in their lives (Shaffer & Korn, 2002). In New Zealand, research with alcohol treatment providers has identified 11% of clients meet the criteria of pathological gambling (Mackinnon & Paton-Simpson, 1999).

Problem gambling appears to constantly co-exist with a range of other conditions, such as (in varying degrees), depression (up to 78%), anxiety disorders including Post-traumatic Stress, GAD and Panic Disorder, alcohol abuse, personality disorders including Borderline PD and the previously inconsistent Antisocial PD, and the list goes on (Unwin et al, 2000; Shaffer & Korn, 2002). Some researchers have queried whether problem gambling is not better defined with these symptoms rather than described as separate co-existing conditions (Shaffer et al, 1997).

This perception has a considerable impact upon the future development of the field of problem gambling. Questions that arise may rightly be:

- How do these co-existing conditions impact upon the effectiveness of problem gambling focussed therapy (whether the co-existing condition existed before the gambling problem or not)?
- In any event, if these 'additional' conditions commonly co-exist, shouldn't they be addressed in any treatment plan of 'problem gambling'?
- Does the current problem gambling workforce have the skills to identify and address these 'additional' symptoms?

All of these questions require consideration if the signaled importance placed upon addressing problem gambling sent by the mainstreaming effect of the Gambling Act is to be realised in the treatment sector.

The WHO, in a recent seminal paper in the chemical addiction field noted:

> 'There is significant comorbidity of substance dependence with various other mental illnesses; assessment, treatment and research would be most effective if an integrated approach were adopted…Attention to comorbidity of substance use disorders and other mental disorders is thus required as an element of good practice in treating or intervening in either mental illness or substance dependence'
>
> p248, WHO (2004)

This view appears to be even more appropriate to problem gambling addiction. The high degree of comorbidity, and the poor history of problem gamblers to complete referrals, raises the need for a 'one stop shop'. Pathological gambling is defined as a 'persistent and recurrent' behaviour in DSM-IV and it may well be that a major influence on relapsing is failure to address these comorbidities as an integral part of the gambling behaviour.

Some amongst us may note that few therapists in addictions have skills in treating anxiety, depression and particularly personality disorders. The catchcry 'a little knowledge is a dangerous thing' is likely to be voiced strongly, and that referral to experts in these fields is the best practice. In addition, raising the skills of the existing problem gambling workforce to an expert standard in a number of additional fields may seem unlikely.

Others, however, may counter-argue that a level of expertise is not required and would be 'gilding the lily'. Training to recognise the various categories of anxiety disorders, depression and drug misuse, could be supported by brief, effective screens. Brief interventions may reduce the negative effects of these symptoms that may impact upon recovery from problem gambling. Almost certainly not addressing these symptoms will contribute to relapse, while recognising when, as a therapist, you are getting out of your depth would be part of the necessary training to ensure safety. In addition, both training and limits to interventions are determined not only by clinical considerations, but also by funding requirements. The often heard 'we are not funded to do that' can conflict with clinical sensibility.

Perhaps the welcoming of problem gambling into the mainstream health field can be a catalyst for skills enhancement for all addiction therapists. Problem gambling therapists may also be interventionists for substance misuse and anxiety/ depression, while AOD therapists become problem gambling interventionists and anxiety/depression.

The future of problem gambling therapy delivery now appears to be wide open with the possibility of several new 'starters in the field'. The skills appropriate to best practice in this field may require further training, and rather than viewed from the perspective of a barrier, perhaps the better view would be that outcomes may improve while improving the quality and skills of the field as a whole. A parallel approach would be upskilling other addiction therapists to address problem gambling amongst their own clients. The integration of problem gambling treatment into mainstream health provision may be an opportunity to start with a clean slate and model a new approach for all addiction treatment delivery. It could really be a winner!

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For a list of references please contact the TRN Editor

Message from the Chairperson

The March 12 edition of the New Zealand Medical Journal was focussed on addiction, with four original papers and an editorial. The original papers dealt with the contribution of alcohol consumption to the risk of heart disease, smoking in University students, reduction in crime within a methadone treatment programme, and amphetamine use within the general population. The editorial, written by Professor Roger Mulder of the Christchurch School of Medicine and Health Sciences, highlights the paucity of clinical addictions outcomes research being conducted in New Zealand. To illustrate this Professor Mulder identifies the findings of one of the papers as showing that amongst University students Maori women are more likely to be smokers (Kypri & Baxter, 2004, NZMJ 117(1190)). This finding is unlikely to surprise anyone, as we have found time and again that Maori women are over-represented amongst smokers. Professor Mulder suggests that rather than conducting more surveys, research energy should be directed to areas such as developing effective smoking cessation programmes for Maori women.

Evaluation of any treatment targeted specifically at Maori populations would obviously need to be conducted in New Zealand. It is not only with this New Zealand-specific population that treatment interventions would benefit from evaluation in the New Zealand context however. There are a variety of factors, which may differ from one country to another, that may impact on treatment delivery and outcomes. These include the range of substances used and their cost, differences in treatment configuration, and social factors, such as degree of religiosity and tolerance of binge drinking.

Treatment outcome trials have been conducted in New Zealand, but they are few in number. The appeal of survey-oriented studies is that they are comparatively cheap and can collect a large amount of interesting data in a short time. Conducting an outcome trial requires a substantial level of funding and a commitment to the two to five years required to plan, recruit, treat and follow-up the treatment sample.

As the addiction research community in New Zealand grows it is the hope of TRIG that there will be an increase in the number of treatment trials undertaken. Such an aspiration may be supported at a variety of levels. Treatment outcome research in the addiction area in New Zealand is most likely to occur if it is seen as a priority by funders such as ALAC and the HRC, if clinical services are willing to co-operate in the running of treatment trials/evaluations, and if there is a strong addiction research workforce willing to undertake such activities. TRIG has an important role to play in promoting the value of such research to each of these stakeholder groups.

Simon Adamson
TRIG Chairperson

Students Research Addiction Issues in Wellington

Medical students in Wellington have the opportunity to participate in addiction research for their summer holiday jobs. In recent years a number of interesting projects have been undertaken by the students. The following reports on two recent projects:

Elizabeth Stockwell was working full time at Hutt Hospital over Summer 2003/4 on a project entitled "What about pot?". Elizabeth is an Otago medical student who has just completed the 4th year course. Her project is an intervention study using junior medical staff as participants. Elizabeth has delivered personal and group educational messages to the medical staff about the importance of including cannabis smoking history in the smoking history of patients admitted to hospital with medical health problems. An audit of the medical records of patients admitted before she started the interventions will be compared with an audit after her interventions to see if the level of cannabis smoking (and nicotine smoking) documentation has changed. The "before" audit has shown that cannabis smoking was not recorded routinely in medical admission notes. In a qualitative arm to her work she is also interviewing the medical staff to find out how comfortable they feel asking hospital patients about cannabis smoking and what are the barriers to asking . Elizabeth advises medical staff to use motivational interviewing and a brief intervention when they meet a patient who smokes cannabis.

This project is very topical. The BMJ in 2003 has carried a number of recent articles, and a letter debate about the general health hazards of cannabis smoking. Her project is funded by the Asthma Foundation.

Nimeshan Geevasinge has completed the Medical Attitudinal Attributes Survey. Nim is a New Zealander studying for his Medicine degree in Sydney, he returned to Wellington for this summer research project. His is a qualitative project which explored the client perception of the attitudes of health professionals toward problems of addiction. He interviewed 15 longstanding clients of addiction treatment services. Clients were asked to explain what they saw were helpful and less helpful professional attitudes during treatment and to suggest ways in which health professionals in training might develop therapeutic attitudes toward people living with addiction. The findings have highlighted ongoing health professional knowledge gaps and low confidence in tackling addiction problems as well as identifying attitudinal attributes that most impact upon the clients. Nim has already published a brief report, and has submitted a paper for publication. This work has particular relevance to medical curriculum planning. His research project was part-funded by ANZAME, the Australia and New Zealand Association of Medical Educators.

Helen Moriarty
Wellington School of Medicine

Methamphetamine Use Amongst the New Zealand Alcohol and Drug Treatment Population: Results from a National Telephone 2003

The NAC is dedicated to developing and promoting effective interventions for people with alcohol, drug and addiction related problems in Aotearoa New Zealand. In order to achieve this, accurate data on the nature of the problems experienced by people who present for help are necessary. The NAC conducted a comprehensive telephone survey of the field in 1998 [Adamson et al 2000] and subsequently has been conducting a series of smaller annual surveys of the alcohol and drug treatment field. The primary purpose of these annual national surveys has been to monitor over time the drug use patterns of people presenting for help to the dedicated alcohol and drug treatment services, as well as monitor the main substance use problem of people presenting for help at alcohol and drug treatment services.

Over the last few years, the rate of methamphetamine use amongst clinical populations has become of increasing interest as the rate has appeared to rise in general population samples. This article outlines the four national surveys 2000-2003 with particular focus on the 2003 survey results when additional questions were asked related specifically to methamphetamine. For the purposes of this research the broader term "amphetamine" was used to refer to "speed, methamphetamine, P, or pure" in order to include the main street names for methamphetamine.

A database of all dedicated alcohol and drug treatment workers (ADTWs) was first developed for the 1998 National Telephone and has subsequently been updated annually for the ongoing national surveys. An ADTW has been defined from the beginning as any paid staff member working in a dedicated alcohol and drug treatment service who spends at least 70% of their paid time, working with alcohol and drug clients. From the updated database a randomized list of ADTWs is obtained for telephone surveying. Over the course of the 2000-2002 surveys, 105 ADTWs were contacted from 170 identified, yielding a response rate of 61.7%. A higher response rate of 70.2% was achieved in the 2003 survey, when 59 ADTWs were contacted from 84 identified.

A ten-minute telephone interview with each contacted ADTW related to the last patient they had conducted an initial assessment interview with, so long as they had interviewed someone in the previous two weeks. The questionnaire focused on the main substance use problem the patient presented with, followed by a review of all drugs used by the patient in the week prior to presentation. The same questionnaire was then faxed to each ADTW to be used on the next patient they interviewed and the data faxed back. During the 2000-2002 surveys 147 interviews were completed (74 telephone, 73 faxed); 85 interviews were completed in 2003 (48 telephone, 37 faxed).

The mean age of patients in the 2003 survey was 31.5 years, which differed little from that of the 2000-2002 surveys at 30.3 years. The percentage of Maori patients was 24.7%, which again was similar to the 29.3% in the previous surveys. However, there was a significant gender difference between the 2003 survey (47.1% male) and the 2000-2002 survey (65.3% male).

There were two key findings of the 2003 survey. Firstly, amphetamines were the main substance problem of 18% of people presenting to alcohol and drug treatment services in New Zealand in 2003 and had eroded the prominence of alcohol and/or cannabis as the main substance problem from 76.2% to 57.7%. Secondly, stimulant use in the week prior to presentation was found in 22.4% of patients. This had risen from 6.8% across the 2000-2002 surveys and now places stimulants as the fourth most used class of substances in patients presenting for assistance. Methamphetamine is the most commonly used stimulant. These data indicate that the rise in methamphetamine use in the general population over the past five years is now impacting on alcohol and drug treatment services, to the extent that about one in five patients cite methamphetamine alone or in combination with other drugs as their main substance use problem.

There is clearly a workforce development issue in terms of methamphetamine for alcohol and drug treatment services and in fact a number of interviewees spontaneously voiced this during the survey. Clinicians need to quickly become knowledgeable and skilled regarding the nature of methamphetamine dependence and the range of common problems associated with it. This would include: the symptomatology of methamphetamine intoxication and withdrawal, and appropriate treatment strategies; signs, symptoms and treatment of a range of psychiatric syndromes associated with methamphetamine use (particularly mood disorder and psychosis); and the care and management of people with methamphetamine dependence as an addiction, which has the capacity to severely impact on a person's finances, relationships and general health.

Associate Prof Doug Sellman
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References

Adamson SJ, Sellman JD, Futterman-Collier A, Huriwai T, Deering D, Todd F, Robertson P. A profile of alcohol and drug clients in New Zealand: Results from the 1998 national telephone survey. New Zealand Medical Journal 2000;113:414-416.

Research News from the National Addiction Centre

Following my comments in the Message from the Chairperson I feel obliged to briefly highlight treatment outcome research undertaken by the NAC. The most substantial outcome study was the Brief Treatment Programme (BTP, principal investigator Doug Sellman), a randomised controlled trial of Motivational Enhancement Therapy for mild to moderate alcohol dependence. Outcome was evaluated in a more naturalistic context in 1) the Naturalistic Treatment Outcome Project (NTOP, principal investigator Simon Adamson), which evaluated nine-month treatment outcomes for a representative sample receiving treatment as usual at CADS Christchurch and CADS Hamilton, while 2) the Degree of Drug Use Validity Study (DDIVS, principal investigator Daryle Deering) comprised repeat interviewing, twelve months apart, of a large sample of patients on the Christchurch Methadone Treatment Programme. Three treatment outcome studies underway are 1) Te Aka Roa o Te Oranga (TAROTO, principal investigator Paul Robertson) evaluating two existing kaupapa Maori services and focussed primarily on developing an evaluation framework appropriate to such treatments, including outcome evaluation, 2) A four-year outcome study from the original BTP sample (principal investigator Simon Adamson), and 3) The effect of naltrexone on the craving for gambling and other addictions (principal investigator Dominic Lim). Three outcome studies currently being planned are 1) the New Zealand Combined Treatment Study (NZ Combine), a double-blind placebo controlled trial of combined naltrexone/ citalopram or placebo/placebo in addition to comprehensive psychosocial treatment for patients with comorbid alcohol dependence and major depressive disorder (start date July 2004, principal investigator Doug Sellman), 2) A five-year follow-up of the original NTOP sample (start date March 2005, principal investigator Simon Adamson), and 3) An evaluation of a purpose-designed kaupapa Maori treatment programme to be developed following the current stage of TAROTO (date to be advised, principal investigator Paul Robertson).

On a different note, earlier this year a contract was signed with the Ministry of Health establishing the NAC as the venue for a national addictions workforce development programme. This contract ensures the continuation of the NAC following the completion of the seven-year contract from ALAC that saw the establishment of the then National Centre for Treatment Development (NCTD) in 1996.

To deliver on our obligations under this new workforce development contract we have set about increasing our staff, by advertising four research positions and one administrative position, and the establishment of two NAC satellites: one in Wellington, where Ian MacEwan has been appointed to manage the workforce development contract, and one in Hamilton, involving Dr Murray Hunt, Dr Vicki Barrett and Vicki Crarer, with continued involvement by Dr Joel Porter, now with the University of Auckland's Centre for Gambling Studies.

The workforce development contract entails a range of activities that will contribute to a more integrated and professionalised addiction workforce in New Zealand. From a research perspective, the first task will be to conduct a repeat of the 1998 National Telephone Survey (NTS) of the addiction workforce, in order to assist in strategic planning for the five years of the workforce development contract. The 1998 telephone survey involved interviewing over two hundred randomly selected "dedicated alcohol and drug treatment workers" (ADTWs) over a three month period. ADTWs were defined as clinical staff who spent 70% or more of their working time with alcohol and drug clients. The 1998 NTS provided a rich source of data on who the workforce was, in terms of demographics, qualifications, and experience, what their attitudes were towards alcohol and drug clients and towards mental health services, information on optimal and current practice, and also provided a snapshot of a representative sample of alcohol and drug clients.

It is intended that the 2004 NTS will repeat much of what was contained in the original survey and will additionally seek more detail in areas pertinent to workforce development, in particular existing qualifications, training needs and options, and staff retention. Possibly the major finding of the annual Rolling Telephone Survey, which grew out of the initial 1998 NTS, was the high rate of staff attrition – 38% per year – experienced within the alcohol and other drug treatment sector. A companion project to the 2004 NTS will be a series of "exit" interviews with staff having recently left their jobs and also a series of "longstanding" interviews with staff who have been retained within the addiction field for a number of years. The Hamilton satellite will take the lead on this second project.

The 2004 NTS interviews will be conducted from June to August of this year and it is hoped that preliminary data will be available to present at Cutting Edge 2004 (Palmerston North, September 2-4). The success of the study will rely, once again, on the goodwill and co-operation of treatment services and treatment workers asked to participate.

Simon Adamson
Lecturer

CUTTING EDGE 2004

A reminder that Cutting Edge 2004 will take place at the Palmerston North Convention Centre on September 2-4.

The call for papers closes on Friday 28th May.

For further information or registration forms please contact Lisa or Lindsay (lisa.andrews@chmeds.ac.nz or (lindsay.stringer@chmeds.ac.nz)

I've Been Reading ...

To be honest, I have read little in the past few months that has sparked my imagination or seemed to have relevance for my clinical practice. Maybe it's just a lean run for the journals. Maybe my focus is narrowing. Maybe the published research literature is losing its perspective a bit, in terms of what is relevant and less relevant. Whatever the reason, I am only going to mention two articles, both for the peripherally related issues they raised for me rather than their content.

As I have been writing this article, I have been following the advertisements for the visit from a US speaker on behalf of LEAP, a body of interested parties opposing drug prohibition. We seem to be regularly visited in New Zealand by foreign "experts" willing to tell us about their experiences in the "war on drugs". I guess most of these speakers are not paying their own way. The general theme appears to be that those involved in fighting drug use are losing the battle. The key point of difference being that some believe we need to fight harder and others that we need to stop fighting, or at least change the way we fight. There are many examples throughout history of central state or social authorities trying unsuccessfully to control the illicit use of substances. Most of these attempts are aimed at drugs which are produced by means that are difficult to tax and regulate, or at dealers and users who are difficult to tax and regulate. A recent article by Valenstein and colleagues (***Benzodiazepine use among depressed patients treated in Mental Health settings, American Journal of Psychiatry 2004;161:654-661***) while of only peripheral relevance, indirectly raises an important issue. The article describes research showing that 36% of depressed patients treated in a mental health setting, in this case Veterans Administration services in the US, receive prescriptions for benzodiazepines and that these tend to be longer term prescriptions for greater than 90 days supply, despite American Psychiatric Association guidelines recommending the minimization of such prescribing. This raises important issues in the treatment of depression, but even more important issues for the "war on drugs". Now, I have no doubt: that methamphetamine labs are a scourge on society, and that methamphetamine use is of increasing concern; That "tinny houses" are problematic and the world might be better off without them; That drug dealers should probably be prosecuted and put out of business due to their ruthless lack of concern for the problems they play a part in maintaining. But, let's face it, in New Zealand the majority of drug-related harm probably comes from drugs which are quite easy to regulate if the motivation is there to do so. Nicotine and alcohol are the two obvious examples, but we also need to remind ourselves that the vast majority of illicit opioids in New Zealand are prepared from prescribed medications (MST, methadone for example) or pharmacy-only medications. As far as I know, horticultural entrepreneurs have yet to develop a valium plant capable of hiding out in the back blocks. All benzodiazepines are manufactured by drug companies and most are prescribed by doctors. Ritalin is a prescribed medication. Pseudo-ephidrine is usually sold by pharmacies. Now, whether or not we should limit the supply of these drugs is a moral issue that I don't want to get into here, but I must admit that in this context the "war on drugs" appears to be missing the target. The key issue would therefore be one of intent and motivation; how much do governments really want to address these issues? Enough to tackle the biggest sources of drug related harm, or simply the targets more likely to engender public support?

The second research article to mention, by Veen and colleagues (***Cannabis use and age at onset of schizophrenia, American Journal of Psychiatry 2004; 161:501-506)*** is of some consequence in its demonstration that cannabis use is associated with a significantly earlier onset of not only psychotic symptoms, but also prodromal social and occupational impairment and subsequent negative symptoms of schizophrenia, especially prominent for males. This reasonably well designed study gives an even handed discussion of the possible explanations for these findings, but as with many other studies in this area, fails to consider an important issue; when exactly is the onset of schizophrenia? This is often taken for research purposes to be the onset of psychotic symptoms (and thus ignoring the prodromal phase). This study is an improvement in that it does consider the prodromal symptoms of social and occupational dysfunction as a point of onset. However, this was assessed as marked impairment of school, interpersonal or work functioning. In reality, there are highly likely to be subtle cognitive impairments from a much early age in people that will eventually develop schizophrenia. The speculation that cannabis might be the cause of the early onset of schizophrenia in these patients (based on the assumption that cannabis use would usually precede the onset of social dysfunction I suppose) ignores the very real possibility that early cognitive and subtle social dysfunctions not significant enough to be identified in this retrospective study could be the cause of increased cannabis use at an early age. This issue has been poorly dealt with in the literature on the effects of cannabis on schizophrenia and limits the conclusions that can be drawn from this body of research.

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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
- 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)