Treatment Research News

Alcohol, Drugs and Addiction

August 2004 *Newsletter of the Treatment Research Interest Group* **Vol 8 No 2**

EDITORIAL

Time seems to be progressing faster and faster the more years I am around. Frighteningly we are now only a matter of weeks away from Spring and from our annual conference Cutting Edge. This year the Alcohol and Other Drugs (AOD) treatment workers conference is being held in Palmerston North at the Convention Centre from September 2-4. It looks to be an exciting programme and is always such a good opportunity to catch up with friends and colleagues from around the country.

The AOD field continues to grow and alter, even in the few months since our last newsletter. The fluidity of this sector is astounding and often difficult to keep up with. We are not alone in this regard. Reports I am currently reading on the Australian AOD workforce shows that they are experiencing the same issues we are in terms of staff retention and turnover. It appears the AOD field is a difficult one to stay with the world over. So congratulation to those of you who have been around for awhile (or even a little!) and continue to show dedication and resolve to stay in this very demanding and stressful area.

And welcome to another issue of the Treatment Research News. We are well into our second year of bringing the TRN electronically now and it seems to be going well and suitable to most people. It certainly gives us more flexibility in what we are able to give you in each issue. Remember we warmly welcome contributions to the newsletter – especially letters to the editor!!

In this issue we have some very absorbing reading. Alistair Dunn gives us an excellent rundown on the changes to the status of Naltrexone and points out some treatment issues the drug carries with it. Fraser Todd branches out a little from the norm and gives us a look at some books he has been reading and how wider reading can still impact on our AOD practice. Stuart Anderson from Higher Ground in Auckland has written a report on P making its way into treatment services. We have the NAC report as well as the TRIG Chairperson reports from Simon Adamson. Sean Sullivan also gives us a very relevant article on addiction and anxiety. Finally we have a brief update on research underway in the Dunedin and Wellington Schools of Medicine and Health Sciences.

I hope this issue provides you with some new and interesting knowledge to use in your practice or service. Happy reading.

Meg Harvey
Editor
14 August 2004

TRIG MEMBERSHIP

The executive committee of the Treatment Research Interest Group (TRIG) would once again like to take this opportunity to remind current members that membership of TRIG is annual. Currently we have 64 members, only 6 of whom have renewed 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 other drugs field in New Zealand.

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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PATIENCE REWARDED

Naltrexone became listed on the pharmaceutical schedule on June 1st 2004. This means that patients with alcohol dependence now have access to fully funded medication, provided the following conditions are met:

i) Application for Special Authority is made by a doctor working in an AOD service and;
ii) The patient is currently enrolled in a recognised comprehensive treatment programme for alcohol dependence in a service accredited against the NZ Alcohol and Other Drug Sector Standard or the National Mental Health Sector Standard.

Initial Approval is valid for 3 months, whereupon an application may be made for renewal for a further 3 months. An application for Special Authority has a turn around time of approximately one week. Approvals are granted for a maximum of 6 months per year. Application forms can be downloaded from the PHARMAC website www.pharmac.govt.nz (click on *Resources* and go to *Special Authority Forms*).

Note that although Naltrexone can also be used in the treatment of opiate-dependence, *it is not currently funded for this indication.*

Pharmacology

Naltrexone is administered as a single 50mg tablet taken orally once a day. It is an opiate antagonist and can be thought of as an oral, long–acting equivalent of Naloxone ("Narcan"). It is non-addictive and generally seems to be well tolerated. The most commonly encountered side-effects are nausea (10%) and headache (7%). It is not mood altering and may be used in conjunction with psychotropic medication.

Naltrexone and Opiate Dependence

A single dose of naltrexone will precipitate a sudden and severe Abstinence Withdrawal Syndrome (A.W.S.) lasting up to 48hrs in a current opiate user. It is therefore imperative that patients are opiate-free prior to initiating treatment. Patients taking Naltrexone who attempt to override the opiate blockade by self-administering high doses of opiates may risk overdose if the opiates (e.g. methadone) remain in the body beyond the duration of Naltrexone's effects.

Naltrexone treatment returns the opiate user's tolerance to 'normal', so that subsequent ingestion of opiates after a course of Naltrexone will have a much more profound effect than previously, increasing greatly the risk of overdose.

Naltrexone and the Liver

Naltrexone can cause liver damage when given in excessive (300mg per day) doses, and is contraindicated in acute hepatitis or liver failure. The manufacturer recommends that liver function tests (L.F.T.s) measured prior to commencing treatment should be no greater than three times the upper limit of normal. In reality Naltrexone usually results in improved liver function because patients drink less alcohol. Monitoring of L.F.T.s when the patient is reviewed after 12 weeks treatment would seem prudent.

Naltrexone and Pain Relief

Naltrexone will block conventional doses of opiate analgesia for 24-72 hrs. Patients taking naltrexone who require analgesia (e.g. trauma) therefore pose a challenge to the attending doctor.

Alternative analgesic options to opiates are:
- Regional anesthesia
- Conscious sedation with benzodiazepines
- Non-steroidal anti inflammatories (N.S.A.I.D.s)
- General Anaesthetic

If opiates are required:
- Use rapid acting opiate with short half life
- Much higher doses will be required
- Respiratory depression may be deep and prolonged
- Non-receptor actions of opiates due to histamine release may occur (e.g. facial swelling, itching, erythema, bronchoconstriction)

Clinical Requirements for Naltrexone Treatment

Patients referred for consideration of Naltrexone therapy must:
- Have alcohol dependence
- Be prepared to engage in a recognised treatment programme for 12 weeks
- Be opiate free for at least 7 days and have satisfactory L.F.T.s (< 3 times upper limit)

Patient Information

An outline of Naltrexone's mechanism of action and its effects should be explained to the patient:
- Reduced craving
- Decreased drinking days/ improved abstinence
- Reduced amount of alcohol consumed during relapse
- Risks in opiate users (A.W.S. & overdose)

The problems associated with opiate analgesia must be clearly explained, and are outlined in a useful bearer-card provided by the manufacturer, which patients can give to medical personnel. A "Frequently Asked Questions" patient information sheet is also available (for these resources contact Rachel Maurd, Baxter Healthcare 0800 229 837).

Summary

The long-awaited arrival of Naltrexone is a significant advance in the pharmacotherapy of alcohol dependence in New Zealand. AOD services have an important role in informing patients and fellow health professionals about Naltrexone and can expect an increase in demand as awareness grows. In particular, clinicians and patients alike need to be aware of the important interactions between Naltrexone and opiates.

Dr Alistair Dunn
Northland A&D Service

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National Addiction Centre

In the last issue of the *Treatment Research News* I highlighted the major change for the NAC in the signing of an addiction treatment workforce development contract. This has led to an expansion of the NAC research staff, with four new research staff having joined the team, and a further two research staff also joining as a result of specific research projects. All of these appointments have occurred this year.

Our first new appointment was Dr Mark Wallace-Bell who has taken up a position as Senior Lecturer, having moved from the UK with his family. Mark is a chartered psychologist who brings with him expertise in the area of smoking cessation. Mark will be involved in a full range of teaching and research activities within the NAC, and has already been invited to contribute to a number of forums in relation to smoking cessation. We have also been fortunate to recruit Dr Vicki Barratt as a Research Fellow. Vicki is based in Hamilton with Dr Murray Hunt and will be undertaking qualitative interviews with longstanding workers within the AOD sector and also with people who have left the AOD sector in the past two years. These "longstanding" and "exit" interviews will seek to better understand factors underlying retention difficulties previously identified as a concern for our field.

Our two new Assistant Research Fellows are Tracy Haitana and Tami Gibson, both of whom are venued within the Maori/Indigenous Health Institute (MIHI). Tracy and Tami will be involved in a number of training and research activities within the NAC, but primarily those with a Maori focus.

Dr Ria Schroder and Julia Davies have been appointed as Research Fellows. Ria has recently completed a PhD examining early sexual experiences of adolescent females and brings to the NAC expertise in qualitative research methodologies and working with youth. Julia is a nurse by training and has an impressive background in AOD and wider health research and publishing, including a period working at the National Addiction Centre, Maudsley Hospital, London. Ria's primary research activity is a study examining factors impacting the retention of youth in AOD treatment, while Julia will be contributing to the running of a randomised controlled trial of combined pharmacotherapy for patients with comorbid alcohol dependence and major depression.

Collectively these appointments represent a substantial increase in the research capacity of the NAC.

Additionally, the workforce development contract includes several components directly related to building treatment evaluation and research capability and capacity. These include developing a database that contains information on the addictions treatment workforce including research and evaluation capacity, and conducting research and evaluation that assists the development of effective interventions for a range of addiction related problems.

The range of NAC activities to be undertaken as part of the workforce development contract will be outlined in a plenary session at this year's Cutting Edge conference, which at the time of writing this is only a matter of weeks away. This presentation will include preliminary findings from the National Telephone Survey. This study will provide the opportunity to assess how the field has changed in the six years since the last survey was conducted, and examine empirical evidence of the level of qualifications and access to ongoing training in upskilling of the AOD workforce. This study will generate a wealth of additional information, including the profile of clients presenting to our services, current and optimal practice, and knowledge and attitudes of AOD workers. These data will be analysed and presented in a variety of forums over the coming year or so.

Dr Simon Adamson
Lecturer, NAC

I've Been Reading ...

I have just had this terrible thought. It has eased into a dreadful memory from a gloriously dismal southern youth-hood railing against bad fashion and badder music. The year, 1981, which defined so much of modern New Zealand (underarm, tally ho, Muldoon, no depression in NZ, 69,884,000 sheep and 30 too many rugby players) lies more in my memory for the worst song I have ever heard. "Don't Give Me Culture" by a band named after the volume control on a stereo. It has been intruding on my consciousness over the past few months, probably because much of my reading has been in an attempt to get to grips with the socio-cultural underpinnings of addiction. My reading lately has moved from journals to books, and in an attempt to rid myself of some inner noise I thought I should share some of these with you.

Substance Use and Abuse: Cultural and Historical Perspectives by Russil Durrant and Jo Thakker (Thousand Oaks: Sage Publications, 2003). I am in the process of reviewing this book for a journal so I mustn't pre-empt that review, but it is worth bringing your attention briefly to what is a very interesting and useful book. Russil Durrant is a psychologist based in Melbourne and Jo Thakker is based at the University of Waikato. Together they have written an informative overview of the diverse aspects of culture that impacts on and helps give rise to substance use problems. They don't shirk the political when it is important, their historical perspective is informative and they attempt with some success to integrate cultural aspects of addiction with biological and psychological. It is an important area for alcohol and drug clinicians and researchers to be aware of and this is one of the better introductions to it. My only real criticism is that while the authors take some steps to place the cultural alongside the biological and psychological, they don't really integrate these aspects as well as they might.

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The Emergence of P in AOD Services

Thank you for the opportunity to place an article in the TRN. Like so many providers of Alcohol and Other Drug service, Higher Ground is impacted by the sheer volume of clients seeking treatment for Pure (P) methamphetamine dependency. I hope this article provides an insight to our experience of working with these clients.

The initial contact with our service comes in the form of phone calls from concerned family/whanau/significant others. Higher Ground acknowledges the importance of others role in the process of recovery of the P clients.

Just as family/whanau/significant others have been impacted on by the severity of the clients behaviours in active addiction, it is integral for loved ones to be involved in the clients recovery and to that end their own healing. One of the cornerstones of the Higher Ground programme is the restoration of HOPE.

Higher Ground provides a 12-Step based treatment for individuals with severe dependency. The residential programme is 18-weeks in duration and takes up to 25 residents. Higher Ground is an adult programme and clients are 20 years of age and older. The programme is considered intensive and the majority of counselling provided is through various group counselling sessions. Clients entering treatment are assigned a Case Manager and receive regular individual counselling as part of this relationship. The programme places responsibility on individual members of the therapeutic community in the ongoing functioning of Treatment Centre.

The main motivation for P clients is generally externally focussed on either family/whanau/significant others or court pressure. Other factors that contribute to seeking change include major breakdown in social, work/study functioning and responsibilities. Health related issues such as drug induced psychosis do not appear to be a deterrent from abuse of the drug.

There is often a crisis occurring at the point of the initial interview, however maintaining engagement of the P client beyond first interview can be difficult.

Key characteristics we encountered with the P clients in data collected over a 12-month period identified that they are a lot younger than our traditional opiate dependent clients are. Out of 120 P clients presenting for treatment, 38% were females. Ethnicity comprised of European 81%, Maori 17% and Pacific Island 2%. Maori and Pacific Island clients were still under represented within the residential treatment centre. From the P clients admitted into the programme 78% had School C or above academic qualifications, an indication of the potential for these clients to achieve. Other drugs used with P were predominantly alcohol (36%) followed by cannabis (21%).

It became evident that gambling was also a key characteristic of the P client. P clients reported attempting to make money back that they had previously lost gambling or spent on purchasing their drug of choice. Attending Casinos was also used as a cover by some of the P dealers, collecting large amounts of money.

Our Consultant Psychologist, using the DSM-IV assessment tool interestingly identified an equal number of Post Traumatic Stress Disorder and Anti Social Personality traits within the P clients. Secondary personality traits included Narcissism. In both Primary and Secondary Personality traits significant trauma and shame based defences were present.

During the period we were recording data specifically about the P clients 55% were involved in some form of criminal activity to support their drug dependency. In that group 31% were dealing P. The 45% identified as 'non criminal activity' did not take into account effectively those who had stolen from family or friends, or family and friends that had enabled the P client in some way to continue their dependency.

Over half of the P clients were employed prior to entering the programme. Most had the possibility of returning to work on completion of the residential treatment programme.

The 18-week residential programme is broken into three phases each consisting of 42-day time slots. In the first phase we observed that should there be a shift or reduction in the initial external pressure on the P client they tended to discharge themselves, or behaved in a way that would make it necessary to discharge them. Those that were successful in moving into the second phase appeared to internalise motivation for themselves, in turn improving the retention rate.

A typical treatment plan for the P client includes in the first phase: education on chemical dependency, the 12-Step programme, self-esteem, denial and boundaries. Phase two deals significantly with issues of anger/resentments, loss and shame, family of origin issues (including family counselling) and relationships. The third phase focuses on issues of intimacy, forgiveness, relapse prevention and supportive accommodation.

Relapse prevention education is provided throughout the 18-week programme. Treatment planning needs to match the client's ability and be focussed on containment, re-establishing of healthy communication, and addressing shame based issues to minimise regression on completion/post treatment.

Family/whanau/significant others involvement is crucial not only in the initial containment of the P client, but in the lead up to addressing significant emotional issues, including shame. Installation of hope and the ability for P clients to express their experiences and in turn the families opportunity to respond and share their own experiences were recognised as key tools for change. Ongoing support post treatment was seen as vital.

After Care programmes for clients and their families are still being addressed, funding is an issue in developing this service. The P clients tend to be high functioning and their potential to return to work or study is positive. Their potential for long term recovery is also promising.

Stuart Anderson
Higher Ground Auckland

Message from the Chairperson

This August issue of the *Treatment Research News* closely precedes the 2004 Cutting Edge conference, to be held in Palmerston North. Cutting Edge is a diverse conference, serving a variety of needs. In addition to presentation of research findings, Cutting Edge is a venue for discussion of policy developments, new treatment initiatives, and professional development activities as represented by the various professional bodies taking the opportunity to hold meetings. Cutting Edge also represents an unparalleled opportunity for networking. Members of TRIG typically have a high rate of attendance at Cutting Edge, and are actively engaged in all of the mentioned activities. One remarkable thing about the conference that has struck me from time to time is the lack of conflict between these different interests. Each seems to be accepted as a valuable part of the treatment community. This seems to represent a real maturity in our field, and can only aid our ability to manage change as this occurs in the future. This may sound a little optimistic to some, and to be sure our field probably has its share of one-eyed proponents of various perspectives, but I do believe that the ongoing success of Cutting Edge represents real evidence of a field in good shape.

As a member of TRIG I am particularly interested to see that the value and relevance of research to the treatment community is promoted and I believe that Cutting Edge represents the best regular opportunity for this in New Zealand – without wanting to downplay the importance of the *Treatment Research News!* The value of the conference as a venue for discussing and disseminating research findings has been recognised by TRIG in its formal association as convenor of a "research stream" in past conferences, and an ongoing role in supporting the publication of a Treatment Research Monograph. Regrettably the 2003 Monograph has been delayed due to pressures brought on by the NAC signing the workforce development contract with the Ministry of Health. It is hoped that this Monograph will be sent to last year's Cutting Edge registrants by the end of this month, at which time it will also become available as a downloadable document from the National Addiction Centre website (www.addiction.org.nz). It is our intention that the process of editing and publishing this Monograph will be considerably streamlined for Cutting Edge 2004.

I look forward to seeing current and future members of TRIG at our annual general meeting, to be held on the Friday lunchtime of the conference. This meeting is an opportunity to discuss the future direction of TRIG and any issues that members wish to raise. I would like to encourage readers who will be attending the conference to join us for lunch, and to forward any topics for the agenda to Lindsay Stringer, NAC.

Dr Simon Adamson
TRIG Chairperson

Medical Schools AOD Research Update

Dunedin School of Medicine & Health Sciences

The team down in the Dunedin School of Medicine & Health Sciences has been busy for the past couple of years. In particular Gavin Cape has had a number of studies underway and resulting publications. He has written on Stigma and Movies (Acta Psychiatrica Scandinavica 2003: 107-169), the appropriateness versus practicality of Methadone Maintenance Treatment (New Zealand Bioethics Journal 2002: 2(3); 23-25) and the evaluation of alcohol & drug education and training in NZ medical students (along with Ivory, Sellman, Robinson, & Adams in Focus on Health Professional Education: A Multi-Disciplinary Journal 2002: 4(3); 61-74). This last study is continuing with a cohort follow-up of medical students and due for completion at the end of the year. Gavin has also contributed chapters in The management of alcohol and drug problems (Oxford University Press, 2002) and Alcohol And Drug Problems: Case Studies (2003).

Other research in Dunedin includes Kyp Kypri at the Accident Prevention Unit on college drinking assessment and intervention, and Geoff Noller in Anthropology on cannabis use and experiences. Finally J. Salmon is doing a Masters looking at birth experiences of mothers of FAS babies - due for completion at end of year.

Wellington School of Medicine & Health Sciences

Helen Moriarty has provided us with the following update: The Wellington School has just hosted Early Community Contact Week for 2nd year medical students. This is an annual course in which students get out into community agencies and work with community-based health professionals for an intensively timetabled week. It has always been regarded as an opportunity to showcase the work of addiction and related services with visits to: AA, NA, alanon, methadone clinics, Early Intervention service, alcohol services such as the Bridge, and others including the Soup Kitchen and the night Shelter. They are encouraged to listen to the narrative of clients of such services.

This year the course was the subject of a research project to evaluate the value students place on these learning experiences so early in their clinical career. All students submitted reflective learning journals at the end of the course. Informed consent was sought from the students to allow analysis of their anonymous learning journals. Results are still being analysed, but it was a surprise to the tutors to find that 66 of the class of 76 had given informed consent for their reflective journals to be used in this research. Students reported that the exposure to alcohol and drugs clients during this course had challenged their previous conceptions and given them a different view about addiction to drugs and alcohol. They used words such as "personally moving" and "transforming experience" to describe the insights that the clients gave them. This research will assist course convenors to understand the aspects of early clinical experiences that are most appreciated by students and plan where possible to retain and build on these.

Anxiety Amongst Addiction Clients: Is It Our Business?

Anxiety is a very common emotion. It can arise when we suddenly remember something we should have done, but have forgotten, and it's due now! It can also occur as part of a very primitive survival process when we identify a threat and, often, automatically set in process a 'fight or flight' response. It is likely that without a healthy appropriate fear of situations that may injure us, we might have a very short life indeed. We develop a perception of some risks at a very young age, which suggests some 'hardwiring' in our central nervous system. In other circumstances surges of adrenaline and arousal of our senses may result in an enhanced response – ask any athlete. In any of these situations a level of anxiety is a normal response to our environment, is functional and could generally be described as healthy.

However, for many people anxiety is not an occasional and functional event, but is the daily norm and serves little purpose. Anxiety is detrimental to their wellbeing, restricts their life, and has little relationship to an actual risk in their present environment. For many of these people, it may heighten the risk for addictive behaviour that may offer them a brief respite from anxious thoughts and feelings that persist on a daily basis.

A group of conditions

Anxiety disorders are not representative of a single condition. They are a 'complex grouping of specific mental disorders ranging from general anxiety disorder, panic attacks, obsessive-compulsive disorder to post-traumatic stress disorder' (Shaffer & Korn, 2002). This complexity may be the reason that we generally do not focus upon the identification of anxiety amongst our clients, but more perceive it as either separate from, or a consequence of, the presenting addiction.

Addiction and co-existing anxiety conditions

During the past decade I have noted that high levels of anxiety are common amongst those presenting for addictive behaviour. I recall one client who, despite an ability to attend the casino or gambling machine venue, would have to return to her home by 11am. At home she would then drink on average two bottles of wine to get her through the day. Her agoraphobia had persisted for more that fifteen years, ten of which she never stepped outside of her home. Others would describe debilitating panic attacks (and constant fear of them), describe rituals to avoid fear of contamination by germs (obsessive-compulsive behaviour), common phobias such as fear of embarrassment that have dogged their lives, and just daily worry over matters unlikely to occur. For many others, a traumatic event had occurred in their past which would often involve panic attacks in the present as images presented themselves, prompted by cues of the event.

In many of these cases, the addiction developed long after the anxiety condition and may appear to provide a dysfunctional means of alleviating or escaping the anxiety. The addictive behaviour may provide an 'instant gratification' effect of reliable, but temporary, control of the negative thoughts/ emotions that contrasts strongly with the uncertainty accompanying the anxiety based fear and provides a 'self-medication' of the condition.

In line with the tenets of learning theory, a promptly rewarded behaviour is far more likely to be learned than one with delayed rewards. For addictions, the negative consequences happen later (hangovers, financial consequences, health problems) and we find it hard to learn from our mistakes the greater distance the negative consequences are from the behaviour. Where the escape is from a powerful, persistent negative condition, there appears little wonder that such people will be at greater risk for addiction, and once learned, may find it harder to change the addictive behaviour.

Recognising anxiety

It is now somewhat accepted that the best practice is to identify as comprehensively as is reasonably possible, what issues clients present with, and provide interventions that may not only include the presenting condition, but also interventions that may address co-existing traits or disorders. Many of these co-existing issues may be below the client's awareness threshold or may not seem appropriate to discuss with the counsellor, especially if they are embarrassing. As an example of co-existing problems, more than two-thirds of problem gamblers will present with a depressive disorder (or many of its traits). This is a common feature for those affected by alcohol or drug misuse.

What is less recognised is that many will also be suffering from an anxiety condition. Indeed, some researchers in the field of gambling addiction state that the anxiety that problem gamblers present with is more representative of anxious depression (Shaffer & Korn, 2002) while others will be more explicit and state that there is 'insufficient data to support the theory that anxiety disorders are co-morbid with pathological gambling' (Crockford & el-Guebaly, 1998).

However, research appears to be limited and insufficient to make such a comprehensive statement, particularly in the field of problem gambling. In a small New Zealand study (Sullivan, 2003) 26% of clients responding to two anxiety screen questions answered at least one positively, while 17% responded positively to both questions and stated that they often found the fear of something stopped them enjoying life and often found themselves shaking or nauseous at the thought of something. Although the anxiety-depression association can make it difficult to extract purely anxiety or depression traits from, both of these questions appear to be outside of the agitated depression spectrum.

Anecdotally, in the absence of reliable evidence, it appears that sufficient anxiety exists with clients seeking help for addictions to warrant brief interventions such as screening. A brief screen may be the first step towards a more comprehensive assessment for anxiety.

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Why address anxiety in an addiction treatment setting?

There appear to be a number of factors for and against this approach.

Reasons for addressing anxiety may be:

- Clients may be using the addictive behaviour to self-medicate their anxiety. If the addiction is addressed, and the behaviour ceases, the anxiety condition may reassert itself with resulting high risk of relapse if anxiety is not addressed
- The anxiety may increase with the client's knowledge that they can no longer self-medicate with the addiction
- Anxiety may be the predominant condition, and addressing it may allow the client to experience improved wellbeing
- A holistic approach in dealing with client needs may be best practice and is becoming acknowledged (WHO, 2004)
- Clients with addictions prefer a 'one-stop shop' to deal with their issues and do not refer elsewhere well (Sullivan, 2003)
- Greater counsellor satisfaction through applying skills that may improve client outcomes.

Reasons for not addressing anxiety may be:

- Anxiety may not be associated with the presenting addiction if it does exist
- Anxiety may arise from the addiction and dissipate when the addiction is addressed
- Anxiety may affect a relatively small proportion of clients presenting for help for addictions, and resources are limited and best applied elsewhere
- Few counsellors may feel competent to address the anxiety
- Counsellors may feel that adding a further condition to address may over-reach an already extended workload
- Funding may not identify anxiety as a priority in addiction services.

Certainly further research is required to competently assess these possibilities. One recent barrier to referral out of an addiction service is the relative paucity of specialist counselling services dealing with anxiety and while many of the professionals with these skills may require payment, there is a difficulty with many impoverished clients affected by addiction.

Dealing with anxiety

There are a number of approaches that may reduce the effects of anxiety:

- Medication is a common approach, with many targeting specific anxiety disorders. For example SSRIs like Prozac have been often prescribed for panic disorders, social phobia, obsessive-compulsive disorder and where depression co-exists. Tricyclic antidepressants have been prescribed for generalised anxiety disorder, while benzodiazepines have been sparingly prescribed for a number of anxiety conditions, but have been an important drug for anxiety in the past
- Counselling alongside medication is common for high anxiety levels or counselling alone where levels are lower. Behavioural and CBT approaches are most common
- Relaxation therapy is a common approach that can teach self-help skills alongside counselling
- Acupuncture, hypnotherapy, diet management and alternative medications (rescue remedy, vitamin B, lavender, chamomile) are often used.

Conclusion

Anxiety may be a common condition for many of our clients who may not disclose so unless specifically screened. There may be little thought as to addictions and anxiety being connected or there may be shame that will prevent the client from discussing their behaviour. In many cases, the client will know that the fear is unreasonable, but this doesn't affect their stress. Many addiction counsellors will already have skills and an understanding of stress reduction strategies that can successfully be applied to identified anxiety disorders and traits. Many clients may not be aware of available help that can reduce daily anxiety substantially affecting their wellbeing. Upskilling of counsellors to deal with anxiety, alongside other common conditions such as depression, may be a future trend that has been signalled as appropriate by health authorities. This trend may benefit clients that seek from health professionals solutions for problems that they can no longer tolerate. As recipients of that trust we may be obliged to provide them with the best help we can as professionals, based upon knowledge and skills that result from ongoing research, practice and outcomes.

Dr Sean Sullivan
Registered Psychologist
Abacus Counselling & Training Services Ltd

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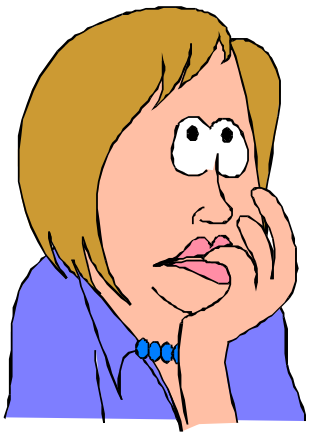


The intimate interaction between genetics and environment (which includes culture) in giving rise to the structure of the human brain and mind is increasingly understood and can inform practice and research. For a somewhat involved, but fascinating read on that topic, try…

The Blank Slate by Steven Pinker (London: Penguin Books, 2002)
Most of you will have heard of this book, such was the impact it has made on mainstream thinking. Pinker is a Professor of Psychology at Harvard University and has written several other books on the workings of the mind. This book succeeds in providing a lucid explanation of how human nature is shaped by an interaction of genes and environment, how each powerfully determine the functioning of the other, and how this relates to the many different facets of the experience of being human. The book has significant implications for human development and as such, contains important information that helps us understand people with alcohol and drug problems better. It is not understating the case to suggest that the material Pinker draws together here represents a significant paradigm shift in the way we think of what it is to be a person.

Writing of important paradigm shifts, the doyen of the history of ideas is probably James Burke. Burke has been around a fair while and was responsible for an intriguing television documentary a few years ago called "Connections". **The Day the Universe Changed** (by James Bourke, Boston: Back Bay Books, 1995) was first published in 1985 and I have read it several times in the past. This book outlines eight major paradigm shifts in thinking that have changed the world, from the re-discovery of Greek philosophies and science intermingled with Muslim philosophies with the ending of the Muslim rule of Spain and its great libraries, through the discovery of perspective in painting and architecture and how that lead to the undermining of religion and the sparking of modern science through the major discoveries of the enlightenment and the development of gunnery, to the climate changes that gave rise to the Industrial Revolution, and on and beyond the "discovery" of the theory of statistics due to the development of battlefield surgery stations during the French Revolution. "Progress" follows an unpredictable and at times chaotic path which Burke outlines in very readable form and in doing so provides an important account of how science arose as a way of seeing the world.

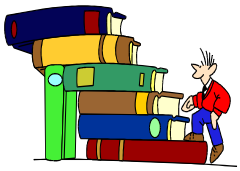
The Heather and the Fern: Scottish Migration & New Zealand Settlement edited by Tom Brooking and Jennie Coleman (Dunedin: University of Otago Press, 2003) is interesting on a personal level, but also documents aspects of the Scottish immigrations to New Zealand and its effects on our culture. Many consider our dominant culture to be Pakeha, or New Zealanders and are proud to think of themselves in this context. However, for various reasons the components that have contributed to this "mainstream New Zealand culture" are being recognized and the fact that they don't sit easily together sometimes is, I think, very important to acknowledge in understanding our own social fabric, and how mainstream culture interacts with other cultures in New Zealand, including Tangata Whenua.

In this context, three landmark books have recently been published placing important aspects of Maori belief systems in the public arena. I won't go into detail here, but simply wish to let you know about these books if you haven't come across them. **Tikanga Maori by Hirini Moko Mead** (Wellington: Huia Publishers, 2003) is described as an introduction to tikanga Maori, but is much more than most introductions. Among other things, Mead is a highly respected academic in this area and rights with depth and authority. **Tohunga Hohepa Kereopa by Paul Moon** (Auckland: David Ling Publishing Limited, 2003) outlines the life and development of the Tuhoe Tohunga, Hohepa Kereopa. A fascinating read, the significance of the book in documenting aspects of Kereopa's development in his calling is added to by the fact that he allowed his story to be written by a Pakeha. In **The Woven Universe: Selected Writings of Rev. Maori Marsden, ed. Te Ahukaramu Charles Royal** (published by the Estate of Rev. Maori Marsden, 2003), collected writings of the great Maori Marsden are collated, outlining his knowledge and experiences in the wide range of roles he undertook, explaining many aspects of more traditional Maori beliefs as he does so. I found all three fascinating in their own right, but it is especially important to respect the meaning of the contents of these books being made public and accessible to all New Zealanders, especially given our current political and cultural circumstances.

And finally, if you must listen to some really badder music that was wholey responsible for driving many youngsters to seek alternative states of consciousness in the early 80's (apologies if you actually like this song), the Knobz song mentioned above can be downloaded in MP3 format at - http://www.geocities.com/dagsyfm/culture.html

… but honestly, I wouldn't bother. "Da da da dum dah… a beehive boy oh yeah…"

Fraser Todd
Senior Lecturer, NAC



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Treatment Research Interest Group (TRIG)

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The objectives of TRIG are:-

- *To foster interest in scientific research on treatment of people with alcohol and other drugs related problems in New Zealand.*
- *To disseminate and promote research findings related to effective treatment of people with alcohol and other drugs related problems within New Zealand.*
- *To support the development of improved treatment services for people with alcohol and other drugs related problems in New Zealand.*

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